



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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January 11, 2018

Tory Bosworth, Administrator
Gateway Transitional Care Center
527 Memorial Drive
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Bosworth:

On **January 4, 2018**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **November 3, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F0157 -- S/S: D -- 483.10(g)(14) -- Notify Of Changes (injury/decline/room, Etc)**
- **F0309 -- S/S: D -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being**
- **F0281 -- S/S: D -- 483.21(b)(3)(i) -- Services Provided Meet Professional Standards**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 22, 2018**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the Bureau of Facility Standards' letter of **October 31, 2017**, following the survey of **October 13, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for:

- A Civil Monetary Penalty
- Denial of Payment for New Admissions effective January 13, 2018 and
- Termination of the provider agreement on **April 13, 2018**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Tory Bosworth, Administrator
January 11, 2018
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If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

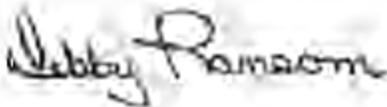
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **January 22, 2018**. If your request for informal dispute resolution is received after **January 22, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj

Tory Bosworth, Administrator
January 11, 2018
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/04/2018
NAME OF PROVIDER OR SUPPLIER GATEWAY TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 000}	INITIAL COMMENTS The following deficiencies were cited during an onsite follow up survey conducted on January 3-4, 2018. The surveyors conducting the survey were: Nina Sanderson, LSW - Team Coordinator David Scott, RN Cecilia Stockdill, RN Survey abbreviations: ADL - Activities of Daily Living BG - Blood Glucose C&S - Culture and Sensitivity CNA - Certified Nurse Aide CVA - Cerebral Vascular Accident (Stroke) DON - Director of Nursing DM - Diabetes Mellitus ESRD - End Stage Renal Disease GERD - Gastroesophageal Reflux Disease IC - Infection Control LPN - Licensed Practical Nurse MAR - Medication Administration Record MDS - Minimum Data Set mg - milligrams mg/dl - milligrams per deciliter RN - Registered Nurse s/sx - signs and symptoms TAR - Treatment Administration Record UA - Urinalysis UTI - Urinary Tract Infection	{F 000}			
{F 157} SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes.	{F 157}			1/12/18

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

TITLE

(X6) DATE

Electronically Signed

01/12/2018

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</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or</p>	{F 157}		

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{F 157}	<p>Continued From page 2</p> <p>State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to inform residents' physicians of low blood glucose levels, or when mediations were routinely not administered as ordered. This was true for 3 of 10 residents (# 18, 22, and 24) sampled for physician notification. The deficient practice created the potential for harm if treatment decisions were made based on inaccurate or incomplete information. Findings include:</p> <p>1. Resident #22 was admitted to the facility on 10/7/17 with diagnoses which included diabetes mellitus with complications, and end stage renal disease. Resident #22 received dialysis treatments three times per week.</p> <p>Resident #22's physician's orders and Medication Administration Records (MARs) for November 3-30, 2017, and December 2017, documented the following medications were ordered at 8:00 am, but not administered:</p> <p>* Aspirin 81 milligrams (mg), start date 10/7/17, not given 17 of 58 opportunities. * Lantus 8 units (insulin), start date 10/7/17, not given 20 of 58 opportunities. * Omeprazole delayed release 40 mg, start date 10/7/17, not given 18 of 58 opportunities. * Probiotic capsule, start date 11/14/17, not given</p>	{F 157}	<p>1. Actions that will be accomplished for residents 18, 22, and 24 found to have been affected by the deficient practice are:</p> <p>A.) Schedule a family meeting to discuss refusal of medication and blood glucose monitoring to plan a more accommodating medication regimen, necessary medications, and blood glucose monitoring to involve resident and family. Scheduled family meeting to involve resident and resident family in medication plan of care regarding refusal of medication and blood glucose monitoring.</p> <p>B.) In-serviced staff to notify Physician when medications are not given for any reason and to notify when blood sugars are out of range, per order.</p> <p>C.) Medication times were adjusted to accommodate dialysis schedule. Audit of all dialysis patients medication times and comparison to dialysis schedule completed and doctors orders received and in place to adjust medication times in relation to dialysis.</p> <p>D.) Dialysis/Nephrology contacted in regards to medications being missed due to dialysis schedule.</p> <p>E.) Coordination and collaboration with</p>		

