STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465139	A. BUILDING _____ B. WING _____	06/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN TERRACE ALZHEIMERS	1201 EAST 4500 SOUTH SALT LAKE CITY, UT 84117

(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) COMPLETION DATE
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not promote care for residents in a manner and in an environment that enhanced each resident's dignity and respect in full recognition of his or her individuality. Specifically, the facility staff members did not redirect 3 of 18 sampled residents and one supplemental resident who were wandering into other residents' rooms and/or going through the other residents' belongings and/or sleeping in the other residents' beds. Resident identifiers: 11, 12, 18. Supplemental resident: 34 Findings included: 1. Resident 11 was admitted to the facility in December of 2004 with diagnoses that included dementia with agitation, osteoarthritis and persistent mental disorder. Resident 11 was residing in a locked unit. On 6/26/05 at 8:00 AM resident 11 was observed lying in resident 29's bed. Resident 29 was not in his/her room at this time. (Resident 29 was readmitted to the facility in June of 2002 with diagnoses that included osteoporosis and dementia.) On 6/27/05 at 8:00 AM resident 11 was observed lying in resident 30's bed. Resident 30 was not in	F 241	*Garden Terrace submits this Plan of Correction (POC) as required by law. This POC does not constitute an admission of liability on the part of the facility, nor does it constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding the findings are correctly applied.* 7/26/05 POC acceptable pending plan date 7/22/05 Bureau Utah Department of Health 631808 HD JUL 22 2005 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Stacey A. Ward — Executive Director — 7/22/05

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.

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F 241	Continued From page 1 his/her room at this time. (Resident 30 was admitted to the facility in December of 2004 with diagnoses that included dementia, arthritis and hypertension.) On 6/27/05 at 8:21 AM resident 11 was observed lying in resident 29's bed. Resident 29 was not in his/her room at this time. On 6/27/05 at 8:45 AM resident 11 was observed lying in resident 29's bed. Resident 29 was not in his/her room at this time. On 6/27/05 at 10:20 AM resident 11 was observed walking in the hallway eating a fig newton. Then resident 11 went into resident 29's room and laid down on resident 29's bed. Resident 29 was not in his/her room at this time. On 6/27/05 at 12:20 PM resident 11 was observed lying on resident 29's bed. Resident 29 was not in his/her room at this time. On 6/27/05 at approximately 12:30 PM the surveyor was observing lunch on the locked unit where resident 11, resident 29 and resident 30 resided. A loud piercing scream was heard from resident 30's room. A facility nurse and CNA 4 ran into the room and found that resident 34 had wandered into resident 30's room while he/she was lying in his/her bed. Resident 34 was removed from the room and then CNA 4 was interviewed. CNA 4 stated that resident 30 hates it when resident 11 or resident 34 enters his/her room. On 6/28/05 at 9:00 AM, resident 30 approached a surveyor sitting at the nurses station and stated	F 241	F 241 NOTE: The 2567 states: " CNA 4 stated that resident 30 hates it when resident 11 or resident 34 enters his/her room." CNA 4 is not listed on the identifier list. Resident 34 does not reside on the same unit as resident 30. The plan of care for residents 11, 12 and 18 has been reviewed. All residents have the potential to be affected by residents wandering into other residents' rooms and going through their belongings. Staff have been inserviced regarding providing privacy for all residents, redirecting residents when they are wandering into resident rooms or going through the belongings of other residents. Random monitoring will be performed by the Social Service Director or designee weekly to ensure residents are being protected. Charge nurse will monitor daily that staff is engaged in ensuring resident needs are met and diversionary tactics are being used with wandering residents. Line staff, including recreation, will continue to engage residents in diversional activities and redirection for wandering. The results of this monitoring will be brought to the facility QA Meeting for 6 months. Executive Director will monitor. Compliance date: July 22, 2005	

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F 241	Continued From page 2 that, "These men are horrible here. They just go into your room and lay in your bed. It's horrible."	F 241		

2. On 6/26/05 at 1:55 PM, an aide put resident 2 in bed while resident 18 was sitting in a chair in his room. The aide did not pull the curtain or close the door. She laid resident 2 down, and undid his boots and his pants.

3. On 6/26/05 at 1:57 PM, Resident 12 wandered into resident 31's room. He yelled and threatened to throw a can of coke at her if she did not leave. An aide ran across the hall and removed resident 12 from the room and placed resident 12 in the hall. Resident 12 then wandered into room 507. On 6/27/05 at 9:03 AM, resident 31 was in his room. Resident 12 removed the Velcro stop sign from resident 31's door and entered the room. Resident 31 yelled, "Get out, I'm tired of telling you to get out." Resident 12 left the room. Later that morning at 11:45 AM, resident 12 wandered into resident 6's room.

On 6/26/05 at 3:42 PM, resident 12 was in room 501, and was observed to go through the middle and bottom drawers of resident 6's nightstand.

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F 241	Continued From page 3 On 6/26/05 at 3:44 PM, resident 12 was observed in the room of resident 14, while a CNA performed personal cares for resident 14. The CNA did not provide privacy for resident 14. Then the CNA left the room without escorting or redirecting resident 12 out of the room. On 6/27/05 at 9:03 AM, resident 12 wandered into resident 31's room. Resident 31 yelled, "Get the h*** out." On 6/27/05 at 9:15 AM, resident 31 was interviewed. He stated,"I don't want her (resident 12) in my room. The only way to get her out is if I yell at her. She has gone through my drawers and she takes paper cups out of the trash, wipes them with a paper towel, and then replaces them for us to use again."	F 241		
F 278 SS=B	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a	F 278		

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F 278	Continued From page 4 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not maintain Minimum Data Set (MDS) assessments that were complete and accurately documented for 4 of 18 sample residents. Residents: 1, 2, 3, 11 Findings included: 1. Resident 1 was admitted to the facility in January 2005 with diagnoses that included: cerebral vascular accident (CVA), hypertension and other persistent mental disorder. Resident 1's admission MDS dated 1/31/05, section K2 documented resident 1's height as 63 inches and weight as 115 pounds. Resident 1's quarterly MDS dated 4/22/05, section K2 documented resident 1's height as 63 inches. On 6/27/05 LPN 4 was asked to obtain resident 1's height. Later in the day on 6/27/05, LPN 4 reported that resident 1 was 68 inches in height. On 6/29/05 at 11:15 AM, a interview was	F 278	F 278 Residents' 1, 2, and 11 charts have been reviewed with significant correction MDS's completed to ensure they are accurate. We have discovered that the original 5-day MDS for Resident 3 was inactivated (due to the fact that it was incorrect), with a new MDS completed that had correct information. However, the correct MDS was never printed for signatures and thus never placed in the chart. The survey team therefore only had access to the incorrect MDS. The correct information has been printed and placed in the chart. All residents have the potential to be affected by inaccurate MDS's. As each resident's MDS review date or a significant change occurs, the interdisciplinary team will review the MDS to ensure it is accurate, reflecting the current status of the resident. An inservice on the RAI/MDS process was given to both of the MDS coordinators. Inservicing regarding proper height and weight measuring was given to the nursing staff. The Director of Nursing or designee will audit 5% of MDS's for accuracy weekly. Results of this monitoring will be brought to the facility QA meeting for 6 months. DON will monitor. Compliance date: July 22, 2005	

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F 278	Continued From page 5 conducted with the Director of Nursing and Administrator of the facility. They stated that resident 1's height was 65.5 inches. 2. Resident 11 was admitted to the facility in December of 2004 with diagnoses that included dementia with agitation, osteoarthritis and persistent mental disorder. A review of Resident 11's medical records was completed on 6/29/05. a. Resident 11's admission MDS dated 1/5/2005 was reviewed on 6/27/05. It was documented in section G 1 - Activities of Daily Living (ADL) self performance and ADL support provided section that resident 11 needed: -extensive assistance with bed mobility (moving to and from lying position, turns side to side and positions while in bed) with one person physical assist, -limited assistance with transferring (moving from bed to chair, from sitting to standing) with one person physical assist, -limited assistance with one person physical assist with walking in room and in corridor. b. Resident 11's quarterly MDS dated 4/1/2005 was reviewed on 6/27/05. It was documented in section G 1- ADL self performance and ADL support provided section that resident 11 needed: - extensive assistance with bed mobility with one person physical assist, - extensive assistance with transferring with one	F 278		

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F 278	Continued From page 6 person physical assist, -extensive assistance with one person physical assist with walking in room and in corridor. c. Resident 11's interdisciplinary progress notes were reviewed. It was documented on 12/31/04 that resident 11 was: "Pacing aimlessly in halls." It was documented on 1/1/05 that resident 11 continues "to ambulate ad lib (without) direction. It was documented on 1/23/05 that resident 11 "wanders in and out of (every) room." It was documented on 3/30/05 that resident 11 was "wandering and pacing up and down the hall room to room and that he had a "steady gait." It was documented on 4/10/05 that resident 11 "continuously wandered this AM." RN 2 was interviewed on 6/27/05 at 9:00 AM. RN 2 stated that he has worked with resident 11 since January of 2005. RN 2 stated that he has observed resident 11 ambulating without difficulty since January of 2005. On 6/29/05 at 11:15 AM, the DON (Director of Nursing) and the Administrator were interviewed. The DON stated that resident 11's admission and quarterly MDS documenting that resident 11 needed assistance ambulating was incorrect. 3. Resident 2 was readmitted to the facility on 5/5/05 with diagnosis including dementia with behaviors, constipation, Alzheimers, and altered level of consciousness. Medical records were reviewed on Residents 2 from 6/27/05 through 6/28/05.	F 278		

