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	145798	A. BUILDING ____ B. WING ____	08/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	1635 EAST 154TH STREET DOLTON, IL 60419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 514	Continued From page 72 R23 had 07-27-06 order to start Megace. 1 page of MAR for 08-06 missing from MAR book. 08-08, 08-09 and 08-10 that included Megace and Humalog Insulin X 3 different doses and times. E3 stated," She didn't give resident Megace 08-09-06 related to not seen on MAR." But observed to add it to the 08-06 MAR page that documented accucheck and sliding scale administration on 08-10-06 at 9:15 am. Surveyor ask for copy of 08-06 MAR again was given at 1:00 pm with the 07-27-06 Megace entry on page with accucheck and sliding scale insulin totally filled in with nurse's initials for twice daily adminnistration 08-01 through 08-10-06 dose. Surveyor question E3 about the added signatures on MAR for Megace and she said I did not fill those in, I just wrote that this morning. Facility had no documentation that resident received his Humalog at all 08-01-06 through 08-10-06.	F 514		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1010h) 300.1210a) 300.1210b)1) 300.1210b)2) 300.1210b)3) 300.1210b)4) 300.1610a)1) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician	F9999		

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of any accident, injury, or significant change in a resident's condition that threatens 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
a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures:
b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.
2) All treatments and procedures shall be administered as ordered by the physician.
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.

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F9999	Continued From page 74 Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 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 follows: Based on record review and interviews the facility failed to ensure that 4 residents in the sample (R 4, R22, R23, R24) and 2 residents outside the sample (R28, R29) with a diagnosis of Insulin Dependent Diabetes Mellitus were free from neglect as evidenced by: -the failure to administer regularly scheduled insulin as ordered; -the failure to monitor blood glucose levels as ordered by the physician; -the failure to administer sliding scale insulin as ordered by the physician; -the failure to notify the physician in a timely manner when residents blood glucose levels exceeded the parameters of the sliding scale orders; These failures resulted in: -2 hospitalizations for Hyperglycemia (R23); -1 Hospitalization for Ketoacidosis (R29); -Episodes of uncontrolled and alarmingly high blood glucose levels (R4, R22, R24, R28, R29); -The potential for harmful consequences of	F9999		

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consistently elevated blood glucose levels (R4, R 22, R24, R28, R29).

Findings include:

1) R23 was readmitted to the facility 5/11/06 with diagnosis to include Uncontrolled Diabetes Mellitus (DM), S/P Renal Obstruction and Urethral Strictures. Review of the clinical record indicated that R23 had consistently high blood glucose levels and that he did not receive his insulin according to the physician's orders. He had two subsequent hospitalizations on 5/16/06 and 6/18/06 for Hyperglycemia requiring intravenous insulin administration.

When R23 was readmitted to the facility on 5/11/06 he had physician orders for blood glucose monitoring twice a day (6:00 AM and 4:00 PM) with sliding scale Regular Insulin coverage, that included parameters to call the physician if the blood sugar was greater than 400:
200-250=3 Units
250-300=5 Units
300-350=7 Units
350-400=9 Units.

Review of the 5/06 MAR and Nurses notes revealed that R23 had multiple instances in which the blood glucose monitoring was not done and the sliding scale coverage was not administered as ordered. In addition, the physician was not notified when the resident's blood glucose level exceeded the parameters of the sliding scale orders (normal range for blood glucose level is 70 -110). On 5/14/06 at 11:29 PM, when the nurse was unable to reach the physician, the nurse administered insulin based on what the nursing supervisor told her to give. The physician should

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have been notified on 5/14/06 at 6:00 AM and he was not notified for more than 48 hours after that (5/16/06 at 11:15 AM).

The information in R23's clinical record was as follows:
5/12/06 at 6:00 AM result was 390 - no coverage (should have been 9 units).
5/12/06 at 4:00 PM - no blood glucose level was checked.
5/13/06 at 6:00 AM - no blood glucose level was checked.
5/13/06 at 4:00 PM - no blood glucose level was checked "refused".

