

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 4, 6, 7, 10, 11, 12, 13 & 14, 2014.</p> <p>Facility number: 001127 Provider number: 155771 AIM number: 200247220</p> <p>Survey team: Marcy Smith, RN-TC Patti Allen, SW (February 4, 7, 10, 11 & 12, 2014) Holly Duckworth, RN (February 4, 6, 7, 10 & 11, 2014) Dottie Plummer RN (February 6, 7, 10, 11, 12 & 13, 2014) Susan Worsham, RN (February 4, 6, 7, 10 & 11, 2014)</p> <p>Census bed type: SNF: 21 NF: 104 SNF/NF: 16 Residential: 132 NCC: 36 Total: 309</p> <p>Census payor source: Medicare: 17 Medicaid: 88</p>	F000000	<p>The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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			
F000323 SS=D	<p>Other: 204 Total: 309</p> <p>Residential sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on February 21, 2014, by Brenda Meredith, R.N.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure resident safety related to the risk of entrapment in regards to a gap between a bedrail and a mattress and a gap between a mattress and a footboard for 2 of 3 residents reviewed for accidents of 12 residents who met the criteria for accidents in a Stage 2 sample of 50. (Resident #149, Resident #99)</p> <p>B. Based on observation, interview</p>	F000323	Administration, licensed nursing staff and all interdisciplinary team members understand the importance of ensuring the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Data printed in red and/or bolded represents additional comments based on correspondence from the Indiana State Department of Health dated March 10, 2014. Bed Rails: In this	03/12/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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 record review, the facility failed to ensure a medication storage cart was locked when unsupervised for 1 of 10 medication carts reviewed.</p> <p>Findings include:</p> <p>A. 1. During a Stage 1 resident room observation on 2/06/2014 at 3:31 p.m., a gap was noted between the raised left upper siderail and the mattress on the bed of Resident #149, which measured 6 1/4 inches.</p> <p>The record of Resident #149 was reviewed on 2/10/2014 at 3:40 p.m. Diagnoses included, but were not limited to, osteoarthritis, osteoporosis, chronic obstructive pulmonary disease, and hypertension.</p> <p>The most recent admission Minimum Data Set (MDS) assessment, dated 11/21/2013, indicated the resident required limited assistance for bed mobility and transfers, and had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #149 was cognitively intact.</p> <p>The record of weights for Resident #149 included a weight of 92.8</p>		<p>case, resident #149 was cited as having a noted gap between the raised left upper side rail and the mattress on the bed. This gap was found to be caused by the right upper side rail not being in the raised position which allowed the mattress to slide to the right. Upon assessment it was found when both upper side rails were in the raised position the mattress remained in the proper alignment to prevent a significant gap on either side of the mattress. All nursing staff was educated; both side rails must be in the upright position to ensure proper positioning of the mattress to prevent any gaps larger than 4.75 inches. This is monitored daily by both nursing and housekeeping staff to ensure this is occurring. When both side rails are in place the mattress is secure with no significant gap on either side. Resident #99 was cited as having a noted gap between the foot board and the mattress. The facility has mattress bolsters available to have in place to ensure no significant (greater than 4.75 inches) gap is present between the foot board and mattress. Upon assessment it was found when the bolster mattress was in place when needed no significant gap was present between the mattress and foot board. All residents who utilize side rails have the potential to be affected</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>pounds on 12/02/2013, a weight of 90.2 pounds on 1/03/2014, a weight of 90.8 pounds on 2/03/2014, and a weight of 90.8 pounds on 2/10/2014.</p> <p>During an interview with RN #1 at 3:45 p.m. on 2/06/2014, RN #1 measured the gap between the raised left upper siderail and the mattress, and indicated the gap was 6 1/4 inches. RN #1 indicated she was not aware of what the gap should be, but the gap appeared to be too large.</p> <p>During an interview with Maintenance staff member #2 at 3:55 p.m., on 2/06/2014, Maintenance staff member #2 indicated the right upper siderail needed to be raised in order to secure the mattress between the siderails.</p> <p>During an interview with the Director of Nursing (DoN) on 2/06/2014 at 4:15 p.m., the she indicated Resident #149 was small and entrapment was a possibility.