

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

PRINTED: 12/20/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145364</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/30/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHAMPAIGN COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTH ART BARTELL DRIVE</b> <b>URBANA, IL 61802</b>		
(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	F 000			
	Investigation of Complaint #0761446 / IL 28091- No deficiencies				
	Investigation of Complaint #0761496 / IL 28140 - F333				
	Investigation of Complaint #0761543 / IL 28201 - F156 and F365				
F 333 SS=D	No extended survey was conducted 483.25(m)(2) MEDICATION ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to give insulin as ordered for 1 of 7 sampled residents (R2).  The findings include:  Review of the Physician's Order Sheet (POS) shows that R2 was admitted to the facility on 12/31/06 with diagnoses including Diabetes Mellitus, Hypertension, Coronary Artery Disease, Hyperlipidemia, Benign Prostatic Hypertrophy, and Cerebral Vascular Accident (Stroke). Review of the Minimum Data Set (MDS) Assessment dated 1/28/06, shows that R2 was moderately cognitively impaired and required extensive to total assistance from staff for Activities of Daily Living (ADLs) including eating, dressing, transfers and hygiene. R2 also	F 333		6/4/07	

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

TITLE

(X6) DATE

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 333	<p>Continued From page 1</p> <p>required staff assistance for intermittent catheterization due to the condition of Neurogenic Bladder along with Benign Prostatic Hypertrophy.</p> <p>Review of the POS showed that the Physician ordered staff to do blood glucose monitoring 4 x a day, which was scheduled at 7:00 am., 11:00 am., 4:00 pm., and 8:00 pm. Based upon the blood glucose levels, the Physician ordered Sliding Scale Novolog Insulin. In addition, R2 was to receive Novolog Insulin at Breakfast (26 units), Lunch (28 units) and Supper (30 units). At 8:00 p.m., the Physician ordered staff to administer 60 units of Lantus Insulin along with a bedtime snack. Review of the Medication Administration Record showed that R2 had a range of blood glucose levels from a low of 59 to a high of 547 from 12/ 31/ 2006 through 1/29/07.</p> <p>According to the Nurses Notes dated 1/29/07 at 3:45 pm. Z1, Agency Licensed Practical Nurse (LPN), documented that the blood glucose level was 132, which according to the sliding scale would not have required any sliding scale insulin. In the Nurses Notes, at 4:00 p.m. on 1/29/07 E10, LPN, documented "Insulin administered as ordered". At 5:30 p.m., Z1, LPN wrote "(Blood glucose) 25.....Orange juice with sugar given. And at 5:45 p.m. "(Blood glucose) 70, patient eating at this time." At 8:00 p.m. E10, wrote "(Blood glucose) 109. Called (Physician) ..order to hold Lantus tonight only". When questioned on 4/11/07 at approximately 2:00 p.m., E2, the Director of Nursing stated that the insulin given at 4:00 p.m. on 1/29/07 was given too early in error. On the Medication Error Report dated 1/29/07, Z1, LPN, wrote "Blood (glucose) and insulin were given too early before supper at 3:45</p>	F 333			

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F 333	Continued From page 2 p.m. Novolog 30 units routine at 4:00 pm. The dose of insulin was given too early before the supper meal causing a severe drop of blood sugar." Z1, also wrote in response to a question regarding adverse effects, "Short time of low blood sugar was quickly reversed with intake. Given orange juice/sugar." The Physician response was "hold bed time insulin."  On the "Approved Med Pass Time" Policy , it states, "Insulin times: 7 am, 11 am, 4 pm, and 8 pm unless, it is Humalog which is to be given only 15 minutes before meals". Interview with E2, DON, on 4/11/07 at approximately 2:00 p.m. confirmed that Novolog insulin, like Humalog, is a fast acting insulin and should be given 15 minutes before the meal. E2, DON, confirmed that E10 did not follow the facility policy.	F 333			
F 365 SS=D	483.35(d)(3) FOOD  Each resident receives and the facility provides food prepared in a form designed to meet individual needs.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to serve food in a form appropriate for one resident with swallowing difficulties for 1 of 7 sampled residents (R4).  The findings include:  According to the Admission Face Sheet, R4 was admitted to the facility on 3/31/07. According to the March/April Physician's Order Sheet, R4 had diagnoses which included Severe Alzheimers Disease, Acute Renal Failure, Malnutrition and a	F 365		6/4/07	

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F 365	<p>Continued From page 3</p> <p>history of Dehydration. On the Nurses Monthly Documentation and Care Plan Review Sheet completed on 4/1/07, R4 was totally dependent upon staff for all Activities of Daily Living (ADLs) including dressing, eating, personal hygiene and bed mobility. Nursing staff have also documented that R4 has full dentures which R4 "does not wear." According to the initial intake information, R4 is 57 inches and weighs 94 pounds.</p> <p>Interview with E6, Social Service Director (SSD) on 4/12/07 at approximately 12:30 p.m. , showed that E6 completed the facility Admission Report Form with R4 and the Power of Attorney (POA) at the hospital prior to admission to the facility. On the Admission Report Form, E6, SSD documented "failed swallow evaluation - likes clear liquids". Review of the hospital "Speech Pathology Bedside Swallow Evaluation" dated 3/28/07, shows that R4 "does not follow commands", is edentulous, and R4 was assessed as, "Patient (Pt.) presents with Severe oral dysphagia, Moderate pharyngeal dysphagia and Pt. is at high risk for aspiration." During interview with E6, SSD, E6 stated, "This information was included in the intake information packet that was provided to nursing at the time of admission to the facility." According to the March/April Physician's Order Sheet at the facility, a No Added Sodium diet with regular liquids was ordered. Interview with E8 and E9, Certified Dietary Managers (CDMs) on 4/11/07 at 1:20 p.m. confirmed that R4 initially received this diet in a regular consistency with regular liquids.</p> <p>Interview with E8 and E9, CDMs on 4/11/07 at 1:20 p.m. showed that the Dietary Department usually does not get any resident history, only the</p>	F 365			

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F 365	Continued From page 4 Physician's Order Sheet (POS) and the diet order is filled. E8 and E9 both stated that when a Speech Therapy evaluation is received with the patient history, nursing should send the previous Speech Therapy Evaluation to the facility Speech Therapy Department for review. In addition, E8 and E9, CDMs, stated that they did not receive any communication that R4 was not accepting the diet. Both stated that it is facility policy that if the facility admits a resident, nursing can lower the diet consistency temporarily if they feel the resident cannot tolerate it. Speech therapy usually sees the resident within 4 to 7 days of admission and any dietary changes from Speech Therapy are phoned to the Dietary Department that same day. Both stated that this did not happen in the case of R4.	F 365			