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F 278	Continued From page 7 On 5/12/05 a significant change five day MDS assessment was done for Resident 2. In section I. (Disease Diagnoses) resident 2 was coded as having Diabetes Mellitus. A record review revealed Resident 2 had no diagnosis of Diabetes Mellitus nor was he admitted with the diagnosis of Diabetes Mellitus. 4. Resident 3 was readmitted to the facility on 4/25/05 with diagnosis including constipation, dementia, congestive heart failure, hypertension and Alzheimers. Medical records were reviewed on Residents 3 from 6/27/05 through 6/28/05. On 5/2/05 an admission five day MDS assessment was done for Resident 3. Section M (Skin Condition) codes Resident 3 as having no pressure or stasis ulcers. A record review revealed Resident 3 was admitted to the facility with a scab over her coccyx area. On 4/28/05, it was documented on the pressure ulcer assessment record that resident 3 had a stage II pressure ulcer on her coccyx. During the five day look back period for the admission five day MDS assessment, Resident 3 would have had the pressure sore on her coccyx. On 6/29/05 at 11:15 AM, the DON (Director of Nursing) and the Administrator were interviewed. The DON stated that resident 2's and resident 3's MDS's were incorrect.	F 278		
F 309 SS=G	483.25 QUALITY OF CARE	F 309		

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F 309	Continued From page 8 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. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined that for 1 of 18 sample residents, the facility did not 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. Specifically, Resident 2 did not receive assistance with activities of daily living, toileting or position change from 10:00 AM through 1:52 PM on June 27, 2005. Resident 2 also, was not offered and did not receive a meal, snack, or fluids during the above mentioned time frame on June 27, 2005. Rsident identifiers: 2 Findings included: Resident 2 was readmitted to the facility on 5/05/2005 with diagnosis that included Alzheimers, dementia with behavioral disturbances, constipation, and altered level of consciousness. Medical Records for Resident 2 were reviewed from June 27, 2005 through June 29, 2005.	F 309	F 309 Resident 2 has been assessed and his careplan reviewed to ensure appropriate staff assistance with ADL's is being provided to maintain the highest practicable standard of care. All residents have the potential to be affected. The facility will continue to provide a standard of care in accordance with accepted professional standards and the needs of each individual resident aimed at maintaining their highest practicable physical, mental and psychosocial well-being. Nursing staff have been inserviced regarding providing timely and proper ADL care, skin care and ensuring food services are adequate. Resident weights are taken weekly to ensure close monitoring. The Interdisciplinary Team has been inserviced regarding the careplan process and the necessity to update the careplan as needed. The DON or designee will monitor resident cares daily. Results of this monitoring to be brought to the facility QA meeting for 6 months. DON to monitor. Compliance date: July 22, 2005	

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F 309	Continued From page 9	F 309		

Altered Urinary Elimination Care Plan effective 5/5/2005 identified Resident 2 as being incontinent with the goal of remaining clean and dry during waking hours and being toileted every two hours and as needed. Approaches included the following: Resident 2 should be toileted every two hours and as needed and toileted upon rising and before and after meals. The Nutritional Care Plan effective 5/13/2005 documented that Resident 2 is "Dependent for food/fluids, Altered Ability to Feed Self". Approaches for the nutritional care plan are, "Extensive assistance, placement at table where resident is fed and encouraged, encourage fluids every 2 hours, and resident will be offered at least 8 ounces of fluid three times a day between meals."

Continous observations on June 27, 2005 from 10:00 AM to 2:00 PM revealed the following:

1) At 10:00 AM on June 27, 2005 Resident 2 was observed in his room sitting in his wheelchair .

2) At 10:45 AM Resident 2 wheeled himself out of the room and into the hallway.

3) At 11:00 AM Resident 2 was viewed out in the hallway by the nurses' station.

4) At 11:50 AM Facility Staff 1 came down the hall and stopped and spoke with Resident 2. After speaking with Resident 2, Facility Staff 1 stood and told CNA (Certified Nursing Assistant) 1 that, "He (Resident 2) smells like he needs some assistance.

5) At 11:52 AM CNA 1 wheeled Resident 2 into his room and left the room . Resident 2 remained

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F 309	Continued From page 10 in his room facing the window. 6) At 11:55 AM two surveyors entered the room and Resident 2 was emanating an odor not unlike feces. 7) At 12:00 PM another surveyor entered the room and verified that Resident 2 was emanating an odor not unlike feces. 8) At 12:30 PM Resident 2 was in his room still facing the window. Resident 2 asked the surveyor if he/she could take him to the toilet. 9) At 1:00 PM RNA (Restorative Nurse's Aide) 1 entered the room to assist Resident 2's roommate. 10) At 1:15 PM the Rehabilitation Aide was seen assisting Resident 2's roommate. 11) At 1:15 PM Resident 2 was seen facing the doorway, sitting in his wheel chair with his lap buddy on the floor next to the wheel chair. Resident 2's Left Thera-boot was not on his foot and a cut could be seen on his left second toe. The foot rests for the wheel chair were swung off to the side of the wheel chair next to the wheels. Resident 2 asked surveyor if he/she could take him to the toilet. 12) At 1:30 PM CNA 2 was seen entering Resident 2's room and asked Resident 2 if he would like to use the restroom. 13) At 1:32 PM CNA 2 noticed the cut on Resident 2's toe and went to get the nurse. 14) At 1:49 PM LPN (Licensed Practical Nurse) 1	F 309		

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F 309	Continued From page 11 applied a dressing to the 2nd toe on the left foot of Resident 2. 15) At 1:52 PM Resident 2 was assisted to the bathroom. Fecal Matter was observed to be in the brief that Resident 2 was wearing. 16) At 1:55 PM all trays had been removed from the dining area. 17) At 2:10 PM two surveyors, the DON (Director of Nursing), and CNAs' 1 and 2 performed a skin check on Resident 2. An area of excoriation (Mosby's Medical, Nursing, and Allied Health Dictionary 5th edition defines excoriation as: an injury to a surface of the body caused by trauma, such as scratching, abrasion, or a chemical or thermal burn.) could be visualized on Resident 2's scrotum and an area of redness could be seen on the coccyx. 18) During the continous observation period no fluids, snacks or meals were offered or provided. It was documented on the most recent weekly skin assessment dated June 3, 2005 that Resident 2 had intact skin. The pressure ulcer assessment record indicated that on June 20, 2005 pressure sores were visualized on both heels. Treatment was initiated at that time. The next entry on the pressure ulcer assessment record is on June 23, 2005 regarding the same two pressure sores on Resident 2's heels. No other entries could be found on the pressure ulcer assessment record. No documentation could be found regarding the excoriation on the scrotum and the redness on the buttocks prior to June 27, 2005. Nursing	F 309		

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F 309	Continued From page 12	F 309		

note entry dated June 27, 2005 at 2:00 PM stated, "Noted slight redness to left buttock and small discolored area on scrotum. Not open. Order for Xenaderm twice daily and as needed per protocol. Also sustained small skin tear to right 2nd toe. Order for bacitracin and band-aid daily til healed. Family notified."

During an interview on June 28, 2005 at 12:27 PM with LPN 2 she stated that Resident 2 was continent most of the time, wore briefs at all times, was toileted every two hours and could not use the call light. LPN 2 further stated that Resident 2's, "Bum was good until yesterday, he (Resident 2) had excoriation on his bum and scrotum."

On June 28, 2005 at 12:52 PM CNA 2 was interviewed. CNA 2 stated the Resident 2 needs help to stand, is continent but he has to be asked if he needs to go to the bathroom and that he has fragile skin.

On June 28, 2005 at 1:15 PM CNA 1 was interviewed regarding Resident 2. CNA 1 stated that Resident 2, "was continent and incontinent, sometimes we take him to the toilet and sometimes we just check him." CNA 1 stated that, "Everyone is toileted before lunch at 11:30 AM." CNA 1 stated during the interview that she did not see Resident 2 at lunch on June 27, 2005.

During an interview on June 29, 2005 at 11:15 AM with the DON and the Administrator, the DON confirmed that on June 27, 2005 Resident 2 did not receive lunch.