</p> <p>A. 2. During a stage one resident room observation on 02/07/2014 at 10:08 a.m., Resident #99 was observed lying in bed. Bilateral half side rails were noted in the up</p>		<p>by potential entrapment. All residents who utilize side rails were reviewed/assessed by February 7, 2014 to ensure their side rails were both up and no significant (greater than 4.75 inches) gap was present between mattress and side rail. This will be monitored to ensure compliance. All resident beds have the potential to be affected by potential entrapment. All resident beds/mattresses were reviewed/assessed by February 7, 2014 to ensure there was not a significant gap between the foot board and the mattress. This will be monitored to ensure compliance. Unit manager or designee will conduct an audit review of all resident beds weekly for the first month. Bi-weekly for the following month and then monthly following that. Unit manager or designee will report any discrepancies to the safety risk manager immediately finding any issues. Collected data from the audit process will be reviewed and reported to the Quality Improvement Committee for further recommendations. The Director of Nursing or designee is responsible for assuring data presentation. An in-service will be conducted for all nursing, housekeeping, and maintenance staff to ensure they have been educated on the importance of maintaining both the side rails in the proper position and appropriate equipment as needed</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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>position at the head of the bed. A gap between the footboard and the mattress measured 5 inches.</p> <p>Resident #99's clinical record was reviewed on 02/10/2014 at 11:53 a.m. Diagnoses included, but were not limited to, chronic pain, dementia with behavior, and anxiety.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 1/02/2014, indicated Resident #99 needed limited assistance with bed mobility and transfers, with one person physical assist. The MDS indicated the Brief Interview of Mental Status (BIMS) was 9 out of a possible 15, which indicated Resident #99 was moderately cognitively impaired. Results of the BIMS testing indicated that Resident #99 was unable to state the correct year, state the correct day of the week, or to recall the word "sock." The MDS indicated Resident #99's height measured 68 inches, and the resident's weight measured 138 pounds.</p> <p>A care plan, dated 10/24/13, for Resident #99, indicated, "...Potential for Falls...Frequent bed checks while in bed...Encourage safety precautions...."</p>		<p>to ensure there is no significant gap anywhere on the bed to potentially pose a hazard to the resident. Substantial compliance date: March 12, 2014 Medication Cart: The facility was cited for a staff member leaving a medication cart unlocked and unattended in a resident area. It is the policy and procedure of this facility that all medication carts remain locked when a licensed nursing staff member is not present. All licensed nursing staff is educated annually on resident safety and hazards, including keeping medication carts locked at all times, when nursing staff is not in attendance. The policy to keep medication carts locked when a licensed nursing staff member is not present is reviewed at least twice annually with licensed nursing staff members. It is part of the orientation process that all nursing staff is trained upon hire, in the importance of locking medication carts when unattended. This education will continue. The facility completes weekly audits on observing the medication carts and monitoring that licensed nursing staff follows the policy and procedure to ensure the residents' environment remains as free from accident hazards as is possible. These audits will continue. These audits will also occur on all shifts daily including weekends. The</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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 2/07/14 at 10:56 a.m., the Director of Nursing indicated a mattress bolster should have been in place if a gap was present.</p> <p>A facility policy provided by the DoN on 2/10/2014 at 4:10 p.m., titled "Side Rails", indicated, "...<u>Entrapment Hazards</u>: The FDA [Food and Drug Administration] has issued a safety alert identifying how entrapment deaths have occurred and preventative measures. All reported entrapments occurred in one of the following ways (numbered 1-4 in the diagram below)... 3. Between the siderail and mattress 4. Between the headboard or footboard, siderail, and mattress...."</p> <p>A document titled, " Guidance for Industry and FDA [Food and Drug Administration] Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued on March 10, 2006, and considered current guidance, indicated, "...FDA is therefore using a head breadth dimension of 120mm (4 3/4 inches) as the basis for its dimensional limit recommendations ...Zone 3- Between the Rail and the</p>		<p>licensed staff member was counseled and educated on the importance of locking their medication cart when not in attendance. Based on the audits completed weekly this is an isolated incident and not a pattern problem. Monitoring of this employee will continue. Documentation of this education is in the employees file. Substantial compliance date: March 12, 2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>Mattress...FDA is recommending a dimensional limit of less than...