

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345555</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRABTREE VALLEY REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3830 BLUE RIDGE ROAD RALEIGH, NC 27612</b>		
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F 157 SS=D	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, physician interview and record review the facility failed to notify the physician of a resident's low blood sugar for one</p>	F 157	This plan of correction constitutes Hillcrest Raleigh at Crabtree, LLC's (Hillcrest's) written allegation of	8/13/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/05/2015

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 157	<p>Continued From page 1 of four sampled residents with diabetes, Resident #4.</p> <p>Findings included: Review of Standing Orders (undated) revealed, "For FSBS (finger stick blood sugar) (procedure in which a finger is pricked with a lancet to obtain a small quantity of capillary blood for testing blood sugar levels.) &lt;60 (if FSBS was less than 60): (give) orange juice with two packets sugar PO (by mouth). If unable to take PO, give Glucagon 1 milligram (mg) IM (intramuscularly) x 1 (one time), monitor vital signs every 5 minutes x 3 (three times). Recheck FSBS in 15 minutes. If still &lt; 60 give 2nd dose of Orange juice or Glucagon 1 mg IM and call MD (physician)." Resident # 4 was readmitted to the facility on 02/23/15 with cumulative diagnoses of diabetes mellitus, chronic kidney disease and coronary artery disease.</p> <p>Review of Resident # 4's quarterly Minimum Data Set of 04/21/15 revealed the resident was cognitively intact and was totally dependent on staff with all activities of daily living.</p> <p>The resident's care plan of 10/11/14, last reviewed 4/27/15, stated, "Problem: diabetes: potential for complications r/t (related to) diabetes. "Approaches included" accuchecks (a test for blood sugar) as ordered, administer insulin as ordered, monitor for signs of hypoglycemia: cold clammy skin, shallow respirations, mental confusion, keep MD (physician) updated of abnormal glucose per policy."</p> <p>The May 2015 Medication Administration Record (MAR) revealed the resident had a blood sugar fingerstick of 55 at 6:30 AM on 05/20/15. The reverse page of the MAR indicated one cup of juice was given [did not specify the type of juice] and did not indicate if two packets of sugar were</p>	F 157	<p>compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The DON/designee clarified the order received by the physician regarding when he should be notified regarding Resident #4's blood sugar readings and developed a MD fax order form, blood glucose flow sheet, and staff to staff reporting procedure, to ensure proper procedures and documentation are in place, and notification of blood sugar results are made in accordance with physician orders for resident #4. Resident #4's care plan will be read and amended as necessary to ensure proper communication has occurred. Implementation of these forms will ensure proper documentation and communication occurs between nursing staff and physicians. The staff member who failed to notify the physician was educated, by the DON, on the proper procedure for notification of changes on 07/16/15.</p> <p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice.</p>		

