

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200052.</p> <p>Complaint IN00200052 - Substantiated. Federal/State deficiencies related to the allegation were cited at F282, F333, and F514.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: May 17, 2016</p> <p>Facility number: 013452 Provider number: 155835 AIM number: 201299290</p> <p>Census bed type: SNF: 64 Residential: 20 Total: 84</p> <p>Census Payor type: Medicare: 54 Other: 10 Total: 64</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Facility respectfully requests consideration for paper compliance / desk review for the attached plan of correction as response for the noted citations.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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 0282 SS=D Bldg. 00	<p>Quality review completed by 32883 on 5/18/16.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure Physician's Orders and care plans were followed related to medication administration and Physician notification of blood sugar results for 3 of 3 residents reviewed for Physician's Orders and care plans in a total sample of 3. (Residents #B, #C, and #D)</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 5/17/16 at 10:05 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, heart</p>	F 0282	<p>F282- SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Failed to ensure Physician's orders and care plans were followed related to medication administration and Physician notification of blood sugar results. 1. What corrective action which will be accomplished for those resident(s) affected by the deficient practice? Resident #C no longer resides in the facility. RN #1 received re-education on 5/18/16 related to physician notification and necessary documentation secondary to blood sugar results outside the ordered physician parameters as</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/17/2016	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307			
(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			
	<p>failure, and atrial fibrillation.</p> <p>A care plan, dated 4/21/16, indicated the resident had diabetes mellitus. The interventions included diabetes medication as ordered by the doctor.</p> <p>A care plan, dated 4/21/16, indicated the resident had an altered cardiovascular status. The interventions included administer medication as ordered.</p> <p>The hospital discharge/ facility admission Physician's Orders dated 4/19/16 included the following medication orders:</p> <ul style="list-style-type: none"> - furosemide (diuretic for edema) 40 mg (milligrams) daily - metformin (diabetic medication) 500 mg twice daily - metoprolol (anti-hypertensive) 25 mg twice daily - carvedilol (anti-hypertensive) 25 mg twice daily - duloxetine (anti-depressant) 60 mg daily - digoxin (atrial fibrillation medication) 125 mcg (micrograms) daily - amiodarone (anti-arrhythmic) 200 mg daily - potassium chloride (supplement) 20 milliequivalents daily - losartan potassium (anti-hypertensive) 100 mg daily - clopidogrel bisulfate (prevent blood clots) 75 mg daily 		<p>per Resident #D. Resident#D's physician validated that he was notified and follow-up orders provided to RN #1 which were implemented. The nurse assigned to Resident #B on 5/10/16 was provided education on 5/18/16 related to physician notification for blood sugar results outside the ordered parameters and documentation of physical assessment for signs/symptoms of hypo/hyperglycemia. Review of both Resident #B and Resident D's current medication administration records resulted in appropriate physician notification related to blood sugar results outside ordered parameters. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Facility audit of all residents' with a diabetes diagnosis was conducted on 5/18/16 to ensure physician's orders and care plans were adhered to with regard to physician notification for any blood sugar results noted outside the ordered parameters. Physician orders were clarified and careplans amended as necessary per audit results. Facility audit of residents' admitted/readmitted from 5/17/16-5/24/16 was completed on 5/24/16 to ensure orders were correct and complete as verified per attending physician. Order clarifications were completed as indicated. 3. What measures</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>The Medication Administration Record (MAR), dated 4/2016, indicated the following medication had not been administered as ordered by the Physician on the following dates and times: Lasix (furosemide) 40 mg at 9 a.m. on April 20 & 21, 2016 metformin 500 mg at 9 a.m. on April 20, 2016 metoprolol 25 mg at 9 a.m. on April 20, 2016 carvedilol 25 mg at 9 a.m. on April 20 & 21, 2016 duloxetine 60 mg at 6 a.m. on April 20 & 21, 2016 digoxin 125 mcg at 9 a.m. on April 20, 2016 amlodarone 200 mg at 9 a.m. on April 20 & 21, 2016 potassium chloride 20 meq at 9 a.m. on April 20, 2016 losartan potassium at 9 a.m. on April 20, 2016 clopidogrel bisulfate 75 mg at 9 a.m. on April 20, 2016</p> <p>The Nurses' Progress Notes indicated the following: 4/20/16 at 5:55 a.m., Cymbalta (duloxetine) 60 mg not given due to the pharmacy had not delivered and no available in the EDK (Emergency Drug Kit).