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{F 157}	<p>Continued From page 3 4 of 16 opportunities.</p> <ul style="list-style-type: none"> * Sertraline HCl 75 mg (antidepressant), start date 11/2/17, 18 of 58 opportunities. * Gabapentin 300 mg, start date 10/24/17, not given 18 of 58 opportunities. * "Active Protein Supplement", no dose specified, start date 10/17/17, not given 18 of 58 opportunities. * Glucerna dietary supplement, no amount specified, start date 10/19/17, not given 21 of 58 opportunities. * Metoclopramide HCl 5 mg, start date 10/7/17, not given 18 of 58 opportunities. * Renvela 800 mg (potassium binder), start date 11/21/17, not given 12 of 40 opportunities. * Blood Glucose checks, start date 10/24/17, used as the basis for determining the need for sliding scale insulin administration, not completed 16 of 58 opportunities. No sliding scale insulin was administered on these occasions. * Colace 100 mg, start date 12/12/17, not given 4 of 19 opportunities. * Keflex 500 mg (antibiotic), start date 11/28/17, not given 8 of 31 opportunities. <p>Resident #22's record did not document the physician was notified of any of the above omissions.</p> <p>On 1/4/17 at 4:00 pm, the DON stated Resident #22 did not receive his insulin in the facility the mornings he was at dialysis, as he had been told by the dialysis unit that they monitored the resident's blood glucose (BG) levels during dialysis.</p> <p>2a. Resident #24 was admitted to the facility on 1/14/15, and readmitted on 8/16/17, with</p>	{F 157}	<p>dialysis center regarding medication regimen accommodating dialysis schedule completed.</p> <p>F.) Hospice and physician notified of resident number 18 and her refusal of medication. Direction given per physician to continue offering medications. family meeting scheduled to discuss refusal of medications and possible changes in medication regimen.</p> <p>2. Facility will identify other residents who have the potential to be affected by the same deficient practice (and our actions are): Current residents with dialysis medications have been adjusted to accommodate dialysis schedule. Measures have been taken to have a second nurse double check (audit) blood sugars to ensure policy and procedures are followed.</p> <p>3. Measures that will be put in place and systematic changes that will be made to ensure the deficient practice does not recur are: The admission process has been updated to include identification of new admissions with dialysis and to ensure that the scheduling of medications accommodates the days that resident is at dialysis. Staff have also been re-inserviced to the diabetic management protocol for blood sugars and a copy has been made available at each medication cart.</p> <p>4.) DNS or Designee to monitor the 2nd nurse double check (verification) of blood</p>		

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{F 157}	<p>Continued From page 4</p> <p>diagnoses that included End Stage Renal Disease (ESRD), Type II diabetes mellitus and gastroesophageal reflux disease (GERD). The resident received hemodialysis from an off-site provider in the community.</p> <p>Physician Orders, dated 8/16/17, directed staff to provide Resident #24 with 11 units of Insulin Detemir each morning and each evening at bedtime, and 5 units of Novolog insulin twice daily prior to meals. A 10/25/17 Physician's Order directed staff to administer Novolog insulin on a sliding scale when the resident's BG exceeded 150 milligrams per deciliter (mg/dl) as determined by BG assessment before meals and at bedtime. Staff were to notify the physician when the resident's BG exceeded 400 mg/dl. Each order was prescribed for the treatment of Resident #24's diabetes mellitus.</p> <p>A hemodialysis care plan, dated 1/14/15, documented Resident #24 received dialysis each Monday, Wednesday, and Friday. Resident #24's diabetes mellitus care plan directed staff to administer "diabetes medication as ordered by doctor."</p> <p>Resident #24's November 2017 Medication Administration Record (MAR) documented staff did not assess morning BG levels on 11 occasions; noon BGs on 9 occasions; evening BGs on 18 occasions; or bedtime BG levels on 14 occasions from 11/3/17 through 11/30/17.</p> <p>Resident #24's November 2017 MAR documented that from 11/3/17 through 11/30/17, staff did not administer the morning dose of Insulin Detemir on 11 occasions; the bedtime</p>	{F 157}	<p>sugars to ensure policy and procedure are followed. Monitoring will be 5x/week for 1 week and weekly for 1 month DNS or Designee will monitor the MAR of all dialysis residents to ensure appropriate measures are taken. Monitoring will be 5x/week for 1 week and 1x/week for 1 month.</p>		

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{F 157}	<p>Continued From page 5</p> <p>dose of Insulin Detemir on 8 occasions; the morning dose of Novolog on 12 occasions; and the evening dose of Novolog on 19 occasions.</p> <p>Resident #24's December 2017 MAR documented staff did not assess morning BG levels on 17 occasions; noon BGs on 12 occasions; evening BGs on 16 occasions; or bedtime BGs on 17 occasions.</p> <p>Resident #24's December 2017 MAR documented staff did not administer the morning dose of Insulin Detemir on 16 occasions; the bedtime dose of Insulin Detemir on 17 occasions; the morning dose of Novolog insulin on 16 occasions; or the evening dose of insulin on 21 occasions.</p> <p>Resident #24's January 2018 MAR from 1/1/18 through 1/3/18 documented staff did not assess morning BG levels on 3 occasions; noon BGs on 1 occasion; evening BGs on 1 occasion; and bedtime BGs on 1 occasion.</p> <p>Resident #24's January 2018 MAR from 1/1/18 through 1/3/18 documented staff did not administer the morning dose of Insulin Detemir on 2 occasions; the bedtime dose of Insulin Detemir on 1 occasion; the morning dose of Novolog insulin on 3 occasions; or the evening dose of Novolog insulin on 1 occasion.</p> <p>Dialysis Communication Forms to the facility from 11/3/17 through 12/29/17 did not document BGs were assessed or insulin medications administered while Resident #24 underwent dialysis.</p>	{F 157}			