5/14/06 at 6:00 AM result was 553 (this number is ABOVE the parameters for sliding scale) - no coverage given (physician should have been notified)
5/14/06 at 4:00 PM result was so high that the monitoring device read "N High" and still no coverage given.
The first nurses note that nursing attempted to call the physician was 5/14/06 at 11:29 PM, but the physician was not able to be reached so the facility night supervisor told the nurse to administer to R23, 4 Units of Insulin and the nurse did so.

5/15/06 at 6:00 AM result was 545 and 9 Units of Regular Insulin was given. There were no orders for sliding scale with a level above 400. The 2nd attempt to call the physician noted was 5/15/06 at 6:45 AM but no physician response to the page was documented.

The only nurses note that the physician was notified was on 5/16/06 at 11:15 AM. The physician ordered hospital transfer on 5/16/06

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due to R23's complaints of scrotal edema, edema to both extremities and of the resident's complaint of uncontrollable bladder. However, R23 was admitted to the hospital with a blood glucose level of 510 and he required Intravenous Insulin administration; his diagnoses included Uncontrolled Diabetes and Hyperglycemia.

R23 was readmitted 5/22/06 with physician orders for blood glucose level monitoring 3 times a day (7:00 AM, 11:00 AM and 4:00 PM), with sliding scale Regular Insulin coverage:
151-200=2 Units
201-250=4 Units
251-300=6 Units
301-350=8 units
351-400=10 Units
401-450=12 Units
451-500=15 Units and
physician orders for Lantus 16 Units subcutaneously (SQ) daily at bed time (HS) and 3 different Humalog Insulin doses to be administered at different times (12 Units at 7:00 AM, 14 Units at 11:00 AM and 16 Units at 4:00 PM).

Review of the 6/06 MAR and nurses notes revealed that R23 had 20 instances in which the sliding scale coverage was not administered as ordered:

6/3 at 11:00 AM result was 395 given 8 Units (should have been 10 units).
6/3 at 4:00 PM result was 388 given 15 Units (should have been 10 units).
6/4 at 7:00 AM result was 340 given 10 Units (should have been 8 units).
6/5 at 7:00 AM result was 360 given 8 Units (should have been 10 units),

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F9999	Continued From page 78 6/7 at 7:00 AM result was 423 given 15 Units (should have been 12 units). 6/11 at 11:00 AM result was 180 no coverage given (should have been 2 units). 6/12 at 6:00 AM result was 380 given 15 Units (should have been 10 units). 6/12 at 4:00 PM result was 313 given 15 Units (should have been 8 units). 6/13 at 11:00 AM result was 557 given 10 Units (physician should have been called - above parameters of sliding scale). 6/14 11:00 AM result was 180 given 10 Units (should have been 2 units). 6/15 11:00 AM result was 211 given 8 Units (should have been 4 units). 6/17 11:00 AM result was 294 given 15 Units (should have been 6 units). The 6/18 and 6/19/06 nurses notes stated that on 6/18/06 at 2:42 PM, R23 was sent to the hospital for evaluation of uncontrollable pain and Hyperglycemia and he was readmitted to the facility on 6/19/06. 6/20 at 11:00 AM result was 385 given 6 Units (should have been 10 units). 6/24 at 7:00 AM result was 305 given 6 Units (should have been 8 units). 6/24 at 4:00 PM result was 337 given 10 Units (should have been 8 units). 6/25 at 11:00 AM result was 204 given 5 Units (should have been 4 units). 6/26 at 7:00 AM result was 308 given 4 Units (should have been 8 units). 6/26 at 11:00 AM result was 148 given 2 Units (should have been 0 units). 6/27 at 11:00 AM result was 330 given 10 Units (should have been 8 units). 6/29 at 7:00 AM result was 281 given 2 Units (	F9999		

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should have been 6 units).

