

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155740	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/13/2015
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NAME OF PROVIDER OR SUPPLIER  TIMBERCREST CHURCH OF THE BRETHERN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 EAST ST NORTH MANCHESTER, IN 46962
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: August 6, 7,10,11, 12 and 13, 2015</p> <p>Facility number: 000448 Provider number: 155740 AIM number: 100275140</p> <p>Census bed type: SNF/NF: 58 Residential: 131 Total:189</p> <p>Census payor type: Medicare: 1 Medicaid: 11 Other: 46 Total: 58</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS			

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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Bldg. 00	<p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure a quarterly MDS (Minimum Data Set) Assessment was completed for 1 of 13 residents whose clinical records were reviewed for the accurate and timely completion of the MDS Assessments. (Resident #12)</p>	F 0272	1.F-272 It is, and always has been the intent of Timbercrest that all residents receive comprehensive, accurate, standardized assessments that can be replicated on at least a quarterly basis and as other indications arise. Immediate	09/11/2015

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	<p>Findings include:</p> <p>A review of Resident #12's clinical record began on 8/11/15 at 10:00 a.m. Diagnoses included but were not limited to, Alzheimer's disease, abnormal loss of weight, hypertension, osteoarthritis, osteoporosis, pain, macular degeneration, hearing loss and anxiety. The resident's clinical record also indicated Resident #12 was admitted to hospice services on 3/26/15 with the diagnosis of Alzheimer's disease.</p> <p>On 8/11/15 at 10:10 a.m., a review of the MDS (Minimum Data Set) Assessment indicated a quarterly assessment, dated 6/19/15, was in process. During the review of the MDS, information was found to be incomplete and questions were not answered.</p> <p>Review of Resident #12's MDS for Special Treatments, Procedures, and Programs (Section O) was not answered for Hospice Care and also the number of days the resident received services for the Restorative Nursing Program for active and passive Range of Motion (ROM), dressing and /or grooming were not answered.</p> <p>On 8/11/15 at 10:15 a.m., a review of the</p>		<p>corrective action taken to ensure comprehensive, accurate, standardize assessment was completed for each resident, was themissed quarterly MDS was completed and submitted.</p> <p>2.An audit of all residents due for an assessmentfrom May 2015 to August 20th was completed to ensure all residentsreceived a comprehensive, accurate, standardize assessment. Completed audit didnot reveal any additional missed assessments.</p> <p>3.A two-step monitoring system will be implementedto ensure future assessments are completed and submitted. The first step willbe written confirmation by the MDS coordinator that the assessment has beencompleted and date submitted. Director of Nursing or designee will auditprinted submission record from Centers for Medicare and Medicaid againstschedule at least monthly.</p> <p>4.Monthly audit results will be reported throughTimbercrest's QAPI process, monthly, until 95% compliance is maintained for 3consecutive months and then quarterly thereafter.</p>	

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	<p>most current completed MDS Assessment, dated 3/6/15, for Resident #12 indicated the assessment was completed for a significant change in the resident's status. The 3/6/15 MDS Assessment also indicated Resident #12's BIMS (Brief Interview for Mental Status) Score was 03/15 which indicated severe impairment of cognition.</p> <p>An interview with the ADON, on 8/11/15 at 11:50 a.m., indicated she did not know why the electronic record for Resident #12 indicated the MDS Assessment, dated 6/19/15, indicated it was "in process". She indicated the assessment should have been completed and would check on the status of the MDS Assessment for Resident #12.</p> <p>An interview with the ADON, on 8/11/15 at 12:10 p.m., indicated she had checked with the MDS Coordinator and indicated Resident #12's MDS Assessment, dated 6/19/15, was missed and not completed. She also indicated the current MDS Coordinator was new and the former MDS Coordinator retired on 5/29/15. The ADON further indicated they had changed the process of tracking for the time period the MDS Assessments were to be completed and the MDS Assessment was missed.</p>			