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{F 157}	<p>Continued From page 6</p> <p>On 1/4/18 at 3:30 pm, the facility's Director of Nursing (DON) stated nursing staff had not informed him that Resident #24's BG assessments and insulin administrations were not provided as ordered by the physician. The DON stated Resident #24's physician was not informed the facility did not assess the resident's BG levels or administer insulin as ordered.</p> <p>2b. Resident #24's Physician Orders documented staff was to provide the following:</p> <ul style="list-style-type: none"> * Sensipar, 60 mg, once daily for ESRD, initiated 8/16/17 * Sertraline HCL, 150 mg, once daily for depression, initiated 8/16/17 * Omeprazole, 20 mg, once daily for GERD, initiated 8/16/17 * Simvastatin, 20 mg, once daily for hypercholesterolemia, initiated 8/16/17 * Sodium Polystyrene Sulfonate Suspension, 15 grams, every Monday, Wednesday, and Friday as a Renal Supplement, initiated 8/16/17 * Docusate Sodium, 100 mg, twice daily for constipation, initiated 8/16/17 * Terazosin HCL, 1 mg, twice daily for hypertension, initiated 8/16/17 * Brinzolamide Suspension, 1 drop in each eye 3 times daily for glaucoma, initiated 8/16/17 * Combigan Solution, 1 drop in each eye 3 times daily for glaucoma, initiated 8/16/17 * Lanthanum Carbonate, 1000 mg, after each meal for ESRD, initiated 8/16/17 * Gabapentin, 100 mg, 3 times daily for neuropathy, initiated 8/16/17 * Hydralazine HCL, 50 mg, 3 times daily for blood pressure, initiated 8/25/17 * Metoclopramide HCL, 25 mg, 3 times daily for 	{F 157}			

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{F 157}	<p>Continued From page 7 GERD, initiated 8/16/17 * Metoprolol Tartrate, 100 mg, 3 times daily for hypertension, initiated 8/16/17 * Sevelamer Carbonate, 4000 mg, 3 times daily as renal supplement, initiated 8/16/17</p> <p>MARs for 11/3/17 through 1/3/18 documented the following:</p> <p>* Sensipar: November 2017 - Administered 16 of 27 opportunities December 2017 - Administered 18 of 31 opportunities January 2018 - Administered 2 of 3 opportunities</p> <p>* Sertraline: November 2017 - Administered 15 of 27 opportunities December 2017 - Administered 19 of 31 opportunities January 2018 - Administered 2 of 3 opportunities</p> <p>* Omeprazole: November 2017 - Administered 18 of 27 opportunities December 2017 - Administered 16 of 31 opportunities January 2018 - Administered 1 of 3 opportunities</p> <p>* Simvastatin: November 2017 - Administered 16 of 27 opportunities December 2017 - Administered 18 of 31 opportunities January 2018 - Administered 2 of 3 opportunities</p> <p>* Sodium Polystyrene Sulfonate Suspension:</p>	{F 157}		

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{F 157}	Continued From page 8 November 2017 - Administered 2 of 11 opportunities December 2017 - Administered 3 of 13 opportunities January 2018 - Administered 1 of 2 opportunities * Docusate Sodium: November 2017 - Administered 30 of 54 opportunities December 2017 - Administered 34 of 62 opportunities January 2018 - Administered 3 of 6 opportunities * Terazosin HCL: November 2017 - Administered 35 of 54 opportunities December 2017 - Administered 34 of 62 opportunities January 2018 - Administered 3 of 6 opportunities * Brinzolamide Suspension: November 2017 - Administered 44 of 81 opportunities December 2017 - Administered 46 of 93 opportunities January 2018 - Administered 3 of 9 opportunities * Combigan Solution: November 2017 - Administered 45 of 81 opportunities December 2017 - Administered 46 of 93 opportunities January 2018 - Administered 3 of 9 opportunities * Lanthanum Carbonate: November 2017 - Administered 31 of 81 opportunities December 2017 - Administered 30 of 93	{F 157}			

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{F 157}	Continued From page 9 opportunities January 2018 - Administered 1 of 9 opportunities * Gabapentin: November 2017 - Administered 58 of 81 opportunities December 2017 - Administered 66 of 93 opportunities January 2018 - Administered 5 of 9 opportunities * Hydralazine HCL: November 2017 - Administered 58 of 81 opportunities December 2017 - Administered 66 of 93 opportunities January 2018 - Administered 6 of 9 opportunities * Metoclopramide HCL: November 2017 - Administered 50 of 81 opportunities December 2017 - Administered 52 of 93 opportunities January 2018 - Administered 3 of 9 opportunities * Metoprolol Tartrate: November 2017 - Administered 59 of 81 opportunities December 2017 - Administered 67 of 93 opportunities January 2018 - Administered 5 of 9 opportunities * Sevelamer Carbonate: November 2017 - Administered 44 of 81 opportunities December 2017 - Administered 50 of 93 opportunities January 2018 - Administered 4 of 9 of opportunities	{F 157}		