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F 157	<p>Continued From page 2</p> <p>added. Two additional blood sugar fingersticks were recorded on that day, which were 67 and 80.</p> <p>Review of the resident's medical record revealed no evidence that the physician was notified of the resident low blood sugar.</p> <p>An interview was conducted on 07/16/15 at 4:00 PM with the dayshift nurse (Nurse #1) that was assigned to the resident on 05/20/15. She stated that she got a report of the resident's low blood sugar (55) from the night nurse. The resident did eat his breakfast. She did not call the doctor because the sugars were coming up.</p> <p>In an Interview with the charge nurse on the 400 hall (Nurse #2) on 07/16/15 at 12 noon, she said she would call the doctor at a blood sugar of 55.</p> <p>Interview with the unit manager on 07/16/15 at 1:30 PM, she stated the standing orders for the facility directed staff to intervene if the FSBS is &lt;60. She would have called the doctor.</p> <p>Interview with Director of Nursing was conducted on 07/16/15 at 4:00 PM. She stated the house standard would be to call the physician for sugars &lt;60 or &gt;400 and to follow facility standing orders. She confirmed that there was no notation of the physician being called in either the nurses' notes or the communication book. She stated that her expectation was the nurses follow the standing orders.</p> <p>During an interview with the attending physician on 07/16/15 at 4:40 PM, he stated he did not remember being called for either the low sugar or when the resident was sent to the hospital. He stated that his expectation was that he should be called when sugars were low specifically &lt; 70. The doctor stated that this resident was very difficult to treat because of his comorbidities. He acknowledged that his standing orders say sugars &lt;60.</p>	F 157	<p>A review of residents receiving finger stick blood sugars found no other incidents of sugars less than 60 without MD notification. The facility will implement new documentation procedures, and update education of staff in regards to notification of changes to physician. MD fax order form, blood glucose flow sheets, and telephone order shift to shift verification of orders are in place for all residents receiving finger stick blood sugars and it has been confirmed that all orders match the MAR. Shift to shift verification includes: nurse to nurse hand-off of all orders received and documentation verified on chart. Both nurses initial telephone order sheet. DON/designee will verify that shift verification occurs. All nurses will be educated on procedures for notification of changes in regards to communicating with the physician. This education will be conducted by the DON/designee.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>MD fax order sheets and blood glucose flow sheets will be put in place to ensure nurses follow up with communication procedures. The DON/designee will verify standing orders for diabetic events are being followed and ensure orders are updated and nursing staff have been educated. Diabetic events and notification of the M.D. will be handled in accordance</p>		

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F 157	Continued From page 3 The resident was sent to the emergency room at 12:30 PM on 05/20/15.	F 157	with each resident's plan of care and the MD orders set forth in resident's records.  4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The Plan of Correction is integrated into the quality assurance system of the facility.  Monitoring of these changes, specifically, the appropriate use of the MD fax order sheets and blood glucose logs, will be performed by the DON/designee weekly x4, bi-monthly x2 months, and monthly x1. The facility QA committee and administrator/designee will review the monitoring results during QA meetings. DON/designee will be responsible for monitoring and reporting.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to write a physician order to discontinue sliding scale insulin, to start scheduled insulin therapy and to change the frequency of blood sugar fingersticks. The facility failed to follow their diabetic standing orders to	F 281	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/designee clarified the order received by the physician and developed	8/13/15	

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F 281	<p>Continued From page 4</p> <p>treat a resident that had low blood sugar in one of four sampled residents with diabetes, Resident #4.</p> <p>Findings included:</p> <p>1a. Resident #4 was admitted to the facility on 01/15/13 and readmitted on 01/20/15 with cumulative diagnoses of diabetes mellitus, hypertension, chronic kidney disease and coronary artery disease. January 2015 physician orders revealed resident was on Lantus insulin 100 units/ml, 45 units subcutaneously twice daily, Humalog insulin 100 units/ml, 5 units subcutaneously three times a day before meals and a sliding scale insulin order for Novolog 100 units/ml. The amount that needed to be administered was determined by computing the following formula: (value of the fingerstick) - 140) / 20= # of units to give. Blood sugar fingersticks were to be done before meals and at bedtime, at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM.</p> <p>The pharmacist "Consultation Report" of 03/12/15 stated "Please consider improving glycemic control by discontinuing sliding scale insulin Novolog and starting Novolog 4 units before lunch and dinner." The physician accepted the recommendations and asked to implement them as written. The physician signed the report on 03/26/15. The report had a handwritten note dated 03/31/15 that read "on POS" (physician order sheet). This note was signed by Nurse #4.</p> <p>Review of Resident # 4's quarterly Minimum Data Set of 04/21/15 revealed the resident was cognitively intact and was totally dependent on staff with all activities of daily living.</p> <p>According to the April 2015 Medication Administration Record (MAR), the resident</p>	F 281	<p>a MD fax order form and blood glucose flow sheet was initiated to ensure proper procedures and documentation are in place, for resident #4. Implementation of these forms will ensure proper documentation is in place and carried out in a timely manner. The staff member who failed to write the physician order, to discontinue sliding scale insulin and to start scheduled insulin therapy and to change the frequency of the blood sugar finger sticks was educated, by the DON, on the proper professional standard regarding transcribing orders on 7/16/15.</p> <p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice.</p> <p>A review of residents receiving finger stick blood sugars will be completed by 8/13/15 to ensure all no other residents have been affected. If any incidents are found the same measures will be put in place as were done for Resident #4. The facility will implement new documentation procedures, update education of staff in regards to transcribing physician orders. The DON/ADON receives pharmacy recommendations and goes over those with the physician monthly/as needed. The physician signs off if in agreement of recommendation and orders are transcribed to the MAR as appropriate. The MD fax order form and blood glucose flow sheets, along with telephone order shift to shift verification of orders/documentation are in place for all</p>		