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F 0371	<p>On 8/12/15 at 9:30 a.m., Resident #12's MDS Assessment, dated 6/19/15, was printed and provided by the DON. It indicated, "...Signature of RN Assessment Coordinator Verifying Assessment Completion...A. Signature: electronically Signed by the MDS Coordinator...B. Date RN Assessment Coordinator signed assessment as complete: 08-11-2015."</p> <p>On 8/12/15 at 10:00 a.m., a review of the current facility's policy, provided by the DON, titled Minimum Data Set (MDS) and Comprehensive Care Plan, with revised date 4/2015, indicated, "...Policy: All Healthcare and Crestwood Residents will have an MDS completed by the 14th day after admission...MDS assessments will also be completed quarterly ...Med A residents will have MDS assessments completed per CMS guidelines....For quarterly reviews, care plans will be updated by interdisciplinary team approach and the MDS coordinator [sic] will be completed as required by law....It is the responsibility of each team member to assure timely documentation and signatures of the MDS forms."</p> <p>3.1-31(d)(3)</p>			
	483.35(i)			

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SS=E Bldg. 00	<p>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to perform hand hygiene after touching soiled items in the dining room and before assisting residents with their meals. The facility also failed to protect clean clothing protectors from potential contamination and failed to ensure staff did not handle food from a resident's meal tray with bare fingers before giving it to the resident to eat potentially affecting 43 of the 58 residents who ate their meals in the main dining room.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the main dining room on 8/6/15, the following was observed:</p> <p>At 12:04 p.m., an un-identified resident seated in a wheelchair, wearing golf gloves on his hands, was observed to have a stack of 4 clean clothing protectors on his lap. The bottom clothing protector in the stack was resting directly on his slacks and the edges of all</p>	F 0371	<p>1. F-371 Itis, and always has been the intent of Timbercrest that all food is stored,prepared and stored sanitarly. The cited non-compliance is that our handhygine did not meet expectations and residents assisting other residents withclothing protectors. Immediatecorrective action taken to ensure food was handled and distributed by sanitaryconditions according to State, Federal and local agencies was individualC.N.A's were verbally educated on proper hand hygiene and food handling.Timbercrest will refrain from allowing other healthcenter residents fromhelping pass out clothing protectors.</p> <p>2.All nursing staff will be educated on properhand hygiene and food handling procedures as related to their functions ofassisting to eat and feeding residents. Specific education on the use of handsanitizer during the dining process.</p> <p>3.Timbercrest will implement a revised diningprogram that focuses on giving staff members individual tasks to decrease thepotential for contamination, as</p>	09/11/2015			

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	<p>the clothing protectors were resting against his shirt. He delivered the clean clothing protectors to place settings for residents at 2 different tables by picking up the clothing protectors with his golf-gloved hands.</p> <p>At 12:07 p.m., Qualified Medication Aide (QMA) #4 pushed a resident who was seated in his geri-chair into the dining room and up to a dining room table. She then picked up a clean clothing protector which was on his table and placed it around his neck. She did not perform hand hygiene prior to handling the clean clothing protector and placing it on the resident.</p> <p>At 12:09 p.m., QMA #4 pushed a resident who was seated in a wheelchair into the dining room and up to a dining room table. She then picked up a clean clothing protector which was on his table and placed it around his neck. She did not perform hand hygiene prior to handling the clean clothing protector and placing it on the resident.</p> <p>At 12:11 p.m., QMA #4 pushed a resident who was seated in a wheelchair into the dining room and up to a dining room table. She then picked up a clean clothing protector which was on her table and placed it around her neck. She did</p>		<p>staff transition between tasks.</p> <p>4. Nursing or dietary leadership will audit atleast 30% of the meals for adherents to dining program and hand hygiene expectations. Administrator or designee will audit dining room weekly. Audit results will be reported through Timbercrest's QAPI process, monthly, until 95% compliance is maintained for 3 consecutive months and then quarterly thereafter.</p>	

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	<p>not perform hand hygiene prior to handling the clean clothing protector and placing it on the resident.</p> <p>At 12:16 p.m., Certified Nursing Assistant (CNA) #5 picked up a small stool on wheels, carried it to a dining room table, and sat down on the small stool on wheels next to a resident seated at a dining room table. She picked up the eating utensils of a resident to prepare her food for her to eat. She then started to feed another resident at the same table. She did not perform hand hygiene prior to handling a resident's eating utensil or feeding another resident.</p> <p>At 12:18 p.m., CNA #6 picked up a small stool on wheels, carried it to a dining room table, and sat down on the small stool on wheels next to a resident seated at a dining room table. She used sanitizer on her hands, but then placed her hands palm side down on her uniform slacks. She then fed a resident the lunch meal without re-sanitizing her hands.</p> <p>At 12:20 p.m., QMA #7 carried a small stool on wheels to a dining room table and sat down on the small stool on wheels next to a resident seated at a dining room table. She started feeding a resident the lunch meal without performing hand hygiene.</p>			