(4 3/4 inches) for the area between the inside surface of the rail and the compressed mattress...Zone 7 - Between the Head or Foot Board and the End of the Mattress...This space may present a risk of head entrapment..."</p> <p>B. During an observation on 2/10/14 at 4:29 p.m., a medication cart located on Health Center 3 West Unit was unlocked and unsupervised. No residents or staff were in the area of the medication cart. RN #3 returned to the cart as RN #2 was approaching the cart.</p> <p>Interview with RN #2 on 2/10/2014 at 4:35 p.m., indicated medication carts should be locked when unattended.</p> <p>Interview with RN #3 on 2/10/2014 at 4:50 p.m., indicated the medication cart was unlocked and unattended.</p> <p>A facility policy provided by the DoN on 2/10/2014 at 2:15 p.m., titled "PHARMACEUTICALS STORAGE" , indicated, "...<u>Drug Storage</u>: All drugs shall be stored in a medication cart, cabinet, or room that shall be kept</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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>locked at all times when not attended by an authorized person...."</p> <p>3.1-45(a)(1)</p> <p>2. During a stage one resident room observation on 02/07/2014 at 10:08 a.m., Resident #99 was observed lying in bed. Bilateral half side rails were noted in the up position at the head of the bed. A gap between the footboard and the mattress measured 5 inches.</p> <p>Resident #99's clinical record was reviewed on 02/10/2014 at 11:53 a.m. Diagnoses included, but were not limited to, chronic pain, dementia with behavior, and anxiety.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 1/02/2014, indicated Resident #99 needed limited assistance with bed mobility and transfers, with one person physical assist. The MDS indicated the Brief Interview of Mental Status (BIMS) was 9 out of a possible 15, which indicated Resident #99 was moderately cognitively impaired. Results of the BIMS testing indicated that Resident #99 was unable to state the correct</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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>year, state the correct day of the week, or to recall the word "sock." The MDS indicated Resident #99's height measured 68 inches, and the resident's weight measured 138 pounds.</p> <p>A care plan, dated 10/24/13, for Resident #99, indicated, "...Potential for Falls...Frequent bed checks while in bed...Encourage safety precautions...."</p> <p>During an interview on 2/07/14 at 10:56 a.m., the Director of Nursing indicated a mattress bolster should have been in place if a gap was present.</p> <p>A document titled, " Guidance for Industry and FDA [Food and Drug Administration] Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued on March 10, 2006, and considered current guidance, indicated, "...FDA is therefore using a head breadth dimension of 120mm (4 3/4 inches) as the basis for its dimensional limit recommendations ...Zone 3- Between the Rail and the Mattress...FDA is recommending a dimensional limit of less than...(4 3/4 inches) for the area between the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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			
F000364 SS=D	<p>inside surface of the rail and the compressed mattress...Zone 7 - Between the Head or Foot Board and the End of the Mattress...This space may present a risk of head entrapment..."</p> <p>3.1-45(a)(1)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on interview, record review and observation of meal delivery service and food temperatures, the facility failed to provide residents with food meeting their taste requirements for palatability. This had the potential to effect 40 of 40</p>	F000364	Data printed in red and/or bolded represents additional comments based on correspondence from the Indiana State Department of Health dated March 10,	03/12/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>residents who eat from the facility Health Center 2 unit kitchen.</p> <p>Findings include:</p> <p>1. Review of the Resident Council Minutes, with permission of the Council President given 2/09/14, indicated from August of 2013 to November of 2013, the residents had complained of meals being delivered late, cold, and of poor palatability. The residents indicated in the meeting minutes that there were no improvements in 4 months of 4 months complaining of the same problems. August thru November 2013)</p> <p>On 02/10/ 14 at 11:50 a.m., during an observation of the lunch meal preparation, the cook/ dietary aide was preparing trays for the Health Center 2 unit. The first tray went out 12:04 p.m. At 12:50 p.m., a test tray was served and temperatures were taken by nursing staff #15 and were as follows: chicken 100 Degrees Fahrenheit, wild rice 112 Degrees Fahrenheit, broccoli 100 Degrees Fahrenheit. The foods were cold to taste and touch.