After careful, continuous observation it was confirmed that Resident 2 was neither changed/

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN TERRACE ALZHEIMERS	1201 EAST 4500 SOUTH SALT LAKE CITY, UT 84117

(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) COMPLETION DATE
F 309	Continued From page 13 toileted, nor repositioned for 3 hours and 52 minutes. Also confirmed through said observation, Resident 2 received no form of food or fluid intake for the above mentioned time until 2:30 PM when observations ceased.	F 309		
F 323 SS=E	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility did not ensure that the residents' environment remained as free of accident hazards as possible. Findings included: The Sunflower shower rooms was observed on 6/26/05, at approximately 7:30 AM. The shower room door was observed to be held open by a trash can, which remained opened until 10:30 AM. Observations inside the shower room revealed a open spray bottle of Oasis 531 on a counter. There was a aerosol can of Re-Act Malodor Neutralizer on a counter. The directions on the Re-Act Malodor bottle state, if swallowed do not induce vomiting, contact physician immediately. The Material Safety Data Sheet for Oasis 531 documented to flush eyes at once with cool running water. Remove contact lenses and	F 323	F 323 Facility rounds have been completed and all chemicals secured. Cabinets with locks have been examined to ensure all locks are in proper working order, with all recreation cabinet locks changed on 7/6/05 to ensure they are working properly. All residents have the potential to be affected. The facility will continue to maintain a safe environment free of accident hazards. Staff have been inserviced regarding the importance of ensuring cabinets and doors are secured and in good repair. Department heads or designee are conducting daily rounds to ensure continued compliance. The Recreation Director or designee will do weekly audits and rounds to ensure all recreation supply cabinets are secured. All audits will be brought to facility QA meeting and reviewed for 6 months. Staff Development Coordinator to monitor. Compliance date: July 22, 2005	

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F 323	Continued From page 14 continue flushing for 15 minutes, holding eyelids apart so as to rinse entire eye. Seek medical attention immediately. Immediately flush skin with plenty of cool running water for at least 15 minutes while removing contaminated clothing and shoes. Discard or wash before reuse. If swallowed: Rinse mouth at once; then drink one or two large glasses of water. Do not induce vomiting. Never give anything by mouth to unconscious person. If inhaled immediate move to fresh air. On June 26, 2005 at 2:00 PM the Arts and Crafts closet located in the Morning Glory Way Dining Area was observed to be unlocked. Inspection of the unlocked cabinet revealed a 1/2 full 6 ounce bottle of Acetone Nail Polish remover, a 19 ounce bottle of Ajax dish soap with 6 ounces left in the bottle, and 7 pairs of scissors. During an exit conference on June 27, 2005 the Assistant TRT (Therapeutic Recreational Therapist) acknowledged that the lock on the cabinet in the Morning Glory Way Dining Area was broken.	F 323		
F 367 SS=D	483.35(e) DIETARY SERVICES Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview it was determined, that for 1 of 18 sampled residents the facility did not provide a diet in the appropriate form and/or the appropriate	F 367		

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F 367	Continued From page 15 nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the treatment and plan of care. Specifically, Resident 3 received a regular diet for all meals instead of the prescribed mechanically soft diet. Resident identifier: 3 Findings included: Resident 3 was readmitted to the facility on 4/25/2005 with diagnoses including Alzheimer's, constipation, congestive heart failure, hypertension, and dementia. Medical records for Resident 3 were reviewed from 6/26/2005 through 6/28/2005. A Speech Therapy evaluation dated 5/6/2005 documented that, "Pt. demonstrates oral stage dysphagia as well as signs and symptoms of pharyngeal stage dysphagia. Skilled Speech Therapy required to address this deficit." Documented goals were, "Pt. will tolerate mechanical soft diet with regular liquids without signs and symptoms of aspiration." A physician's order dated 5/9/2005 documented, "Speech Therapy clarification / Diet change: discontinue regular diet, change to mechanical soft." A dietary communication slip dated 5/9/2005 documented, "Discontinue regular diet, change to mechanical soft diet." The computer print out of the therapeutic diets provided to the surveyors on 6/27/2005 documented that Resident 3 was to receive a Regular diet with salt and pepper upon request.	F 367	F 367 The chart has been reviewed and resident #3 is now receiving the appropriate diet as prescribed by her physician. All residents have the potential to be affected. All resident charts and tray cards have been reviewed to ensure they are receiving the appropriate diet as prescribed by their physician. Dietary and Nursing Staff have been inserviced on the dietary communication process. Nursing staff have also been inserviced on diet consistencies and the appropriate protocol for upgrading and downgrading resident diets. The Dietary Services Manager or designee will audit diet tray cards daily to ensure proper diet and consistency is being given to each resident. Results will be brought to the facility QA meeting for 6 months. Dietary Services Manager to monitor. Compliance date: July 22, 2005	

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F 367	Continued From page 16 Observation of several meals revealed the following: 1) On 6/26/2005 Resident 3 received a Regular diet for breakfast. 2) On 6/27/2005 Resident 3 received a Regular diet for breakfast and lunch. 3) On 6/28/2005 Resident 3 received a Regular diet for breakfast. 4) On 6/29/2005 Resident 3 received a Regular diet for breakfast. On 6/29/2005 at 10:30 AM Facility Staff 2 was interviewed regarding Resident 3's diet. Facility Staff 2 stated that Resident 3 was on a mechanical soft diet and the meat that Resident 3 receives on her tray should be chopped up by staff or come from the kitchen already chopped with extra gravy. Facility Staff 2 further stated that the staff would not need extra training as to how to feed Resident 3 due to the fact that the meat should come already chopped from the kitchen. When questioned regarding the Regular breakfast tray Resident 3 received, Facility Staff 2 stated, " Oh now that you mention it, she (Resident 3) has been receiving a regular diet." On 6/28/2005 at 1:00 PM RN 1 was interviewed regarding Resident 3's diet. When questioned about the type of diet Resident 3 was to receive RN 1 stated that Resident 3 received a regular diet.	F 367		
F 369 SS=D	483.35(g) DIETARY SERVICES The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced	F 369		

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F 369	Continued From page 17 by: Based on observation, medical record review, and staff interview it was determined that for 1 of 18 sampled residents the facility did not provide special eating equipment and utensils for residents who need them. Specifically, Resident 6 was not provided a plate guard or weighted utensils during meals. Resident identifier: 6. Findings Included: Resident 6 was admitted to the facility on 6/4/2005 with diagnoses including, hypertension, esophageal reflux, congestive heart failure, macular degeneration, hypothyroidism, aphasia, and constipation. Medical records for Resident 6 were reviewed from 6/27/2005 through 6/28/2005. According to documentation Resident 6 sustained a left olecranon elbow fracture on 6/4/2005. Resident 6 had a splint placed on the left arm to stabilize the fracture until surgery could be done. A Nutritional care plan dated 6/13/2005 documented that Resident 6 was to receive a plate guard and weighted utensils during meal times due to an altered ability to feed self. A Nutritional Risk Assessment dated 6/21/2005 indicated that Resident 6 needed to have a plate guard and weighted utensils with meals. A computer printout of the therapeutic diets provided to surveyors on 6/27/2005 indicated that Resident 6 was to receive a plate guard and weighted utensils during meals.	F 369	F 369 Resident #6 has been assessed and is now receiving the appropriate assistive devices and utensils as order by her physician. All residents with assistive devices and utensils have the potential to be affected. 100% of tray cards and diet orders have been reviewed to ensure appropriate devices and utensils are noted when necessary. Nursing staff have been inserviced regarding ensuring residents with such orders receive the proper devices and utensils for dining. Dietary staff have been inserviced to ensure the appropriate devices and utensils are being sent with each resident's tray. The Dietary Services Manager or designee will audit trays daily to ensure the appropriate devices and utensils are present for each resident. Results will be brought to the facility QA meeting for 6 months. Dietary Services Manager to monitor. Compliance date: July 22, 2005	

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F 369	Continued From page 18 On 6/27/2005 observation of breakfast showed that Resident 6 was provided a plate guard, but the plate guard was placed on the back of the plate not the front making the plate guard non-functional. Observation of breakfast on 6/27/2005, breakfast and lunch on 6/28/2005 and breakfast on 6/29/2005 showed Resident 6 was not provided a plate guard or weighted utensils. On June 28,2005 at 1:15 PM CNA 1 was interviewed regarding the assistive devices that Resident 6 was to receive. CNA 1 stated "I have never seen her (Resident 6) with a plateguard or weighted utensils." On June 28, 2005 at 1:00 PM RN 1 was interviewed regarding Resident 6's dining experience. RN 1 stated that Resident 6 needed assistance with meals including her meat cut up, cartons opened and within reach but did not have a plate guard or weighted utensils.	F 369		
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 and interview the facility did not store, prepare, distribute, and serve food under sanitary conditions. Findings included:	F 371		

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F 371	Continued From page 19 On 6/26/06 at 7:35 AM, observations were done in the kitchen. 1. The walk-in refrigerator had the following items with no date/label: 4 packages ground beef of 5 lbs. each, sauerkraut in clear plastic container uncovered. The walk-in freezer had four unmarked bags in brown paper unlabeled and undated. 2. The reach in refrigerator had opened pineapple in container with no label or date, and a carton of cottage cheese with expiration date of 6/22/05. 3. There were 12 thawed health shakes 4 oz individual cartons on a tray in the refrigerator. They were not dated. There was a crate of thawed health shakes with two dates on it 6/20 and 6/23. The individual shakes were not dated. 4. A box of bacon dated 6/11 was open with the bacon uncovered. 5. The can opener had food residue on it. 6. The kitchen aid mixer on the counter had dried splattered food particles on the neck. 7. The handle of the flour bin had peanut butter smeared on it. 8. The log for the reach in refrigerator showed on 6/13/05 a temperature of 45 degrees Fahrenheit. 9. A kitchen staff person had a pony tail with no hair net. On 6/27/05 at 7:10 AM, observations were made	F 371	F 371 All identified issues regarding appropriate storage, preparation, distribution and sanitation in the kitchen have been remedied. All residents have the potential to be affected. Dietary staff have been inserviced regarding the rotation of stock, labeling and dating foods, cleaning schedules, hairnet usage, temp logs, appropriate use of gloves and hand washing. The CNA who sneezed into her hand in the Morning Glory Dining Room has received a 1:1 inservice regarding infection control procedures. All staff have been educated regarding appropriate infection control during resident dining. The Dietary Service Manager or designee will do rounds daily to ensure the kitchen is meeting appropriate standards of storage, preparation, distribution and sanitation. Results will be brought to the facility QA meeting for 6 months. Dietary Service Manager to monitor. Compliance date: July 22, 2005	