</p>		<p>will facility will take or system the facility will alter to ensure that the problem will be corrected? Nursing Administration to provide education to licensed nurses related to physician notification for blood sugar levels outside ordered parameters; adherence to the plan of care as per diabetes diagnosis; physical assessment for both hypo/hyperglycemia. This education will be completed by 6/06/16. Blood sugar results, physician ordered parameters, and documentation of hypo/hyperglycemia assessments will be reviewed in the facility clinical meeting at least 5 days per week to ensure all areas are completed. Issues will be addressed in a timely manner with subsequent education provided to the involved nurse. Audit will be ongoing to ensure continued compliance with these specified areas. Issues will be addressed in a timely manner with subsequent education provided to the involved nurse. Audit will be ongoing to ensure continued compliance with these specified areas. Nursing administration to provide education to licensed nurses related to clarification of admission orders to ensure correct medication and dosages of medications are as per physician's orders. Education will be completed by 6/6/16 of current</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>4/20/16 at 3:03 p.m., amiodarone 200 mg and losartan potassium 100mg was not given due to waiting on the Pharmacy to deliver.</p> <p>4/20/16 at 3:04 p.m., clopidogrel bisulfate 75 mg was not given due to waiting on the Pharmacy to deliver.</p> <p>4/20/16 at 3:05 p.m., Coreg (carvedilol) 25 mg was not given due to waiting on the Pharmacy to deliver.</p> <p>4/20/16 at 3:06 p.m., digoxin 125 mcg was not given due to waiting on the Pharmacy to deliver.</p> <p>4/20/16 at 3:07 p.m., Lasix (furosemide) 40 mg was not given due to waiting on the Pharmacy to deliver.</p> <p>4/20/16 at 3:08 p.m., potassium chloride 20 meq, metformin 500 mg, and metoprolol 25 mg was not given due to waiting on the Pharmacy to deliver.</p> <p>4/21/16 at 6:07 a.m., Cymbalta 60 mg was not given due to medication was not available.</p> <p>4/21/16 at 9:32 a.m., metformin 500 mg was not given due to waiting on the Pharmacy to deliver.</p>		<p>staff nurses and education will be included in the orientation program for newly hired nurses.</p> <p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not occur, i.e., what quality assurance program will be put into place? Director of Nursing/designee to complete random audit on 5 residents' weekly for 12 weeks and then 5 residents' monthly for an additional 12 weeks to monitor continued compliance with the following: Blood sugar results, physician ordered parameters, and documentation of hypo/hyperglycemia assessments. Director of Nursing/designee to complete random audits on 5 admission/readmissions weekly for 12 weeks and then 5 admission/readmissions monthly for an additional 12 weeks to monitor continued compliance with the accuracy of physician orders. Audit results will be reviewed monthly in facility QAPI meeting with recommendations made and implemented as deemed necessary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>4/21/16 at 9:34 a.m., lasix 40 mg not given de to waiting on the Pharmacy to deliver.</p> <p>4/21/16 at 9:35 a.m., Coreg 25 mg not given due to waiting on the Pharmacy to deliver.</p> <p>4/21/16 at 9:40 a.m., amiodarone 200 mg not given due to waiting on the Pharmacy to deliver.</p> <p>A list of medications available from the, "Convenience Drug Supply", (Emergency Drug Kit), provided by the RN Corporate Consult, on 5/17/16 at 4:30 p.m., indicated the following medications were available for usage until Pharmacy delivered the medication:</p> <ul style="list-style-type: none"> amiodarone 200 mg carvedilol 12.5 mg clopidogrel 75 mg digoxin 0.125 mg (125 mcg) duloxetine 30 mg furosemide 20 mg losartan 25 mg metformin 500 mg metoprolol 25 mg potassium chloride 10 meq <p>The MAR, dated 4/2016, indicated the resident received levemir insulin 15 units at 9 p.m. on 4/20/16 and magnesium</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>oxide (supplement) 400 mg at 9 a.m. on 4/21/16.</p> <p>The hospital discharge/ facility admission Physician's Orders, dated 4/19/16, indicated there were no Physician Orders for the levemir insulin or magnesium oxide.</p> <p>The E-Chart, indicated the magnesium oxide 400 mg had been ordered on a past admission on 11/22/15 and the levemir insulin 15 units was also ordered on a past admission on 12/15/16. The E-Chart indicated the resident had been discharged from the facility with return not anticipated on 12/24/15.