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{F 157}	Continued From page 10 There was no documentation in the clinical record that staff reapproached Resident #24 when he refused medications, coordinated medication administration with the dialysis provider, and/or attempted to reschedule medication administration times to accommodate the resident's dialysis appointments. On 1/4/18 at 4:00 pm, the DON stated the facility had not notified the physician that staff had not administered medications as ordered to aide in the provision of dialysis and/or treat Resident #24's hypertension, glaucoma, End Stage Renal Disease, constipation, depression, hypercholestremia, neuropathy, and gastroesophogeal reflux disease. 3. The facility's Diabetic Policy/Procedure documented the following: * Residents with BG levels assessed at 0-65 mg/dl who are conscious and able to swallow were to receive 4 ounces of fruit juice, 8 ounces of milk, or 1 pouch of glucose gel combined with a sandwich or snack containing protein. * Supervisor was to be notified and BG reassessed in 15 minutes. * The physician was to be notified of BGs of 65 mg/dl or higher above after the reassessment and previous assessment orders resumed. * For residents with BGs remaining less than 65 mg/dl and who were alert, staff was to provide an additional 4 ounces of juice, glucose gel, or carbohydrate snack, and reassess BG levels in	{F 157}			

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{F 157}	<p>Continued From page 11</p> <p>15 minutes. If BG remained less than 65 mg/dl and the resident was alert, staff were to repeat the above sequence and contact the physician immediately (STAT).</p> <p>* BGs that remained at 65 mg/dl or greater required staff to document, reassess the BG in 1 hour, and resume previous testing orders.</p> <p>* Staff were to call 911 if a resident became unresponsive or extremely lethargic at any time.</p> <p>* For residents who were unconscious or unable to swallow, staff were directed to:</p> <ol style="list-style-type: none"> 1. Give 1 mg of Glucagon (an injection to raise blood sugar levels). 2. Notify the physician STAT and notify the supervisor. 3. Recheck the BG in 15 minutes. 4. If BG was still less than 60 mg/dl, call 911. 5. Recheck BG in 1 hour and resume previous testing orders. 6. "Document all actions in nursing notes including exact timelines." <p>Resident #18 was admitted to the facility on 8/25/17 with diagnoses that included cirrhosis of the liver and diabetes mellitus.</p> <p>Resident #18's 12/8/17 Significant Change MDS (Minimum Data Set) assessment documented she was cognitively intact.</p> <p>A 1/4/18 Physician's Order Summary Report documented staff were to administer the following:</p>	{F 157}			

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{F 157}	<p>Continued From page 12</p> <p>* Glucagon 1 mg intramuscularly as needed one time for BG less than 50 mg/dl and only if the resident was unable to eat or drink.</p> <p>* Novolin R Solution (Insulin Regular Human) per sliding scale and notify the physician for BGs less than 65 mg/dl.</p> <p>Resident #18's diabetes mellitus care plan directed staff to follow the diabetic policy and report signs and symptoms of hypoglycemia (low blood sugar) - such as sweating, tremors, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, and/or staggering gait - to the physician.</p> <p>Resident #18's clinical record documented the following BG assessments that were less than 65 mg/dl:</p> <p>* 12/14/17 at 6:44 am = 62 mg/dl</p> <p>* 12/17/17 at 1:09 pm = 61 mg/dl</p> <p>* 12/18/17 at 9:20 am = 63 mg/dl</p> <p>Resident #18's MAR on 12/14/17 at 6:44 am documented orange juice was administered for a BG of 62 mg/dl. There was no documentation the physician was notified the resident's BG was less than 65 mg/dl, or that the facility's diabetic policy/procedure was followed. The next documented BG assessment on 12/14/17 was 99 mg/dl at 1:47 pm, seven hours after the resident's blood BG was assessed at less than 65 mg/dl.</p> <p>A 12/17/17 Change of Condition Note</p>	{F 157}			

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{F 157}	Continued From page 13 documented Resident #18 "refused all medications today. She also refused both breakfast and lunch as well as snacks today." Resident #18's morning BG was 66 mg/dl and she consumed orange juice but "did not want BS (blood sugar) retaken." The resident's BG at lunch was assessed at 61 mg/dl and "she was not responsive enough to get her to eat or drink anything. However we were unable to get VS (vital signs) as she would pull her arm back would start to get upset when we tried. She did not have any orders for is have became [sic] unconscious. Retook VS at [2:00 pm] was 71, but she would still barely respond. Notified hospice. They notified [resident's physician]." The next documented BG assessment was 121 mg/dl on 12/17/17 at 5:35 pm, more than 4 hours after the assessment of 61 mg/dl. A 12/18/17 Change of Condition Note documented Resident #18's BG was 63 mg/dl prior to breakfast. There was no documentation the facility's diabetic policy/procedure protocol was followed. The next documented BG assessment on 12/18/17 was 110 at 11:58 am, more than 2 hours after the resident's BG was assessed at less than 65 mg/dl. On 1/4/18 at 4:30 pm, the DON (Director of Nursing) said he did not find any documentation the physician was notified of Resident #18's BG assessment of 62 mg/dl on 12/14/17. The DON stated the physician should be notified any time the resident's BG was less than 65 mg/dl.	{F 157}			
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i)	F 281			1/12/18