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	<p>At 12:22 p.m., CNA #8 moved a small stool on wheels with her hands and sat down on the small stool on wheels next to a resident seated at a dining room table. She assisted a resident with moving her plates of food around. She did not perform hand hygiene. She then placed her hands palm down on her uniform slacks and scratched her right leg.</p> <p>At 12:28 p.m., food trays were delivered to another resident seated next to CNA #8. CNA #8 began feeding the resident the lunch meal without performing hand hygiene.</p> <p>2. During an observation of the lunch meal in the main dining room on 8/11/15, the following was observed:</p> <p>At 12:02 p.m., CNA #9 carried clean clothing protectors through the dining room by holding the clothing protectors up against her uniform. She placed the clean clothing protectors on residents while holding the other clothing protectors between her arm and her uniform.</p> <p>At 12:17 p.m., CNA #10 pushed a small stool on wheels with her hands and sat down on the small stool on wheels next</p>			

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	<p>to a resident seated at a dining room table. She started feeding a resident the lunch meal without performing hand hygiene.</p> <p>At 12:26 p.m., QMA #11 picked up a dining room chair, carried the chair to a dining room table, and sat next to a resident seated at the dining room table. She got up from the table and obtained a handful of drinking straws from the medicine cart and placed them in a square black container in the middle of the table. She then prepared 2 drinking straws for the resident seated next to her. She did not perform hand hygiene. QMA #11 kept her hands in her lap with her hands touching her uniform slacks. She then moved a plate of pie over in front of the same resident. She did not perform hand hygiene.</p> <p>3. During an observation of the breakfast meal in the main dining room on 8/13/15 at 9:10 a.m., CNA #12 broke off a piece of banana and handed the piece to a resident with her bare hands. The resident then proceeded to eat the piece of banana.</p> <p>The Director of Dietary Services was interviewed on 8/13/15 at 9:00 a.m. During the interview, she indicated the department did not have a policy</p>			

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	<p>concerning the use of hand sanitizer in the dining room since hand sanitizer was not used by the dietary department. She also indicated several residents in the main dining room liked to help out by passing the clean clothing protectors.</p> <p>During an observation of the main dining room on 8/13/15 at 9:10 a.m., there was a sign inside the cabinet containing the clean clothing protectors with the shape of a stop sign, which indicated "Stop Staff Only."</p> <p>The Director of Nursing was interviewed on 8/13/15 at 9:35 a.m. During the interview, she indicated staff should never touch food for residents with their bare hands. She also indicated clean clothing protectors should not touch the uniform of staff and should be protected from contamination.</p> <p>A current facility policy "Hand Cleaner, Antiseptic Handrub", with a revision date of April 2015 and provided by the Assistant Director of Nursing on 8/11/15 at 3:45 p.m., indicated "...Improved adherence to hand hygiene (i.e. hand washing or use of alcohol-based hand rubs) has been shown to terminate outbreaks in health care facilities, to reduce transmission of antimicrobial resistant organisms (e.g. methicillin</p>			

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F 0431 SS=E Bldg. 00	<p>resistant staphylococcus aureas) and reduce overall infection rates...."</p> <p>A current undated facility policy "Linen Handling - Nursing", provided by the Director of Nursing on 8/13/15 at 9:55 a.m., indicated "...To ensure proper handling of soiled and clean linen...to prevent the spread of micro-organisms....Nursing personnel shall handle clean...linen in a manner to prevent contamination of the linen...."</p> <p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under</p>			

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	<p>proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure prescription treatments and creams were identified with a prescription label in 2 of 4 treatment carts (200 and 400 hall) and failed to ensure over the counter creams and ointments were labeled with a resident name in 1 of 4 medication carts (200 hall cart) and 3 of 4 treatment carts (100, 200 and 400 hall).</p> <p>B. Based on observation, interview and record review, the facility failed to ensure expired insulin was not administered to a resident after the 28th day from the opened date for 1 of 6 residents who were administered insulin by the facility. (Resident #9)</p> <p>Findings include:</p> <p>A. A review of the 200 hall Medication Cart with Qualified Medication Aide</p>	F 0431	<p>1.F-431 It is, and always has been the intent of Timbercrest to maintain drug records properly as related to labeling and storage procedures. The cited non-compliance of lotions not being properly labeled in the treatment cart and expired insulin present in the medication cart, is not our standard practice. Immediate corrective action taken to ensure medications/treatments were properly labeled and not expired was noted lotions were discarded and new items were labeled individual for residents using; expired insulin was discarded and new medication to be used.</p> <p>2. An audit of all treatment and medication carts was completed to ensure proper labeling/storage practices and guidelines were followed. All items identified were discharged if found not following proper labeling/storage practices.</p> <p>3. Licensed nurses and</p>	09/11/2015