</p> <p>During an interview on 5/17/16 at 2:10 p.m., the RN Nurse Consultant indicated medications were available from the convenience drug supply and the Nurses' were to pull what medications were needed from the supply until the Pharmacy delivered the medications. She also indicated the medications from previous admissions had not been discontinued in the system, so the medications continued to be on the MAR.</p> <p>During an interview on 5/17/16 at 3:30 p.m., LPN #1, who documented the levemir insulin 15 units was administered on 5/20/16 at 9 p.m., indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>levemir had been administered.</p> <p>A facility policy, dated 9/1/2014, titled, "Pharmacy Services Agreement", received from the Director of Nursing (DON) as current, indicated, "...Provide, maintain, and replenish in a prompt and timely manner an acceptable container and labeled, 'Emergency Drug Supply'..."</p> <p>2. Resident #D's record was reviewed on 5/17/16 at 1:45 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and stroke.</p> <p>A care plan, dated 4/21/16, indicated the resident had diabetes mellitus. The interventions included, blood glucose checks as ordered and observe/document/report signs and symptoms of hyperglycemia.</p> <p>A Physician's Order, dated 4/28/16, indicated to administer Novolin Regular Insulin per sliding scale (units of insulin given per the blood sugar result). The order indicated for a blood sugar 351 and above to give 10 units of insulin and notify the Physician.</p> <p>The MAR, dated 5/2016, indicated the resident's blood sugar was 385 and 10 units of insulin were given on 5/3/16 at 7:30 a.m., blood sugar of 355 and 10</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>units of insulin were given on 5/14/16 at 7:30 a.m., and blood sugar of 369 and 10 units of insulin were given on 5/16/16 at 11 a.m.</p> <p>The MAR and the Nurses' Notes, dated 5/3/16, 5/14/16, and 5/16/16, had not indicated the resident's Physician was notified of the blood sugar results over 351.</p> <p>The MAR, dated 5/13/16 at 5 p.m., indicated the resident's blood sugar was 575.</p> <p>The Nurses' Notes, dated 5/3/16, 5/13/16, 5/14/16, and 5/16/16, indicated no assessment of the resident for signs and symptoms of hyperglycemia.</p> <p>During an interview on 5/17/16 at 2:10 p.m., the RN Nurse Consultant indicated the Physician had not been notified as ordered.</p> <p>During an interview on 5/17/16 at 2:40 p.m., RN #1 indicated she had notified the Physician about the blood sugar of 575 on 5/13/16 and the Physician had given an order to monitor and recheck the blood sugar in an hour. She indicated the glucometer indicated the resident's blood sugar was, "hi" when rechecked and she notified the Physician again and was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>given an order to "watch it". She indicated she thought she had documented the information.</p> <p>During an interview on 5/17/16 at 3:45 p.m., the ADON (Assistant Director of Nursing) indicated there were no "Skilled Look Back" notes to indicate the Physician had been notified and assessments had been completed.</p> <p>3. Resident #B's record was reviewed on 5/17/16 at 1:05 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus and hypertension.</p> <p>A care plan, dated 5/4/16, indicated the resident had diabetes mellitus. The interventions included, observe/document/report to MD as needed for signs and symptoms of hyperglycemia.</p> <p>A Physician's Order, dated 4/30/16, indicated Novolog Insulin to be given per sliding scale before meals and at bedtime and if the blood sugar was 351 or above to give 12 units and notify the Physician.</p> <p>The MAR, dated 5/2016, indicated at 5 p.m. on 5/10/16 the blood sugar was 377 and 12 units of insulin was given.</p> <p>The MAR and the Nurses' Notes dated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>5/10/16 had not indicated the Physician was notified of the blood sugar of 377.</p> <p>The Nurses' Notes dated 5/10/16 had not indicated an assessment of the hyperglycemia had been completed.</p> <p>During an interview on 5/17/16 at 2:10 p.m., the RN Nurse Consultant indicated the Physician had not been notified as ordered.</p> <p>During an interview on 5/17/16 at 4:40 p.m., the DON indicated there was no policy for sliding scale insulin and hyperglycemia monitoring.</p> <p>This Federal Tag relates to complaint IN00200052.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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 0333 SS=D Bldg. 00	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident was free of significant medication errors, related to incorrect insulin dosages, for which a resident required an Emergency Room visit and hospital observation due to a low blood sugar, for 1 of 3 residents reviewed for significant medication errors in a total sample of 3. (Resident #C)</p> <p>Finding includes:</p> <p>Resident #C's record was reviewed on 5/17/16 at 10:05 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, heart failure, and atrial fibrillation.