

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/23/2011	
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706			
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F0000	<p>This visit was for the Investigation of Complaint IN00091929.</p> <p>Complaint IN00091929- Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies cited</p> <p>Survey dates: June 21, 22, 23, 2011</p> <p>Facility number: 000306 Provider number: 155694 AIM number: 100273860</p> <p>Survey team: Ann Armey, RN</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 15 Medicaid: 47 Other: 29 Total: 91</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>			F0000			

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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F0157 SS=D	<p>Quality review completed on June 24, 2011 by Bev Faulkner,RN</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interviews and record review, the facility failed to immediately notify the physician when there was a change in</p>	F0157	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set	07/23/2011	

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	<p>condition of a resident related to a medication error. This deficiency affected 1 of 3 resident's reviewed for medication errors in a sample of 5. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record of Resident #D was reviewed on 6/22/11 at 10:00 a.m., and indicated the resident was admitted to the facility on 10/3/09, with diagnoses which included but were not limited to, non-insulin dependent diabetes mellitus and dementia.</p> <p>The Quarterly Minimum Data Set Assessment, dated 3/17/11, indicated Resident #D had severe cognitive impairment and required extensive assistance for transfer, dressing, and hygiene.</p> <p>The May 2011 and June 2011 MARs (Medication Administration Records) indicated the resident received an oral antidiabetic, Avandamet 4-1000, one tablet by mouth twice daily at 7:00 a.m. and 5:00 p.m.</p> <p>Nursing notes, dated 5/4/11 indicated the following: At 7:00 p.m., "(Resident's Name) was in her w/c (wheelchair) in the hall, her extremities began to shake, she had wet</p>		<p>forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the allegation of compliance. Due to the relative low scope and severity for the deficiencies cited, request a desk review in lieu of a post survey revisit on or after July 23, 2011.</p> <p>1. LPN involved in medication error was instructed by the DNS that the physician is to be called immediately after a medication error. 2. An in-service was provided by our SDC on 6/2/11 and will be reiterated at the 7/7/11 in-service for the Nurses and QMA's regarding Notification of the physician immediately after a medication error. There was a pre / post test following the 6/2/11 in-service to evaluate the understanding of training provided on Medication administration. 3. A copy of the medication error policy and procedure will be placed in the MAR's and TAR's to remind staff the steps to be taken if an error should occur. 4. Continuous Quality Improvement tool will be used to monitor medication errors montly x 4 months then quarterly thereafter to ensure proper procedure is being followed. If concerns are identified, they will be addressed by the quality imiprovment committee. July 23, 2011</p>		

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	<p>her pants &amp; (and) was slipping down in her chair. Her BS (Blood Sugar) was 59. She was given juice c (with) sugar. The CNA (Certified Nursing Assistant) that was helping me made a comment that (Resident's Name) had gotten insulin in the dining rm (room)."</p> <p>At 7:15 p.m., "Her BS was 52. (LPN #3's Name) suggested glucagon which she was then given. The girls put her to bed. @ (at) this time."</p> <p>At 7:30 p.m., the Blood Sugar was 72. At 8:30 p.m., the Blood Sugar was 114. At 10:00 p.m., the blood sugar was 137. The note further indicated "called (Physician's Name) &amp; explained what we had done for (Resident's Name). Everything we had done was ok c (with) him."</p> <p>On 6/22/11 at 11:00 a.m., LPN #1 was interviewed. She indicated she was called and questioned by the evening nurse (LPN #2), on 5/4/11 and suddenly remembered she had mistakenly given Resident #E's 5:00 p.m. Novolog insulin to Resident #D. LPN #1 indicated, at the time she administered the insulin in the West dining room, she was not aware she had confused the residents, who were roommates. She indicated she had not worked on the unit for sometime.</p>						