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F 371	Continued From page 20 in the kitchen. 1. A female kitchen staff was wearing a hat with no hair net and hair was hanging out of the hat. 2. The cook and a tray line worker, who were wearing gloves, were observed to put items in the garbage by lifting the garbage can lid with their hands and then proceeded to serve food without changing their gloves or washing their hands. 3. The Spring Pak dish plate warmer that was being used for breakfast dishes had food on top and had food on the metal warmer disc that included dried rice particles, crumbs and dried, splattered food. 4. A kitchen staff worker was observed to change the thaw date on health supplements on a tray from 6/23 to 6/27, extending the expiration date by 4 days. A supervisor was interviewed on 6/27/05 at 7:30 AM and she said the date should have remained 6/23, which was the thaw date on the Sysco delivery label. The manager said that the delivery date on the label is the facility's thaw date. Shakes expire 14 days from thaw date as indicated on the carton. On 6/27/05 at 8:25 AM, CNA 1 was in Morning Glory Dining Room serving breakfast to residents. CNA 1 was observed to sneeze into her hand. She did not wash her hands. She continued to serve the breakfast trays to three residents. Then CNA 1 picked up the toast for a resident with her hands and spread jelly on the toast.	F 371		
F 372 SS=B	483.35(h)(3) DIETARY SERVICES The facility must dispose of garbage and refuse	F 372		

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F 372	Continued From page 21 properly. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not dispose of garbage and refuse properly. Specifically, the dumpsters were not covered for four days and garbage could be seen on the ground around the garbage container. Findings included: On June 26, 2005 at 7:15 AM, the dumpsters at the north west corner of the property were observed to not have the lids securely in place. Garbage could be visualized from the parking area on the ground around the two dumpsters. On June 27, 2005 at 7:00 AM the dumpsters were observed from the parking area to be uncovered. Garbage could be visualized on the ground around the dumpsters. On June 28, 2005 at 7:00 AM the dumpsters were observed from the parking area to be uncovered. Garbage could be visualized on the ground around the dumpsters. On June 29, 2005 at 2:15 PM during a tour with the maintenance assistant, the dumpsters were observed to be uncovered. Garbage could be seen all around the east dumpster. An odor was emanating from the garbage behind the dumpster.	F 372	F 372 Facility dumpsters now have lids covering them. Staff have been inserviced regarding the necessity to keep the lids secured at all times. Maintenance Director or designee will monitor daily to ensure compliance. Results will be brought to the facility QA meeting for 6 months. Executive Director to monitor. Compliance date: July 22, 2005	
F 426 SS=E	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services	F 426		

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F 426	Continued From page 22 (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 interview and record review it was determined that the facility licensed staff did not provide accurate pharmaceutical services to meet the needs of 2 of 18 sampled residents and 4 supplemental residents as evidenced by lack of documentation that medications were dispensed as ordered. Resident identifiers: 7, 15, and supplemental 18, 20, 21, 22 Findings included: An interview was conducted at the facility on 6/27/05 with LPN 3 for the facility's protocol on blood sugar monitoring and insulin administration. LPN 3 stated that; Step#1 was to make sure that the test strip code matches the glucometer code. Step #2 was to do the fingerstick and record the results on the Blood Glucose Monitoring Record (BGMR). Step #3 was to then administer the correct insulin dosage as ordered by MD. If the BS was high, she recorded it on the BGMR, called the MD, rechecked the BS in 30 minutes, then recorded the second BS on the BGMR, wrote a telephone order, and made a note in the comments column on the BGMR. LPN 3 noted the time the insulin was given and her initials on the MAR. An interview was conducted at the facility on	F 426	F 426 All identified residents have been reviewed and adjustments made to ensure they are receiving the appropriate pharmaceutical services. All diabetic residents have the potential to be affected. They have all been reviewed to ensure they are receiving the appropriate pharmaceutical services to meet their individual needs. Nursing staff have been inserviced regarding the importance of timely and complete documentation for diabetic interventions. The Resident Care Manager or designee will perform daily audits of the MAR to ensure appropriate diabetic intervention and documentation. Results will be brought to the facility QA meeting for 6 months. Director of Nursing to monitor. Compliance date: July 22, 2005	

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F 426	Continued From page 23	F 426		

6/27/05 with LPN 4 for the facility's protocol on blood sugar monitoring and insulin administration. LPN 4 stated that;
Step#1 was to do the fingerstick and record the results on the Blood Glucose Monitoring Record (BGMR).
Step #2 was to then check the MAR and administer the correct insulin dosage as ordered by MD.
If the BS was high, she noted it on the BGMR and the nurse's notes, called the MD and wrote a telephone order. LPN 4 noted the units of insulin given and her initials on the MAR.

1. Resident 7 was readmitted to the facility in November of 2004 with diagnoses that included dementia, hypertension and insulin dependent diabetes.

Resident 7's medical records were reviewed from 6/26/05 to 6/30/05.

Resident 7's Physician's Orders for June of 2005 were reviewed.

The physician ordered that the resident's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS)regular insulin as follows:

Sliding scale insulin:

Regular insulin 2 U (units) if BS (blood sugar) 151-200
Regular insulin 4 U if BS 201-250
Regular insulin 6 U if BS 251-300
Regular insulin 8 U if BS 301-350
Regular insulin 10 U if BS > 350

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F 426	Continued From page 24 From June 1st through June 25th of 2005, 26 errors in administration or documentation of administration of sliding scale insulin were identified for resident 7. It was recorded on resident 7's Blood Glucose Monitoring Record (BGMR) that on 6/1/05 at 7:00 AM the resident's BS was 194. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 7:00 AM the resident's BS was 202. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 7:00 AM the resident's BS was 202. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 12:00 PM the resident's BS was 194. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 5:00 PM the resident's BS was 218. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 7:00 AM the resident's BS was 202. Resident 7 should have received 4 U of regular	F 426		

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(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) COMPLETION DATE
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insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/6/05 at 7:00 AM the resident's BS was 207. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/6/05 at 12:00 PM the resident's BS was 219. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/6/05 at 5:00 PM the resident's BS was 181. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/7/05 at 7:00 AM the resident's BS was 238 and at 5:00 PM the resident's BS was 226. Resident 7 should have received 4 U of regular insulin at 8:00 AM and at 5:00 PM. It was documented in the MAR that resident 7 was administered 4 U of regular insulin once that day. Resident 7 should have been administered 4 U twice that day.

It was recorded on resident 7's BGMR that on 6/8/05 at 12:00 PM the resident's BS was 193. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/9/05 at 5:00 PM the resident's BS documentation space was blank.

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	465139	A. BUILDING _____ B. WING _____	06/29/2005

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F 426	Continued From page 26 It was recorded on resident 7's BGMR that on 6/10/05 at 12:00 PM the resident's BS was 183. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/11/05 at 12:00 PM the resident's BS was 172. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/12/05 at 7:00 AM the resident's BS was 318. Resident 7 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/12/05 at 12:00 PM the resident's BS was 180. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/13/05 at 7:00 PM the resident's BS was 302. Resident 7 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/13/05 at 12:00 PM the resident's BS was 171. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/14/05 at 7:00 AM the resident's BS was 234.	F 426		

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F 426	Continued From page 27 Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/14/05 at 12:00 PM the resident's BS was 183. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. Resident 7's BGMR documentation space for 6/15/05 at 8:00 PM was blank. It was recorded on resident 7's BGMR that on 6/6/05 at 5:00 PM the resident's BS was 181. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/17/05 at 7:00 AM the resident's BS was 194 and at 12:00 PM the resident's BS was 193. Resident 7 should have received 2 U of regular insulin at 8:00 AM and at 12:00 PM. It was documented in the MAR that resident 7 was administered 2 U of regular insulin once that day. Resident 7 should have been administered 2 U twice that day. It was recorded on resident 7's BGMR that on 6/20/05 at 7:00 AM the resident's BS was 183, at 12:00 PM the BS was 193, at 5:00 PM the resident's BS was 166 and at 8:00 PM the BS was 158. Resident 7 should have received 2 U of regular insulin at 8:00 AM, at 12:00 PM, at 5:00 PM and at 9:00 PM. It was documented in the MAR that resident 7 was administered 2 U of regular insulin three times that day. Resident 7 should have been administered 2 U of insulin,	F 426		

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F 426	Continued From page 28 four times that day. Resident 7's BGMR documentation space for 6/22/05 at 8:00 PM was blank. It was recorded on resident 7's BGMR that on 6/25/05 at 5:00 PM the resident's BS was 164. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. 2. Resident 15 was admitted to the facility on May 25, 2005 with diagnoses that included dementia, osteoporosis, edema and insulin dependent diabetes. Resident 15's medical records were reviewed from 6/26/05 to 6/30/05. Resident 15's Physician's Orders for June of 2005 were reviewed. The physician ordered that the resident's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS)humulin R insulin as follows: Sliding scale insulin: Regular insulin 3 U (units) if BS (blood sugar) 151-200 Regular insulin 5 U if BS 201-250 Regular insulin 7 U if BS 251-300 Regular insulin 10 U if BS 301-350 Regular insulin 12 U if BS 351-400 Call MD if >400 From June 1st through June 26th of 2005, 18	F 426		

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errors in administration or documentation of administration of sliding scale insulin were identified for resident 15.