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F 281	Continued From page 14 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure residents were provided with medications ordered by physicians to treat diabetes mellitus, neuropathy, glaucoma, End Stage Renal Disease, and more in accordance with professional standards of practice. This was true for 2 of 10 residents (#22 and #24) reviewed for pharmaceutical therapy and had the potential for harm if residents' health declined due to the facility's failure to follow physician orders. Findings include: 1a. Resident #24 was admitted to the facility on 1/14/15, and readmitted on 8/16/17, with diagnoses that included End Stage Renal Disease (ESRD), Type II diabetes mellitus and gastroesophageal reflux disease (GERD). The resident received hemodialysis from an off-site provider in the community. Physician Orders, dated 8/16/17, directed staff to provide Resident #24 with 11 units of Insulin Detemir each morning and each evening at bedtime, and 5 units of Novolog insulin twice daily prior to meals. A 10/25/17 Physician's Order directed staff to administer Novolog insulin on a sliding scale when the resident's BG exceeded 150 milligrams per deciliter (mg/dl) as determined	F 281	1. Corrective actions that will be accomplished for residents found to have been affected by deficient practice are: A.) In-service provided to clinical staff to appropriately follow care plan and physician orders to provide medications and monitoring per the order. B.)Orders were rescheduled to accommodate patient dialysis schedule. C.) Dialysis / Nephrology were contacted to collaborate and coordinate medication regime with dialysis schedule. Family meetings were scheduled to discuss patient preference for implementing physician orders. 2. How will facility identify other residents who have the potential to be affected by the same deficient practice (and corrective actions): Clinical staff in-serviced to appropriately follow physician orders and care plan and appropriate follow-up when orders or patient care plan cannot be followed. 3.) What measures and systemic changes will be made to ensure the deficient practice does not recur: Policy and		

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F 281	<p>Continued From page 15</p> <p>by BG assessment before meals and at bedtime. Staff were to notify the physician when the resident's BG exceeded 400 mg/dl. Each order was prescribed for the treatment of Resident #24's diabetes mellitus.</p> <p>A hemodialysis care plan, dated 1/14/15, documented Resident #24 received dialysis each Monday, Wednesday, and Friday. Resident #24's diabetes mellitus care plan directed staff to administer "diabetes medication as ordered by doctor."</p> <p>Resident #24's November 2017 Medication Administration Record (MAR) documented staff did not assess morning BG levels on 11 occasions; noon BGs on 9 occasions; evening BGs on 18 occasions; or bedtime BG levels on 14 occasions from 11/3/17 through 11/30/17.</p> <p>The November 2017 MAR from 11/3/17 through 11/30/17 also documented staff did not administer the morning dose of Insulin Detemir on 11 occasions; the bedtime dose of Insulin Detemir on 8 occasions; the morning dose of Novolog on 12 occasions; and the evening dose of Novolog on 19 occasions.</p> <p>Resident #24's December 2017 MAR documented staff did not assess morning BG levels on 17 occasions; noon BGs on 12 occasions; evening BGs on 16 occasions; or bedtime BGs on 17 occasions.</p> <p>The December 2017 MAR documented staff did not administer the morning dose of Insulin Detemir on 16 occasions; the bedtime dose of Insulin Detemir on 17 occasions; the morning</p>	F 281	<p>Procedure updated to include following physician order and care plan and appropriate response and follow-up when orders or care plan cannot be implemented. staff in-serviced to the policy.</p> <p>4.) DNS or Designee will audit orders and Care Plan of 5 random residents to ensure policy and procedure is followed. Monitoring will be 5x/week for 1 week and 1x/week for 1 month</p>		

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F 281	<p>Continued From page 16</p> <p>dose of Novolog insulin on 16 occasions; or the evening dose of insulin on 21 occasions.</p> <p>Resident #24's January 2018 MAR from 1/1/18 through 1/3/18 documented staff did not assess morning BG levels on 3 occasions; noon BGs on 1 occasion; evening BGs on 1 occasion; and bedtime BGs on 1 occasion.</p> <p>The January 2018 MAR from 1/1/18 through 1/3/18 documented staff did not administer Resident #24's morning dose of Insulin Detemir on 2 occasions; the bedtime dose of Insulin Detemir on 1 occasion; the morning dose of Novolog insulin on 3 occasions; or the evening dose of Novolog insulin on 1 occasion.</p> <p>Dialysis Communication Forms to the facility from 11/3/17 through 12/29/17 did not document BGs were assessed or insulin medications administered while Resident #24 underwent dialysis.</p> <p>On 1/4/18 at 3:30 pm, the facility's Director of Nursing (DON) stated nursing staff had not informed him that Resident #24's BG assessments and insulin administrations were not provided as ordered by the physician.</p> <p>1b. Resident #24's Physician Orders documented staff was to provide the following:</p> <ul style="list-style-type: none"> * Sensipar, 60 mg, once daily for ESRD, initiated 8/16/17 * Sertraline HCL, 150 mg, once daily for depression, initiated 8/16/17 * Omeprazole, 20 mg, once daily for GERD, initiated 8/16/17 	F 281			