</p> <p>The hospital discharge/ facility admission Physician's Orders, dated 4/19/16, indicated an order for regular insulin, 2-12 units before meals and nightly.</p> <p>A Nurses' Note, dated 4/19/16 at 10:15 p.m., indicated the resident's Admission Orders were verified with the Nurse</p>	F 0333	<p>F333 - RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>Failed to ensure a resident was free of significant med errors, related to incorrect insulin dosages, for which resident required emergency room visit and hospital observation due to low blood sugar. Insulin sliding scale not clarified with incorrect dosage ordered. Insulin given without an order. Medications not given due to not available. 1. What corrective action which will be accomplished for those resident(s) affected by the deficient practice? Resident #C no longer resides in the facility. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Facility audit of residents' admitted from 5/17/16 to 5/24/16 was completed on 5/24/16 to ensure admission orders were correct and complete as verified per the attending physician. Order clarifications were completed as indicated. Admission/re-admission audits to continue to ensure ongoing compliance with prevention of medication transcription errors. Facility audit of current residents'</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/17/2016	
NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307			
(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			
	<p>Practioner.</p> <p>The Medication Administration Record (MAR), dated 4/2016, indicated the regular insulin was transcribed as, "Humulin R (regular, fast-acting insulin)...inject 12 units subcutaneously four times a day..." The humulin insulin was scheduled for 8 a.m., 12 p.m., 4 p.m., and 8 p.m.</p> <p>The MAR indicated the humulin insulin 12 units was given on 4/20/16 at 12 p.m., 4 p.m., and 8 p.m. and on 4/21/16 at 8 a.m. and 12 p.m.</p> <p>The MAR indicated the resident's blood sugars were to be checked at 8 a.m. and 4 p.m. On 4/19/16 at 4 p.m. the blood sugar was 144 (normal 70-99). The blood sugars for 4/20/16 at 8 a.m. and 4 p.m. and on 4/21/16 at 8 a.m. were checked off with initials, with no result documented.</p> <p>The blood sugars listed in the E-Chart vital signs indicated the resident's blood sugar on 4/20/16 at 12:37 a.m. was 144 and 4/21/16 at 5:41 p.m. was 145.</p> <p>A Nurses' Note, dated 4/21/16 at 5:25 p.m., written by LPN #2, indicated the resident's mental status had declined, was unable to answer simple questions, and</p>		<p>with diabetes diagnosis was also conducted on 5/18/16 to validate accuracy of physician orders related to insulin administration. No issues were identified via this audit. 3. What measures will facility will take or system the facility will alter to ensure that the problem will be corrected?</p> <p>Nursing Administration to provide education to licensed nurses related to the following: clarification of admission orders to ensure correct medication and dosages of medications are as per physician's orders; verification of insulin related orders and outlined parameters for physician notification; proper use of the facility EDK (Emergency drug kit)boxes secured in the medication rooms; pharmacy protocol for ordering medications. Education will be completed by 6/06/16 to current staff nurses and education will be included in the orientation program for newly hired nurses to the facility. Facility admission audit tool will be completed on each admission/readmission by Nursing Administration to ensure accuracy of physician orders. Electronic medication administration records will be reviewed at least 5 days per week during facility clinical meeting to ensure medications are pulled from EDK when available or necessary steps taken to ensure medication arrives in a timely manner. Physician orders will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>had left sided weakness. The Physician was notified and the resident was sent to the Emergency Room.</p> <p>The Emergency Room Physician's Note, dated 4/21/16 at 6:28 p.m., indicated the resident's blood sugar completed by the Emergency Management System (EMS) upon their arrival to the facility was 47 and the EMS administered glucagon (sugar) and the resident's husband indicated the resident received the dinner dose of insulin and the resident had not eaten dinner. The resident's blood sugar at 7:48 p.m. was 86. Labs were non acute and the resident's Primary Care Physician recommended admission to the Hospital for monitoring of the blood sugar, mental status and antibiotic treatment.