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HALSTED TERRACE NURSING CTR	10935 SOUTH HALSTED STREET CHICAGO, IL 60628

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F 501	Continued From page 40 elevated blood sugars in a timely manner, and obtaining necessary laboratory reports. The medical director failed to work with the facility in providing coordination of resident care for R27 when the attending physician did not promptly contact the facility.	F 501		
F9999	FINAL OBSERVATIONS Licensure Violations 300.610a) 300.1010h) 300.1210b)1) 300.1210b)2) 300.1210b)3) 330.1610a)1) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician, or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) Facility staff shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens	F9999		

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F9999	Continued From page 41 the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b)1) Medications including oral, rectal, hypodermic, intravenous, and imtramuscular shall be properly administered. b)2) All treatments and procedures shall be administered as ordered by the physician. b)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1610 Medication Policies and Procedures a)1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. These regulations were not met as based on observations, record review and interviews the	F9999		

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facility failed to:
[1] Monitor and report to the physician seriously abnormal blood sugar levels,
[2] Follow their policy and procedure for monitoring blood sugars, and
[3] Obtain laboratory values for R27 and R25.
These failures resulted in R27 being hospitalized for high blood sugar.

Findings include:

1) R27 is a 72 year old resident with diagnoses of Diabetes Mellitus, Hypertension and Dementia. R27 resides on the Alzheimer's Unit of the facility. R27 was observed during the medication pass of 06/14/2006. During record review it was noted that R27 had several instances of severely elevated blood sugar. Normal blood sugar per the facility's laboratory is 64 to 112 mg/dl. R27 has physician's order for "blood sugar monitoring twice a day and record, call the physician if over 400." In addition R27 has orders for Insulin coverage (sliding scale) based on the blood sugar level. The order for coverage ends at 400 mg/dl. A review of R27's blood glucose monitoring sheet indicates that R27 had the following abnormal blood sugar results:

06/01 at 6:00am: low
06/02 at 4:00pm: 400mg/dl
06/05 at 4:00pm: 432mg/dl
06/06 at 4:00pm: 400mg/dl
06/10 at 4:00pm: Hi (to high to be read)
06/11 at 4:00pm: 403mg/dl

On 06/10/2006, the facility attempted to contactZ 1 (physician) about R27's elevated blood sugar, the page was not returned. The facility finally contacted Z1 on 06/11/2006 at 7:00am and at

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that time Z1 ordered a fasting CMP (Comprehensive Metabolic Panel) for the next day, 06/12/2006. Nursing notes state: "Fasting lab for CMP scheduled for am." The lab report was not collected until June 14, 2006 at 5:00am. E2 (Director of Nursing) presented this lab report to the survey team June 15, 2006. The results were as follows: Glucose: 416mg/dl (normal 64 to 112), Blood Urea Nitrogen: 47mg/dl (normal 5. 0 to 28.0mg/dl), Creatinine 1.7mg/dl (normal 0.6 to 1.2mg/dl) and BUN/CREA Ration: 27.6 ratio(normal 12 to 30). According to the laboratory report, the results were significant; they were called and faxed to the facility at 2:55pm. Z1 was notified at 4:35pm about the lab values and ordered the resident sent out to the hospital.

R27 was transferred at 5:10pm to the hospital and returned to the facility 06/15/2006 at 4:00am. The hospital orders were as follows: "Offer more fluids, check blood sugar four times a day". Later that morning, the hospital called the facility with additional lab values and the resident was returned to the hospital for further treatment.

Z1 (attending physician) was interviewed by phone 06/15/2006 at 10:20am. Z1 stated that "R27 was sent out to the hospital due to elevated blood sugar levels." Z1 stated that, "I want to be aware of blood sugar levels over 400." "R27 was hyperglycemic and dehydrated based on her labs ....I question compliance with blood sugar monitoring, as sometimes they do it at the wrong time." Z1 also confirmed during the interview that he was not aware of the other occasions of R27's elevated blood sugar. Z1 stated that he bases his treatment plan (insulin dosages) upon review of the history of blood sugars. Z1 also stated that

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he did not want the resident to have a seriously low blood sugar so he relies on the daily blood sugar monitoring. Finally, Z1 stated that a prolonged elevated blood sugar is often a sign that some other problem is going on with the resident. Z1 stated that R27's elevated blood sugars were related to the elevated cardiac enzymes. Z1 also stated that based on the fasting level of over 400mg/dl that R27 most likely had an elevated blood sugar for some time.