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F 281	<p>Continued From page 5</p> <p>Novolog sliding scale order (including the fingersticks four times a day) was discontinued on 03/31/15 (a line was drawn across the order and D/C (discontinued) 3/31/15 was written beside the line). Review of the resident's medical record revealed the resident did not receive the Novolog sliding scale after 03/31/15. Review of the April 2015 MAR indicated that the resident did receive Novolog 4 units before lunch and dinner starting 04/01/15. However, there was no telephone physician order written to discontinue the Novolog sliding scale and start the scheduled Novolog twice a day until 04/08/15 when a physician order was written to discontinue Novolog sliding scale and to start Novolog 4 units before lunch and before dinner. Nurse #4 was interviewed on 07/16/15 at 4 PM. Nurse #4 revealed that she did not write a telephone order to discontinue the Novolog sliding scale and to start on Novolog 4 units twice a day because she did not believe that she needed a telephone order for that.</p> <p>1b. Resident #4 was admitted to the facility on 01/15/13 and readmitted on 01/20/15 with cumulative diagnoses of diabetes mellitus, hypertension, chronic kidney disease and coronary artery disease. January 2015 physician orders revealed resident was on Lantus insulin 100 units/ml, 45 units subcutaneously twice daily, Humalog insulin 100 units/ml, 5 units subcutaneously three times a day before meals and a sliding scale insulin order for Novolog 100 units/ml. The amount that needed to be administered was determined by computing the following formula: (value of the fingerstick) - 140) / 20= # of units to give. Blood sugar fingersticks were to be done before meals and at bedtime, at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM.</p>	F 281	<p>residents receiving finger blood stick sugars to ensure that orders match the MAR. This shift to shift verification includes: nurse to nurse hand-off of all orders received and documentation verified on chart. Both nurses initial telephone order sheet. DON/designee will verify that shift verification report occurs daily. All nurses will be educated on procedures for notification of changes in regards to communicating with the physician and hand-off. This education will be conducted by the DON/designee.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>MD fax order sheets and blood glucose flow sheets will be put in place to ensure nurses follow up with communication along with telephone order shift to shift hand-off verification procedures. The DON/designee will verify standing orders for diabetic events and ensure orders are updated and nursing staff have been educated.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.</p>		