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F 281	<p>Continued From page 17</p> <ul style="list-style-type: none"> * Simvastatin, 20 mg, once daily for hypercholesterolemia, initiated 8/16/17 * Sodium Polystyrene Sulfonate Suspension, 15 grams, every Monday, Wednesday, and Friday as a Renal Supplement, initiated 8/16/17 * Docusate Sodium, 100 mg, twice daily for constipation, initiated 8/16/17 * Terazosin HCL, 1 mg, twice daily for hypertension, initiated 8/16/17 * Brinzolamide Suspension, 1 drop in each eye 3 times daily for glaucoma, initiated 8/16/17 * Combigan Solution, 1 drop in each eye 3 times daily for glaucoma, initiated 8/16/17 * Lanthanum Carbonate, 1000 mg, after each meal for ESRD, initiated 8/16/17 * Gabapentin, 100 mg, 3 times daily for neuropathy, initiated 8/16/17 * Hydralazine HCL, 50 mg, 3 times daily for blood pressure, initiated 8/25/17 * Metoclopramide HCL, 25 mg, 3 times daily for GERD, initiated 8/16/17 * Metoprolol Tartrate, 100 mg, 3 times daily for hypertension, initiated 8/16/17 * Sevelamer Carbonate, 4000 mg, 3 times daily as renal supplement, initiated 8/16/17 <p>MARs for 11/3/17 through 1/3/18 documented the following:</p> <ul style="list-style-type: none"> * Sensipar: November 2017 - Administered 16 of 27 opportunities December 2017 - Administered 18 of 31 opportunities January 2018 - Administered 2 of 3 opportunities * Sertraline: November 2017 - Administered 15 of 27 	F 281			

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F 281	Continued From page 18 opportunities December 2017 - Administered 19 of 31 opportunities January 2018 - Administered 2 of 3 opportunities * Omeprazole: November 2017 - Administered 18 of 27 opportunities December 2017 - Administered 16 of 31 opportunities January 2018 - Administered 1 of 3 opportunities * Simvastatin: November 2017 - Administered 16 of 27 opportunities December 2017 - Administered 18 of 31 opportunities January 2018 - Administered 2 of 3 opportunities * Sodium Polystyrene Sulfonate Suspension: November 2017 - Administered 2 of 11 opportunities December 2017 - Administered 3 of 13 opportunities January 2018 - Administered 1 of 2 opportunities * Docusate Sodium: November 2017 - Administered 30 of 54 opportunities December 2017 - Administered 34 of 62 opportunities January 2018 - Administered 3 of 6 opportunities * Terazosin HCL: November 2017 - Administered 35 of 54 opportunities December 2017 - Administered 34 of 62 opportunities	F 281			

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F 281	<p>Continued From page 19 January 2018 - Administered 3 of 6 opportunities</p> <p>* Brinzolamide Suspension: November 2017 - Administered 44 of 81 opportunities December 2017 - Administered 46 of 93 opportunities January 2018 - Administered 3 of 9 opportunities</p> <p>* Combigan Solution: November 2017 - Administered 45 of 81 opportunities December 2017 - Administered 46 of 93 opportunities January 2018 - Administered 3 of 9 opportunities</p> <p>* Lanthanum Carbonate: November 2017 - Administered 31 of 81 opportunities December 2017 - Administered 30 of 93 opportunities January 2018 - Administered 1 of 9 opportunities</p> <p>* Gabapentin: November 2017 - Administered 58 of 81 opportunities December 2017 - Administered 66 of 93 opportunities January 2018 - Administered 5 of 9 opportunities</p> <p>* Hydralazine HCL: November 2017 - Administered 58 of 81 opportunities December 2017 - Administered 66 of 93 opportunities January 2018 - Administered 6 of 9 opportunities</p> <p>* Metoclopramide HCL:</p>	F 281			

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F 281	<p>Continued From page 20</p> <p>November 2017 - Administered 50 of 81 opportunities December 2017 - Administered 52 of 93 opportunities January 2018 - Administered 3 of 9 opportunities</p> <p>* Metoprolol Tartrate: November 2017 - Administered 59 of 81 opportunities December 2017 - Administered 67 of 93 opportunities January 2018 - Administered 5 of 9 opportunities</p> <p>* Sevelamer Carbonate: November 2017 - Administered 44 of 81 opportunities December 2017 - Administered 50 of 93 opportunities January 2018 - Administered 4 of 9 of opportunities</p> <p>There was no documentation in the clinical record that staff reapproached Resident #24 when he refused medications, coordinated medication administration with the dialysis provider, and/or attempted to reschedule medication administration times to accommodate the resident's dialysis appointments.</p> <p>On 1/4/18 at 4:00 pm, the DON stated it was "possible" the facility failed to assess residents' BG levels and/or provide insulin and other medications on those days residents were out of the facility for dialysis.</p> <p>2. Resident #22 was admitted to the facility on 10/7/17 with diagnoses which included diabetes mellitus with complications, and end stage renal</p>	F 281			

