

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 08/09/2016
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NAME OF PROVIDER OR SUPPLIER ROSEWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 S BURLINGTON DR MUNCIE, IN 47302
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(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
R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 8 & 9, 2016</p> <p>Facility number: 000312 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 36 Total: 36</p> <p>Census payor type: Other: 36 Total: 36</p> <p>Residential Census: 36</p> <p>Sample: 7</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed on August 10, 2016 by 17934.</p>	R 0000		
R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and</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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	<p>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, record review and interview, the facility failed to ensure nurses administered sliding scale insulin in accordance with physician's orders for 2 of 2 residents reviewed with sliding scale insulin coverage (Resident #R28 and #R36).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #R28 was reviewed on 8/9/16 at 8:2 a.m. Diagnoses for Resident #R 28 included, but were not limited to, diabetes, hypertension, and major depressive disorder with recurrent psychotic features.</p> <p>Current physician's orders for Resident #R 28 included, but were not limited to, the following:</p> <p>a. Glucometer readings 4 times daily before meals and bedtime, 6 a.m., 11 a.m., 4 p.m., 8 p.m. The original date of this order was 2/1/11.</p> <p>b. Inject novolog (insulin) per sliding</p>	R 0241	<p>R241410 IAC 16.2-5-4(e)(1) POC Completion date 8-22-16CORRECTIVE ACTION FOR RESIDENTS AFFECTED:All administrations of medications shall be administered by licensed staff as ordered by the resident's physician. Staff will observe and monitor all proper usage, dosage and route of all medications given as well as residents who participate in self administration of medication/PRN'S.HOW WILL WE IDENTIFY OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTION TAKEN: All residents have the potential to be affected. MEASURES TO ENSURE PRACTICE DOES NOT RECUR:All nursing staff will be in-serviced on the importance of following physicians orders. Clearly reading and understanding all orders on physicians orders. Ensuring proper usage, dosage and route of all meds. THIS CORRECTIVE ACTION WILL BE MONITORED BY:All nursing employees will be monitored on a daily basis by the Director of Nursing. This includes but not limited to all medical records, physicians orders and</p>	09/30/2016

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	<p>scale at 7 a.m., 12 noon, and 5 p.m., if blood sugar is less than 200 as follows:</p> <p>200 - 250 = 2 units 251 - 300 = 4 units 301 - 350 = 6 units 351 - 400 = 8 units 401 - 450 = 10 units >450 = 12 units</p> <p>hold novolog if blood sugar is below 60 or NPO (nothing by mouth).</p> <p>The original date of this order was 11/10/15.</p> <p>c. Levemir (an insulin) inject 74 units subcutaneously (sub-q) twice daily 7 a.m., and 8 p.m., for diabetes. The original date of this order was 6/17/16.</p> <p>d. Novolog (an insulin) inject 28 units subcutaneously (sub-q) with each meal breakfast lunch and supper 7 a.m., 12 noon, and 5 p.m. The original date of this order was 6/17/16.</p> <p>Review of the July, 2016, June 2016, "Diabetic Monthly Log Sheet", and the Medication Administration Records for July, 2016, June 2016, for Resident #R28 indicated the following:</p> <p>July 1, bedtime (B), blood sugar recorded</p>		<p>flow sheets. This will be monitored each shift, daily until corrected and continued after the POC completion date. POC Completed by September 30, 2016</p>				

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	<p>as 347. Coverage recorded as 6 units. There was no time indicated for the 8 p.m. coverage on the sliding scale order on the July, 2016, and June, 2016 Medication Administration Record (MAR).</p> <p>July 4, bedtime (B), blood sugar recorded as 238. Coverage recorded as 2 units. There was no time indicated for the 8 p.m. coverage on the sliding scale order on the July, 2016, and June, 2016 Medication Administration Record (MAR).</p> <p>July 14, bedtime (B), blood sugar recorded as 216. Coverage recorded as 2 units. There was no time indicated for the 8 p.m. coverage on the sliding scale order on the July, 2016, and June, 2016 Medication Administration Record (MAR).</p> <p>July 19, bedtime (B), blood sugar recorded as 213. Coverage recorded as 2 units. There was no time indicated for the 8 p.m. coverage on the sliding scale order on the July, 2016, and June, 2016 Medication Administration Record (MAR).</p> <p>June 3, bedtime (B), blood sugar recorded as 240. Coverage recorded as 2 units. There was no time indicated for</p>			