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F 281	<p>Continued From page 6</p> <p>The pharmacist "Consultation Report" of 03/12/15 stated "Please consider improving glycemic control by discontinuing sliding scale insulin Novolog and starting Novolog 4 units before lunch and dinner." The physician accepted the recommendations and asked to implement them as written. The physician signed the report on 03/26/15. The report had a handwritten note dated 03/31/15 that read "on POS" (physician order sheet). This note was signed by Nurse #4.</p> <p>According to the April 2015 Medication Administration Record (MAR), the resident Novolog sliding scale order (including the fingersticks four times a day) was discontinued on 03/31/15 (a line was drawn across the order and written D/c (discontinued) 3/31/15). A document titled "Fingerstick Blood Sugar Record" revealed the resident continued to get fingersticks at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM on 04/01/15 and 04/02/15. The Fingersticks records also revealed the resident was given 4 units of insulin (the type was not specified) on 04/01/15 at 4:30 PM. Review of the April 2015 MAR indicated the resident was given 4 units of Novolog on 04/01/15 at 4:30 PM with no site of injection specified. Even though the pharmacist "Consultation Report" of 03/12/15 indicated the physician agreed to discontinue the sliding scale insulin, and the MAR indicated the sliding scale insulin was discontinued on 03/31/15. The resident continued to have fingersticks four times a day on 04/01/15 and 04/02/15. There was no order to do fingersticks on 04/01/15 or 04/02/15 four times a day and the fingersticks readings were not documented on the MAR.</p> <p>Review of a statement written by Nurse #4 dated 04/03/15 revealed that Nurse #5 expressed to her that she continued to do fingersticks for 04/01/15</p>	F 281	<p>Monitoring of these changes, through review of new forms and the medical records ensuring physician orders are documented, followed and physician is notified in accordance with plan of care and/or physician orders, will be performed by the DON/designee weekly x4, bi-monthly x 2 months, and monthly x1. The facility QA committee and administrator/designee will review monitoring during QA meetings. DON/designee will be responsible for monitoring and reporting. The monitoring will be implemented to ensure that the forms and order sheets put in place reflect accurate documentation and implementation of physician orders.</p>		

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F 281	<p>Continued From page 7 and 04/02/15. However, Nurse #5 said that she was unsure if the new orders meant to discontinue the sliding scale insulin only or the sliding scale and the fingersticks. Review of the 24-Hour Report of Resident Condition of 04/03/15 revealed that Nurse #5 wrote a note that read "clarification BS (blood sugar (fingerstick)) q (every) 0630 (6:30 AM) and (zero) sliding scale." However, there was no physician telephone order written on 4/3/15 regarding the change in the fingersticks order and it was not transcribed on the MAR.</p> <p>Record review of the statement from Nurse #4 dated 04/03/15 revealed that Nurse #5 asked the pharmacy consultant on 04/03/15 to clarify what the consultant meant. The physician was contacted and he gave an order to do BS (blood sugar) once daily at 6:30 AM. Nurse #5 stated she was in the middle of shift change when the attending physician called back. She wrote the new order on the 24 hour report sheet. The new physician order was not written as a telephone order and was not transcribed to the chart or the MAR.</p> <p>A telephone physician order was written on 04/08/15 to start Novolog 4 units before lunch and before dinner. There was no physician telephone order for doing fingersticks once daily at 6:30 AM.</p> <p>Review of April, 2015 MAR showed no documentation of blood sugar fingersticks. However, the daily fingersticks continued to be documented on the Fingerstick Blood Sugar Record for once a day at 6:30 AM.</p> <p>Review of pharmacist consultant sheet dated 05/12/15 revealed she realized there was no monitoring of blood sugar fingersticks on the MARs and wrote a recommendation for monitoring.</p>	F 281			



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F 281	Continued From page 8 On 05/12/15 Nurse #5 wrote the telephone order "order clarification for MAR/POS-Check blood sugar once a day at 6:30 AM d/t (Due to) insulin use." 1c. Review of Standing Orders (undated) revealed, "For FSBS (finger stick blood sugar) (procedure in which a finger is pricked with a lancet to obtain a small quantity of capillary blood for testing blood sugar levels.) <60 (if FSBS was less than 60): (give) orange juice with two packets sugar PO (by mouth). If unable to take PO, give Glucagon 1 mg (milligram) IM (intramuscularly) x 1 (one time), monitor vital signs every 5 minutes x 3 (three times). Recheck FSBS in 15 minutes. If still < 60 give 2nd dose of Orange juice or Glucagon 1 mg IM and call MD." Record review of the May 2015 MAR revealed that the resident had a blood sugar fingerstick of 55 at 6:30 AM on 05/20/15. The reverse page of the MAR indicated the resident was given one cup of juice was given [did not specify the type of juice] but did not indicate if two packets of sugar were added. Two additional blood sugar fingersticks were recorded on that day, which were 67 and 80. But the record did not indicate what time the blood sugar fingersticks were taken. There were no nursing signatures on any of the values. Interview with Nurse #1 on 07/16/15 at 5 PM revealed that on 5/20/15, the resident's blood sugar read 55. She gave him a cup of juice and she did not remember if she used two packets of sugar.	F 281			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each	F 514		8/13/15	

