DEPARTMENT OF HEALTH AND H 'AN SERVICES
HEALTH CARE FINANCING ADMIN.. TRATION

...PI ...NT
...BER. 4271

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FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465109	A. BUILDING _____ B. WING _____	03/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLADAY HEALTHCARE CENTER	4782 SOUTH HOLLADAY BLVD 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) COMPLETE DATE
F 000	Memo INITIAL COMMENTS On 1/3/00 through 1/6/00, an abbreviated survey was conducted at the facility. The findings of this abbreviated survey revealed substantial non-compliance in the areas of F-241 Dignity, F-281 Professional Standards, and F-309 Highest Practicable Physical Well-being. A follow-up survey to determine if the facility had achieved substantial compliance, in all regulatory areas was completed on 3/16/00. At the conclusion of the follow-up survey, there was a remaining concern in the area of F-281 Professional Standards; however, these concerns were determined to be at a s/s (B), which constitutes substantial compliance. The areas of concern in professional standards were as follows: 1. The facility staff did not always follow their policies in regards to proper insulin administration. 2. The facility staff did not always follow their policies in regards to proper blood glucose monitoring. As a results of these concerns in the area of F-281, the follow-up survey found that no actual harm had occurred, but there was a pattern of potential for minimal harm.	F 000 OK 4/13/00 Busenbark RN	This plan of correction is being submitted in accordance with specific regulatory requirements and should not be construed as an admission of guilt to any statements, finds, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, finds, facts, and conclusions that form the basis for the deficiency. F000 The facility is committed to providing services that meet professional standards of quality for insulin administration and/or blood glucose (sugar) monitoring. Corrective Action Residents #2, 7, 4, and 5 had their blood glucose checks scheduled on 3-17-00 to conform with the facilities present policy of being done one-half hour before meals. Insulin administration for Residents #2 7, 4, and 5 with the policy to administer fast acting insulin one-half hour before meals. Residents #2, 7, 4, and 5 had their care plans updated on 1-6-00 to reflect these changes. per administrator in telephone call 4/13/00 3:15 pm Busenbark RN 5/8/00	
{F 281} SS=B	483.20(d)(3)(i) Requirement RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: Based on observation, staff interview, resident record review, and facility policy review, it was determined that the facility did not always provide services that	{F 281}		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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{F 281}	Continued From page 1 met professional standards of quality for 4 of 12 residents at the facility that required insulin administration and/or blood glucose (sugar) monitoring. (Residents: 2, 4, 5, and 7) In an interview with the corporate district nurse on 3/14/00 at 10:45 AM, she stated that the facility policy for insulin administration was to administer insulin 30 minutes before meals or per the resident's attending physician's orders. She further stated that the facility policy for blood glucose monitoring (glucoscan checks) was to be done 30 minutes before meals, just prior to administration of prescribed insulin, when the prescribed insulin dose contained a short acting insulin (regular insulin, semilente insulin, etc.) or as prescribed by the resident's physician. The corporate nurse also stated that it was a facility policy that a resident's attending physician was to be notified immediately if a resident's glucoscan results were less than 50 or more than 400. Resident 2 Resident 2 is a 75 year old male who was admitted to the facility on 8/23/99 with diagnoses of diabetes mellitus and diabetic retinopathy. Resident 2 resided on the second floor of the facility. Review of resident 2's physician's orders, dated 1/15/00 through 3/14/00, revealed orders for the following: 2/24/00: "1. (Increase) Ultra Lente (a long acting insulin) to 22 U (units) q (each) AM." "2. (Increase) 70/30 insulin (70% NPH and 30% Regular short acting insulin) to 32 U q AM." 8/24/99: "Sliding scale insulin injection:	{F 281}	Identification of Residents having Potential to be Affected All residents on blood glucose (sugar) checks and insulin administration have the potential to be affected by the practices cited. Measures to Protect against Recurrences of Practices Cited Licensed nursing staff will be inserviced by Director of Nursing or designee by 5-8-00 on the following: 1. The facility's policy of doing ordered blood glucose checks one-half hour prior to meals. 2. The facility's policy of administrating fast acting insulin one-half prior to meals. 3. Importance of doing blood glucose checks prior to administering fast acting insulin ordered with a sliding scale. 4. Necessity of charting insulin and blood glucose checks accurately and timely. 5. Documentation as to notification of physician as to high and low blood glucose levels. The facility's present standard is to notify the physician on blood sugar levels below 50 or over 400 or as directed by the physician. 6. Documentation of physician notification when insulin is held.	