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	<p>On 6/22/11 at 11:30 a.m., LPN #3, who had assisted LPN #2 with Resident #D on 5/4/11 was interviewed. She indicated she had been called to the West unit because Resident #D's blood sugars were low and the orange juice with sugar was not working. LPN #3 indicated the resident was unresponsive, they gave her Glucagon (A medication used to raise blood sugars) and they did not call the Physician for an order because they needed to do something immediately. She indicated Resident #D began to improve after the Glucagon was administered.</p> <p>On 6/22/11 at 12:00 p.m., LPN #2, who was on duty during the evening of 5/4/11, was interviewed. LPN #2 indicated Resident #D was shaking and incontinent which was unusual for the resident and when she checked the blood sugar it was low. She indicated a CNA (she could not remember which CNA) said she saw LPN #1 holding the back of Resident #D's arm and thought she had received insulin. LPN #2 indicated Resident #D did not have a physician's order for insulin. She indicated she called LPN #1 and LPN #1 confirmed she had given Resident #D insulin and had not given Resident #E her insulin. LPN #2 indicated she did not call the</p>						

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	<p>Physician until 10:00 p.m. and he approved the administration of the Glucagon and did not order further monitoring.</p> <p>On 6/22/11 at 3:00 p.m., CNA (Certified Nursing Assistant) #4, who assisted Resident #D on the evening of 5/4/11, was interviewed. The aide indicated when she put Resident #D in bed, she was limp, gray, and had to be lifted by two CNA'S.</p> <p>The current policy for medication errors, revised 1/06, provided by the Assistant Director of Nursing, was reviewed on 6/22/11, and indicated "It is the policy of this provider to ensure residents residing in the facility are free of medication errors... *When a suspected medication error is identified, the nurse will immediately assess the condition of the affected resident and notify the physician of the event. *Physicians orders received for monitoring will be initiated immediately upon receipt..."</p> <p>3.1-5(a)</p>				

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F0281 SS=D	<p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interviews and record review, the facility failed to ensure professional standards of quality during a medication pass were upheld, in that a LPN failed to verify the identity of a resident before administering an insulin injection. Resident #D received insulin ordered for Resident #E.</p> <p>This deficiency affected 1 of 3 diabetic residents reviewed in a sample of 5. (Resident #D)</p> <p>Findings include:</p> <p>On 6/22/11 between 7:00 a.m. and 7:15 a.m., LPN #5 was observed administering insulin to two residents. The insulin medication administration records were in a separate book identified as the nurse's treatment book. The insulin administration book did not have identifying pictures for each of the residents who received insulin.</p> <p>On 6/22/11 at 7:15 a.m., LPN #5 indicated at the end of May 2011, medications/treatments administered by the licensed nurse, including insulin, were placed in a separate book because a QMA was added to the unit staffing.</p> <p>The nurse indicated residents were</p>	F0281	<p>1. The LPN involved in the medication error was suspended until further investigation. The LPN was given a re-education with the SDC (staff development coordinator) regarding medication administration and was observed performing a medication pass correctly before allowing her to pass medications again. 2. An In-service was provided by the SDC on 6/2/11 and will be again on 7/7/11 reiterating importance of identifying the Residents before administering medications. A pre / post test was given on the 6/2/11 in-service to evaluate the understanding of training provided. 3. Medical Records &amp; or designee will place pictures of all new residents within 24 hours of admission on all MAR and TAR books. 4. CQI (continuous quality improvement) tool: Resident Identification will be done monthly x four months and bi-annually thereafter by Medical Records to ensure all residents have pictures on all the MAR's and TAR's for Nurses and QMA's for identification purposes. If concerns are identified, they will be addressed by the quality improvement committee. July 23, 2011.</p>	07/23/2011	

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	<p>identified, during the administration of medication, by asking the residents their name, or by the verifying the identity of each resident using the name posted above each bed. LPN #5 indicated, if residents were confused or out of their room then they should be identified using pictures in the medication administration books.</p> <p>Although the medication administration book had pictures that could be used to identify residents, the nurse treatment book, used to administer insulin, did not have identifying pictures.</p> <p>The clinical record of Resident #D was reviewed on 6/22/11 at 10:00 a.m., and indicated the resident was admitted to the facility on 10/3/09, with diagnosis which included but were not limited to, non-insulin dependent diabetes mellitus and dementia.</p> <p>The Quarterly Minimum Data Set Assessment, dated 3/17/11, indicated Resident #D had severe cognitive impairment and required extensive assistance for transfer, dressing, and hygiene.</p> <p>The May 2011 and June 2011 Mars (Medication Administration Records) indicated the resident received an oral</p>						