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F 281	<p>Continued From page 21</p> <p>disease. Resident #22 received dialysis treatments three times per week.</p> <p>Resident #22's physician's orders and (MAR) for November 3-30, 2017, and December 2017, documented the following medications were ordered at 8:00 am, but not administered:</p> <ul style="list-style-type: none"> * Aspirin 81 mg, start date 10/7/17, for a diagnosis of CVA, not given 16 of 58 opportunities. * Omeprazole delayed release 40 mg, for a diagnosis of GERD, with a start date of 10/7/17, not given 18 of 58 opportunities. * Probiotic capsule, start date 11/14/17, not given 4 of 16 opportunities. * Sertraline HCl 75 mg for a diagnosis of depression, start date 11/2/17, not given 18 of 58 opportunities. * Gabapentin 300 mg, for a diagnosis of neuropathy, start date 10/24/17, not given 18 of 58 opportunities. * "Active Protein Supplement", no dose specified, start date 10/17/17, not given 18 of 58 opportunities. * Glucerna dietary supplement, no amount specified, start date 10/19/17, not given 21 of 58 opportunities. * Metoclopramide HCl 5 mg for a diagnosis of indigestion, start date 10/7/17, not given 18 of 58 opportunities. * Renvela 800 mg (potassium binder), start date 11/21/17, not given 12 of 40 opportunities. * Colace 100 mg (stool softener), start date 12/12/17, not given 4 of 19 opportunities. * Keflex 500 mg, an antibiotic ordered for a wound infection starting 11/28/17, not given 8 of 31 opportunities. 	F 281			

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F 281	Continued From page 22	F 281			
{F 309} SS=D	<p>On 1/4/17 at 4:00 pm, the DON stated he was unaware the resident was not receiving the above medications. The DON stated he believed many of the dates the medications were not administered to Resident #22 coincided with his dialysis treatments. The DON stated the facility had not coordinated with the dialysis unit to determine which medications were not being given. The DON stated the facility's expectation was medications would be administered as ordered, and if dialysis was a barrier the orders should be reviewed with the physician.</p> <p>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l)</p> <p>483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.</p> <p>483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:</p>	{F 309}		1/12/18	

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{F 309}	<p>Continued From page 23</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure residents with diabetes mellitus consistently received blood glucose (BG) assessments and/or insulin per physician order. This was true for 2 of 6 residents (#22 and #24) reviewed for diabetic management and had the potential for harm if residents' BG levels fluctuated beyond safe parameters due to a lack of assessment and/or effective treatment. Findings include:</p> <p>1. Resident #24 was admitted to the facility on 1/14/15, and readmitted on 8/16/17, with diagnoses that included End Stage Renal Disease (ESRD), and Type II diabetes mellitus. The resident received hemodialysis from an off-site provider in the community.</p> <p>Physician Orders, dated 8/16/17, directed staff to provide Resident #24 with 11 units of Insulin Detemir each morning and each evening at bedtime, and 5 units of Novolog insulin twice</p>	{F 309}	<p>What corrective action will be accomplished for residents found to be affected by the deficient practice:</p> <p>A.) Staff in-serviced to appropriately administer ordered medications/monitoring and to appropriately follow-up when orders cannot be implemented. B.) Orders rescheduled to accommodate dialysis schedule C.) Family meetings scheduled to discuss refusal of orders and how to ascertain resident preferences in the scheduling and implementation of physician orders.</p> <p>2.) How will facility identify other residents who have the potential to be affected by the deficient practice and ensure the practice does not recur: All residents who are diabetic and have insulin/blood glucose monitoring have the potential to be affected by the deficient</p>		

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{F 309}	<p>Continued From page 24</p> <p>daily prior to meals. A 10/25/17 Physician's Order directed staff to administer Novolog insulin on a sliding scale when the resident's BG exceeded 150 milligrams per deciliter (mg/dl) as determined by BG assessment before meals and at bedtime. Each order was prescribed for the treatment of Resident #24's diabetes mellitus.</p> <p>A hemodialysis care plan, dated 1/14/15, documented Resident #24 received dialysis each Monday, Wednesday, and Friday. Resident #24's diabetes mellitus care plan directed staff to administer "diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness." The care plan did not document staff were to monitor the resident's BG levels.</p> <p>Resident #24's November 2017 Medication Administration Record (MAR) documented staff did not assess morning BG levels on 11 occasions; noon BGs on 9 occasions; evening BGs on 18 occasions; or bedtime BG levels on 14 occasions from 11/3/17 through 11/30/17.</p> <p>Resident #24's November 2017 MAR documented that from 11/3/17 through 11/30/17, staff did not administer the morning dose of Insulin Detemir on 11 occasions; the bedtime dose of Insulin Detemir on 8 occasions; the morning dose of Novolog on 12 occasions; and the evening dose of Novolog on 19 occasions.</p> <p>Resident #24's December 2017 MAR documented staff did not assess morning BG levels on 17 occasions; noon BGs on 12 occasions; evening BGs on 16 occasions; or bedtime BGs on 17 occasions.</p>	{F 309}	<p>practices. All residents who are diabetic and have insulin / blood glucose monitoring. MARS and orders reviewed to ensure insulin / blood glucose monitoring and other orders were appropriately followed and to ensure appropriate measures taken if insulin / blood glucose monitoring orders could not be implemented.</p> <p>3.) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The measures and systemic changes put in place so the deficient practice does not recur are : Policy and procedure has been updated to guide clinicians in appropriately following physician orders and to follow appropriate steps when orders cannot be implemented. Clinicians have been in-serviced to the updated policy.</p> <p>4.) how the facility plans to monitor performance to ensure the corrective actions are effective and compliance sustained: DNS/ Designee will audit 5 random residents who have diabetes and orders for insulin/Blood glucose monitoring and other orders to ensure they are appropriately followed and to ensure appropriate measures taken if insulin/ blood glucose monitoring and other orders could not be implemented. 5 times a week for 1 week then weekly for 1 month.</p>		

