

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2016
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 7235 RIVERWALK WAY N NOBLESVILLE, IN 46062
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R 0000 Bldg. 00	<p>This visit was for a State Licensure Survey.</p> <p>Survey Dates: August 3, 4, 2016</p> <p>Facility Number: 004417 Provider Number: 004417 AIM Number: N/A</p> <p>Residential Census: 78</p> <p>Sample: 7</p> <p>These State findings are in accordance with 410 IAC 16.2.</p> <p>QR completed by 11474 on August 5, 2016.</p>	R 0000	<p>This creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and request Desk Review in lieu of a Post Survey Review on or after August 19, 2016.</p>	
R 0144 Bldg. 00	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the carpeting in the common areas were well maintained and clean for the 100, 200, and 300 hall hallways leading to resident apartments</p>	R 0144	<p>1. There was not just one resident(s) that was affected by this deficiency. 2. On the whole the entire community will benefit from having stain free carpet by a frequent cleaning and/or replacing the affected areas.</p>	08/29/2016

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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	<p>and the front entrance of the building. This deficient practice had the potential to impact 78 of 78 residents residing in the facility.</p> <p>Findings include:</p> <p>During the environmental tour with the Maintenance Director, on 8/4/16 at 10:35 a.m., soiled and worn areas were identified throughout the facility including, but not limited to the following:</p> <p>100 hall, hallway under the water fountain,a worn and stained area measured at 4 feet by 2 feet.</p> <p>100 hall, hallway measured 300 feet x 1/2 inch wide stain in the center of the hall complete length of hall.</p> <p>100 hall, hallway outside public restroom in front of activity room, round stain measured 1 foot by 16 inches,</p> <p>200 hall, hallway next to dining room, stained circular area, measured 10 inches.</p> <p>200 hall, hallway leading to dementia unit, measured 4 feet by 4 and 1/2 feet.</p> <p>200 hall, hallway outside apartment 218, 1 stained area measured 2 feet by 1 and</p>		<p>3.Cleaning schedule of the carpet will be increased from bi-weekly to weekly cleaning of the affected areas. This process will be in place until the affected areas are stain free or when new carpeting is put in place.4. Maintenance director has an agreement with an outside contractor for the weekly cleaning and he will monitor for new/ or worsening stains. 5. The first weekly cleaning will start on 08-29-2016</p>	

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	<p>1/2 feet.</p> <p>200 hall, hallway outside laundry room across from apartment 215, stained area measured 2 feet by 6 inches.</p> <p>200 hall, hallway across from apartment 212, stained circular area, measured 8 inches.</p> <p>200 hall, hallway outside wellness center, large stain measured 6 feet by 2 and 1/2 feet.</p> <p>300 hall, hallway across from apartment 314, 1 and 1/2 feet.</p> <p>The Maintenance Director indicated the carpet has a rubber backing and in the high humidly the stains return even after cleaning. He used the facility extractor for small areas. He indicated he has had professional carpet cleaners clean the carpet about 2 or 3 times in July. He indicated the carpet has not been replaced in 14 years since the building was built.</p> <p>During an interview on 8/4/16 at 10:50 a.m., the Administrator indicated carpet required cleaning about every 2 to 3 weeks in the summer. The rubber backing kept the stains coming back when the weather had high humidly.</p>			

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R 0241 Bldg. 00	<p>A 7/27/16 invoice, titled "carpet cleaning", provided by Maintenance Supervisor on 8/4/16 at 12:25 p.m., indicated: extraction of carpets.</p> <p>A 7/21/16 invoice, titled "carpet cleaning", provided by Maintenance Supervisor on 8/4/16 at 12:25 p.m., indicated: extraction of spots carpets.</p> <p>A 7/15/16 invoice, titled "carpet cleaning", provided by Maintenance Supervisor on 8/4/16 at 12:25 p.m., indicated: extraction of spots carpets for halls 100, 200 and 300.</p> <p>A 7/5/16 invoice, titled "carpet cleaning", provided by Maintenance Supervisor on 8/3/16 at 11:25 a.m., indicated: extraction of carpets for 200 hall.</p> <p>A 7/5/16 invoice, titled "carpet cleaning", provided by Maintenance Supervisor on 8/3/16 at 11:25 a.m., indicated: cleaning of carpets for hall 100, 200, 300, and front hall.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:</p>			

