

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/16/2016
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NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00202677.</p> <p>Complaint IN00202677 - Substantiated. Federal/State deficiencies related to the allegation are cited at F279 and F323.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date: June 16, 2016</p> <p>Facility number: 000460 Provider number: 155532 AIM number: 100290620</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 3 Medicaid: 30 Total: 33</p> <p>Sample: 03</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on June 24,</p>	F 0000	<p>This Plan of Correction constitutes written allegation of compliance effective July 11, 2016. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. This facility respectfully requests desk review to establish compliance effective July 11, 2016</p>	

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 0279 SS=D Bldg. 00	<p>2016.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to review and revise the care plan after a resident with insulin fixation took two vials of insulin and seven syringes for 1 of 3 residents reviewed for care plans.</p>	F 0279	F279 DEVELOP COMPREHENSIVECARE PLANS It is the intent of this facility to use the results of theassessment to develop, review and revise each resident's comprehensive plan ofcare. WHAT CORRECTIVE ACTION	07/11/2016	

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	<p>(Resident #A).</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 6/16/16 at 10:15 a.m. Resident #A's diagnoses included, but were not limited to: Asperger disorder.</p> <p>The current MDS (Minimum Data Set) Assessment dated 5/3/2016, indicated Resident #A had a BIMS (brief initial for mental status) of 15/15 (cognitively intact). Resident #A's mobility status was unrestricted and behaviors included, but were not limited to fixation on their insulin.</p> <p>A care plan with no title, dated 01/04/2016, with goals current through 08/4/16, indicated Resident #A had a diagnoses of Asperger's syndrome and fixates/focuses on their insulin. Goals indicated were for Resident #A will have fewer episodes of (specific behavior) less than 3 times a week. Interventions included, but not limited to: educate the resident/responsible party on the causal factors of the behavior and the planned interventions, anticipate care needs, and provide them before the resident becomes overly stressed.</p> <p>Facility provided incident dated 6/12/16,</p>		<p>WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE? Resident A's care plan was updated to include additional interventions related to resident's fixation with insulin administration. Resident A has discharged from the facility. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WILL BE IDENTIFIED AND CORRECTIVE ACTION WILL BE TAKEN: All resident care plans were reviewed by the Interdisciplinary Team to ensure care plans of all resident's with identified behaviors were reviewed and updated to ensure measurable objectives and timetables to meet each resident's medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: To enhance currently compliant operations and under the direction of the Administrator or designee all reported resident behaviors and care plans are reviewed by the Interdisciplinary Team Monday through Friday during daily Quality Assurance Stand Up</p>		

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	<p>indicated Resident #A had taken 2 vials of insulin and 7 syringes. Resident #A had taken the medication cart keys from behind the nurse's station and entered the cart with the keys.</p> <p>Observation of Resident #A's room, the location of the medication cart was just to the left of Resident #A's room, where Resident #A removed 2 vials of insulin and 7 syringes from the medication cart. Resident #A indicated, on 6/16/16 at 10:20 a.m., on one interview that he got the insulin and syringes from inside the medication cart and in a second interview, on 6/16/16 at 2:10 p.m., Resident #A indicated he took the insulin and syringes off of the top of the cart.</p> <p>On 6/16/16 at 2:00 p.m., interview with DON indicated the care plan had not been updated after the incident, to prevent recurrence of the incident. The facility's policy for care plan revisions was requested. By survey exit on 6/16/16 at 3:00 p.m., the Administrator had not provided a policy.</p> <p>This Federal tag relates to complaint IN00202677.</p> <p>3.1-35(a)</p>		<p>Committee to ensure identified behaviors have been care reviewed and care plans revised to include measureable objectives and timetables to meet each resident's medical, nursing, mental and psychosocial needs.</p> <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE AND BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED: Effective July 11, 2016 a Quality Assurance Performance Improvement (QAPI) program will be implemented under the direction of the Administrator or designee to monitor timely updates to care plans using the "Care Plan Audit Tool" weekly x 4 weeks and monthly thereafter.</p> <p>Any deficiencies will be corrected immediately and findings of the quality assurance performance improvement audits will be forwarded to the monthly Quality Assurance Performance Improvement (QAPI) Committee for further review and to ensure continuing compliance.</p>		

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to administer insulin as indicated by physician orders and protocol for 2 of 3 residents reviewed for insulin administration. (Resident #A and Resident #B)</p> <p>Findings include:</p> <p>1.) Resident #B's clinical record was reviewed on 06/16/16 at 11:00 a.m. Resident #B's diagnoses included, but were not limited to: diabetes, type 1, without complications.</p> <p>Current June 2016, physician's order for Resident #B indicated NovoLog insulin 100 unit/ml vial, 5/11/16 (start date). Resident #B was to receive NovoLog insulin sub-Q via a sliding scale.</p>	F 0309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING It is the intent of this facility that each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care. WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE? Resident B's insulin orders were reviewed with the Medical Director and updated to include time of administration. Resident A has discharged from the facility. HOW OTHER RESIDENT'S HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME ALLEGED</p>	07/11/2016