It was recorded on resident 15's Blood Glucose Monitoring Record (BGMR) that on 6/3/05 at 12:00 NOON the resident's BS was 180. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 15's BGMR that on 6/4/05 at 8:00 AM the resident's BS was 169. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 15's BGMR that on 6/4/05 at 12:00 PM the resident's BS was 171. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 15's BGMR that on 6/5/05 at 8:00 AM the resident's BS was 151. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 15's BGMR that on 6/8/05 at 8:00 PM the resident's BS was 180. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 15's BGMR that on 6/10/05 at 8:00 AM the resident's BS was 175. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that

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F 426	Continued From page 30 SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/10/05 at 12:00 Noon the resident's BS was 195. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/10/05 at 8:00 PM the resident's BS was 193. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/11/05 at 8:00 PM the resident's BS was 234. Resident 15 should have received 5 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/14/05 at 5:00 PM the resident's BS was 200. Resident 15 should have received 3 U of regular insulin at 5:00 PM. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/15/05 at 8:00 PM the resident's BS was 240. Resident 15 should have received 5 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/17/05 at 5:00 PM the resident's BS was 163. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on	F 426		

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F 426	Continued From page 31 6/18/05 at 5:00 PM the resident's BS was 195. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/19/05 at 8:00 AM the resident's BS was 153. Resident 15 should have received 3 U of regular insulin. At 12:00 Noon Resident 15 's BS was 245. Resident 15 should have received 5 U regular insulin. At 5:00 PM resident 15's BS was 291. Resident 15 should have received 7 U regular insulin. There was no documentation to show that SS insulin had been administered that day. It was recorded on resident 15's BGMR that on 6/23/05 at 5:00 PM the resident's BS was 175. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. On 6/24/05, resident 15's BGMR showed BS readings of: Noon 249, 5:00 PM 185, and 8:00 PM 180. Resident 15 should have received SS insulin at each of these times. There was no documentation to show that SS insulin had been administered that day. It was recorded on resident 15's BGMR that on 6/26/05 at 5:00 PM the resident's BS was 256. Resident 15 should have received 7 U of regular insulin. There was no documentation to show that SS insulin had been administered. 3. Resident 18 was admitted to the facility 4/21/05 with diagnoses including diabetes mellitus, cardiac dysrhythmias, edema, and dementia.	F 426		

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F 426	Continued From page 32 Resident 18's medical records were reviewed 6/30/05. Resident 18's Physician's Orders for June of 2005 were reviewed. The physician ordered that the resident's blood sugar (BS) was to monitored four times a day and to administer sliding scale (SS) Novolog insulin as follows: Sliding scale insulin: Novolog insulin 2 U if BS 200-250 Novolog insulin 4 U if BS 251-300 Novolog insulin 6 U if BS 301-350 Novolog insulin 8 U if BS 351-400 Call MD if BS > 400 From June 1st through June 27th of 2005, 7 errors in administration or documentation of administration of sliding scale insulin were identified for resident 18. It was recorded on resident 18's BGMR that on 6/3/05 at 9:30 PM the resident's BS was 212. Resident 18 should have received 2 U of SS insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 18's BGMR that on 6/7/05 at 12:15 PM the resident's BS was 396. Resident 18 should have received 8 U of SS insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 18's BGMR that on 6/13/05 at 5:00 PM the resident's BS was 402. There was no MD order written to document what the physician requested for resident 18.	F 426		

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It was recorded on resident 18's BGMR that on 6/19/05 at 9:00 PM the resident's BS was 261. Resident 18 should have received 4 U SS insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 18's BGMR that on 6/21/05 at 8:00 PM the resident's BS was 200. Resident 18 should have received 2 U SS insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 18's BGMR that on 6/25/05 at 8:00 PM the resident's BS was 251. Resident 18 should have received 4 U SS insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 18's BGMR that on 6/27/05 at 11:30 AM the resident's BS was 206. Resident 18 should have received 2 U SS insulin. There was no documentation to show that SS insulin had been administered.

4. Resident 20 was admitted to the facility in March of 2005 with diagnoses that included persistent mental disorder, hypertension and insulin dependent diabetes.

Resident 20's medical records were reviewed from 6/26/05 to 6/27/05.

Resident 20's Physician's Orders for May of 2005 were reviewed.

The physician ordered that the resident's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS)Novolog

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F 426	Continued From page 34 insulin as follows: Sliding scale insulin: Novolog insulin 2 U (units) if BS (blood sugar) 151-200 Novolog insulin 6 U if BS 201-250 Novolog insulin 8 U if BS 251-300 Novolog insulin 10 U if BS 301-350 Novolog insulin 12 U if BS 351-400 Novolog insulin 12 U if BS >400 & Call MD From May 1st through May 31st of 2005, 45 errors in administration or documentation of administration of sliding scale insulin were identified for resident 20. It was recorded on resident 20's Blood Glucose Monitoring Record (BGMR) that on 5/2/05 at 8:00 AM the resident's BS was 162. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/4/05 at 8:00 AM the resident's BS was 161. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/4/05 at 9:00 PM the resident's BS was 160. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/5/05 at 8:00 AM the resident's BS was 172. Resident 20 should have received 2 U of novolog	F 426		

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insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/5/05 at 12:00 PM the resident's BS was 194. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/6/05 at 8:00 AM the resident's BS was 190. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/6/05 at 12:00 PM the resident's BS was 186. Resident 20 should have received 2 U of Novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/6/05 at 8:00 PM the resident's BS was 220. Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/7/05 at 8:00 AM the resident's BS was 192. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/7/05 at 12:00 PM the resident's BS was 199. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

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It was recorded on resident 20's BGMR that on 5/8/05 at 5:00 PM the resident's BS was 178. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/10/05 at 8:00 AM the resident's BS was 156. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/10/05 at 12:00 PM the resident's BS was 253. Resident 20 should have received 8 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/12/05 at 8:00 AM the resident's BS was 158. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/12/05 at 12:00 PM the resident's BS was 186. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/12/05 at 5:00 PM the resident's BS was 152. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/13/05 at 12:00 PM the resident's BS was 210.

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F 426	Continued From page 37 Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/13/05 at 8:00 PM the resident's BS was 188. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/14/05 at 5:00 PM the resident's BS was 202 . Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/15/05 at 5:00 PM the resident's BS was 153 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/16/05 at 8:00 AM the resident's BS was 163 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/17/05 at 8:00 AM the resident's BS was 168 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/17/05 at 5:00 PM the resident's BS was 163 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.	F 426		

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F 426	Continued From page 38 It was recorded on resident 20's BGMR that on 5/18/05 at 8:00 PM the resident's BS was 211 . Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/19/05 at 5:00 PM the resident's BS was 158 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS It was recorded on resident 20's BGMR that on 5/19/05 at 8:00 PM the resident's BS was 211 . Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/20/05 at 8:00 AM the resident's BS was 173 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/20/05 at 8:00 PM the resident's BS was 206 . Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/22/05 at 8:00 AM the resident's BS was 163. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/22/05 at 5:00 PM the resident's BS was not	F 426		

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documented as being checked.

It was recorded on resident 20's BGMR that on 5/25/05 at 8:00 AM the resident's BS was 175. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/25/05 at 12:00 PM the resident's BS was 169. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/25/05 at 5:00 PM the resident's BS was 201. Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/25/05 at 8:00 PM the resident's BS was 171. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/26/05 at 8:00 AM the resident's BS was 179. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/27/05 at 8:00 AM the resident's BS was 166. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on

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F 426	Continued From page 40 5/27/05 at 12:00 PM the resident's BS was 193. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/27/05 at 5:00 PM the resident's BS was 196. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/27/05 at 8:00 PM the resident's BS was 190. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/28/05 at 8:00 AM the resident's BS was 172. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/28/05 at 12:00 PM the resident's BS was 180. Resident 20 should have received FÜR of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/28/05 at 5:00 PM the resident's BS was 203. Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/28/05 at 8:00 PM the resident's BS was 161. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that	F 426		

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SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/29/05 at 8:00 AM the resident's BS was 160. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/29/05 at 5:00 PM the resident's BS was 162. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

5. Resident 21 was admitted to the facility in September of 2003 with diagnoses that included dementia with behaviors, and insulin dependent diabetes.

Resident 21's medical records were reviewed from 6/24/05 to 6/27/05.

Resident 21's Physician's Orders for May of 2005 were reviewed.

The physician ordered that the resident's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS)regular insulin as follows:

Sliding scale insulin:

Regular insulin 2 U (units) if BS (blood sugar) 200-250
Regular insulin 4 U if BS 251-300
Regular insulin 6 U if BS 301-350
Regular insulin 8 U if BS 351-400
>400 Call MD

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F 426	Continued From page 42 From May 1st through May 31st of 2005, 37 errors in administration or documentation of administration of sliding scale insulin were identified for resident 21. It was recorded on resident 21's Blood Glucose Monitoring Record (BGMR) that on 5/2/05 at 12:00 PM the resident's BS was 224. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/2/05 at 5:00 PM the resident's BS was 215. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/2/05 at 9:30 PM the resident's BS was 255. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/3/05 at 12:00 PM the resident's BS was 234. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/3/05 at 8:45 PM the resident's BS was 219. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/4/05 at 9:00 PM the resident's BS was 236.	F 426		

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Resident 21 should have received 2 U of regular insulin. Documentation on resident 21's Medication Administration Record (MAR) shows that resident 21 received 4 U of regular insulin.

It was recorded on resident 21's BGMR that on 5/7/05 at 5:00 PM the resident's BS was 241. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/7/05 at 8:00 PM the resident's BS was 291. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/8/05 at 12:00 PM the resident's BS was 285. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/8/05 at 5:00 PM the resident's BS was 259. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

On 5/8/05 there was no documentation on resident 21's BGMR that a bedtime BS was done.