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	<p>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review and interview, the facility failed to ensure nurses obtained blood sugar readings for which sliding scale insulin administration was based, and failed to administer sliding scale insulin in accordance with physician's orders for 1 of 1 resident reviewed with sliding scale insulin coverage (Resident #R26).</p> <p>Findings include:</p> <p>Resident #R26 was observed during a blood sugar reading and insulin administration on 8/3/16 at 11:51 a.m., with LPN #2.</p> <p>The clinical record for Resident #R26 was reviewed on 8/3/16 at 2:28 p.m. Diagnoses for Resident #R 26 included, but were not limited to, diabetes, hypertension, and congestive heart failure.</p> <p>Current physician's orders for Resident #R 26 included, but were not limited to, the following:</p> <p>a. Check blood sugar levels at all meals and at bedtime; record on the flow sheet. The original date of this order was</p>	R 0241	<p>1. The corrective action to take place will be; the nurses will have additional education on Insulin Dependent Diabetes within the next 7 days. The RSD and/or designee will follow up 5x per week on the MAR and blood sugar log to ensure that all orders are being followed for insulin dosage and call orders. The audits will continue for the next 90 days and then weekly as long as there are residents with sliding scale insulin in the community. Two of the nurses were terminated prior to the survey.</p> <p>2. The facility will identify other residents having the potential to be affected by; there are no other residents on sliding scale insulin in the community. Moving forward, nursing managers will work with ED and Admissions Director to openly communicate to the physicians the risks of sliding scale insulin in the elderly. Residents and families will be educated during the pre-admission screening process of the risks of sliding scale insulin. Sliding scale insulin will be used by the community only if there are no other options available per MD.</p> <p>3. The measures to be put in place to ensure that that no other residents would In addition to the Riverwalk Commons nursing staff in-servicing, the nursing team will</p>	09/09/2016			

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	<p>4/28/15.</p> <p>B. Humalog (insulin) inject subcutaneously per sliding scale</p> <p>151 - 200 = 6 units 201 - 250 = 8 units 251 - 300 = 9 units 301 - 350 = 11 units</p> <p>The original date of this order was 4/19/16. This order had been discontinued 4/12/16 and restarted on 4/19/16.</p> <p>c. Call the physician if the blood sugar level is less than 60 or greater than 350. The original date of this order was 3/24/15.</p> <p>d. Lantus (an insulin) inject 40 units subcutaneously (sub-q) every bedtime for a blood sugar level greater than 200. The original date of this order was 12/1/15.</p> <p>e. Lantus (an insulin) inject 18 units sub-q every bedtime for a blood sugar level less than 200. The original date of this order was 12/1/15.</p> <p>Review of the July, 2016, June 2016, May, 2016, and April, 2016, "Blood Sugar Monitoring Sheets", and the Medication Administration Records for</p>		<p>reach out to the attending physician to educate on the risks of sliding scale insulin in the elderly, current best practices for treatment of diabetes in the elderly and all ensure that all possible diagnostic and treatment have been carefully considered. Food and Beverage Director will work with Dietician on a resident to resident basis to assist residents and family members with education on food choices.</p> <p>4. The RSD will monitor to ensure compliance with all blood glucose monitoring and sliding scale insulin 5 x per week for the next 90 days and then monthly as long as there are residents in the community with sliding scale insulin orders.</p>				

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	<p>July, 2016, June 2016, May, 2016, and April, 2016, for Resident #R26 indicated the following:</p> <p>July 11, 8:00 p.m., no blood sugar level was documented. No insulin had been documented as given. No insulin had been documented as given on the July 2016, Medication Administration Record (MAR).</p> <p>June 22, 4:00 p.m., the blood sugar result was 202, 6 units of Humalog was documented as given. The resident should have received 8 units of Humalog.</p> <p>May 9, 11:00 a.m., the blood sugar result was blank with no documented Humalog as given. The MAR indicated the resident received 6 units of Humalog.</p> <p>May 11, 7:00 a.m., the blood sugar result was 217, 6 units of Humalog was documented as given. The resident should have received 8 units of Humalog.</p> <p>May 11, 11:00 a.m., the blood sugar result was blank with no documented Humalog as given. The MAR had no documented Humalog as given.</p> <p>May 16, 11:00 a.m., the blood sugar result was 160, zero had been documented as the amount of Humalog</p>			

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	<p>given. The MAR indicated zero had been documented as the amount of Humalog given. The resident should have received 6 units of Humalog.</p> <p>April 5, 7:00 a.m., the blood sugar result was 219, no Humalog had been documented as given. The MAR indicated 9 units of Humalog as given. The resident should have received 8 units of Humalog.</p> <p>April 25, 7:00 a.m., the blood sugar result was 307, no Humalog had been documented as given. The MAR had no documented Humalog as given. The resident should have received 11 units of Humalog.</p> <p>This resulted in 5 incorrect doses of sliding scale insulin coverage, and 3 missed blood sugar results and the possible need of sliding scale coverage for Resident #R26 throughout July, June, May, and April, 2016.</p> <p>During an interview on 8/4/16 at 10:20 a.m., LPN #2 and LPN #3 indicated blood sugar levels and the amount of sliding scale insulin given were to be documented on the diabetic log. They indicated the amount of insulin given was to be documented on the MAR as well.</p>			