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	<p>On 6/16/16 at 11:30 a.m. (30 minutes before lunch), observed LPN #2 to draw up NovoLog insulin and prepared to give it to Resident #B. LPN #2 was requested, at this time, to check the facility's drug book on administering NovoLog insulin. LPN #2 indicated NovoLog was to be administered 5-10 minutes prior to meals. LPN#2 indicated they would wait and administer the NovoLog insulin until closer to lunch being served.</p> <p>Review on 6/16/16 at 6:40 a.m., of the MAR (medication administration record) indicated Resident #B was to receive NovoLog insulin on a sliding scale after blood sugars were obtained before meals and at bedtime. Review of Resident #B's blood glucose monitoring flow sheet indicated Resident #B had received sliding scale NovoLog insulin approximately 1 (one) hour prior to eating meals.</p> <p>Review of the nursing drug handbook by Lippincott, Williams, and Wilkins, 2014 edition, page 748, indicated NovoLog was to be given 5 to 10 minutes before start of a meal by subcutaneous injection (underneath the skin) in the abdominal wall, thigh, or upper arm.</p> <p>2.) Resident #A's clinical record was</p>		<p>DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents within insulin orders had orders reviewed with the Medical Director and updated to clarify time of administration. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THIS ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: To enhance currently complaint operations and under the direction of the Director of Nursing or Designee all nursing staff were re-instructed on July 8, 2016 to the new orders and to the facility policy stating that indicated insulin needs to be given as indicated by the M.D. order. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE WILL NOT RECUR I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE AND BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED: Effective July 11, 2016 a Quality Assurance Performance Improvement (QAPI) will be implemented under the direction of the Director of Nursing or Designated QAPI representative who will audit the Medication Administration Record daily and will randomly audit medication administration of insulin daily to ensure timeliness</p>				

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	<p>reviewed on 6/16/16 at 10:15 a.m. Resident #A's diagnoses included, but were not limited to: diabetes with ketoacidosis.</p> <p>Current June 2016, physician's order indicated Humalog insulin 100 unit/ml vial, 04/08/16 (start date), to be administered sub-Q (under skin) after meals. Review on 6/16/16 at 6:30 a.m., of the MAR (medication administration record) indicated Resident #A's physician order dated 04/08/16, indicated Humalog 100 units/ml per sliding scale was to be given after meals.</p> <p>Observation of Resident #A after breakfast on 6/16/16 at approximately 7:30 a.m., Resident #A did not receive insulin.</p> <p>Review of Resident #A's blood glucose monitoring flow sheet for June 2016, Indicated Humalog insulin was given prior to meal times, which were noted as being 7:00 a.m., breakfast, 12:00 p.m., lunch, and 5:00 p.m., dinner.</p> <p>Review on June 16, 2016; of the Medication Administration Record indicated Resident #A had been given sliding scale insulin at 6:00 a.m., before breakfast.</p>		<p>of administration x 30 days encompassing all shifts then biweekly x 30 days to encompass all shifts and monthly thereafter with any noncompliance addressed immediately including appropriate disciplinary action. Audit results will be submitted to the monthly Quality Assurance Performance Improvement Committee to ensure continuing compliance.</p>	

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	<p>1.) Resident #B's clinical record was reviewed on 06/16/16 at 11:00 a.m. Resident #B's diagnoses included, but were not limited to: diabetes, type 1, without complications.</p> <p>Current June 2016, physician's order for Resident #B indicated NovoLog insulin 100 unit/ml vial, 5/11/16 (start date). Resident #B was to receive NovoLog insulin sub-Q via a sliding scale from 150 to 300.</p> <p>On 6/16/16 at 11:30 a.m., observation of LPN #2 obtaining a blood sugar fingerstick, drew up insulin, and prepared to give it. LPN #2 was requested at this time to check the facility's drug book on administering NovoLog insulin. LPN #2 indicated NovoLog was to be administered 5-10 minutes prior to meals, and LPN#2 indicated they would wait and administer the NovoLog insulin until closer to lunch being served at 12:00 p.m.</p> <p>Review on 6/16/16 at 6:40 a.m., of the MAR (medication administration record) indicated Resident #B's physician order indicated Resident #B was to receive NovoLog insulin on a sliding scale after blood sugars were obtained before meals and at bedtime. Review of Resident #B's blood glucose monitoring flow sheet indicated Resident #B had received</p>			