</p> <p>During an interview on 5/17/16 at 2 p.m., LPN #3 indicated when the resident was admitted to the facility, she had notified the Nurse Practitioner and had gone over the medication order list. LPN #3 indicated she read her the insulin orders, which said 2-12 units of regular insulin before meals and bedtime and the Nurse Practitioner said, "OK". LPN #3 indicated she did not clarify the order for the number of units or the sliding scale with the Nurse Practitioner. LPN #3 indicated she usually just reads the orders and the Physician/Nurse Practitioner says yes or</p>		<p>reviewed during clinical meeting at least 5 days to ensure orders are transcribed correctly. The above audits will be ongoing to ensure continued compliance and continued education 4. How will the corrective action(s) be monitored to ensure the deficient practice will not occur, i.e., what quality assurance program will be put into place? Director of Nursing/designee to complete random audit on 5 admission/re-admissions weekly for 12 weeks and then 5 admissions/re-admissions monthly for an additional 12 weeks to monitor continued compliance with the accuracy of physician orders. Audit results will be reviewed monthly in facility QAPI meeting with recommendations made and implemented as deemed necessary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>no. LPN #3 indicated since the Nurse Practioner said ok, she didn't clarify the order. LPN #3 indicated she had transcribed the order incorrectly in the computer and just transcribed the order as 12 units four times a day.</p> <p>During an interview on 5/17/16 at 3:20 p.m., LPN #2 indicated she had checked the resident's blood sugar around 4 p.m. and the blood sugar was around 140. LPN #2 indicated the resident had a small lunch so she held the insulin until the resident ate her supper and within 30 minutes the resident had the condition change. LPN #2 indicated she notified 911 and the medics arrived and checked the blood sugar and it was 42.</p> <p>During an interview on 5/17/16 at 3:35 p.m., the RN Nurse Consultant indicated she had interviewed the Nurse Practioner during the investigation and the Nurse Practioner remembered the call but not what was ordered.</p> <p>During an interview on 5/17/16 at 3:40 p.m., LPN #4 indicated on 4/20/16 at 12 p.m. the resident's blood sugar was 184, on 4/21/16 at 8 a.m. the blood sugar was 149, and on 4/21/16 at 12 p.m. the blood sugar was 167 and 12 units of regular insulin had been given as written on the MAR. She indicated she had written the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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 0425 SS=D Bldg. 00	<p>blood sugars on the 24 hour report sheet but not in the chart or on the MAR.</p> <p>This Federal Tag relates to complaint IN00200052.</p> <p>3.1-48(c)(2)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure a resident received medications as ordered by the Physician in a timely manner related to</p>	F 0425	F425 - PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH Failed to ensure a resident received medications as ordered by the	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>medications not being delivered from the Pharmacy for 1 of 3 residents reviewed for availability of medications in a total sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 5/17/16 at 10:05 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, heart failure, and atrial fibrillation.</p> <p>The hospital discharge/ facility admission Physician's Orders dated 4/19/16, indicated orders for the following medications:</p> <ul style="list-style-type: none"> - Colace (stool softener) 100 mg (milligrams) two times a day - Lyrica (used to treat neuropathy) 100 mg two times a day - Cyanocobalamin (vitamin B-12) 1000 mcg (micrograms) daily - Anastrozole (used to treat breast cancer) 1 mg daily <p>The Medication Administration Record (MAR) dated 4/2016 indicated the following:</p> <p>Colace was not given at 9 a.m. on 4/20/16 or 4/21/16.</p> <p>Lyrica was not given at 9 a.m. on 4/20/16 at 6 a.m. or 4/21/16.</p> <p>Cyanocobalamin was not given at 9 a.m.</p>		<p>Physician in a timely manner related to medications not being delivered from the Pharmacy. 1. What corrective action which will be accomplished for those resident(s) affected by the deficient practice? Resident #C no longer resides in the facility. RN #1 received re-education on 5/18/16 related to physician notification and necessary documentation secondary to blood sugar results outside the ordered physician parameters as per Resident #D. Resident #D's physician validated that he was notified about the elevated blood sugar and follow-up orders provided to RN #1 which were implemented 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Full facility Audit of current residents' electronic medication administration records was completed on 5/23/16 to ensure all ordered medications are being administered in a timely manner and/or the attending physician made aware of reason for delay in administration. 