It was recorded on resident 21's BGMR that on 5/10/05 at 8:30 PM the resident's BS was 299. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on

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5/11/05 at 8:00 PM the resident's BS was 201. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/12/05 at 5:00 PM the resident's BS was 209. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/13/05 at 8:00 PM the resident's BS was 301. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/14/05 at 12:00 PM the resident's BS was 206. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/14/05 at 5:00 PM the resident's BS was 207. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/15/05 at 12:00 PM the resident's BS was 306. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/15/05 at 8:30 PM the resident's BS was 278. Resident 21 should have received 4 U of regular insulin. There was no documentation to show

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that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/17/05 at 8:30 PM the resident's BS was 253. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/18/05 at 8:00 PM the resident's BS was 329. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/19/05 at 12:00 PM the resident's BS was 208. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/19/05 at 8:00 PM the resident's BS was 299. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/20/05 at 5:00 PM the resident's BS was 218. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/20/05 at 8:00 PM the resident's BS was 220. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on

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5/21/05 at 5:00 PM the resident's BS was 276. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/21/05 at 8:00 PM the resident's BS was 353. Resident 21 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/22/05 at 12:00 PM the resident's BS was 238. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/22/05 at 5:00 PM the resident's BS was 226. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/22/05 at 8:30 PM the resident's BS was 327. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/23/05 at 8:30 PM the resident's BS was 352. Resident 21 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/24/05 at 8:30 PM the resident's BS was 261. Resident 21 should have received 4 U of regular insulin. There was no documentation to show

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that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/25/05 at 8:00 PM the resident's BS was 218. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/27/05 at 8:00 PM the resident's BS was 263. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/28/05 at 8:00 PM the resident's BS was 249. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/29/05 at 8:00 PM the resident's BS was 336. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/30/05 at 8:30 PM the resident's BS was 381. Resident 21 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered.

6. Resident 22 was admitted to the facility in June of 2004 with diagnoses that included hypertension, congestive heart failure and insulin dependent diabetes.

Resident 22's medical records were reviewed from 6/24/05 to 6/27/05.

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F 426	Continued From page 48 Resident 22's Physician's Orders for May of 2005 were reviewed. The physician ordered that the resident 22's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS) regular insulin as follows: Sliding scale insulin: Regular insulin 2 U (units) if BS (blood sugar) 200-250 Regular insulin 4 U if BS 251-300 Regular insulin 6 U if BS 301-350 Regular insulin 8 U if BS 351-400 >400 Call MD From May 1st through May 31st of 2005, 14 errors in administration or documentation of administration of sliding scale insulin were identified for resident 22. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/4/05 at 9:00 PM the resident's BS was 236. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/5/05 at 8:00 PM the resident's BS was 309. Resident 22 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/6/05 at 8:00	F 426		

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F 426	Continued From page 49 PM the resident's BS was 160. Resident 22 should not have received any regular insulin. There was documentation to show that 6 U of regular SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/8/05 at 12:00 PM the resident's BS was 201. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/8/05 at 5:00 PM the resident's BS was 245. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/13/05 at 8:00 PM the resident's BS was 350. Resident 22 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/14/05 at 9:00 PM there was no documentation to show resident 22's BS had been tested. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/15/05 at 12:00 PM the resident's BS was 464. There was no documentation to show that MD had been notified. It was recorded on resident 22's Blood Glucose Monitoring Record(BGMR) that on 5/17/05 at 8:00	F 426		

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AM the resident's BS was 230. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 22's Blood Glucose Monitoring Record(BGMR) that on 5/17/05 at 12:00 PM the resident's BS was 248. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/18/05 at 8:00 AM the resident's BS was 208. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/18/05 at 12:00 PM the resident's BS was 253. Resident 22 should have received 4 U of regular insulin. There was documentation to show that resident 22 received 2 U regular SS insulin.

It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/27/05 at 7:00 AM the resident's BS was 220. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/29/05 at 12:00 PM the resident's BS was 314. Resident 22 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

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F 465 SS=E	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility did not provide sufficient space to accommodate all activities. Specifically,during the dining process, residents and staff did not have maximum flexibility to accommodate residents who use walkers, wheelchairs and other mobility aides. Findings included: Observations of movement within the Sunflower dining area were made on 6/26/2005 for breakfast, 6/27/05 for lunch and 6/29/05 for breakfast. The following instances are of residents being moved away from their meal so another resident could be brought in or removed from the dining area. 1) On 6/26/05 at 8:56 AM Resident 21 was moved away from her meal in order for Resident 32 to be removed from the dining area. 2) On 6/26/05 at 9:10 AM Resident 21 was moved away from her meal in order for Resident 33 to be removed from the dining area. 3) On 6/26/05 at 9:12 AM Resident 21 was moved away from her meal again in order for Resident 32 to be returned to the dining area. 4) On 6/27/05 at 1:10 AM Resident 33 was	F 465	F 465 New seating arrangements and dining protocol have been developed to ensure all identified residents have been afforded maximum flexibility. New dining seating arrangements and protocol have been developed, ensuring sufficient space is provided to accommodate all residents during the dining process without excessive interruption. All residents have the potential to be affected. Staff have been inserviced regarding the new dining room procedure. Daily audits will be performed by the Staff Development Coordinator or designee to ensure maximum flexibility to accommodate residents in dining rooms is provided. Results will be brought to the facility QA meeting quarterly for 6 months. Staff Development Coordinator to monitor. Compliance date: July 22, 2005	

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	465139	A. BUILDING _____ B. WING _____	06/29/2005

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F 465	Continued From page 52 unable to leave the dining area without Resident 34 being moved away from her meal.. 5) On 6/29/05 at 8:36 AM, CNA 3 stated to LPN 3, that she could not put resident 35 at the feeders table because it was too crowded. Resident 33 was placed at table 1. At 8:41 AM resident 33 was moved to table 2 so she could receive assistance with feeding. Observations of movement within the Morning Glory Way dining area were made on 6/27/2005 for breakfast and lunch. The following instances are of Residents being moved away from their meal so another resident could be brought in or removed from the dining area. 1) On 6/27/05 at 8:32 AM Resident 23 was moved away from his meal in order for Resident 24 to be removed from the dining area. When asked by Therapy aide 1 if he was finished eating Resident 23 responded, "They just pushed me away." Resident 23 was then removed from the dining area and did not return. 2) On 6/27/05 at 8:41 AM Resident 26 was moved away from his meal in order for Resident 25 to be removed from the dining area. 3) On 6/27/05 at 12:25 PM Resident 23 was moved away from his meal in order for Resident 27 to be removed from the dining area. 4) On 6/27/05 at 12:37 PM Resident 28 was moved away from her meal by Resident 12 who was trying to maneuver herself to a table to begin eating. At 12:40 PM Resident 28 was moved away from her meal by CNA 1 so Resident 12 could remove herself from the dining area.	F 465		

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F 514	Continued From page 53	F 514		
F 514 SS=E	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility did not maintain each residents' records in accordance with accepted professional standards that are complete and accurately documented and systematically organized. Resident identifiers: 7, 15, and supplemental 18, 20, 21, 22 Findings included: An interview was conducted at the facility on 6/27/05 with LPN 3 for the facility's protocol on blood sugar monitoring and insulin administration. LPN 3 stated that; Step#1 was to make sure that the test strip code matches the glucometer code. Step #2 was to do the fingerstick and record the results on the Blood Glucose Monitoring Record (BGMR). Step #3 was to then administer the correct insulin dosage as ordered by MD. If the BS was high, she recorded it on the BGMR, called the MD, rechecked the BS in 30 minutes, then recorded the second BS on the BGMR, wrote a telephone order, and made a note in the comments column on the BGMR. LPN 3 noted the time the insulin was given and her initials on the MAR.	F 514	F 514 All identified residents have been reviewed and adjustments made to ensure they are receiving the appropriate pharmaceutical services. Residents' records will be maintained in accordance with accepted standards of practice. All diabetic residents have the potential to be affected. They have all been reviewed to ensure they are receiving the appropriate pharmaceutical services to meet their individual needs. Nursing staff have been inserviced regarding the importance of timely and complete documentation for diabetic interventions. The Director of Nursing or designee will perform daily audits to ensure appropriate diabetic intervention and documentation. The Health Information Manager will continue to audit medical records on a weekly basis. Results of these audits will be given to the Director of Nursing for review and follow up. Results will be brought to the facility QA meeting for 6 months. Director of Nursing to monitor. Compliance Date: July 22, 2005	

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F 514	Continued From page 54 An interview was conducted at the facility on 6/27/05 with LPN 4 for the facility's protocol on blood sugar monitoring and insulin administration. LPN 4 stated that; Step#1 was to do the fingerstick and record the results on the Blood Glucose Monitoring Record (BGMR). Step #2 was to then check the MAR and administer the correct insulin dosage as ordered by MD. If the BS was high, she noted it on the BGMR and the nurse's notes, called the MD and wrote a telephone order. LPN 4 noted the units of insulin given and her initials on the MAR. 1. Resident 7 was readmitted to the facility in November of 2004 with diagnoses that included dementia, hypertension and insulin dependent diabetes. Resident 7's medical records were reviewed from 6/26/05 to 6/30/05. Resident 7's Physician's Orders for June of 2005 were reviewed. The physician ordered that the resident's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS)regular insulin as follows: Sliding scale insulin: Regular insulin 2 U (units) if BS (blood sugar) 151-200 Regular insulin 4 U if BS 201-250 Regular insulin 6 U if BS 251-300 Regular insulin 8 U if BS 301-350	F 514		

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F 514	Continued From page 55 Regular insulin 10 U if BS > 350 From June 1st through June 25th of 2005, 26 errors in administration or documentation of administration of sliding scale insulin were identified for resident 7. It was recorded on resident 7's Blood Glucose Monitoring Record (BGMR) that on 6/1/05 at 7:00 AM the resident's BS was 194. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 7:00 AM the resident's BS was 202. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 7:00 AM the resident's BS was 202. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 12:00 PM the resident's BS was 194. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/5/05 at 5:00 PM the resident's BS was 218. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on	F 514		

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6/5/05 at 7:00 AM the resident's BS was 202. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/6/05 at 7:00 AM the resident's BS was 207. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/6/05 at 12:00 PM the resident's BS was 219. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/6/05 at 5:00 PM the resident's BS was 181. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/7/05 at 7:00 AM the resident's BS was 238 and at 5:00 PM the resident's BS was 226. Resident 7 should have received 4 U of regular insulin at 8:00 AM and at 5:00 PM. It was documented in the MAR that resident 7 was administered 4 U of regular insulin once that day. Resident 7 should have been administered 4 U twice that day.