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F 281}	Continued From page 2 < (less than) 200 = no insulin:, >(more than) 201 -300 = 4 units regular (insulin) sq (subcutaneous):, > 301 - 400 = 6 units regular sq:, >401 = 10 units regular sq." 8/24/99: "Glucoscan QID (4 times daily)." Review of resident 2's Patient Diabetic Record, dated 3/1/00 through 3/31/00, revealed documentation that resident 2 had his blood glucose checked 4 times daily at 7:30 AM, 12:00 noon, 5:00 PM, and 9:00 PM. Documentation also revealed that resident 2 received a sliding scale administration of regular insulin, based on these blood glucose results. In an interview with a licensed nurse on 3/13/00, the nurse stated resident 2 ate all of his meals in his room. The nurse stated the meal times for resident 7 were: Breakfast at 8:45 AM, Lunch at 1:15 PM, an Dinner at 5:30 PM. The facility failed to follow the scheduled times for blood glucose checks as evidenced by the following: Review of the Patient Diabetic Record on 3/14/00 at 7:00 AM revealed documentation that resident 2's blood glucose result was already recorded. This blood glucose result was documented 1/2 hour before it was scheduled to be checked. Review of the MAR (medication administration record), dated 3/1/00 through 3/31/00, revealed documentation that resident 2 was scheduled and had received his AM insulin each day at 7:30 AM. Documentation also revealed resident 2 was scheduled and had received his PM insulin each day at 4:30 PM. The facility failed to follow the scheduled times for	{F 281}	7. Importance of preserving the resident's privacy when licensed nurse is obtaining blood glucose checks or administrating insulin. 8. Importance of accurately performing and documenting glucometer checks per the facility policy. Also, necessity of ordering and keeping control solutions that are kept current and not outdated. The Director of Nursing will enlist the help with inservicing and/or Medical Director's Nurse Practitioner, a Registered Dietitian and/or Certified Diabetic Nurse Instructor. Monitoring Continued Compliance Continued compliance of blood glucose checks, glucometer checks, insulin administration and documentation will be through weekly audits for six weeks starting on April 24, 2000, by the Director of Nursing or designee. The Director of Nursing will report monthly to the Performance Improvement Committee for three months starting on May 1, 2000 and then as directed by the Performance Improvement Committee. The Director of Nursing will be responsible for continued compliance.	

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{F 281}	Continued From page 3 the daily administration of resident 2's insulin as evidenced by the following: On 3/14/00 at 8:40 AM, the charge nurse was observed to draw up and administer Ultra Lente insulin 22 units and 70/30 insulin 32 units to resident 2 while he was eating breakfast. This was 1 hour and 10 minutes after the insulin was scheduled to be administered. After administering the insulin at 8:40 AM, the charge nurse was then observed to document on the MAR that the insulin had been administered at 7:30 AM. Administration of resident 2's AM insulin, while he was eating breakfast, did not meet the facility's policy to administer insulin 30 minutes before the meals were served. In the Brunner and Suddarth's Textbook of Medical Surgical Nursing, eighth edition, Lippencott-Raven Publishers, 1996; Suzanne Smeltzer, RN and Brenda Bare, RN, page 1028 and 1029 states "Blood glucose monitoring is a useful procedure for all people with diabetes. It is the cornerstone of treatment for any intensive insulin therapy regime (including two to four injections per day). ...The ideal (blood glucose) testing schedule is 30 minutes before meals..." Review of the scheduled times for blood glucose checks and insulin administration revealed the following: Resident 2's AM insulin administration and blood glucose checks were ordered to done daily at the same time of 7:30 AM. Resident 2's PM insulin was ordered to be administered daily at 4:30 PM and the blood glucose check was scheduled for 5:00 PM (1/2 hour after the insulin would be administered). This	{F 281}		

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{F 281}	Continued From page 4 does not meet the facility policy. During the review of resident 2's Patient Diabetic Record for March 2000, the following blood glucose results were noted. Blood glucose results that were high (over 400): 3/3/00 at 12:00 noon = 455. 3/9/00 at 9:00 PM = 425. Blood glucose levels that were low (below 50): 3/2/00 at 7:30 AM = 44. 3/6/00 at 12:00 noon = 41. 3/8/00 at 7:30 AM = 48. Documentation on the back of the form revealed: "BS (blood sugar was only 49. No Ultra Lente (insulin) given." 3/9/00 at 7:30 AM = 75. Documentation on the back of the form revealed: "BS was only 75. No Ultra Lente given." 3/13/00 at 12:00 noon = 30. There was no documentation in resident 2's medical record that the physician was notified of the high and low blood glucose results or for holding administration of the resident's Ultra Lente insulin dosage on 3/8/00 and 3/9/00. In multiple interviews with licensed staff on 3/14/00 and 3/15/00, it was revealed that the licensed staff was unaware of what the facility's high and low blood glucose parameters were for notification of the physician. Resident 7 Resident 7 was admitted to the facility on 7/28/99 with the diagnosis of diabetes. Resident 7 resided on the second floor of the facility.	{F 281}		