3. What measures will facility will take or system the facility will alter to ensure that the problem will be corrected? Nursing Administration to provide education to licensed nurses on the use of the EDK (emergency drug kit) boxes and the pharmacy protocol to follow to ensure medications are available and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>on 4/20/16 or 4/21/16. Anastrozole was not given at 9 a.m. on 4/20/16 or 4/21/16.</p> <p>The Nurses' Notes indicated the following: 4/20/16 at 5:52 a.m., the Lyrica was not available from Pharmacy.</p> <p>4/20/16 at 3:03 p.m., the Anastrozole was not available from Pharmacy.</p> <p>4/20/16 at 3:05 p.m., the cyanocobalamin and Colace were not available from Pharmacy.</p> <p>4/21/16 at 9:34 a.m., the Lyrica was not available from Pharmacy.</p> <p>4/21/16 at 9:35 a.m., the Colace was not available from Pharmacy.</p> <p>4/21/16 at 9:36 a.m., the cyanocobalamin was not available from Pharmacy.</p> <p>4/21/16 at 9:40 a.m., the Anastrozole was not available from Pharmacy.</p> <p>During an interview on 5/17/16 at 12:05 p.m., LPN #4 indicated once the orders were faxed to the Pharmacy, they had a four hour window to deliver the medications.</p>		<p>administered as ordered. Education will be completed by 6/06/16 to current staff nurses and education will be included in the orientation program for newly hired nurses to the facility. The 24 hour report/EMAR will be reviewed during the facility clinical meeting at least 5 days to ensure residents receive all medications as ordered by the physician, EDK is utilized for any medication needed prior to pharmacy delivery and/or arrangements with facility back-up pharmacy are secured. Audit will be ongoing to ensure continued compliance. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not occur, i.e., what quality assurance program will be put into place? Director of Nursing/designee to complete random audit on 5 admission/re-admissions weekly for 12 weeks and then 5 admissions/re-admissions monthly for an additional 12 weeks to monitor continued compliance with medication availability and ordering process. Audit results will be reviewed monthly in facility QAPI meeting with recommendations made and implemented as deemed necessary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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 0514 SS=D Bldg. 00	<p>A facility policy dated 9/1/2014, titled "Pharmacy Services Agreement", was received from the Director of Nursing (DON) and deemed as current. The policy indicated, "...Provide routine pharmacy services seven (7) days per week and emergency pharmacy services twenty four (24) hours per day, seven (7) days per week...Provide drugs, biologicals, and supplies in a prompt and timely manner..."</p> <p>3.1-25(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure residents' clinical records were complete and accurate, related to transcription of Physician's Orders, and documentation of assessments, blood sugars, and Physician notification for 2 of 3 residents reviewed for clinical records in a total sample of 3. (Residents #C and #D)</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 5/17/16 at 10:05 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, heart failure, and atrial fibrillation.</p> <p>The MAR (Medication Administration Record) dated 4/2016 indicated the resident's blood sugars were to be checked at 8 a.m. and 4 p.m. On 4/19/16 at 4 p.m. the blood sugar was 144 (normal 70-99). The blood sugars for 4/20/16 at 8 a.m. and 4 p.m. and 4/21/16 at 8 a.m. were checked off with initials, with no results documented.</p> <p>The blood sugars listed in the E-Chart vital signs indicated the resident's blood sugar on 4/20/16 at 12:37 a.m. was 144</p>	F 0514	<p>F514 - RECORDS-COMPLETE/ACCURATE/ACCESSIBLE Failed to ensure residents' clinical records were complete and accurate, related to transcription of Physician's Orders, and documentation of assessments, blood sugars and physician notification. 1. What corrective action which will be accomplished for those resident(s) affected by the deficient practice? Resident #C no longer resides in the facility. RN #1 received re-education on 5/18/16 related to physician notification and necessary documentation secondary to blood sugar results outside the ordered physician parameters as per Resident #D. Resident#D's physician validated that he was notified about the elevated blood sugar and follow-up orders provided to RN #1 which were implemented. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Facility audit of all residents' with a diagnosis of diabetes was conducted on 5/18/16 to ensure MD notification of blood sugars that were outside the ordered parameters was completed and appropriate hypo/hyperglycemia assessments were documented as indicated</p>	06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>and 4/21/16 at 5:41 p.m. was 145.