The facility's policy for Blood Glucose Monitoring states: "Inform Doctor of abnormal blood glucose and lab values", "Reassess abnormal findings 1 hour after administration of coverage. Inform MD of findings as indicated."

The facility failed to promptly notify the physician of R27's severely elevated blood sugar, failed to obtain a medication order for blood sugars over 400, and failed to obtain a fasting lab as ordered. When Z1 did not respond to the facility's page, the medical director or alternative physician was not notified on 06/10/2006 of a seriously high blood sugar level. Sliding scale insulin was administered to R27 without a physician's order. On 06/02, 06/05, 06/09, and 06/11 the blood sugar was not checked again to see if the level had decreased.

2) R25 is a 78 year old resident who resides on the Alzheimer Unit of the facility. R25 has the following diagnosis: Insulin Dependent Diabetes, Alzheimer Disease, Hypertension, and Depression. R25 has physician orders that include monitoring blood sugar and notifying the physician of levels above 400mg/dl. R25 also has orders for insulin coverage based on the

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blood sugar results. R25 was also observed during the medication pass of 06/14/2006. Surveyor noted that the 6:00am blood sugar test was not completed for that day. Surveyor asked E5 (floor nurse) about the results. E5 stated that the results would be found in the blood glucose monitoring sheet. E5 confirmed that this information was not recorded in the blood glucose monitoring sheet. E5 also reviewed the daily report book and could not locate the 6:00am blood sugar level. A review of the blood sugar record indicates that R25 had an elevated level of 402mg/dl on 06/02/2006 at 4:00pm and a level of 400mg/dl on 06/11/2006. Furthermore the blood sugar level for 06/13/2006 at 4:00pm was 119mg/dl; however no level could be located for the morning of 06/14/2006. In addition, the physician ordered an HbA1c (hemoglobin A1c) value 04/25/2006. This lab was not completed on R25. HbA 1c is the long term measurement of blood sugar levels in Diabetics. An elevated level would demonstrate poor blood sugar control.

Surveyor interviewed Z2 (physician) and Z3 (physician) on 06/15/2006 at 12:10 and 12:15pm. Both physicians provide care to R25. Z2 stated during the interview that he monitors and checks the HgA1c to make the determination about insulin dosages. Z2 stated that this measure gives the history of the resident's blood sugar. In addition, Z2 also confirmed that he wants to be notified of blood sugars of 400mg/dl and above. Z2 stated he looks at the whole history before changing insulin doses since he does not want the resident to have a low blood sugar. Z2 stated that he was not notified of the elevated blood sugars or the missing HgA1c lab value. Z2 stated that blood sugars of 400 or above are

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F9999	Continued From page 46 relevant. Z3 also confirmed that he should be notified of blood sugar of 400 or above and that he bases insulin doses on the blood sugar checks and the HbA1c. The facility failed to notify the physician of dangerously elevated blood sugars in a timely manner, and failed to obtain a necessary lab result. The facility failed to obtain a morning blood sugar level as ordered for 06/14/2006. This failure resulted in the physician being unaware of R25's blood sugar levels. (A) 300.7040a) 300.7040d) 300.7040e) Section 300.7040 Activities a) The unit's activity program shall use ability-centered care programming. d) Activity programming shall be planned and provided throughout the day and evening, at least 7 days a week for an average of 8 hours per day e) Activities shall be adapted, as needed, to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of 4 activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team. Based on observation, interview and record	F9999		