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R 0242 Bldg. 00	<p>During an interview on 8/4/16, at 10:31 a.m., the Director of Nursing (DON) indicated she would review Resident #R26's clinical record for any further information regarding the blood sugar levels and sliding scale insulin administration. No further information was found in the resident's record.</p> <p>Review of the current facility policy, dated 12/28/12, titled "Insulin Administration [Assisted Living]", provided by the Administrator on 8/4/16 at 12:17 p.m., included, but was not limited to, the following:</p> <p>"...3.0 FUNDAMENTAL INFORMATION... ...A resident's blood sugar must be checked before insulin administration....</p> <p>...4.0 PROCEDURE 1. Verify MD order using doctors order sheet and MAR/MOR.... ...6. Draw up appropriate dose of insulin into syringe... ...10. Document the injection on the MAR/MOR...."</p> <p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for</p>			

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	<p>effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on interview and record review, the facility failed to notify the physician of blood sugar levels which may have required a change in medication or treatment for 1 of 2 diabetic residents. (Resident #R26)</p> <p>Findings include:</p> <p>Resident #R26 was observed during a blood sugar reading and insulin administration on 8/3/16 at 11:51 a.m., with LPN #2.</p> <p>The clinical record for Resident #R26 was reviewed on 8/3/16 at 2:28 p.m. Diagnoses for Resident #R26 included, but were not limited to, diabetes, hypertension, and congestive heart failure.</p> <p>Current physician's orders for Resident #R26 included, but were not limited to, the following:</p> <p>a. Check blood sugar levels at all meals and at bedtime; record on the flow sheet. The original date of this order was 4/28/15.</p>	R 0242	<p>1. The nurses will have additional education on Insulin Dependent Diabetes within the next 7 days. Shift to shift nurse report will include review of the resident on sliding scale insulin's blood glucose monitoring results, call to MD if outside of parameters, insulin dosage given. The RSD and/or designee will follow up 5x per week on the MAR and blood sugar log to ensure that all orders are being followed for insulin dosage and call orders. The audits will continue for the next 90 days and then weekly as long as there are residents with sliding scale insulin in the community. Two of the nurses were terminated prior to the survey.</p> <p>2. There are no other residents on sliding scale insulin in the community. Moving forward, nursing managers will work with ED and Admissions Director to openly communicate to the physicians the risks of sliding scale insulin in the elderly. Residents and families will be educated during the pre-admission screening process of the risks of sliding scale insulin. Sliding scale insulin will be used by the community only if there are no other options</p>	09/09/2016			

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	<p>b. Call the physician if blood sugar level is less than 60 or greater than 350. The original date of this order was 3/214/15.</p> <p>Review of the April 2016, "Blood Sugar Monitoring Sheet", for Resident #R26 indicated the following:</p> <p>April 13, at 8:00 p.m., the blood sugar level was 353;</p> <p>April 14, at 8:00 p.m., the blood sugar level was 373;</p> <p>April 18, at 7:00 a.m., the blood sugar level was 363.</p> <p>Resident #R26's clinical record lacked any documentation related to the physician having been notified of the blood sugar levels on April 13, at 8:00 p.m., April 14, at 8:00 p.m., or April 18, at 7:00 a.m. The nurses notes indicated on April 13, at 8:00 a.m., the physician was notified of a blood sugar level of 264. The physician gave a new order for a one time dose of 9 units of Humalog (an insulin) subcutaneously. The nurses notes indicated on April 18, at 9:00 p.m., the physician was notified of a blood sugar level of 400. The physician indicated he would see the resident tomorrow (April 19). On April 19, the</p>		<p>available perMD. This will identify the potential of residents to be affected.</p> <p>3. Inaddition to the Riverwalk Commons nursing staff in-servicing, the nursing teamwill reach out to the attending physician to educate on the risks of slidingscale insulin in the elderly, current best practices for treatment of diabetesin the elderly and all ensure that all possible diagnostic and treatment havebeen carefully considered. Food and Beverage Director will work with Dieticianon a resident to resident basis to assist residents and family members witheducation on food choices.</p> <p>4. The RSDwill monitor to ensure compliance with all blood glucose monitoring and slidingscale insulin 5 x per week for the next 90 days and then monthly as long asthere are residents in the community with sliding scale insulin orders.</p>	

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	<p>physician restarted Resident #R26's insulin sliding scale coverage.</p> <p>During an interview on 8/4/16, at 10:31 a.m., the Director of Nursing indicated she would review Resident #R26's clinical record to determine if the physician had been notified regarding the resident's blood sugar levels on April 13, April 14, and April 18, not documented in the nurses notes. No futher information was provided.</p> <p>Review of the current facility policy, dated 12/28/12, titled "Blood Glucose Monitoring [Assisted Living]", provided by the Administrator on 8/4/16 at 12:17 p.m., included, but was not limited to, the following:</p> <p>"1.0 PURPOSE To detect or monitor resident's blood glucose levels....</p> <p>...4.0 PROCEDURE... ...14. If the glucose level is outside of established ranges ordered by the physician: a. Repeat the test, b. Report to nurse/supervisor, c. Contact the physician/health care provider,..."</p>			

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

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