In addition, R23's MAR and nurses notes document 5 separate instances when R23's blood glucose level was 500 or greater and the physician was not notified.
6/8/06 at 4:00 PM - 525
6/10/06 at 11:00 AM - 500
6/13/06 at 11:00 AM - 557
6/28/06 at 11:00 AM - 500
6/28/06 at 10:25 PM - 528

Review of R23's 7/06 MAR and Nurses notes documented 7 separate instances when no blood glucose level was checked and therefore no sliding scale was administered:
at 6:00 AM on 7/9/06, 7/19/06, 7/24/06 and 7/31/06,
at 11:00 AM on 7/31/06
at 4:00 PM on 7/7/06 and 7/13/06

The 7/06 documentation also showed 18 separate times in which the sliding scale Insulin coverage was not administered as the physician ordered :
7/1/06 at 6:00 AM result was 460 - no coverage given (should have been 15 units)
7/3/06 at 11:00 AM result was 500 - 10 Units given (should have been 15 units)
7/3/06 at 4:00 PM result was 301 - 6 Units (should have been 8 units)
7/4/06 at 4:00 PM result was 138 - 10 units given (should have been 0 units) *
7/10/06 at 4:00 PM result was 441 - 10 Units given (should have been 12 units)
7/12/06 at 4:00 PM result was 367 - 8 Units given (should have been 10 units)
7/13/06 at 11:00 AM result was 108 - 6 Units given (should have been 0 units)

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F9999	Continued From page 80 7/13/06 at 4:00 PM no blood glucose result but MAR noted that 10 Units administered 7/14/06 at 6:00 AM result was 292 - no coverage (should have been 6 units) 7/14/06 at 11:00 AM result was 126 - 6 Units given noted on MAR (should have been 0 units) 7/16/06 at 6:00 AM result was 360 - 8 Units given (should have been 10 units) 7/17/06 at 6:00 AM result was 409 - ? coverage given (illegible) 7/23/06 at 6:00 AM result was 202 - no coverage given (should have been 4 units) 7/23/06 at 11:00 AM result was 341 - 10 Units given (should have been 8 units) 7/26/06 at 11:00 AM result was 134 - 2 Units given (should have been 0 units) 7/26/06 at 4:00 PM result was 392 - no coverage given (should have been 10 units) 7/28/06 at 6:00 AM result was 287 - no coverage (should have been 6 units) 7/30/06 at 6:00 AM result was 350 - no coverage (should have been 8 units) *On 7/4/06 at 6:00 AM the result was 138. 10 Units of insulin was administered when according to the sliding scale order no insulin should have been administered. This was followed by a 7:00 AM blood glucose level that read "Low BGM" and no nurses notes about this or of physician notification. According to the Physician Order Sheet (POS) for 8/06 R23 had physician orders for Humalog Insulin 12 units before breakfast, 14 units before lunch and 16 units before dinner since 5/22/06. This order was on the 3rd page of the POS. Review of the Medication Administration Record (MAR) for 7/06 indicated that the resident was receiving Humalog Insulin, as ordered, during the	F9999		

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F9999	Continued From page 81 month of July. Review of the MAR for 8/06 indicated that the 3rd page (with the orders for the Humalog) was missing. The facility was unable to locate the missing page - it was not in the MAR book. The nurses' were not aware that it was missing. R23 did not receive his ordered doses of Humalog insulin for 10 days. The resident's blood glucose monitoring indicated that during that time his blood glucose was between 280 and 502. In addition, on the occasions that sliding scale was administered, it was not given according to the parameters stated in the physician's orders. 8/2/06 at 11:00 AM result was 280 - given 8 units (should have been 6 units) 8/2/06 at 4:00 PM result was 323 - no coverage given (should have been 8 units) 8/3/06 at 6:00 AM result was 502 - no coverage given (physician should have been notified) 8/3/06 at 11:00 AM result was 320 - given 6 units (should have been 8 units) 8/5/06 at 11:00 AM result was 408 - given 4 units (should have been 12 units) 8/6/06 at 11:00 AM result was 308 - given 6 units (should have been 8 units) 8/7/06 at 11:00 AM result was 322 - no coverage given (should have been 8 units) 8/7/06 at 4:00 PM - illegible 8/8/06 at 11:00 AM result was 356 - given 12 units (should have been 10 units) 8/8/06 at 4:00 PM illegible R23's physician (Z1) was interviewed on 8/11/06 and stated that he could not recall when and for which times he was called by facility with R23's altered elevated blood sugars. On 8/10/06 at 12:35 PM surveyor observed R23	F9999		