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	<p>the 8 p.m. coverage on the sliding scale order on the July, 2016, and June, 2016 Medication Administration Record (MAR).</p> <p>June 30, bedtime (B), blood sugar recorded as 251. Coverage recorded as 4 units. There was no time indicated for the 8 p.m. coverage on the sliding scale order on the July, 2016, and June, 2016 Medication Administration Record (MAR).</p> <p>During an interview on 8/9/16 at 9:50 a.m., the Director of Nursing indicated the lettering on the "Diabetic Monthly Log Sheet" indicated the following: morning (M), noon (N), evening (E), bedtime (B). She indicated (M) corresponds with 7 a.m., (N) corresponds with 12 noon, (E) corresponds with 5 p.m., and (B) corresponds with 8 p.m.</p> <p>During an interview on 8/9/16 at 9:50 a.m., the Director of Nursing indicated the sliding scale order did not indicate the resident should have received Novolog (an insulin) coverage at (B) bedtime.</p> <p>2. Resident #R36 was observed during self administration of insulin on 8/9/16 at 11:51 a.m., with QMA #2.</p> <p>The clinical record for Resident #R36 was reviewed on 8/8/16 at 2:10 p.m.</p>			

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	<p>Diagnoses for Resident #R36 included, but were not limited to, diabetes, paranoid schizophrenia, and personality disorder.</p> <p>Current physician's orders for Resident #R36 included, but were not limited to, the following:</p> <p>a. Humalog Kwik (an insulin pen) inject 8 units subcutaneously before breakfast. The original date of this order was 10/18/13.</p> <p>b. Humalog Kwik (an insulin pen) inject 20 units subcutaneously at dinner. The original date of this order was 1/16/15.</p> <p>c. Levemir Flex touc (an insulin pen) inject 28 units subcutaneously in the morning. The original date of this order was 4/12/16.</p> <p>d. Levemir Flex touc (an insulin pen) inject 43 units subcutaneously at dinner. The original date of this order was 4/12/16.</p> <p>e. Humalog (insulin) inject subcutaneously per sliding scale</p> <p>151 - 200 = 3 units 201 - 250 = 5 units 251 - 300 = 8 units</p>			

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	<p>301 - 350 = 12 units 351 - 400 = 15 units 401 - 450 = 18 units</p> <p>Give 1/2 dose at bedtime. Round up to the nearest whole number. The original date of this order was 6/8/09.</p> <p>f. Glucometer checks four times a day with Humalog sliding scale coverage. The original date of this order was 9/23/13.</p> <p>g. Glucometer check as needed for signs/symptoms of high or low blood sugar. The original date of this order was 9/23/13.</p> <p>Review of the July 2016, blood sugar and insulin coverage flowsheet for Resident #R36 indicated the following:</p> <p>July 1, bedtime, the blood sugar result was 345, 12 units of insulin had been documented as given. The resident should have received 6 units of insulin.</p> <p>July 2, bedtime, the blood sugar result was 231, 5 units of insulin had been documented as given. The resident should have received 3 units of insulin.</p> <p>July 4, bedtime, the blood sugar result was 255, 8 units of insulin had been</p>			

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	<p>documented as given. The resident should have received 4 units of insulin.</p> <p>July 5, bedtime, the blood sugar result was 152, 3 units of insulin had been documented as given. The resident should have received 2 units of insulin.</p> <p>July 7, bedtime, the blood sugar result was 231, 5 units of insulin had been documented as given. The resident should have received 3 units of insulin.</p> <p>July 8, bedtime, the blood sugar result was 242, 5 units of insulin had been documented as given. The resident should have received 3 units of insulin.</p> <p>July 9, bedtime, the blood sugar result was 347, 12 units of insulin had been documented as given. The resident should have received 6 units of insulin.</p> <p>July 10, bedtime, the blood sugar result was 164, 3 units of insulin had been documented as given. The resident should have received 2 units of insulin.</p> <p>July 13, bedtime, the blood sugar result was 168, 3 units of insulin had been documented as given. The resident should have received 2 units of insulin.</p> <p>July 14, bedtime, the blood sugar result</p>			