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F 514	<p>Continued From page 9</p> <p>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to keep accurate medical records for one of four sampled residents with diabetes, Resident #4. Findings included: 1a. Resident #4 was admitted to the facility on 01/15/13 and readmitted on 01/20/15. January 2015 physician orders revealed the resident was on Lantus insulin 100 units/ml, 45 units subcutaneously twice daily, Humalog insulin 100 units/ml, 5 units subcutaneously three times a day before meals and a sliding scale insulin order for Novolog 100 units/ml. The pharmacist "Consultation Report" of 03/12/15 stated "Please consider improving glycemic control by discontinuing sliding scale insulin Novolog and starting Novolog 4 units before lunch and dinner." The physician accepted the recommendations and asked to implement them as written. The physician signed the report on 03/26/15. The report had a handwritten note dated 03/31/15 that read "on POS" (physician order sheet). This note was signed by Nurse #4.</p>	F 514	<p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The DON clarified the order received by the physician and developed a MD fax order form and blood glucose flow sheet to ensure proper procedures and documentation are in place. No negative outcome was noted for Resident #4. Implementation of these forms will ensure proper documentation is in place and physician orders are appropriately documented and carried out in a timely manner. The staff member who failed to write the physician order, to discontinue sliding scale insulin and to start scheduled insulin therapy and to change the frequency of the blood sugar finger sticks was educated, by the DON, on the proper professional standard regarding transcribing orders. Education for this staff member occurred 7-16-15</p>		

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F 514	<p>Continued From page 10</p> <p>According to the April 2015 Medication Administration Record (MAR), the resident Novolog sliding scale order (including the fingersticks four times a day) was discontinued on 03/31/15 (a line was drawn across the order and D/c (discontinued) 3/31/15 was written beside the line). Review of the resident 's medical record revealed the resident did not receive the Novolog sliding scale after 03/31/15. Review of the April 2015 MAR indicated that the resident did receive Novolog 4 units before lunch and dinner starting 04/01/15. However, there was no telephone physician order written to discontinue the Novolog sliding scale and start the scheduled Novolog twice a day until 04/08/15 when a physician order was written to discontinue Novolog sliding scale and to start Novolog 4 units before lunch and before dinner. Nurse #4 was interviewed on 07/16/15 at 4 PM. Nurse #4 revealed that she did not write a telephone order to discontinue the Novolog sliding scale and to start on Novolog 4 units twice a day because she did not believe that she needed a telephone order for that.</p> <p>1b. Resident #4 was admitted to the facility on 01/15/13 and readmitted on 01/20/15. January 2015 physician orders revealed resident was on Lantus insulin 100 units/ml, 45 units subcutaneously twice daily, Humalog insulin 100 units/ml, 5 units subcutaneously three times a day before meals and a sliding scale insulin order for Novolog 100 units/ml. Blood sugar fingersticks were to be done before meals and at bedtime, at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM.</p> <p>The pharmacist "Consultation Report" of 03/12/15 stated "Please consider improving glycemic control by discontinuing sliding scale insulin Novolog and starting Novolog 4 units</p>	F 514	<p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice.</p> <p>A review of residents receiving finger stick blood sugars will be conducted by DON/designee to ensure no other residents of sugars less than 60 have occurred without MD notification and documentation. The facility will implement new documentation procedures, update education of staff in regards to transcribing physician orders. This will establish MD fax order form and blood glucose flow sheets are in place for all residents receiving finger stick blood sugars and that orders match the MAR. All nurses will be educated on procedures for notification of changes in regards to communicating with the physician and there responsibility with charting. This education will be conducted by the DON/designee</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>MD fax order sheets and blood glucose flow sheets will be put in place to ensure nurses follow up with communication procedures. The DON/designee will verify standing orders for diabetic events and ensure orders are updated and nursing staff have been educated.</p>		