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F9999	Continued From page 82 in his wheelchair in front of the CD nurses station eating a powdered sugar donut and multiple staff in his view. No staff observed to approach or redirect R23 from eating the donut. In addition, R23 was assessed on readmission of 5/12/06 to have scrotal and penial edema, 2+ pitting edema to the left ankle, 3+ pitting edema to the right ankle, faint pulses to lower extremities, complaint of dull pain and discomfort in the groin and fullness palpated over the bladder. The charting also stated that R23 complained of inability to ambulate due to friction from the edematous penis and scrotum. R23's 5/16/06 hospital diagnosis was Acute Peripheral Edema, Congestive Heart Failure, Hyperglycemia and Uncontrolled DM and a Urinary Tract Infection and R23 was hospitalized until 5/22/06. There was no documentation in the nurses notes about assessing R23's penis, scrotal or lower extremity edema. The first time this condition was documented was 5/16/06, when R23 came to the nurses station complaining of uncontrollable bladder. 2. R28 was admitted into the facility with diagnoses that included Insulin Dependent Diabetes Mellitus. Orders included sliding scale insulin coverage including notification of MD (Medical Doctor) for Blood sugar above 400. Review of the Physician order dated 03-01-06 through 08-31-06 stated, "Novolin 70/30 unit/ml via inject 24 units sub-q every morning (6:00 am) and Inject 18 units sub-q every evening (4:00 PM). Blood sugar monitoring twice daily (6:00 AM and 4:00 PM). Novolin R 100 units/ML-Give sliding scale subcutaneous (sub-q) twice daily (6:00 AM and 4:00 PM) 200-250=3 units, 251-300=	F9999		

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F9999	Continued From page 83 5 units, 301-350=7 units, 351-400=9 units and above 400 call MD." Review of the MAR for June 2006 confirmed that the Novolin 70/30 unit was not given on the following days: 6:00 AM-June 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 13, 14,15, 16, 17, 26, 28, 29 and 30. 4:00 PM-June 8, 13, 17 and 23. On 03/28/2006 5:26 PM, nurses notes documented," Blood sugar 714 ML/DL. Insulin given as ordered. 07-13-06 1:02 AM Blood sugar 421 insulin given." There was no order for sliding scale insulin order over 400. "There was no documented amount insulin was given for the 714ML/DL blood sugar. The MAR for July 13, 2006 at 1:02 AM also did not document the dose amount of insulin to give." Review of the Medication Administration Sheet (MAR) dated 03-01-06 through 03-31-06 states," March 28, 2006 - Blood sugar monitoring twice a day." There were blank spaces for the 6:00 AM and 4:00 PM. Further review of the MAR for the following dates there was missing blood sugar monitoring or no insulin coverage. -March 03, 14, 15, 16, 18, 19, 24, 25, and 28, 2006 at 6:00 am - No blood sugar (BS)monitoring was done. March 30, 2006 at 4:00 PM accucheck was 218 - No scale sliding insulin covered. -May 04, 2006 at 4:00 PM - BS 234 - No sliding scale covered. May 30, 2006 6:00 PM -No BS monitoring done. - June 13 2006 at 4:00 PM - No BS monitoring and June 24, 2006 at 4:00 PM - BS 201- No	F9999		

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insulin was given.
-July 12 through 31, 2006 - There were no blood sugar or sliding scale insulin monitoring documented in the MAR or nurses notes.

According to interview with Z1 (MD) on 08-16-06 at 12:00 PM per telephone stated, "I don't remember the specific resident. I do want my insulin given according to the sliding scale. If the glucose level was 714. I would order 15 units insulin to be given if no symptoms. If there were symptoms resident would be sent out to the hospital."

3) R29 is a 59 year old female with multiple diagnoses to include uncontrolled IDDM (insulin dependent diabetes mellitus).