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{F 281}	Continued From page 5 Review of the physician's orders, dated 8/5/99, revealed resident 7 was to have insulin 70/30 12 units sq q AM and 70/30 8 units sq q PM. The resident also had an order, dated 8/16/99, for glucoscan checks BID (2 times daily). Resident 7 ate her meals in the second floor dining room. The posted mealtimes for the dining room were: Breakfast at 8:15-8:30 AM, Lunch at 1:00-1:15 PM, Dinner at 6:15-6:30 PM. Review of the MAR revealed resident 7 was scheduled to have insulin administered and a glucoscan check daily at 7:30 AM and 5:00 PM. Review of the Patient Diabetic Record on 3/14/00 at 7:00 AM revealed documentation that resident 7's blood glucose result was already recorded. This blood glucose result was documented 1/2 hour before it was scheduled to be checked. At 6:25 PM, the resident was observed to enter the dining room. The resident's meal was served at this time. When asked about the administration of resident 7's PM insulin, which was scheduled to have been administered at 5:00 PM, the charge nurse stated she had held the insulin until the resident's meal was served. The charge nurse stated she would administer the resident's PM insulin at this time. This was 1 hour and 25 minutes after resident 7's insulin was scheduled to be administered Administration of resident 7's AM insulin while she was eating dinner, did not meet the facility's policy to administer insulin 30 minutes before the meals were served.	{F 281}		

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{F 281}	Continued From page 6 Resident 4 Resident 4 was admitted to the facility on 1/21/00 with diagnoses that included diabetes mellitus, hypertension, cerebrovascular accident, and dementia. Resident 4 resided on the first floor of the facility. Review of resident 4's medication record revealed a physician's order for NPH insulin 17 units with regular insulin 10 units every morning. This dose of insulin was scheduled to be administered to resident 4 at 7:30 AM each morning. The medication record further documented an order for NPH insulin 10 units with regular insulin 5 units every evening. This dose of insulin was scheduled to be administered to resident 4 at 5:00 PM. Review of resident 4's "Patient Diabetic Record" dated 3/1/00 through 3/31/00 documented that resident 4 had a physician's order for Glucoscans BID. There were no specific times ordered by resident 4's physician. The glucoscans were scheduled on the "Patient Diabetic Record" to be done at 6:30 AM and 5:45 PM each day. In an interview with a facility nurse on 3/13/00 at 3:00 PM, the nurse stated that dinner was served to the residents on the first floor from 5:45 PM to 6:15 PM. She also stated that breakfast was served to the first floor residents from 7:45 AM to 8:15 AM Review of resident 4's diabetic record sheet on 3/14/00 at 7:00 AM, revealed documentation that resident 4's glucoscan check for 3/14/00 at 6:30 AM	{F 281}		

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was 134.

Observation of resident 4 on 3/14/00 during the breakfast meal revealed that resident 4 was brought to the dining room at 8:00 AM. The facility nurse was observed to administer resident 4's morning insulin to resident 4 at 8:10 AM. Resident 4 was served his breakfast meal at 8:20 AM.

Resident 4 was observed on 3/15/00 from 5:00 PM to 6:15 PM. Resident 4 was observed to be stopped in the hallway by the nurse. The facility nurse attempted to do a glucoscan check on resident 4 at 5:00 PM, but resident 4 refused the check. While resident 4 remained in the hallway, the nurse was then observed to administer resident 4's evening insulin dose at 5:10 PM. At 6:10 PM, resident 4 was observed in the dining room being served his evening meal by the facility staff.

Resident 4's physician orders for insulin contained orders for a short acting insulin twice a day. Resident 4's morning glucoscan checks were scheduled to be done 11/2 hours before his breakfast was scheduled to be served and 1 hour before resident 4 was to have his insulin administered. Resident 4's evening glucoscan checks were scheduled to be done 45 minutes after resident 4's evening dose of insulin was scheduled to be administered. Resident 4's evening dose of insulin was scheduled 1 hour before resident 4 was scheduled to be served his evening meal. Resident 4 did not receive his meals within 1/2 of receiving his prescribed insulin as per the facility policy. Resident 4 did not receive his prescribed glucoscan checks as per the facility policy.