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F 0323 SS=D Bldg. 00	<p>sliding scale NovoLog insulin approximately 1 (one) hour prior to eating meal.</p> <p>Review of the nursing drug handbook by Lippincott, Williams, and Wilkins, 2014 edition, page 748, indicated NovoLog was to be given 5 to 10 minutes before start of a meal by subcutaneous injection (underneath the skin) in the abdominal wall, thigh, or upper arm.</p> <p>Facility's policy and procedure titled Diabetes Mellitus - Routine Care, (no date noted), provided by the DON and indicated as current on 6/16/16 at 2:00 p.m., indicated Insulin needs to be given 30 minutes before the scheduled meal unless specifically ordered otherwise by the physician.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>				

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	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the safety of a resident who has a care plan in place related to fixation of their insulin and syringes for 1 of 3 residents reviewed for safety. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 6/16/16 at 10:15 a.m. Resident #A's diagnoses included, but were not limited to: Asperger's syndrome.</p> <p>The current MDS (Minimum Data Set) Assessment dated 5/3/2016, indicated Resident #A had a BIMS (brief initial mental status) of 15/15 (cognitively intact). Resident #A's mobility status was unrestricted. Behaviors include, but were not limited to fixation on their insulin.</p> <p>A care plan with no title, dated 01/04/2016, with goals current through 08/4/16, indicated Resident #A had a diagnoses of Asperger's syndrome and fixates/focuses on his insulin. Goals indicated were for Resident #A will have fewer episodes of (specify behavior) less than 3 times a week. Interventions</p>	F 0323	<p>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICE It is the intent of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Resident A's care plans were updated to include additional interventions related to resident's fixation with insulin administration. Resident A has discharged from the facility. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All resident care plans were reviewed by the Interdisciplinary Team to ensure care plans of all resident's with identified behaviors were reviewed and updated to ensure measurable objectives and timetables to meet each resident's medical, nursing and</p>	07/11/2016

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	<p>included, but not limited to: educate the resident/responsible party on the causal factors of the behavior and the planned interventions, anticipate care needs, and provide them before the resident becomes overly stressed.</p> <p>Review of the facility layout, provided by the DON on 6/16/16 at 7:00 a.m., indicated Resident #A's room was on the west side of the facility, 2 doors to the left of the side exit door, and across from the right side of the nurses station. Resident #A's medication was stored in cart #1, which was outside to the left of Resident #A's room.</p> <p>Facility reported incident dated 6/12/16, indicated Resident #A was found to have 2 vials of insulin and 7 syringes in their possession. Resident #A indicated they gave themselves insulin and had taken the the insulin from the medication cart.</p> <p>Interview with LPN #1 on 6/6/16 at 2:02 p.m., indicated LPN# 1 removed Resident #A's insulin bottle out of the drawer, placed it on top of the medication cart #1, and realized they did not have any insulin syringes, so went to get some. After returning to cart #1, LPN #1 indicated they heard another resident call for help, so they believe they locked medication cart #1 and went down to</p>		<p>mental and psychosocialneeds as identified in the comprehensive assessment. All nursing staff werere-inserviced on medication safety including securing medications and securingkeys on June 16, 2016 following the event and prior to the survey. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGESWILL BE MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR? To enhance currently compliant operations and under thedirection of the Director of Nursing Services all nursing staff werere-inserviced on medication safety including securing medications and securingkeys on June 16, 2016 following the event and prior to the survey. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THEALLEGED DEFICIENT PRACTICE DOES NOT RECUR I.E. WHAT QUALITY ASSURANCE PROGRAMWILL BE PUT INTO PLACE AND BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED: Effective July 11, 2016, a Quality Assurance PerformanceImprovement Audit will be implemented under the Director ofNursing or designated Quality Assurance Performance Improvement representativeto audit at random times daily (across all shifts) x 30 days, biweekly x 4weeks and</p>				

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	<p>assist resident.</p> <p>LPN #1 could not indicate if they placed the insulin and syringes back in cart #1 prior to going to said resident's aid, but when they came back, no syringes or insulin bottles were on top of the cart. LPN # 1 did not think anymore about it until the day shift nurse called and asked where Resident #A's insulin could be. After checking Resident #A's room, both insulin and syringes were noted.</p> <p>Resident #A indicated, on 6/16/16 at 10:20 a.m., on one interview that he got the insulin and syringes from inside the medication cart and in a second interview, on 6/16/16 at 2:10 p.m., Resident #A indicated he took the insulin and syringes off of the top of the cart.</p> <p>Review of facility policy on 6/16/16 at 8:40 a.m., related to medication administration/quality of care, dated 11/1/14, provided by the DON, who indicated the policy was the one that was being used by the facility at that time, indicated on page 2, #10, no medications are to be kept on top of the cart .</p> <p>This Federal tag relates to Complaint IN00202677.</p> <p>3.1-45(a)(1)</p>		<p>monthly thereafter ensure medication cart is secure and nurse on dutyhas keys in his or her possession. Any non-compliance will be correctedimmediately including appropriate disciplinary action Audit results will besubmitted monthly to the Quality Assurance Performance Improvement (QAPI)Committee to ensure continuing compliance</p>				

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155532	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/16/2016
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