Review of R29's POS (physician order sheet) dated 6/1/06 through 6/30/06, 7/1/06 through 7/11/06 showed an order for, "Blood glucose monitoring twice daily & record, 6:00 AM and 4:00 PM." There was a sliding scale coverage ordered as follows: Novolin R 100 units/ml via giver per sliding scale Sub-Q BID (twice a day) 201-250 =4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units, call MD if above 400 and to give, Novolog mix 70/30, inject 60 unit Sub-Q twice daily, (6:00 AM and 4:00 PM)."

Review of R29's MAR (medication administration record) dated 6/1/06 through 6/30/06 showed that on the following dates R29 was refusing to have her 4:00 PM blood glucose monitoring done: 6/1, 6/2, 6/3, 6/4, 6/6, 6/7, 6/9, 6/10, 6/11, 6/12, 6/13, 6/14, 6/15, 6/16, 6/19, 6/20 and 6/21. Review of the same MAR showed that R29 refused her 6:00 AM Novolog mix 70/30, 60 units on the following dates: 6/1, 6/2, 6/3 and 6/11. R29 refused her 4:

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F9999	Continued From page 85 00 PM Novolog mix 70/30, 60 units on the following dates: 6/1, 6/2 , 6/3, 6/4, 6/11, 6/12, 6/13, 6/14, 6/15, 6/16, 6/19, 6/20, 6/21, 6/23 and 6/30. Review of the said MAR and R29's nurses' notes showed no documentation the the resident's physician was notified of R29's refusal for blood glucose monitoring and insulin medications. Review of R29's MAR dated 7/1/06 through 7/11/06, showed that the resident refused her 6:00 AM blood glucose monitoring on 7/6, 7/7, 7/8, 7/9 and 7/10. R29's MAR also showed that the resident refused her 4:00 PM blood glucose monitoring on 7/3, 7/4, 7/8, 7/9 and 7/10. Further review of R29 's MAR showed no documentation to indicate if the resident received her Novolog mix 70/30, 60 units on 7/2, 7/3, 7/5, 7/6, 7/7 and 7/8. R29's MAR showed that she refused her Novolog 70/30 mix on 7/9 and 7/10. Review of R29's MAR and nurses' notes dated 7/11/06 showed that the resident's blood glucose level at 6:00 a.m., was high. Per nurses' notes dated 7/11/06 (6 am) showed that 10 units of the Novolin R sliding scale coverage was given and 60 units of Novolog mix. Per nurses' notes R29's physician was paged, awaiting return call, endorsed to the next shift. Nurses' notes dated 7/11/06 (2:48 PM) showed documentation that the facility repeated the blood sugar monitoring of R29 at 10:00 AM and the reading was still High, R29 was cool to touch, sweaty, listless, eyes open and close. R 29 was sent to the hospital. Review of the hospital records dated 7/11/06 showed that R29's admitting diagnosis includes Diabetic Ketoacidosis and renal insufficiency. Review of R29's MAR (7/1/06 through 7/11/06) and R29's nurses' notes for the same dates showed no documentation the the resident's physician was	F9999		

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F9999	Continued From page 86 notified of R29's refusal for blood glucose monitoring and insulin medications. R29 was readmitted to the facility on 7/17/06 with the orders for Blood glucose monitoring twice daily with a sliding scale coverage of Novolin R 100 units/ml Sub-Q BID 201-250 = 4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; call MD if above 400, and to give Novolog mix 70/30, inject 30 units Sub-q twice daily. Review of R 29's MAR from 7/18 through 7/31/06 showed that the facility administered 60 units of Novolog mix 70/30 instead of the ordered 30 units on 6:00 AM of 7/18, 19, 22, 25, 26, 27, 28 and 29 and on 7/18/06 at 4:00 PM. Further review of the MAR showed that R29 was refusing her blood sugar monitoring for 6:00 AM on 7/20, 7/21, 7/22, 7/23 & 7/24 and for 4:00 PM on 7/19/06 through 7/3/06. Review of R29's nurses notes from 7/17/06 through 7/31/06 showed documentation that R29's physician was called only once to inform him of the resident's refusal to take medications, which was on 7/28/06. Review of R29's 8/1/06 through 8/31/06 showed that the resident continuously refused her blood sugar monitoring for 6:00 AM on 8/3, 8/5 and 8/6 and blood sugar monitoring for 4:00 PM on 8/1, 8/2, 8/4, 8/5, 8/6, 8/7, 8/8 and 8/9. Per MAR, R29 was also refusing her Novolog 70/30, 30 units for 6:00 AM on 8/3, 8/4, 8/5, 8/6 & 8/9, and refused her Novolog 70/30, 30 units for 4:00 PM on 8/1, 8/2, 8/3, 8/4, 8/5, 8/6, 8/7, 8/8 and 8/9. Review of the same MAR and nurses notes for 8/06 showed that R29's physician was only notified of the resident's refusal to take her medications and refusal to have her blood sugar monitored. During observations made on 8/10/06 at 3:15 p.m	F9999		