</p> <p>The MAR dated 4/2016 also indicated the resident received levemir insulin 15 units at 9 p.m. on 4/20/16 and magnesium oxide (supplement) 400 mg at 9 a.m. on 4/21/16.</p> <p>The MAR, dated 4/2016, indicated and order for diltiazem (for hypertension) 120 mg (milligrams) daily at 9 a.m. The date of the order was 12/16/15. The diltiazem had not been administered due to awaiting delivery from the Pharmacy.</p> <p>The hospital discharge/ facility admission Physician's Orders dated 4/19/16 did not indicate the resident was to be on diltiazem 120 mg daily.</p> <p>The hospital discharge/ facility admission Physician's Orders dated 4/19/16 indicated there were no Physician Orders for the levemir insulin or magnesium oxide.</p> <p>The E-Chart, indicated the magnesium oxide 400 mg had been ordered on a past admission on 11/22/15 and the levemir insulin 15 units was also ordered on a past admission on 12/15/16. The E-Chart indicated the resident had been discharged from the facility with return not anticipated on 12/24/15.</p>		<p>per blood sugar result. Facility audit of residents' admitted from 5/17/16 to 5/24/16 was completed on 5/24/16 to ensure admission orders were correct and complete as verified per the attending physician and previous orders from any prior admission were deleted and reinstated if appropriate. Order clarifications were completed as indicated per audit results. Admission/re-admission audits to continue to ensure ongoing compliance with prevention of medication transcription errors and to validate accurate physician orders. 3. What measures will facility will take or system the facility will alter to ensure that the problem will be corrected?</p> <p>Nursing Administration to provide education to licensed nurses related to the following: clarification of admission orders to ensure correct medication and dosages of medications are transcribed correctly as per physician's orders; verification of insulin related orders and outlined parameters for physician notification. Education will be completed by 6/06/16 to current staff nurses and education will be included in the orientation program for newly hired nurses to the facility. Blood sugar results, physician ordered parameters, and documentation of hypo/hyperglycemia assessments will be reviewed in the facility</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>During an interview on 5/17/16 at 2:10 p.m., the RN Nurse Consultant indicated the medications from previous admissions had not been discontinued in the system, so the medications continued to be on the MAR.</p> <p>During an interview on 5/17/16 at 3:40 p.m., LPN #4 indicated on 4/20/16 at 12 p.m. the resident's blood sugar was 184, 4/21/16 at 8 a.m. the blood sugar was 149, and at 4/21/16 at 12 p.m. the blood sugar was 167 and 12 units of regular insulin had been given as written on the MAR. She indicated she had written the blood sugars on the 24 hour report sheet but not in the chart or on the MAR.</p> <p>2. Resident #D's record was reviewed on 5/17/16 at 1:45 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and stroke.</p> <p>A Physician's Order, dated 4/28/16, indicated to administer Novolin Regular Insulin per sliding scale (units of insulin given per the blood sugar result). The order indicated for a blood sugar 351 and above to give 10 units of insulin and notify the Physician.</p> <p>The MAR, dated 5/13/16 at 5 p.m., indicated the resident's blood sugar was</p>		<p>clinical meeting at least 5 days per week to ensure all areas are completed. Issues will be addressed in a timely manner with subsequent education provided to the involved nurse. Audit will be ongoing to ensure continued compliance with these specified areas. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not occur, i.e., what quality assurance program will be put into place? Director of Nursing/designee to complete random audit on 5 admission/re-admissions weekly for 12 weeks and then 5 admissions/re-admissions monthly for an additional 12 weeks to monitor continued compliance with accuracy of the clinical record. Audit results will be reviewed monthly in facility QAPI meeting with recommendations made and implemented as deemed necessary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
---	--

(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
	<p>575. No documentation of the Physician being notified was found in the record.</p> <p>During an interview on 5/17/16 at 2:40 p.m., RN #1 indicated she had notified the Physician about the blood sugar of 575 on 5/13/16 and the Physician had given an order to monitor and recheck the blood sugar in an hour. She indicated the glucometer indicated the resident's blood sugar was, "hi" when rechecked and she notified the Physician again and was given an order to "watch it". She indicated she thought she had documented the information.</p> <p>This Federal Tag relates to complaint IN00200052.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			