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F 514	<p>Continued From page 11</p> <p>before lunch and dinner." The physician accepted the recommendations and asked to implement them as written. The physician signed the report on 03/26/15. The report had a handwritten note dated 03/31/15 that read "on POS" (physician order sheet). This note was signed by Nurse #4.</p> <p>According to the April 2015 Medication Administration Record (MAR), the resident Novolog sliding scale order (including the fingersticks four times a day) was discontinued on 03/31/15 (a line was drawn across the order and written D/C (discontinued) 03/31/15). A document titled "Fingerstick Blood Sugar Record" revealed the resident continued to get fingersticks at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM on 04/01/15 and 04/02/15. The Fingersticks records also revealed the resident was given 4 units of insulin (the type was not specified) on 04/01/15 at 4:30 PM. Review of the April 2015 MAR indicated the resident was given 4 units of Novolog on 04/01/15 at 4:30 PM with no site of injection specified. Even though the pharmacist "Consultation Report" of 03/12/15 indicated the physician agreed to discontinue the sliding scale insulin, and the MAR indicated the sliding scale insulin was discontinued on 03/31/15. The resident continued to have fingersticks four times a day on 04/01/15 and 04/02/15. There was no order to do fingersticks on 04/01/15 or 04/02/15 four times a day and the fingersticks readings were not documented on the MAR.</p> <p>Review of a statement written by Nurse #4 dated 04/03/15 revealed that Nurse #5 expressed to her that she continued to do fingersticks for 04/01/15 and 04/02/15. However, Nurse #5 said that she was unsure if the new orders meant to discontinue the sliding scale insulin only or the sliding scale and the fingersticks.</p>	F 514	<p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.</p> <p>Monitoring of the new procedures by review of the new forms and medical records to ensure medical records are complete and have been updated in a timely manner to reflect all physician communication and orders and appropriate notification of the physician will be performed by the DON/designee weekly x4, bi-monthly x2 months and monthly x1. The facility QA committee and administrator/designee will review monitoring during QA meetings. DON/designee will be responsible for monitoring and reporting.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 12</p> <p>Review of the 24-Hour Report of Resident Condition of 04/03/15 revealed that Nurse #5 wrote a note that read "clarification BS (blood sugar (fingerstick)) q (every) 0630 (6:30 AM) and (zero) sliding scale." However, there was no physician telephone order written on 04/03/15 regarding the change in the fingersticks order and it was not transcribed on the MAR.</p> <p>Record review of the statement from Nurse #4 dated 04/03/15 revealed that Nurse #5 asked the pharmacy consultant on 04/03/15 to clarify what the consultant meant. The physician was contacted and he gave an order to do BS (blood sugar) once daily at 6:30 AM. Nurse #5 stated she was in the middle of shift change when the attending physician called back. She wrote the new order on the 24 hour report sheet. The new physician order was not written as a telephone order and was not transcribed to the chart or the MAR.</p> <p>A telephone physician order was written on 04/08/15 to start Novolog 4 units before lunch and before dinner. There was no physician telephone order for doing fingersticks once daily at 6:30 AM.</p> <p>Review of April, 2015 MAR showed no documentation of blood sugar fingersticks. However, the daily fingersticks continued to be documented on the Fingerstick Blood Sugar Record for once a day at 6:30 AM.</p> <p>Review of pharmacist consultant sheet dated 05/12/15 revealed she realized there was no monitoring of blood sugar fingersticks on the MARs and wrote a recommendation for monitoring.</p> <p>On 05/12/15 Nurse #5 wrote the telephone order "order clarification for MAR/POS-Check blood sugar once a day at 6:30 AM d/t (Due to) insulin use."</p>	F 514			

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