

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155770	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2013
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NAME OF PROVIDER OR SUPPLIER  VILLAS OF GUERIN WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 6, 7, 8, 11, and 12, 2013</p> <p>Facility number: 011509 Provider number: 155770 AIM number: 200909280</p> <p>Survey team: Diana Sidell RN, TC Gloria Reisert MSW Debra Peyton RN (2/11 and 2/12/13) Gwen Pumphrey RN (2/11 and 2/12/13) Gordon Tyree RN (2/11 and 2/12/13)</p> <p>Census bed type: SNF/NF: 47 Residential: 10 Total: 57</p> <p>Census payor type: Medicare: 6 Medicaid: 17 Other: 34 Total: 57</p> <p>Residential sample: 6</p> <p>These state findings are cited in</p>	F0000		
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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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R0000	<p>accordance with 410 IAC 16.2.</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p>	R0000	<p>Submission of this plan of correction shall not constitute an admission by the Villas of Guerin Woods to the allegations contained in this survey report. This plan of correction is submitted in accordance with the requirements of the state and federal laws.</p>		

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R0241	<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: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview, and record review the facility failed to administer insulin as ordered by the physician for 1 of 1 resident observed during one of two observations of medication administration. (Resident #5)</p> <p>Findings include:</p> <p>Resident #5's record was reviewed on 2-12-13 at 11:50 A.M. Diagnoses included, but were not limited to, subdermal hemorrhage, diabetes mellitus, hypertension, reflux, cutaneous candidiasis, and high cholesterol.</p> <p>During an observation of medication administration, on 2-11-13 at 12:50 P.M., LPN #1 checked Resident #5's bloodsugar. The bloodsugar reading was 317. LPN #1 then administered 8 units of Humulin R Insulin SQ (Subcutaneous) into Resident #5's</p>	R0241	<p>1. The Physician and family of Elder #5 were notified of the error. Orders recieved from physician to monitor for complications. There was no adverse affects 2. There was only 1 other Elder who had the potential to be affected. Orders and M.A.R. were reviewed and there were no deficient practices identified. 3. LPN #1 completed a medication error report, and has been re-educated on insulin administration, checking blood sugars 15-30 min before meal (See exhibit #1). LPN #1 also was monitored on med pass by DON to assure no errors. All nurses have been re-educated on checking blood sugars 15-30 min before meals, insulin administration with return demonstration. Med pass audits (See exhibit #2) have been completed on all nurses with Elders requiring blood sugars and insulin administration by the DON or designee. Random audits of 25% of nureses will be done weekly x4, monthly x3, quarterly x3. Any defeciciencies noted will result in re-education at</p>	03/12/2013			

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	<p>abdomen per sliding scale order.</p> <p>Physician's recapitulated orders dated 2-1-13 through 2-28-13 indicated an order to give Humulin R Insulin U-100 6 units SQ before meals routinely with a start date of 8-3-12, as well as an order dated 11-27-11 to give Humulin R Insulin U-100, SQ per sliding scale before meals and at bedtime as needed. An order dated 12-19-12 indicated blood sugars to be done four times daily and to document on the sliding scale log.</p> <p>The care plan was updated on 11-27-11 and indicated a problem of "BS (bloodsugar) 400 with an approach of Humulin R with sliding scale AC (before meals) and HS (at bedtime)."</p> <p>During an interview, on 12-12-13 at 9:30 A.M., the DON (Director of Nursing) indicated that bloodsugar levels should be checked prior to meals and that the routine dose of 6 units Humulin R insulin should be given with the sliding scale dose, according to bloodsugar level.</p> <p>During an interview, on 2-12-13 at 9:30 A.M., LPN #1 indicated that no bloodsugar was done prior to Resident #5 eating lunch, as he was</p>		that time. 4. Administrator will assure results of the audits will be reviewed by the QA committee monthly x4 then quarterly x3 to ensure compliance.		