Resident 5

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{F 281}	Continued From page 8 Resident 5 was admitted to the facility on 8/14/98 with diagnoses that included diabetes mellitus, dementia with depressive features, and urinary tract infections. Resident 5 resided on the first floor of the facility. Review of resident 5's physician orders revealed an order for glucoscans QOD (every other day). There was no specific times ordered for the glucoscans to be done. The physician's orders further revealed orders for NPH insulin 45 units with regular insulin 20 units every morning and NPH insulin 25 units with regular insulin 15 units every evening. Review of resident 5's medication record revealed that resident 5's morning insulin dose of NPH insulin 45 units with regular insulin 20 units was scheduled to be administer at 7:30 AM each morning. Resident 5's evening insulin dose of NPH insulin 25 units with regular insulin 15 units was scheduled to be administered at 5:00 PM. Review of the medication record on 3/14/00 at 9:15 AM revealed that the facility nurse had administered resident 5's morning insulin dose at 7:30 AM. Review of the "Patient Diabetic Record" for resident 5 revealed that resident 5's glucoscan checks were scheduled to be done at 7:45 AM every other day. On 3/14/00 at 7:00 AM, review of resident 5's diabetic record revealed documentation of a glucoscan check result for 3/14/00 of 118. This result was documented on the record 45 minutes before the actual glucoscan check was scheduled to be completed. Observation of resident 5 on 3/14/00, during the breakfast meal, revealed that resident 5 was served	{F 281}		

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her breakfast meal at 8:15 AM. This is 45 minutes after resident 5 was documented as having her morning insulin.

Review of resident 5's medication record on 3/15/00 revealed that the nurse had documented that resident 5 had received her evening dose of insulin at 5:00 PM.

Observation of resident 5 on 3/15/00 during the evening meal revealed that resident 5 was served her evening meal at 6:00 PM. This is 1 hour after resident 5 was documented as having her evening dose of insulin.

Resident 5's physician's orders for insulin included a short acting insulin to be administered twice a day. Resident 5's evening dose of insulin was scheduled 1 hour prior to when resident 5's evening meal is scheduled to be served. Resident 5's glucoscan checks were scheduled 15 minutes after the morning insulin was scheduled to be given. Resident 5 did not receive her meals within 1/2 hour after receiving her prescribed insulin.

Blood Glucose Monitor

Review of the facility's Policy and Procedure for the Blood Glucoscan Monitoring System revealed the following:
"Policy: Accurate blood glucose monitoring will be maintained.
Procedure: Staff on the noc (night) shift are to check the blood glucose monitoring meter to assure that there is accuracy in the glucose readings.
1. Each nurse on each unit will perform a quality control test on each blood glucose monitoring meter on his/her unit between 5 AM and 6 AM, prior to

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morning glucose checks. The results of the quality control test is to be documented on the Quality Assurance Daily Checks.
2. See attached information on how to perform quality control tests.
3. Additionally perform a quality control test:
a. If a patient test has been repeated and the blood glucose results are still lower or higher than expected.
b. When trouble shooting the system.
c. If the meter is dropped.
d. If a control solution result falls outside the expected range, repeat the quality control test."

Review of a memo, dated 2/25/00 and posted at the 200 floor nurses station, revealed the following: "Night Shift Nurses- effective immediately, the glucometers are to be tested on night shift as per protocol and the results charted on the flow sheets. Please review the protocol for testing them, a copy is in the communications binder." The memo was signed by the Staff Development Coordinator.

The SureStepPro Control blood glucose monitor operation manual states, "Quality Control Test: Important Control Solution Test Information...Do not use beyond the expiration date. Write the opened date on the control solution vial when you first open it. Discard the vial 3 months after opening..."

Review of the facility's Blood Glucose Monitoring System Quality Assurance Daily Checks revealed the following:
First floor: The form, dated 2/29/00 through 3/9/00 revealed documentation that there was " No test solution" available to perform the daily quality control blood glucose checks. Documentation for the dates 3/11/00 and 3/13/00 revealed that only the low control

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{F 281}	Continued From page 11 parameters were checked. The high control parameters were left blank for the whole form. Second floor: The form, dated 2/26/00 through 3/13/00 revealed no documentation of low or high control results. On 2/26/00, documentation on the form indicated the expiration date for the control solutions was 7/99. All further entries through 3/31/00 documented, "As above." This indicated the facility had been using a control solution that had been expired for 7 months. In an interview with a facility staff nurse, working on the first floor, on 3/13/00 at 3:30 PM, she stated that the quality control solutions for the glucoscan machines had expired and that the facility had not received any new solutions to replace the expired solutions. She stated that the first floor had not had any new solutions since before the first of March 2000 and that is why the quality control tests had not been done on the glucoscan machine. The facility staff failed to follow their policy by not accurately performing a daily quality control blood glucose check and by using expired control solutions. By not performing the daily quality control test, the staff would not know if the glucose monitor results were correct. This potentially put the residents at risk for improper insulin dose calculation directly related to blood glucose monitoring results.	{F 281}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
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