It was recorded on resident 7's BGMR that on 6/8/05 at 12:00 PM the resident's BS was 193. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on

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6/9/05 at 5:00 PM the resident's BS documentation space was blank.

It was recorded on resident 7's BGMR that on 6/10/05 at 12:00 PM the resident's BS was 183. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/11/05 at 12:00 PM the resident's BS was 172. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/12/05 at 7:00 AM the resident's BS was 318. Resident 7 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/12/05 at 12:00 PM the resident's BS was 180. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/13/05 at 7:00 PM the resident's BS was 302. Resident 7 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 7's BGMR that on 6/13/05 at 12:00 PM the resident's BS was 171. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

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F 514	Continued From page 58 It was recorded on resident 7's BGMR that on 6/14/05 at 7:00 AM the resident's BS was 234. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/14/05 at 12:00 PM the resident's BS was 183. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. Resident 7's BGMR documentation space for 6/15/05 at 8:00 PM was blank. It was recorded on resident 7's BGMR that on 6/6/05 at 5:00 PM the resident's BS was 181. Resident 7 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 7's BGMR that on 6/17/05 at 7:00 AM the resident's BS was 194 and at 12:00 PM the resident's BS was 193. Resident 7 should have received 2 U of regular insulin at 8:00 AM and at 12:00 PM. It was documented in the MAR that resident 7 was administered 2 U of regular insulin once that day. Resident 7 should have been administered 2 U twice that day. It was recorded on resident 7's BGMR that on 6/20/05 at 7:00 AM the resident's BS was 183, at 12:00 PM the BS was 193, at 5:00 PM the resident's BS was 166 and at 8:00 PM the BS was 158. Resident 7 should have received 2 U of regular insulin at 8:00 AM, at 12:00 PM, at 5:00 PM and at 9:00 PM. It was documented in the MAR that resident 7 was administered 2 U of	F 514		

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F 514	Continued From page 59 regular insulin three times that day. Resident 7 should have been administered 2 U of insulin, four times that day. Resident 7's BGMR documentation space for 6/22/05 at 8:00 PM was blank. It was recorded on resident 7's BGMR that on 6/25/05 at 5:00 PM the resident's BS was 164. Resident 7 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. 2. Resident 15 was admitted to the facility on May 25, 2005 with diagnoses that included dementia, osteoporosis, edema and insulin dependent diabetes. Resident 15's medical records were reviewed from 6/26/05 to 6/30/05. Resident 15's Physician's Orders for June of 2005 were reviewed. The physician ordered that the resident's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS)humulin R insulin as follows: Sliding scale insulin: Regular insulin 3 U (units) if BS (blood sugar) 151-200 Regular insulin 5 U if BS 201-250 Regular insulin 7 U if BS 251-300 Regular insulin 10 U if BS 301-350 Regular insulin 12 U if BS 351-400 Call MD if >400	F 514		

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F 514	Continued From page 60 From June 1st through June 26th of 2005, 18 errors in administration or documentation of administration of sliding scale insulin were identified for resident 15. It was recorded on resident 15's Blood Glucose Monitoring Record (BGMR) that on 6/3/05 at 12:00 NOON the resident's BS was 180. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/4/05 at 8:00 AM the resident's BS was 169. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/4/05 at 12:00 PM the resident's BS was 171. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/5/05 at 8:00 AM the resident's BS was 151. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/8/05 at 8:00 PM the resident's BS was 180. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/10/05 at 8:00 AM the resident's BS was 175.	F 514		

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F 514	Continued From page 61 Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/10/05 at 12:00 Noon the resident's BS was 195. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/10/05 at 8:00 PM the resident's BS was 193. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/11/05 at 8:00 PM the resident's BS was 234. Resident 15 should have received 5 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/14/05 at 5:00 PM the resident's BS was 200. Resident 15 should have received 3 U of regular insulin at 5:00 PM. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/15/05 at 8:00 PM the resident's BS was 240. Resident 15 should have received 5 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 15's BGMR that on 6/17/05 at 5:00 PM the resident's BS was 163. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered.	F 514		

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It was recorded on resident 15's BGMR that on 6/18/05 at 5:00 PM the resident's BS was 195. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 15's BGMR that on 6/19/05 at 8:00 AM the resident's BS was 153. Resident 15 should have received 3 U of regular insulin. At 12:00 Noon Resident 15 's BS was 245. Resident 15 should have received 5 U regular insulin. At 5:00 PM resident 15's BS was 291. Resident 15 should have received 7 U regular insulin. There was no documentation to show that SS insulin had been administered that day.

It was recorded on resident 15's BGMR that on 6/23/05 at 5:00 PM the resident's BS was 175. Resident 15 should have received 3 U of regular insulin. There was no documentation to show that SS insulin had been administered.

On 6/24/05, resident 15's BGMR showed BS readings of: Noon 249, 5:00 PM 185, and 8:00 PM 180. Resident 15 should have received SS insulin at each of these times. There was no documentation to show that SS insulin had been administered that day.

It was recorded on resident 15's BGMR that on 6/26/05 at 5:00 PM the resident's BS was 256. Resident 15 should have received 7 U of regular insulin. There was no documentation to show that SS insulin had been administered.

3. Resident 18 was admitted to the facility 4/21/05 with diagnoses including diabetes

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mellitus, cardiac dysrhythmias, edema, and dementia.

Resident 18's medical records were reviewed 6/30/05. Resident 18's Physician's Orders for June of 2005 were reviewed.

The physician ordered that the resident's blood sugar (BS) was to monitored four times a day and to administer sliding scale (SS) Novolog insulin as follows:

Sliding scale insulin:

Novolog insulin 2 U if BS 200-250
Novolog insulin 4 U if BS 251-300
Novolog insulin 6 U if BS 301-350
Novolog insulin 8 U if BS 351-400
Call MD if BS > 400

From June 1st through June 27th of 2005, 7 errors in administration or documentation of administration of sliding scale insulin were identified for resident 18.

It was recorded on resident 18's BGMR that on 6/3/05 at 9:30 PM the resident's BS was 212. Resident 18 should have received 2 U of SS insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 18's BGMR that on 6/7/05 at 12:15 PM the resident's BS was 396. Resident 18 should have received 8 U of SS insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 18's BGMR that on 6/13/05 at 5:00 PM the resident's BS was 402.

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F 514	Continued From page 64 There was no MD order written to document what the physician requested for resident 18. It was recorded on resident 18's BGMR that on 6/19/05 at 9:00 PM the resident's BS was 261. Resident 18 should have received 4 U SS insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 18's BGMR that on 6/21/05 at 8:00 PM the resident's BS was 200. Resident 18 should have received 2 U SS insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 18's BGMR that on 6/25/05 at 8:00 PM the resident's BS was 251. Resident 18 should have received 4 U SS insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 18's BGMR that on 6/27/05 at 11:30 AM the resident's BS was 206. Resident 18 should have received 2 U SS insulin. There was no documentation to show that SS insulin had been administered. 4. Resident 20 was admitted to the facility in March of 2005 with diagnoses that included persistent mental disorder, hypertension and insulin dependent diabetes. Resident 20's medical records were reviewed from 6/26/05 to 6/27/05. Resident 20's Physician's Orders for May of 2005 were reviewed. The physician ordered that the resident's blood	F 514		

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	465139	A. BUILDING _____ B. WING _____	06/29/2005

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F 514	Continued From page 65 sugar (BS) was to be monitored four times a day and to administer sliding scale (SS)Novolog insulin as follows: Sliding scale insulin: Novolog insulin 2 U (units) if BS (blood sugar) 151-200 Novolog insulin 6 U if BS 201-250 Novolog insulin 8 U if BS 251-300 Novolog insulin 10 U if BS 301-350 Novolog insulin 12 U if BS 351-400 Novolog insulin 12 U if BS >400 & Call MD From May 1st through May 31st of 2005, 45 errors in administration or documentation of administration of sliding scale insulin were identified for resident 20. It was recorded on resident 20's Blood Glucose Monitoring Record (BGMR) that on 5/2/05 at 8:00 AM the resident's BS was 162. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/4/05 at 8:00 AM the resident's BS was 161. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/4/05 at 9:00 PM the resident's BS was 160. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on	F 514		