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	<p>antidiabetic, Avandamet 4-1000, one tablet by mouth twice daily at 7:00 a.m. and 5:00 p.m. This resident did not have an order for injectable insulin.</p> <p>Nursing notes, dated 5/4/11, indicated the following: At 7:00 p.m., "(Resident's Name) was in her w/c (wheelchair) in the hall, her extremities began to shake, she had wet her pants &amp; (and) was slipping down in her chair. Her BS (Blood Sugar) was 59. She was given juice c (with) sugar. The CNA (Certified Nursing Assistant) that was helping me made a comment that (Resident's Name) had gotten insulin in the dining rm (room)." At 7:15 p.m., "Her BS was 52 (LPN #3's Name) suggested glucagon which she was then given. The girls put her to bed. @ (at) this time." At 7:30 p.m., the Blood Sugar was 72. At 8:30 p.m., the Blood Sugar was 114. At 10:00 p.m., the blood sugar was 137. the note further indicated "called (Physician's Name) &amp; explained what we had done for (Resident's Name). Everything we had done was ok c (with) him."  The May 2011 MAR (Medication Administration Record) indicated the resident had been given one dose of "Glucagon 1 gm SQ (subcutaneously)</p>				

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	<p>PRN (as needed) for BS (blood sugar) (less than) 60 et (and) res (resident) unresponsive et (and) unable to swallow..."</p> <p>On 6/22/11 at 11:00 a.m., LPN #1 was interviewed. She indicated she was called and questioned by the evening nurse (LPN #2), on 5/4/11 and suddenly remembered she had mistakenly given Resident #E's 5:00 p.m. Novolog insulin to Resident #D. LPN #1 indicated, at the time she administered the insulin in the West dining room, she was not aware she had confused the residents, who were roommates. She indicated she had not worked on the unit for sometime.</p> <p>On 6/22/11 at 12:00 p.m., LPN #2, who was on duty during the evening of 5/4/11, was interviewed.</p> <p>LPN #2 indicated Resident #D was shaking and incontinent which was unusual for the resident and when she checked the blood sugar it was low. She indicated a CNA (she could not remember which CNA) said she saw LPN #1 holding the back of Resident #D'S arm and thought she had received insulin. LPN #2 indicated Resident #D did not have a physician's order for insulin. She indicated she called LPN #1 and LPN #1 confirmed she had given Resident #D insulin and had not given Resident #E her</p>				

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	<p>insulin.</p> <p>LPN #2 indicated, after she talked to the nurse, she administered 8 units of Novolog insulin to Resident #E.</p> <p>On 6/22/11 at 2:50 p.m., the Administrator indicated the incident was investigated by the DON, who was currently out of the country, but they were not able to find the investigation. The Administrator indicated it had been determined there were identifying pictures in the MAR at the time of the incident.</p> <p>The Nursing Spectrum Handbook, edition 2010, page xiv, included the following: "The five rights of drug administration" "Nurses are legally responsible for applying and ensuring the five rights of drug administration. To help achieve these goals use the following strategies: Right patient. Always confirm the patient's identity before administering a drug. Check his ID bracelet (if applicable) and ask him to state his name... Be especially cautious if your patient is confused, because he may answer to the wrong name. "</p> <p>3.1-35(g)(1)</p>				

