

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 08/20/2015
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R 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) for the State Residential Licensure Survey completed on 5/28/15.</p> <p>Survey dates: August 19 and 20, 2015</p> <p>Facility number: 011970 Provider number: 011970 AIM number: N/A</p> <p>Census bed type: Residential: 41 Total: 41</p> <p>Censor payor type: Other: 41 Total: 41</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</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 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>			

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>Based on record review and interview, the facility failed to ensure nurses obtained glucometer readings for which sliding scale insulin administration was based and failed to administer sliding scale insulin in accordance with physician's orders for 1 of 2 residents reviewed for sliding scale insulin coverage. (Resident #R30)</p> <p>Findings include:</p> <p>Resident #R30's clinical record was reviewed on 8/19/15 at 11:15 a.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus, hypertension, and history of depression.</p> <p>The resident had a current, 7/16/15, physician's order for staff to do blood sugar checks before meals and at bedtime. The order indicated the staff was to administer the resident's insulin at bedtime and before meals.</p> <p>Resident #R30 had an order for Humalog [to control blood sugar] insulin 20 units three times a day and Lantus [to control blood sugar] insulin 65 units at bedtime.</p> <p>Resident #R30 had an order for sliding scale Humalog insulin coverage to be given for the following blood sugar</p>	R 0241	<p>A new form was created which is individualized for each diabetic resident that uses the sliding scale. The new form (see attachment #1) adds a line for nursing staff that do Accuchecks to initial upon completion. The new form also has been customized to include the physician's orders and the resident's individualized sliding scale on the form where readings are recorded. Accuchecks will be completed per doctor's orders and recorded in both the MAR and the glucometer log. The Director of Nursing or his/her designee will review all diabetic residents on a daily basis to assure blood sugar levels have been checked and recorded appropriately in both the MAR and the glucometer log and that all physician orders are being followed. The DON or his/her designee will also check the MAR and the glucometer log on a daily basis to ensure that when insulin is administered that it is done so in the correct dosage per the sliding scale and that nurses who administer insulin and do Accuchecks have initialed the form. Nurses were inserviced on this process and the new form. The DON or his/her designee will monitor the MAR and the glucometer log on a daily basis to ensure blood sugar levels are recorded and any insulin given is done so in the appropriate amounts per the sliding scale. The director of nursing or his/her designee will review all</p>	10/08/2015			

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	<p>ranges to be given three times a day.</p> <p>"150 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units 401 - 450 = 12 units over 450 call the medical doctor."</p> <p>Review of the August, 2015, Medication Administration Record [MAR] indicated the following blood sugars and units of sliding scale Humalog insulin were administered:</p> <p>On 8/1/15 at 11:00 a.m., the resident's blood sugar was 297 with 10 units of insulin coverage given. The resident should have received 6 units of coverage.</p> <p>On 8/3/15 at 4:00 p.m., the resident's blood sugar was 208 with 2 units of insulin coverage given. The resident should have received 4 units of coverage.</p> <p>On 8/9/15 at 4:00 p.m., the resident's blood sugar was 199 with no coverage given. The resident should have received 2 units of insulin coverage.</p> <p>On 8/12/15 at 11:00 a.m., the resident's blood sugar was 206 and the resident received 2 units of insulin coverage. The</p>		<p>admission orders for accuracy and completeness. A chart audit will be completed to document this review. The Administrator will monitor this process on a routine basis.</p>				

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	<p>resident should have received 4 units of insulin coverage.</p> <p>There was no indication of the blood sugar being tested and/insulin coverage being administered on 8/17/15 at 4:00 p.m. and 10:00 p.m., on 8/18/15 at 10:00 p.m., and on 8/19/15 at 4:00 p.m. and 10:00 p.m.</p> <p>The record indicated the resident received the wrong dose of insulin coverage four times and lacked an indication of the blood sugar being monitored five times in August 2015.</p> <p>The resident had an untimed 8/12/15, Nurse's Note. The note indicated the physician had been in to visit the resident and had increased the resident's oral diabetic medication and wanted the facility to continue to monitor and record the resident's blood sugar results. The physician wanted the results faxed to his office in one month.</p> <p>During an interview with the Director of Nursing on 8/19/15 at 2:40 p.m., she indicated the facility administered all of the resident's medications including monitoring his blood sugars and administering his insulins.</p> <p>During an interview with the Director of</p>			

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	<p>Nursing on 8/20/15 at 9:20 a.m., she indicated she did not monitor the Medication Administration Records for blood sugar checks or insulin administration. She indicated it was not necessary to monitor them [MAR] because she knew her nurses and they knew what to do. She indicated the residents with sliding scale insulin orders have the dosages to be given in their rooms so the nurses knew what to give. She indicated she knew it was hard to remember what the blood sugar was and how much insulin was given because she has forgotten herself when she has passed medications. She indicated she had to go back through the 24 Hour Shift Reports to find out who had given the incorrect doses and to fill in some blanks on the MAR. She indicated the nurses were not doing a very good job of documenting.</p> <p>The Administrator provided the 8/19/15, 24 Hour Shift Report on 8/20/15 at 10:25 a.m. The Shift Report indicated the resident's blood sugars were obtained and insulins administered as ordered on 8/19/15. She indicated this was not in the resident's record.</p> <p>The undated, "Hyper-&amp;Hypo-glycemic Reactions" policy was provided by the Director of Nursing on 8/20/15 at 1:33 p.m. The policy indicated "...Calculate</p>			