</p> <p>Dietary staff #1, on 2/10/14, at 1:00 p.m., took the following temperatures at the steam table:</p>		<p>2014. It was cited that the facility failed to maintain food temperatures at one meal to meet the resident's taste requirements for palatability. The citation states the following temperatures were taken: Chicken 100 degrees F at the plate, Rice 112 degrees F at the plate, and broccoli 100 degrees F at the plate. It should be noted the temperatures at the serving line were as following: Ribs 160 degrees F, white rice 150 degrees F, baked beans 130 degrees F, wild rice 140 degrees F, broccoli 130 degrees F, and Chicken 104 degrees F. It is the practice of the facility dietary department to procure, store/prepare/serve food in a sanitary manner. Temperature logs, daily follow-up, quality assurance assessments and weekly dietician reports are consistently used and available for review which supports positive policy goal outcomes. All dietary staff was re-in-serviced on maintaining desirable food temperatures to maintain palatability of food for residents. In-servicing included review of holding temperatures for food during preparation and serving. All dietary staff was also educated that any food item that did not meet the 140 degrees F temperature per the facility policy would be removed and corrected. These in-services were completed by February 28,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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>ribs, 160 Degrees Fahrenheit, white rice 150 Degrees Fahrenheit, baked beans 130 Degrees Fahrenheit, wild rice 140 Degrees Fahrenheit, broccoli 130 Degrees Fahrenheit, chicken 104 Degrees Fahrenheit,</p> <p>During an interview at this time with the Dietary staff #1, it was indicated the steam table was still on and the temperatures of hot food should be at least 130 Degrees Fahrenheit, and above.</p> <p>A facility policy, titled, "Holding Foods during Preparation and Before Service," dated 7/2007, received from the Dietary Manager on 2/13/14 at 12:30 p.m., indicated, "...Hot foods must be maintained at a temperature of at least 140F(Fahrenheit)."</p>		<p>2014. An equipment inspection was completed (hot food holding table) and no issues were found. This equipment is and will continue to be inspected routinely. Director of Food Services or designee attends all resident council meetings per resident request. All food concerns will be noted and addressed as they arise. Repeat concerns will be addressed and actions will be documented in the minutes. Food temperatures will be taken at the beginning and ending of each and every meal service. This is the practice of the facility and it will continue. This includes weekend meals. Dietician consultant and Food Service Director will audit weekly to ensure compliance. Franklin United Methodist Community utilizes Abaqis a system designed to audit each resident. This system consists of interviewing all residents/or designated family members at a minimum of each quarter. Included in the questions asked are specific questions regarding food quality and temp, including palatability. The results from this system are compiled and reviewed. Collected data from the audit process will be reviewed monthly and reported to the Quality Improvement Committee for further recommendations. The Director of Food Service or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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
R000000	<p>2. During a stage one resident interview on 2/06/2014 at 03:40 p.m., Resident #136 indicated her food was usually cold when it was served.</p> <p>Resident #136's clinical record was reviewed on 02/10/2014 at 11:42 a.m.</p> <p>The most recent annual Minimum Data Set (MDS) assessment, dated 01/09/2014, indicated the Brief Interview of Mental Status (BIMS) for Resident #136 was a 15 out of a possible 15, which indicated Resident #136 was cognitively intact.</p> <p>During an interview on 02/10/2014 at 12:33 p.m., during the lunch meal, Resident #136 indicated her lunch was "sort of warm."</p> <p>3.1-21(a)(2)</p>		<p>designee is responsible for assuring data presentation. Substantial Compliance date: March 12, 2014.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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	
R000349	<p>The following residential finding was cited in accordance with 410 IAC 16.2-5.</p> <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. Based on record review and interview, the facility failed to ensure accuchecks and insulin doses were documented for 2 of 3 residents reviewed for diabetic care in a sample of 9. (Residents #528 and #451)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #528 was reviewed on 2/12/14 at</p>	R000000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain.		