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	<p>was 255, 5 units of insulin had been documented as given. The resident should have received 3 units of insulin.</p> <p>July 15, bedtime, the blood sugar result was 174, 3 units of insulin had been documented as given. The resident should have received 2 units of insulin.</p> <p>July 21, bedtime, the blood sugar result was 360, 15 units of insulin had been documented as given. The resident should have received 8 units of insulin.</p> <p>July 22, bedtime, the blood sugar result was 285, 8 units of insulin had been documented as given. The resident should have received 4 units of insulin.</p> <p>July 23, bedtime, the blood sugar result was 197, 3 units of insulin had been documented as given. The resident should have received 2 units of insulin.</p> <p>July 24, bedtime, the blood sugar result was 184, 3 units of insulin had been documented as given. The resident should have received 2 units of insulin.</p> <p>July 26, bedtime, the blood sugar result was 322, 12 units of insulin had been documented as given. The resident should have received 6 units of insulin.</p>			

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	<p>July 28, bedtime, the blood sugar result was 216, 5 units of insulin had been documented as given. The resident should have received 3 units of insulin.</p> <p>July 30, bedtime, the blood sugar result was 168, 3 units of insulin had been documented as given. The resident should have received 2 units of insulin.</p> <p>Review of the July, 2016, Medication Administration Record for Resident #R36 indicated the incorrect dose of insulin had been given for the above 18 dates at bedtime. This resulted in 18 incorrect bedtime doses of sliding scale insulin coverage in July, 2016, for Resident #R36.</p> <p>During an interview on 8/9/16, at 7:12 a.m., QMA #2 indicated she had worked here for approximately 3 years and had worked all shifts. QMA #2 indicated blood sugar results and sliding scale insulin given were documented on the diabetic flowsheet. She indicated the sliding scale insulin was also documented on the Medication Administration Record.</p> <p>During an interview on 8/9/16, at 7:59 a.m., additional information was requested from the Director of Nursing (DON) related to the incorrect insulin</p>			

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R 0242 Bldg. 00	<p>sliding scale coverage for Resident #R36.</p> <p>During an interview on 8/9/16 at 12:35 p.m., the DON indicated Resident #R36's bedtime insulin sliding scale coverage doses in July had been incorrect.</p> <p>Review of the current facility policy, revised 1/2011 titled "Administration and Self Administration of Medication ", provided by the Director of Nursing on 8/9/16 at 8:56 a.m., included, but was not limited to the following:</p> <p>"POLICY... ...Meds [medications] are issued by a qualified staff member upon the direction of a physician and over sight of a licensed nurse...</p> <p>...PROCEDURE... ...Staff will observe and monitor proper usage, dosage and route of all meds [medications] given as well as of residents who participate in self administration of medication / PRN's [sic] [as needed]...."</p> <p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be</p>			

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	<p>notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on observation, interview and record review, the facility failed to notify the physician of blood sugar results which may have required a change in medication or treatment for 1 of 2 diabetic residents. (Resident #R36)</p> <p>Findings include:</p> <p>Resident #R36 was observed during self administration of insulin on 8/9/16 at 11:51 a.m., with QMA #2.</p> <p>The clinical record for Resident #R36 was reviewed on 8/8/16 at 2:10 p.m. Diagnoses for Resident #R36 included, but were not limited to, diabetes, paranoid schizophrenia, and personality disorder.</p> <p>Current physician's orders for Resident #R36 included, but were not limited to, the following:</p> <p>a. Humalog Kwik (an insulin pen) inject 8 units subcutaneously before breakfast. The original date of this order was 10/18/13.</p> <p>b. Humalog Kwik (an insulin pen) inject 20 units subcutaneously at dinner. The</p>	R 0242	<p>R242410 IAC 16.2-5-4(e)(2)POC Completion Date 8-2-16CORRECTIVE ATION FOR RESIDENTS AFFECTED:All resident will be monitored for any and all side effects of medications. Staff shall notify physician if so ordered immediately if there are any undesirable effects and document in medical record accordingly. HOW WILL WE IDENTIFY OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTION TAKEN:All residents have the potential to be affected. MEASURES TO ENSURE PRACTICE DOES NOT RECUR:All nursing staff will be in-serviced on the importance of following physicians orders, monitoring undesirable effects which warrant physician notification and documentation of all of the above.THIS CORRECTIVE ACTION WILL BE MONITORED BY :All employees will be monitored as well as medical records on a daily on going basis by the administrator and/or director of nursing. This will continue after the POC completion date.POC Completed by September 30,2016</p>	09/30/2016			