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., inside R29's bedroom by her bedside table, surveyor observed 1 empty can of regular soda and 1 empty can of orange juice.

During interviews held on 8/10/06 at 3:20 PM, R 29 stated to the surveyor that she got the regular soda from the facility vending machine and the orange juice came from the facility kitchen. R29 stated that she refuses her blood sugar monitoring, insulins and medications because she does not trust the facility nurses. R29 further stated that the only person she trusts with her medications and blood sugar monitoring is E8 (nurse)

During interviews held on 8/16/06 at 10:30 AM, Z 2 (physician) stated that he expects the facility to follow his orders. He expect the facility to call him when the resident's blood sugar is above the parameters given and he expect the facility to call him when the resident refuses his medications and blood sugar monitoring.

The facility failed to notify Z2 of R29's refusal to have her blood sugar checked as ordered based on the absence of the documentation in the resident's records. This resulted in the hospitalization of R29 on 7/11/06 with admitting diagnosis of Diabetic Ketoacidosis and renal failure. The facility did not follow the physician's order on 7/17/06 to administer Novolog 70/30, 30 units twice daily for R29 as shown in the MAR dated 7/18/06 through 7/31/06

4) R22 is a 47 year old male with multiple diagnosis to include uncontrolled diabetes mellitus and renal insufficiency.

Review of R22's POS dated 6/17/06 showed an

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order to perform blood glucose monitoring 3x/ day, AC (before meals, 6 am, 11 am, and 4 PM) and HS (before bed time, 9:00 PM). There were also orders to administer Novolin R 100 units/ml, Sub-q 3x/day, AC (before meals) and HS (before bed time), with sliding scale coverage of 140-200 = give 4 units, 201-250 = give 8 units, 251-300 = give 10 units and to call the physician if above 301.

Review of R22's POS and nurses' notes dated 7/ 1/06 through 7/31/06 showed no documentation that the resident's blood sugar was checked and if sliding scale coverage was given as ordered at 9:00 p.m. on the following dates: 7/1, 7/2 ,7/3, 7/ 6, 7/9, 7/10, 7/13, 7/14, 7/15, 7/16, 7/17, 7/18, 7/ 19, 7/21, 7/22, 7/23, 7/24, 7/25, 7/26, 7/27, 7/28, 7/29, 7/30 and 7/31. This totals to 24 days of resident not receiving his 9:00 PM, insulin coverage .

Review of R22's POS and nurses' notes dated 8/ 1/06 through 8/31/06 showed no documentation that the resident received his ordered sliding scale coverage when the resident blood sugar level was: 209 (9:00 PM on 8/2/06), 248 (9:00 PM on 8/4/06), 213 (9:00 PM on 8/5/06), 209 (9: 00 PM on 8/6/06) and 217 (9:00 PM on 8/7/06). This totals five (5) days of resident not receiving his 9:00 PM insulin coverage.

During interviews held on 8/16/06 at 10:30 AM, Z 2 (physician) stated that he expects the facility to follow his orders.