		R000349	It is the policy and procedure of the facility to ensure documentation in each resident's clinical record is current, complete and accurate. Licensed nursing staff recognizes and understands the importance of having clinical documentation accurate with the correct time a procedure was completed. Resident #528 and Resident #451 were identified by the survey team as not having accuchecks and insulin doses documented accurately, in that	03/12/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>10:00 a.m. Diagnoses for Resident #528 included, but were not limited to, insulin dependent diabetes mellitus and neuropathy.</p> <p>A recapitulated physician's order for January, 2014, with an original date of 4/20/13, indicated Resident #528 was to receive accuchecks (a finger stick blood test to measure blood sugar) 3 times per day at 7:00 a.m., 11:00 a.m. and 4:00 p.m.</p> <p>Resident #528's Blood Sugar Record for January, 2014, did not have documentation that an accucheck was done and/or recorded on: 1/8 at 11:00 a.m., 1/10 at 11:00 a.m., 1/24 at 4:00 p.m., 1/27 at 4:00 p.m., and 1/28 at 7:00 a.m.</p> <p>Resident #528's Blood Sugar Record for December, 2013, did not have documentation an accucheck was done and/or recorded on: 12/9 at 11:00 a.m., 12/18 at 11:00 a.m., 12/20 at 11:00 a.m., 12/21 at 11:00 a.m. and 4:00 p.m., and 12/22 at 4:00 p.m.</p> <p>Resident #528's Blood Sugar Record for November, 2013, did not have documentation an accucheck</p>		<p>the licensed nursing staff did not consistently document the accucheck results and insulin doses on the MARs. All Residents receiving accuchecks and/or insulin have the potential to be affected by inaccurate documentation when entering the results of a test or procedure done prior to documentation. Monthly audits will be completed weekly for one month, then bi-weekly for one month, and then monthly thereafter to ensure accuchecks and/or insulin doses are documented. All licensed nursing staff will be re-educated and receive on-going education on ensuring the process of entering data on the electronic medical record is followed and the time of the actual treatment or procedure is entered correctly upon documenting. This in-servicing will be completed by March 12, 2014. All newly hired nursing staff will receive the same education. Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. Substantial compliance date: March 12, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>was done and/or recorded on: 11/6 at 4:00 p.m., 11/8 at 7:00 a.m. and 11:00 a.m., 11/10 at 4:00 p.m. 11/15 at 11:00 a.m., 11/28 at 11:00 a.m. and 4:00 p.m., 11/29 at 7:00 a.m., 11:00 a.m. and 4:00 p.m.</p> <p>Resident #528's Blood Sugar Record for October, 2013, did not have documentation an accucheck was done and/or recorded on: 10/2 at 11:00 a.m., 10/4 at 11:00 a.m., 10/6 at 11:00 a.m., 10/9 at 11:00 a.m., 10/11 at 11:00 a.m., 10/22 at 11:00 a.m., 10/27 at 7:00 a.m. and 11:00 a.m., and 10/30 at 7:00 a.m.</p> <p>A recapitulated physician's order for January, 2014, with an original date of 1/25/13, indicated Resident #528 was to receive Novolog insulin according to the following sliding scale: Blood sugar = 150-180 2 units insulin Blood sugar = 181-210 4 units Blood sugar = 211-240 6 units Blood sugar = 241-270 8 units Blood sugar = 271-300 10 units Blood sugar = 301-330 12 units Blood sugar = 331-360 14 units Blood sugar = 361-390 16 units Over 390 call physician</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>A Medication Administration Record (MAR) for January, 2014, for Resident #528, indicated:</p> <p>1/4 at 7:00 a.m. blood sugar (BS) = 249. No insulin documented as given. Should have received 8 units</p> <p>1/4 at 4:00 p.m. BS = 184. 2 units of insulin given. Should have received 4 units.</p> <p>1/12 at 7:00 a.m. BS = 248 No insulin given. Should have received 8 units.</p> <p>1/17 at 11:00 a.m. BS = 185. No insulin given. Should have received 4 units.</p> <p>1/21 at 7:00 a.m. BS = 165. No insulin given. Should have received 2 units.</p> <p>1/22 at 11:00 a.m. BS = 219. No insulin given. Should have received 6 units</p> <p>1/22 at 4:00 p.m. BS = 184. Received 2 units. Should have received 4 units.</p> <p>1/23 at 11:00 a.m. BS = 201. No insulin given. Should have received 4 units.</p> <p>1/24 at 11:00 a.m. BS = 198. No insulin given. Should have received 4 units.</p> <p>1/25 at 7:00 a.m. BS = 168. No insulin given. Should have received 2 units.</p> <p>1/26 at 4:00 p.m. BS = 190. No insulin given. Should have received</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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 units. 1/27 at 11:00 a.m. BS = 183. Received 6 units of insulin. Should have received 4 units.</p> <p>A MAR for December, 2014, for Resident #528, indicated: 12/2 at 11:00 a.m. BS = 248. No insulin was documented as given. Should have received 8 units. 12/3 at 7:00 a.m. BS = 188. No insulin was documented as given. Should have received 4 units. 12/3 at 11:00 a.m. BS = 248. No insulin was documented as given. Should have received 8 units. 12/4 at 11:00 a.m. BS = 275. No insulin was documented as given. Should have received 10 units. 12/5 at 7:00 a.m. BS = 182. No insulin was documented as given. Should have received 4 units. 12/5 at 11:00 a.m. BS = 207. No insulin was documented as given. Should have received 4 units. 