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F 514	Continued From page 66 5/5/05 at 8:00 AM the resident's BS was 172. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/5/05 at 12:00 PM the resident's BS was 194. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/6/05 at 8:00 AM the resident's BS was 190. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/6/05 at 12:00 PM the resident's BS was 186. Resident 20 should have received 2 U of Novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/6/05 at 8:00 PM the resident's BS was 220. Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/7/05 at 8:00 AM the resident's BS was 192. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/7/05 at 12:00 PM the resident's BS was 199. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that	F 514		

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SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/8/05 at 5:00 PM the resident's BS was 178. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/10/05 at 8:00 AM the resident's BS was 156. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/10/05 at 12:00 PM the resident's BS was 253. Resident 20 should have received 8 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/12/05 at 8:00 AM the resident's BS was 158. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/12/05 at 12:00 PM the resident's BS was 186. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/12/05 at 5:00 PM the resident's BS was 152. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

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It was recorded on resident 20's BGMR that on 5/13/05 at 12:00 PM the resident's BS was 210. Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/13/05 at 8:00 PM the resident's BS was 188. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/14/05 at 5:00 PM the resident's BS was 202 . Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/15/05 at 5:00 PM the resident's BS was 153 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/16/05 at 8:00 AM the resident's BS was 163 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/17/05 at 8:00 AM the resident's BS was 168 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/17/05 at 5:00 PM the resident's BS was 163 . Resident 20 should have received 2 U of novolog

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insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/18/05 at 8:00 PM the resident's BS was 211 . Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/19/05 at 5:00 PM the resident's BS was 158 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS

It was recorded on resident 20's BGMR that on 5/19/05 at 8:00 PM the resident's BS was 211 . Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/20/05 at 8:00 AM the resident's BS was 173 . Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/20/05 at 8:00 PM the resident's BS was 206 . Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 20's BGMR that on 5/22/05 at 8:00 AM the resident's BS was 163. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.

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F 514	Continued From page 70 It was recorded on resident 20's BGMR that on 5/22/05 at 5:00 PM the resident's BS was not documented as being checked. It was recorded on resident 20's BGMR that on 5/25/05 at 8:00 AM the resident's BS was 175. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/25/05 at 12:00 PM the resident's BS was 169. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/25/05 at 5:00 PM the resident's BS was 201. Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/25/05 at 8:00 PM the resident's BS was 171. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/26/05 at 8:00 AM the resident's BS was 179. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/27/05 at 8:00 AM the resident's BS was 166. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered.	F 514		

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F 514	Continued From page 71 It was recorded on resident 20's BGMR that on 5/27/05 at 12:00 PM the resident's BS was 193. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/27/05 at 5:00 PM the resident's BS was 196. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/27/05 at 8:00 PM the resident's BS was 190. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/28/05 at 8:00 AM the resident's BS was 172. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/28/05 at 12:00 PM the resident's BS was 180. Resident 20 should have received FÜR of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/28/05 at 5:00 PM the resident's BS was 203. Resident 20 should have received 6 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/28/05 at 8:00 PM the resident's BS was 161.	F 514		

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F 514	Continued From page 72 Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/29/05 at 8:00 AM the resident's BS was 160. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 20's BGMR that on 5/29/05 at 5:00 PM the resident's BS was 162. Resident 20 should have received 2 U of novolog insulin. There was no documentation to show that SS insulin had been administered. 5. Resident 21 was admitted to the facility in September of 2003 with diagnoses that included dementia with behaviors, and insulin dependent diabetes. Resident 21's medical records were reviewed from 6/24/05 to 6/27/05. Resident 21's Physician's Orders for May of 2005 were reviewed. The physician ordered that the resident's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS)regular insulin as follows: Sliding scale insulin: Regular insulin 2 U (units) if BS (blood sugar) 200-250 Regular insulin 4 U if BS 251-300 Regular insulin 6 U if BS 301-350 Regular insulin 8 U if BS 351-400	F 514		

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F 514	Continued From page 73 >400 Call MD From May 1st through May 31st of 2005, 37 errors in administration or documentation of administration of sliding scale insulin were identified for resident 21. It was recorded on resident 21's Blood Glucose Monitoring Record (BGMR) that on 5/2/05 at 12:00 PM the resident's BS was 224. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/2/05 at 5:00 PM the resident's BS was 215. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/2/05 at 9:30 PM the resident's BS was 255. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/3/05 at 12:00 PM the resident's BS was 234. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/3/05 at 8:45 PM the resident's BS was 219. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.	F 514		

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It was recorded on resident 21's BGMR that on 5/4/05 at 9:00 PM the resident's BS was 236. Resident 21 should have received 2 U of regular insulin. Documentation on resident 21's Medication Administration Record (MAR) shows that resident 21 received 4 U of regular insulin.

It was recorded on resident 21's BGMR that on 5/7/05 at 5:00 PM the resident's BS was 241. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/7/05 at 8:00 PM the resident's BS was 291. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/8/05 at 12:00 PM the resident's BS was 285. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/8/05 at 5:00 PM the resident's BS was 259. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

On 5/8/05 there was no documentation on resident 21's BGMR that a bedtime BS was done.

It was recorded on resident 21's BGMR that on 5/10/05 at 8:30 PM the resident's BS was 299. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

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It was recorded on resident 21's BGMR that on 5/11/05 at 8:00 PM the resident's BS was 201. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/12/05 at 5:00 PM the resident's BS was 209. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/13/05 at 8:00 PM the resident's BS was 301. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/14/05 at 12:00 PM the resident's BS was 206. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/14/05 at 5:00 PM the resident's BS was 207. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/15/05 at 12:00 PM the resident's BS was 306. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/15/05 at 8:30 PM the resident's BS was 278.

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F 514	Continued From page 76 Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/17/05 at 8:30 PM the resident's BS was 253. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/18/05 at 8:00 PM the resident's BS was 329. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/19/05 at 12:00 PM the resident's BS was 208. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/19/05 at 8:00 PM the resident's BS was 299. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/20/05 at 5:00 PM the resident's BS was 218. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/20/05 at 8:00 PM the resident's BS was 220. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.	F 514		

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F 514	Continued From page 77 It was recorded on resident 21's BGMR that on 5/21/05 at 5:00 PM the resident's BS was 276. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/21/05 at 8:00 PM the resident's BS was 353. Resident 21 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/22/05 at 12:00 PM the resident's BS was 238. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/22/05 at 5:00 PM the resident's BS was 226. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/22/05 at 8:30 PM the resident's BS was 327. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/23/05 at 8:30 PM the resident's BS was 352. Resident 21 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 21's BGMR that on 5/24/05 at 8:30 PM the resident's BS was 261.	F 514		

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	465139	A. BUILDING _____ B. WING _____	06/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 78	F 514		

Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/25/05 at 8:00 PM the resident's BS was 218. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/27/05 at 8:00 PM the resident's BS was 263. Resident 21 should have received 4 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/28/05 at 8:00 PM the resident's BS was 249. Resident 21 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/29/05 at 8:00 PM the resident's BS was 336. Resident 21 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.

It was recorded on resident 21's BGMR that on 5/30/05 at 8:30 PM the resident's BS was 381. Resident 21 should have received 8 U of regular insulin. There was no documentation to show that SS insulin had been administered.

6. Resident 22 was admitted to the facility in June of 2004 with diagnoses that included hypertension, congestive heart failure and insulin dependent diabetes.

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F 514	Continued From page 79 Resident 22's medical records were reviewed from 6/24/05 to 6/27/05. Resident 22's Physician's Orders for May of 2005 were reviewed. The physician ordered that the resident 22's blood sugar (BS) was to be monitored four times a day and to administer sliding scale (SS) regular insulin as follows: Sliding scale insulin: Regular insulin 2 U (units) if BS (blood sugar) 200-250 Regular insulin 4 U if BS 251-300 Regular insulin 6 U if BS 301-350 Regular insulin 8 U if BS 351-400 >400 Call MD From May 1st through May 31st of 2005, 14 errors in administration or documentation of administration of sliding scale insulin were identified for resident 22. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/4/05 at 9:00 PM the resident's BS was 236. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/5/05 at 8:00 PM the resident's BS was 309. Resident 22 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered.	F 514		

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F 514	Continued From page 80 It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/6/05 at 8:00 PM the resident's BS was 160. Resident 22 should not have received any regular insulin. There was documentation to show that 6 U of regular SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/8/05 at 12:00 PM the resident's BS was 201. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/8/05 at 5:00 PM the resident's BS was 245. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/13/05 at 8:00 PM the resident's BS was 350. Resident 22 should have received 6 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/14/05 at 9:00 PM there was no documentation to show resident 22's BS had been tested. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/15/05 at 12:00 PM the resident's BS was 464. There was no documentation to show that MD had been notified.	F 514		

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F 514	Continued From page 81 It was recorded on resident 22's Blood Glucose Monitoring Record(BGMR) that on 5/17/05 at 8:00 AM the resident's BS was 230. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record(BGMR) that on 5/17/05 at 12:00 PM the resident's BS was 248. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/18/05 at 8:00 AM the resident's BS was 208. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/18/05 at 12:00 PM the resident's BS was 253. Resident 22 should have received 4 U of regular insulin. There was documentation to show that resident 22 received 2 U regular SS insulin. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/27/05 at 7:00 AM the resident's BS was 220. Resident 22 should have received 2 U of regular insulin. There was no documentation to show that SS insulin had been administered. It was recorded on resident 22's Blood Glucose Monitoring Record (BGMR) that on 5/29/05 at 12:00 PM the resident's BS was 314. Resident 22 should have received 6 U of regular insulin.	F 514		

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F 514	Continued From page 82 There was no documentation to show that SS insulin had been administered.	F 514		