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F9999	Continued From page 47 review, the facility failed to provide an ongoing activity program for the residents residing in the Corinthian's Place (Alzheimer's unit) that is designed around their physical and mental capabilities. Residents were observed sitting in two day rooms engaged in very little activity. Findings Include: 1. 6/13/05, during an activity and meal observation that started at approximately 10am and ended at approximately 1:20pm in the 3rd floor Corinthian's Place two day rooms, the following was observed: Upon entering the 3rd floor back little day room (302), 11 residents were observed sitting around tables at approximately 10am. 2 of the 11 were in recliners. E17 (Activity aide) was sitting in a chair at the back of the room. Religious music was on. R5, R24 and a 3rd resident was sitting at a table in the back of the room. R5's head was face down on the table; R24 was slumped over to one side of the chair that she was sitting in; and 3rd resident was staring into space. E17 got up and offered only the residents that were awake, and sitting in chairs or wheelchairs, water in a cone shaped cup without holders. E17 then changed the music and engaged 4 residents in a card game. The remaining resident were left sitting or reclining not engaged. The only other staff member to enter the room was a CNA, who came in with one disposal diaper in her hand and lead R18, away to change his diaper. The CNA did not check any of the other residents in the room for wetness. R26 had stood up at approximately 10: 20am before the CNA arrived for R18 and his gray pants were wet between his legs and bottom	F9999		

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F9999	Continued From page 48 . R26 ate lunch at approximately 1pm in the same wet pants. After starting the card game with 4 residents, E17 passed around cookies to some of the residents that could hold them. E17 attempted to give R24 a cookie who was asleep slumped to one side of the chair she was in. E17 pushed the resident up in her chair and pushed the cookie in her mouth. The cookie fell to the floor. E17 pushed a cookie in R5's mouth without trying to get the resident to raise her head up from the table. R5 started chewing on the cookie, however much of the cookie was lost in the afghan throw on the table. R5 started eating the Afghan. No intervention by E17, although she was called back to the table by the surveyor. E17 sat down at the table with R18. She put a magazine in front of the resident and started turning pages and commenting on the pictures. The resident said nothing. Per record review, R 18's cognitive abilities are severely impaired (assessment dated 3/24/06). Upon entering the large day room decorated like a church, approximately 29 residents including R 16 were observed sitting and E18 (Activity Aide) was standing in the middle of the room at approximately 11:15am. Religious music was being played. E18 walked to the front of the room to read the Activity Calendar. No Activity Calendar was posted in the back little day room. E18 asked the residents what kind of music they wanted to hear. They said jazz. E18 played one jazz recording and then R&B. During the observation, E18 danced with the one resident twice and for only 3 recordings asked the residents if knew the artist. The 3rd floor Corinthian's Place Activity Calendar	F9999		

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located in the large day room stated that 6/13/06 the following activities should be taking place:
10am - Obey your thirst/Easy listening
10:15am - Exercise
10:30am - Current Events
11am - Getting to know you/Patio time-checkers
11:30am - Daily chores/Music appreciation

The facility, during the Daily Status Meeting, was asked if the Activity calendar posted in the large day room was the schedule for both day rooms? The answer was "Yes". Therefore, only music appreciation (Jazz/R&B) was done in the large day room. Whatever, activities were done in the small day room, could not be enjoyed by all residents because they were not based on the residents cognitive and physical abilities.

2. 6/12/06, during the initial tour of the facility that started at approximately 10am, E24 (Alzheimer's Unit Director) was interviewed in the large Corinthian's Place day room. E24 was asked how many activity staff members does she have and what are the hours for activities? E24 stated that there are 3 activity aides dedicated to the Alzheimer's unit and activities run from 9am to 6 pm. E17, E18 and E25 (Activity Aides) were interviewed 6/12/06 and 6/13/06 and asked for their work hours. The facility was asked for the Activity staff schedule. One hour every day there is only one activity staff member for 55 residents of Corinthian's Place.

3. 6/14/05, during the Daily Status meeting, the facility was asked for activity assessment on R5, R16, R17, R18, R24, R25 and R26 that were to be done on residents of Corinthian's Place. The assessments did not reflect the residents present

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F9999	Continued From page 50 physical and cognitive abilities. (B)	F9999		