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{F 309}	<p>Continued From page 25</p> <p>Resident #24's December 2017 MAR documented staff did not administer the morning dose of Insulin Detemir on 16 occasions; the bedtime dose of Insulin Detemir on 17 occasions; the morning dose of Novolog insulin on 16 occasions; or the evening dose of insulin on 21 occasions.</p> <p>Resident #24's January 2018 MAR from 1/1/18 through 1/3/18 documented staff did not assess morning BG levels on 3 occasions; noon BGs on 1 occasion; evening BGs on 1 occasion; and bedtime BGs on 1 occasion.</p> <p>Resident #24's January 2018 MAR from 1/1/18 through 1/3/18 documented staff did not administer the morning dose of Insulin Detemir on 2 occasions; the bedtime dose of Insulin Detemir on 1 occasion; the morning dose of Novolog insulin on 3 occasions; or the evening dose of Novolog insulin on 1 occasion.</p> <p>Of the 120 BGs that were not assessed and 127 insulin administrations not provided from 11/3/17 through 1/3/18, the November and December 2017 MARs and January 2018 MAR documented Resident #24 was out of the facility for 37 scheduled BG assessments and 57 insulin administrations; sleeping for 48 scheduled BG assessments and 43 insulin administrations; and refused 33 scheduled BG assessments and 24 insulin administrations.</p> <p>Neither the MARS nor Nursing Notes from 11/3/17 through 1/3/18 documented Resident #24 was reapproached for BG assessment and/or insulin administrations when he refused, was sleeping, or returned to the facility.</p>	{F 309}			

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{F 309}	Continued From page 26 Dialysis Communication Forms to the facility from 11/3/17 through 12/29/17 did not document BGs were assessed or insulin medications administered while Resident #24 underwent dialysis. On 1/4/18 at 3:30 pm, the facility's Director of Nursing (DON) stated nursing staff had not informed him that Resident #24's BG assessments and insulin administrations had not been provided as ordered by the physician. When informed of the frequency Resident #24's BG levels were not assessed and/or insulin administered by the facility, the DON stated both assessments and insulin administrations documented as not given by the facility were provided by the resident's dialysis providers. When asked for documentation regarding dialysis providers assessing Resident #24's BGs and/or administering insulin, the DON stated dialysis providers did not include that information on the Dialysis Communication Forms or through any other documentation, but communicated that information by telephone. 2. Resident #22 was admitted to the facility on 10/7/17 with diagnoses which included diabetes mellitus with complications, and end stage renal disease. Resident #22 received dialysis treatments three times per week. Resident #22's care plan did not document BG levels were monitored or adjusted during dialysis treatments. The care plan documented the facility would provide diabetic medications as ordered by the physician, and monitor Resident #22 for signs of hypo- and hyperglycemia.	{F 309}			

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{F 309}	<p>Continued From page 27</p> <p>Resident #22's Dialysis Communication Forms from 11/2/17 through 1/3/18 did not document medications were administered or BG checks completed during dialysis treatments.</p> <p>a. Resident # 22's physician's orders documented Lantus (long acting) insulin 8 units each morning, beginning beginning 10/7/17. The orders also documented Resident #22's blood glucose (BG) levels should be monitored 4 times daily, and sliding scale insulin administered according to the reading.</p> <p>Resident # 22's MAR documented Resident # 22's Lantus insulin was not administered on 9 of 27 opportunities in November 2017, and 10 of 30 opportunities in December 2017.</p> <p>b. Resident #22's physician orders documented the need for BG readings before each meal and at bedtime, with the administration of sliding scale insulin based on that reading beginning 10/27/17. The order also documented the resident's physician should be notified of BG readings under 65 mg/dl or over 500 mg/dl.</p> <p>Resident # 22's MAR documented the resident's BG reading was not taken on before breakfast for 9 of 27 opportunities in November 2017, and 9 of 31 opportunities in December 2017. The MAR documented Resident #22's BG reading was not taken before lunch for 4 of 27 opportunities in November 2017, and 3 of 31 opportunities in December 2017. No sliding scale insulin was administered for those opportunities, and there was no documentation of physician notification of the lack of BG readings.</p>	{F 309}			

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{F 309}	Continued From page 28 On 1/4/17 at 4:00 pm, the Director of Nursing (DON) stated the resident did not receive his insulin in the facility the mornings he was at dialysis, as he had been told by the dialysis unit that they monitored the resident's blood glucose (BG) levels and make adjustments during dialysis treatments. The DON stated there was no documentation to show BG levels were being monitored and adjusted at dialysis.	{F 309}		