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R 0246 Bldg. 00	<p>correct amount (volume) of insulin to administer...Document the administration, dose (if sliding scale), and injection site (to ensure rotation of injection sites) on the MAR using the appropriate injection site code...."</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure the Qualified Medication Aide (QMA) obtained authorization prior to giving an "as needed" medication for 3 of 3 residents reviewed for "as needed" medication administration (Resident #R23, #R4, #R10). This deficient practice had the potential to impact 36 residents who received oral medication by the facility out of 41 residents residing in the facility.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #R10 was reviewed on 8/19/15, at 11:20 a.m. The diagnoses for Resident #R10</p>	R 0246	<p>A chart audit was completed to assure that no other residents were affected by this violation. The QMA has been inserviced to obtain a nurse's authorization before administering any PRN Medication. Vermillion Place's Policy was reviewed and revised (see attachment #2) for PRN Medication protocol adding that the nurse who authorizes the QMA to give PRN Medications will sign the Med Book indicating authorization was given. Nurses have been inserviced that when giving the QMA authorization to give PRN Medication they must also sign off in the MAR. This process will be monitored by the DON.</p>	10/08/2015

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	<p>included, but not limited to, depression, diabetes, and pain.</p> <p>Current physician orders for Resident #R10 included, but were not limited to, the following.</p> <p>a. Hydrocodone (a pain medication) 5-325 mg one tablet by mouth four times daily as needed for pain.</p> <p>The August 2015 MAR record indicated Resident #R10 received an as needed hydrocodone 5-325 mg by mouth on 8/12/15 at 6:00 a.m. and on 8/20/15 at 2:00 a.m. by QMA #3.</p> <p>During an interview on 8/19/15 at 10:30 a.m., the Director of Nursing (DON) indicated there is no place for a QMA to document who and when they received prior authorization to administrator an "as needed" medication. The DON identified staff #3 was a QMA.</p> <p>During an interview on 8/20/15 at 10:30 a.m., the DON indicated the QMA is supposed to call the DON for prior authorization to administrator an "as needed" medication. The DON indicated if the DON was unavailable, the QMA should call the licensed nurse who was scheduled for the next shift.</p>		The Administrator will audit this procedure for compliance on a routine basis.				

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	<p>During an interview on 8/20/15 at 11:00 a.m., LPN #1 indicated she had not received a call for prior authorization to administrator an "as needed" medication from a QMA during the month of August, 2015.</p> <p>2. The clinical record for Resident #R23 was reviewed on 8/20/15, at 1:25 p.m. The diagnoses for Resident #R23 included, but were not limited to, paralysis, cognitive deficit, gait abnormality, muscle weakness, and dysphagia.</p> <p>Current physician orders for Resident #R23 included, but were not limited to, the following:</p> <p>a. Loperamide (an antidiarrhea medication) 2 milligrams (mg). Give 2 capsules (4 mg) by mouth after first the loose stool, followed by one capsule after each subsequent loose stool (not exceed 16 mg/day).</p> <p>The August 2015 Medication Administration Record (MAR) indicated Resident #R23 received an "as needed" Loperamide 2 mg by mouth at 5:00 a.m., on 8/1/15, 8/2/15, 8/5/15, 8/6/15, 8/7/15, 8/14/15, 8/15/15, 8/16/15, 8/19/15, and 8/20/15 by QMA #3.</p> <p>3. The clinical record for Resident #R4</p>			

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	<p>was reviewed on 8/20/15 at 1:13 p.m. The diagnoses for Resident #R4 included, but were not limited to, anxiety, hypertension, and tremors.</p> <p>Current physician orders for Resident #R4 included, but were not limited to, the following:</p> <p>a. Ativan (an anti-anxiety medication) 0.5 milligrams (mg) by mouth "as needed" for anxiety between routine doses at 8:00 p.m. and 8:00 a.m.</p> <p>The August 2015 Medication Administration Record (MAR) indicated Resident #R4 received an "as needed" dose of Ativan 0.5 mg by mouth on 8/14/15 at 3:00 a.m., by QMA #3. The nurses notes for Resident #R4 lacked any documentation of prior authorization from a nurse before the "as needed" medication which was given by QMA #3 on 8/15/14.</p> <p>A current, undated, facility policy titled "Medication Administration", which was provided by the Director of Nursing on 8/20/15 at 1:33 p.m., indicated:</p> <p>"It is the policy of this facility that all mediations and treatments shall be ordered by a physician and administered by a licensed nurse, or a QMA under the</p>			

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

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FORM APPROVED

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	supervision of a licensed nurse."				