5) R24 has diagnosis to include Schizo Affective Disorder, Depression and DM. R24 has physician orders to include lab tests of "HGBA1C" every 3 months, Novolin 70/30 Insulin 28 Units SQ every

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F9999	Continued From page 89 6:00 AM and 18 Units every 4:00 PM and blood glucose monitoring 2 times a day with sliding scale Regular Insulin coverage as follows: 250-300=3 Units 301-350=5 Units 351-400=10 Units and to call physician if below 80 or above 401. Review of R24's 6/06, 7/06 and 8/06 MAR's and Nurses Notes found that R24 was not receiving sliding scale Insulin coverage as ordered : -June 2006 6/3/06 at 4:00 PM result was 337 and given 10 Units (should have been 5 units). 6/7/06 at 6:00 AM result was 321 and given 10 Units (should have been 5 units). 6/20/06 result was 250 and 10 Units given (should have been 3 units). In addition, on 6/06/06 R24 had results of 439 and there is no documentation that the physician was notified. -July 2006-13 separate times when sliding scale coverage was not provided as ordered: 7/1-4:00 PM; 7/7-6:00 AM, 7/11-4:00 PM; 7/12-6:00 AM; 7/15-4:00 PM; 7/17-6:00 AM, 7/18-4:00 PM; 7/20-4:00 PM; 7/21-4:00 PM; 7/23-6:00 AM; 7/25 -4:00 PM; 7/26-4:00 PM and 7/30-4:00 PM. In addition, -on 7/7 at 6:00 AM R24's blood glucose levels were also documented to be greater than 401 and the physician was not notified as was ordered. -on 7/13 at 6:00 AM R24's blood glucose levels were also documented to be greater than 401 and the physician was not notified as was ordered.	F9999		

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F9999	Continued From page 90 -on 7/17 at 6:00 AM blood glucose result was 147 and the resident was administered 2 Units of Regular Insulin (there is no sliding scale for that level). -on 7/17 at 4:00 PM the blood glucose level fell down to a very low 48 result and the physician was not notified. -August 2006 - (between 8/01/06 and 8/09/06) On 8/9/06 at 6:00 AM blood glucose level was 306 and no coverage was given. On 8/3/06 at 6:00 AM blood glucose level was 401 and the physician was not notified. R24's HGBA1C level was not evaluated every 3 months as ordered. R24 only had it tested 01/25/06 with elevated results of 9.9 (normal range is 4.4-6.3%) and on 8/02/06 and still with elevated results of 8.5. R24's care plan includes an identified problem with fluctuating blood sugars, hyper and hypoglycemia and includes an intervention to administer sliding scale Insulin as needed. Z1 told surveyor on 8/11/06 that he could not say when and for which times facility notified him of altered blood sugars. 6. R4 was admitted on 03-9-06 with diagnoses Insulin Dependent Diabetes Mellitus and Alcoholic Abuse. The physician order dated 07-03-06 stated, "Accucheck AC (before meals) and HS (bedtime) Also the physician order stated, " Novolin R 100 units/ML give sliding scale insulin 151-200= 2 units, 201-250= 4 units, 251-300 = 6 units, 301-350 = 8 unit, 351-400=10 unit and above 400 =12 Unit call MD. Review of the MAR on the following dates	F9999		

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F9999	Continued From page 91 confirm there were blank spaces for blood sugar monitoring or no insulin covered in July 2006. The following dates were blank or no insulin covered at 4:00 PM and 9:00 PM: -4:00 PM-7/8/06-BS 155; 7/12/06-BS 212; 7/25/06-BS 179. No sliding scale insulin was given for the blood sugar. - 9:00 PM-7/10/06-BS 184; 7/12/06-BS 151; 7/20/06-BS 267; 7/21/06-BS 211; 7/23/06-BS 211; 7/25/06-BS-179 and 7/29/06-BS-150. There was no documentation on the MAR to indicate that the sliding scale was followed. The 9:00 PM sliding scale insulin was not written on the MAR. Surveyor asked E1 (Director of Nursing) where is the MAR for the 9:00 PM sliding scale insulin. Per interview with E1 on 08-09-06 at 12:45 PM she stated, "The 9:00 PM insulin sliding scale should be charted on the MAR. They should follow the physician order for the sliding scale insulin. I will look for the MAR with the 9:00 PM sliding scale insulin signature." The facility did not present the missing document with signature of the nurse whom gave the insulin. (A)	F9999		