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	<p>already at the table ready to eat and she didn't want to disrupt him. She indicated that the 206 bloodsugar documented for 11:30 A.M., on 2-11-13 was actually an 8 A.M. level. She indicated that she was confused and thought her initials for the routine dose of 6 units Humulin R Insulin at 11:30 A.M. was actually for the sliding scale dose that she gave at 1 P.M. of 8 units, and that Resident #5 did not receive the routine dose of 6 units Humulin R Insulin, only the 8 units per sliding scale after lunch.</p> <p>A policy provided by the DON, on 2-12-13 at 3:30 P.M., titled "Hyperglycemia" and identified as their current policy indicated "...it is appropriate at time of admission to request a physician order for residents with a history of diabetes to have...sliding scale insulin coverage and notification of parameters." Nursing interventions indicated "...administer sliding scale insulin coverage as ordered."</p>				

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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review the facility failed to insure insulin and a bloodsugar level was accurately documented for 1 of 1 residents reviewed for complete and accurate records. (Resident #5)</p> <p>Findings include:</p> <p>Resident #5's record was reviewed on 2-12-13 at 11:50 A.M. Diagnoses included, but were not limited to, subdermal hemorrhage, diabetes mellitus, hypertension, reflux, cutaneous candidiasis, and high cholesterol.</p> <p>Physician's recapitulated orders dated 2-1-13 through 2-28-13 indicated an order to give Humulin R Insulin U-100 6 units SQ before meals routinely with a start date of 8-3-12, as well as an order dated 11-27-11 to give Humulin R Insulin U-100, SQ per sliding scale</p>	R0349	<p>1. Elder #5 has had blood sugars and insulin orders on the M.A.R. reviewed and a revised accu-check log (See exhibit #3) has been put in place to decrease any chance for errors. Insulin has been put on a single M.A.R. separate from any other medications. 2. One other Elder had the potential to be affected and that Elder has had a revised accu-check log (See exhibit #3) put in place although, after review of the M.A.R. no errors had been made on this Elder. Insulin orders and accu-check orders have been placed on a single M.A.R. to decrease any potential errors. 3. LPN #1 has been re-educated on accu-checks, insulin administration and accurate documentation by the DON. All nurses have been re-educated on accurate documentation by the ADON or designee on accu-checks and insulin administration (See exhibit #2). A revised accu-check log (See exhibit #3) has been put in place. Documentation audits of 25% of</p>	03/12/2013			

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	<p>before meals and at bedtime as needed. An order dated 12-19-12 indicated blood sugars to be done four times daily and to document on the sliding scale log.</p> <p>During an interview, on 12-12-13 at 9:30 A.M., the DON (Director of Nursing) indicated that blood sugar levels should be checked prior to meals and that the routine dose of 6 units Humulin R insulin should be given with the sliding scale dose, according to blood sugar level.</p> <p>During an interview, on 2-12-13 at 9:30 A.M., LPN #1 indicated that no blood sugar was done prior to Resident #5 eating lunch, as he was already at the table ready to eat and she didn't want to disrupt him. She indicated that the 206 blood sugar documented for 11:30 A.M. on 2-11-13 was actually an 8 A.M. level. She indicated that she was confused and thought her initials for the routine dose of 6 units Humulin R Insulin at 11:30 A.M. was actually for the sliding scale dose that she gave at 1 P.M. of 8 units, and that Resident #5 did not receive the routine dose of 6 units Humulin R Insulin, only the 8 units per sliding scale after lunch.</p> <p>Review of the February 2013</p>		nurses will be completed weekly x4, monthly x3, and quarterly x3.4. Administrator will assure the results of audit will be reviewed by the Q.A committee monthly x4 then quarterly x3 to ensure compliance.				

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	<p>Medication Administration Records, on 2-12-13 at 9:40 A.M., indicated LPN #1 had initialed the box for administering the 11:30 A.M. Insulin dose of 6 units even though she previously stated she had not given that dose.</p> <p>A policy provided by the DON, on 2-12-13 at 3:30 P.M., titled "Hyperglycemia" and identified as their current policy indicated "...it is appropriate at time of admission to request a physician order for residents with a history of diabetes to have...sliding scale insulin coverage and notification of parameters." Nursing interventions indicated "...administer sliding scale insulin coverage as ordered...Suggested Documentation: ...vital signs, blood pressure and blood sugar readings..."</p>			