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	<p>original date of this order was 1/16/15.</p> <p>c. Levemir Flex touc (an insulin pen) inject 28 units subcutaneously in the morning. The original date of this order was 4/12/16.</p> <p>d. Levemir Flex touc (an insulin pen) inject 43 units subcutaneously at dinner. The original date of this order was 4/12/16.</p> <p>e. Humalog (insulin) inject subcutaneously per sliding scale</p> <p>151 - 200 = 3 units 201 - 250 = 5 units 251 - 300 = 8 units 301 - 350 = 12 units 351 - 400 = 15 units 401 - 450 = 18 units</p> <p>Give 1/2 dose at bedtime. Round up to the nearest whole number. The original date of this order was 6/8/09.</p> <p>f. Glucometer checks four times a day with Humalog sliding scale coverage. The original date of this order was 9/23/13.</p> <p>g. Glucometer check as needed for signs/symptoms of high or low blood sugar. The original date of this order was</p>			

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	<p>9/23/13.</p> <p>The May, 2016, June, 2016, and July, 2016, blood sugar and insulin coverage flowsheets for Resident #R36 had the instructions "< [less than] 60 or > [greater than] 450 call doctor", at the top of the flowsheets.</p> <p>Review of the May, 2016, June, 2016, and July, 2016, blood sugar and insulin coverage flowsheets for Resident #R36 indicated the following:</p> <p>July 3, noon, the blood sugar result was 57;</p> <p>June 7, evening, the blood sugar result was 57;</p> <p>June 14, bedtime, the blood sugar result was 57;</p> <p>June 16, morning, the blood sugar results were 58 and 179;</p> <p>May 30, morning, the blood sugar result was 504.</p> <p>Resident #R36's clinical record lacked any documentation related to the physician having been notified of the blood sugar results on July 3, June 7, June 14, June 16, and May 30, 2016. The</p>			

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(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>nurses notes indicated the Director of Nursing had been notified of the blood sugar result of 58 on June 16, 2016. The staff was instructed to recheck the blood sugar after resident finished breakfast.</p> <p>During an interview on 8/9/16, at 7:12 a.m., QMA #2 indicated she had worked here for approximately 3 years and had worked all shifts. QMA #2 indicated she had never had to contact a physician regarding a change of condition, including a blood sugar result outside of the call parameters. She indicated staff would need to document the information in the nurses notes even if a change of condition fax had been sent to the physician.</p> <p>During an interview on 8/9/16, at 7:59 a.m., the Director of Nursing (DON) indicated she would review Resident #R36's clinical record to determine if the physician had been notified regarding the resident's blood sugar results on July 3, June 7, June 14, June 16, and May 30, 2016.</p> <p>During an interview on 8/9/16 at 8:16 a.m., the DON indicated she did not find any documentation of the physician having been notified of Resident #R36's blood sugar results on July 3, June 7, June 14, June 16, and May 30, 2016.</p>			

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 08/09/2016
NAME OF PROVIDER OR SUPPLIER ROSEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5200 S BURLINGTON DR MUNCIE, IN 47302		
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	<p>Review of the current facility policy, revised 10/2011, titled "CAPILLARY BLOOD GLUCOSE MONITORING", provided by the DON on 8/9/16 at 8:56 a.m., included, but was not limited to, the following:</p> <p>"...SYMPTOMS OF HYPOGLYCEMIA & HYPERGLYCEMIA</p> <p>1. Observe for the following symptoms and report to physician when notifying of glucometer [sic] reading outside of the stated parameters...."</p>				