12/6 at 11:00 a.m. BS = 238. No insulin was documented as given. Should have received 6 units. 12/10 at 7:00 a.m. BS = 160. No insulin was documented as given. Should have received 2 units. 12/10 at 11:00 a.m. BS = 211. No insulin was documented as given. Should have received 6 units. 12/11 at 11:00 a.m. BS = 332. No</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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>insulin was documented as given. Should have received 12 units. 12/12 at 7:00 a.m. BS = 182. No insulin was documented as given. Should have received 4 units. 12/12 at 11:00 a.m. BS = 188. No insulin was documented as given. Should have received 4 units. 12/13 at 11:00 a.m. BS = 220. No insulin was documented as given. Should have received 6 units. 12/16 at 7:00 a.m. BS = 183. No insulin was documented as given. Should have received 4 units. 12/16 at 11:00 a.m. BS = 233. No insulin was documented as given. Should have received 6 units. 12/17 at 11:00 a.m. BS = 233. No insulin was documented as given. Should have received 6 units. 12/18 at 7:00 a.m. BS = 191. No insulin was documented as given. Should have received 4 units. 12/19 at 7:00 a.m. BS = 154. No insulin was documented as given. Should have received 2 units. 12/19 at 11:00 a.m. BS = 184. No insulin was documented as given. Should have received 4 units. 12/22 at 1100 a.m. BS = 176. No insulin was documented as given. Should have received 2 units. 12/23 at 7:00 a.m., BS = 159. No insulin was documented as given. Should have received 2 units.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>12/23 at 11:00 a.m. BS = 177. No insulin was documented as given. Should have received 2 units.</p> <p>12/28 at 7:00 a.m. BS = 170. No insulin was documented as given. Should have received 2 units.</p> <p>12/28 at 11:00 a.m. BS = 251. No insulin was documented as given. Should have received 8 units.</p> <p>12/29 at 11:00 a.m. BS = 233. No insulin was documented as given. Should have received 6 units.</p> <p>2. The clinical record of Resident #451 was reviewed on 2/12/14 at 11:15 a.m.</p> <p>Diagnoses for Resident #451 included, but were not limited to diabetes mellitus.</p> <p>A recapitulated physician's order for January, 2014, with an original date of 11/27/12, indicated Resident #451 was to receive accuchecks daily at 4:00 p.m.</p> <p>A Blood Sugar Report for Resident #451 did not have documentation accuchecks were done and/or recorded on: 1/27/14, 12/29/13, 12/19/13, 12/4/13, 11/28/13, 11/24/13, 11/18/13, 11/12/13, 11/10/13, and 11/6/13.</p> <p>A recapitulated physician's order for</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>January, 2014, with an original date of 7/2/12, indicated Resident #451 was to receive Novolog insulin at 4:00 p.m. according to the following sliding scale:</p> <p>BS = 150-180 = 2 units BS = 181-210 = 4 units BS = 211-240 = 6 units BS = 241-270 = 8 units BS = 271-300 = 10 units BS = 301 - 330 = 12 units BS = 331-360 = 14 units BS = 361-390 = 14 units Call physician if BS over 390</p> <p>A Medication Administration Record (MAR) for January, 2014, for Resident #451, indicated:</p> <p>1/14 BS 8 = 271. Received 8 units of insulin. Should have received 10 units. 1/21 BS = 185. Received 2 units of insulin. Should have received 4 units. 1/22 BS = 183. Received 2 units of insulin. Should have received 4 units. 1/26 BS = 232. No insulin was documented as given. Should have received 6 units.</p> <p>A MAR for December, 2013, for Resident #451, indicated:</p> <p>12/2 BS = 192. No insulin was documented as given. Should have</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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>received 4 units.</p> <p>A MAR for November, 2013, for Resident #451, indicated: 11/17 BS = 188. No insulin was documented as given. should have received 4 units. 11/21 BS = 208. No insulin was documented as given. Should have received 4 units.</p> <p>A MAR for October, 2013, for Resident #451, indicated: 10/6 BS = 152 No insulin was documented as given. Should have received 2 units. 10/7 BS = 147. Received 2 units of insulin. No insulin should have been given. 10/9 BS = 242. Received 2 units of insulin. Should have received 8 units. 10/17 BS = 193. Received 2 units of insulin. Should have received 4 units. 10/18 BS = 234 Received 10 units of insulin. Should have received 6 units. 10/22 BS = 223. Received 4 units of insulin. Should have received 6 units. 10/25 BS = 167. No insulin was documented as given. Should have received 2 units.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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 with the Charge Nurse on 2/12/14 at 2:00 p.m., she indicated all accuchecks for Residents #528 and #451 were supposed to be documented on the Blood Sugar Reports. She indicated sliding scale insulin doses were supposed to be administered according to the physicians' orders.</p> <p>A facility policy, dated 3/287/05, received from the DON on 2/13/14 at 5:30 p.m., titled Blood Glucose Measurement, indicated, "...2. Document results on graphic sheet...."</p>			