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	<p>(QMA) #1 on 8-11-2015 at 9:50 a.m., indicated a partially used tube of skin repair cream was not labeled and was found in the bottom drawer of the medication cart. An interview with QMA #1, indicated she was not sure who the tube of skin repair cream belonged or why it was in the medication cart.</p> <p>A review of the 200 hall treatment cart with Licensed Practical Nurse (LPN) # 2 on 8-11-2015 at 10:13 a.m. indicated the following:</p> <p>The top drawer contained a partially used 4 ounce container of Blue Emu cream and a partially used 4 ounce container of Aquaphor ointment and both were without a resident name on the containers.</p> <p>The 3rd drawer contained a tube of SF 5000 Plus dental cream with "Rx only" (prescription only) on the tube and was without a prescription label or resident name on the tube.</p> <p>The 4th drawer contained an opened foil package of albuterol sulfate inhalation and was without a prescription label or resident name on the package.</p> <p>The 4th drawer contained 2 tubes of partially used Nutrashield cream and 1 partially used tube of skin repair cream and were not labeled with a resident name on the tubes.</p>		<p>Qualified Medication Aides will be educated on proper storage and labeling of medications and treatments. Timbercrest will implement a two-step auditing system of medication and treatment carts. Nursing staff will audit carts at least weekly, pharmacy representative will audit medication carts at least monthly, nursing leadership will audit treatment and medication carts at least monthly.</p> <p>4. Audit results will be reported through Timbercrest's QAPI process, monthly, until 95% compliance is maintained for 3 consecutive months and then quarterly thereafter.</p>	

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NAME OF PROVIDER OR SUPPLIER  TIMBERCREST CHURCH OF THE BRETHERN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 EAST ST NORTH MANCHESTER, IN 46962
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	<p>A review of the 400 hall treatment cart with LPN # 2 on 8-11-2015 at 10:20 a.m., indicated the following: The top drawer contained a box with a tube of lidocaine-prilocaine cream with Rx only on the box. The cream was not labeled with a prescription label or resident name. The 4th drawer contained a mostly used tube of clotrimazole cream and did not have a resident name on the tube.</p> <p>An interview with LPN #2 on 8-11-2015 at 10:16 p.m., indicated the albuterol sulfate inhalation package should have been in a box with a prescription label and the nurse did not know which resident the package belonged. Further interview with LPN #2, indicated the lidocaine-prilocaine cream should have had a prescription label attached and the over the counter creams and ointments should have had resident names on them. LPN #2 was unsure which residents the creams and ointments belonged.</p> <p>An observation of the 100 hall treatment cart with LPN #3 on 8-11-2015 at 10:35 a.m., indicated the following: The 3rd drawer contained a tube of skin repair cream and was without a resident name on the tube. The 3rd drawer contained a partially used 2.75 ounce can of Dermoplast and was</p>			

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	<p>without a label or name to identify to whom the Dermoplast belonged.</p> <p>The 3rd drawer contained a partially used container of Blue Stop massage gel and was without a resident name on the container</p> <p>The bottom drawer contained a 4.37 ounce tin of Petro Cariso first Aid Salve without a resident name on the tin.</p> <p>An interview with LPN #3 on 8-11-2015 at 10:38 a.m., indicated she did not know to whom the first Aid Salve belonged. Further interview with LPN #3 indicated labels were not placed on creams, just a resident name and room number should have been written on the containers.</p> <p>An interview with LPN #3 on 8-11-2015 at 10:47 a.m., indicated there was not any one set person to go through the treatment carts and there was not a routine to check the treatment carts.</p> <p>An interview with the Director of Nursing (DON), on 8-12-2015 at 11:15 a.m., indicated the Prescription creams and treatments in the treatment carts should have had a prescription label on them and the over the counter creams should have had a name on the container.</p> <p>A current policy, "Medication Ordering and Receiving From Pharmacy dated</p>			

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	<p>January 2007 and provided by the ADON (Assistant Director of Nursing) on 8-12-2015 at 9:00 a.m., indicated "...Medications are labeled in accordance with facility requirements and state and federal laws..."</p> <p>"Procedures...labels are permanently affixed to the outside of the prescription container...the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container...each prescription medication label includes:</p> <ol style="list-style-type: none"> <li>1) Resident's name</li> <li>2) Specific directions for use...</li> <li>3) Medication name...</li> <li>4) Strength of medication...</li> <li>5) Prescriber's name</li> <li>6) Date Dispensed</li> <li>7) Quantity of medication</li> <li>8) Expiration date of medication...."</li> </ol> <p>"...Nonprescription medications not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name...."</p> <p>B. An observation of the insulin storage container, located in the medication refrigerator in the medication room on 8-11-2015 at 2:40 p.m., indicated a Humalog KwikPen for Resident #9 had an opened date of 6-6-2015 on the label.</p>			

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	<p>An interview with the ADON, on 8-11-2015 at 2:45 p.m., indicated an information sheet in the medication room was available for the nurse that would indicate how many days the insulin could be used after it was opened. The ADON provided the current information for insulin expiration after opening. The information indicated regardless if insulin was stored in the refrigerator or at room temperature, the insulin would expire 28 days after opening.</p> <p>An interview with the ADON on 8-11-2015 at 3:57 p.m., indicated Resident #9 did have the Humalog KwikPen insulin administered past the 28 days after opening which was after July 3, 2015. The ADON provided the Diabetic Administration History for July 2015.</p> <p>An interview with the DON on 8-12-2015 at 11:34 a.m., indicated Resident #9 received insulin from the Humalog KwikPen past the 28 days after opening. The DON provided the Diabetic Administration History for August 2015.</p> <p>A review of the Diabetic Administration history for Resident #9 indicated the resident received the Humalog KwikPen</p>			

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	<p>insulin injection 7 times after the 28 days past the opening date on the following dates/times:</p> <p>On 8-5-2015 at 12:00 p.m., Humalog was administered for a blood sugar of 228 to site #17 with no amount of insulin documented.</p> <p>On 8-2-2015 at 12:00 p.m., Humalog was administered for a blood sugar of 199 to site #17 with no amount of insulin documented.</p> <p>(The order on the Diabetic Administration History indicated "...Humalog KwikPen...amount to administer...per sliding scale...if blood sugar is 151 to 200, give 4 units...if blood sugar is 201 to 250, give 6 units...")</p> <p>On 7-16-2015 at 5 p.m., 4 units of Humalog were administered.</p> <p>On 7-12-2015 at 12:00 p.m., 4 units of Humalog were administered.</p> <p>On 7-12-2014 at 5:00 p.m., 4 units were administered.</p> <p>On 7-9-2015 at 12:00 p.m., 4 units were administered.</p> <p>On 7-5-2015 at 5:00 p.m., 5 units were administered.</p> <p>An interview with the ADON, on 8-13-215 at 9:37 a.m., indicated there were 6 residents who received insulin in Healthcare.</p> <p>A current and undated information sheet,</p>						

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R 0000	<p>"Summary of expiration of dating of products..." was provided by the ADON on 8-11-2015 at 4:00 p.m. and indicated for "...Insulin..." whether refrigerated or room temperature would expire after "28 days from date opened..."</p> <p>On 8-12-2015 at 9:00 a.m., the ADON provided the most current and undated "Expirations of Medications [Once Opened]" which did not include the Humalog KwikPen.</p> <p>An interview with the DON on 8-12-2015 at 11:15 a.m., indicated the updated "Expirations of Medications [Once Opened]" did not include Humalog KwikPen and information from the manufacturer was obtained and provided.</p> <p>A review of the Humalog KwikPen storage information from Eli Lilly and Company and dated 2007 and provided by the ADON on 8-12-2015 at 9:00 a.m., indicated "...the Humalog Pen...should be thrown away after 28 days, even if it still has insulin left in it..."</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l)</p>			

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Bldg. 00	<p>This visit was for a State Residential Licensure. This visit included the a Recertification and State Licensure Survey.</p> <p>Survey dates: August 6, 7,10,11, 12 and 13, 2015</p> <p>Facility number: 000448 Provider number: 155740 AIM number: 100275140</p> <p>Census bed type: Residential: 131 Total:131</p> <p>Census payor type: Other: 131 Total: 131</p> <p>Residential Sample: 7</p> <p>Timbercrest Church of The Brethren Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000		