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F0333 SS=D	<p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on observation, interviews and record review, the facility failed to assure a resident was free from a significant medication error in regard to a diabetic resident receiving insulin that had not been ordered by a physician. This deficiency affected 1 of 3 diabetic residents in a sample of 5. (Resident #D)</p> <p>Findings include:</p> <p>On 6/22/11 between 7:00 a.m. and 7:15 a.m., LPN #5 was observed administering insulin to two residents. The insulin medication administration records were in a separate book identified as the nurse's treatment book. The insulin administration book did not have identifying pictures for each of the residents who received insulin.</p> <p>On 6/22/11 at 7:15 a.m., LPN #5 indicated at the end of May 2011, medications/treatments administered by the licensed nurse, including insulin, were placed in a separate book because a QMA was added to the unit staffing.</p> <p>The nurse indicated residents were identified, during the administration of medication, by asking the residents their name, or by the verifying the identity of</p>	F0333	<p>1 &amp; 2. Inservice was provided by our SDC on 6/2/11 and again on 7/7/11 reiterating the 6 rights to administrating medication. The LPN involved with the medication error was suspended until further investigation was completed and then brought in for one on one re-education with the SDC (staff development coordinator) before allowing the nurse to pass medications again. 3. A copy of the medication error policy and procedure will be placed in all MAR's and TAR's for Nurses and QMA's. Medical records and or designee will place pictures of all new admissions in MAR's and TAR's within 24 hours of admission. The Unit Managers will ensure that all pictures of the residents are in the MAR's and TAR's at the end of each month during change over / re-writes. 4. The CQI tool: medication error audit tool will be completed monthly x 4 months and then quarterly thereafter by the DNS or designee to ensure the deficient practice will not recur. If concerns are identified, they will be addressed by the quality improvement committee. July 23, 2011.</p>	07/23/2011	

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	<p>each resident using the name posted above each bed. LPN #5 indicated, if residents were confused or out of their room then they should be identified using pictures in the medication administration books.</p> <p>Although the medication administration book had pictures that could be used to identify residents, the nurse treatment book, used to administer insulin, did not have identifying pictures.</p> <p>The clinical record of Resident #D was reviewed on 6/22/11 at 10:00 a.m., and indicated the resident was admitted to the facility on 10/3/09, with diagnoses which included but were not limited to, non-insulin dependent diabetes mellitus and dementia.</p> <p>The Quarterly Minimum Data Set Assessment, dated 3/17/11, indicated Resident #D had severe cognitive impairment and required extensive assistance for transfer, dressing, and hygiene.</p> <p>The May 2011 and June 2011 MARs (Medication Administration Records) indicated the resident received an oral antidiabetic, Avandamet 4-1000, one tablet by mouth twice daily at 7:00 a.m. and 5:00 p.m.</p>				

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	<p>Nursing notes, dated 5/4/11, indicated the following:</p> <p>At 7:00 p.m., "(Resident's Name) was in her w/c (wheelchair) in the hall, her extremities began to shake, she had wet her pants &amp; (and) was slipping down in her chair. Her BS (Blood Sugar) was 59. She was given juice c (with) sugar. The CNA (Certified Nursing Assistant) that was helping me made a comment that (Resident's Name) had gotten insulin in the dining rm (room)."</p> <p>At 7:15 p.m., "Her BS was 52. (LPN #3's Name) suggested glucagon which she was then given. The girls put her to bed. @ (at) this time."</p> <p>At 7:30 p.m., the Blood Sugar was 72. At 8:30 p.m., the Blood Sugar was 114. At 10:00 p.m., the blood sugar was 137. the note further indicated "called (Physician's Name) &amp; explained what we had done for (Resident's Name). Everything we had done was ok c (with) him."</p> <p>The May 2011 MAR (Medication Administration Record) indicated the resident had been given one dose of "Glucagon 1 gm SQ (subcutaneously) PRN (as needed) for BS (blood sugar) (less than) 60 et (and) res (resident) unresponsive et (and) unable to swallow..."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706		
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	<p>On 6/22/11 at 11:00 a.m., LPN #1 was interviewed. She indicated she was called and questioned by the evening nurse (LPN #2), on 5/4/11 and suddenly remembered she had mistakenly given Resident #E's 5:00 p.m. Novolog insulin to Resident #D. LPN #1 indicated, at the time she administered the insulin in the West dining room, she was not aware she had confused the residents, who were roommates. She indicated she had not worked on the unit for sometime.</p> <p>On 6/22/11 at 12:00 p.m., LPN #2, who was on duty during the evening of 5/4/11, was interviewed. LPN #2 indicated Resident #D was shaking and incontinent which was unusual for the resident and when she checked the blood sugar it was low. She indicated a CNA (she could not remember which CNA) said she saw LPN #1 holding the back of Resident #D's arm and thought she had received insulin. LPN #2 indicated Resident #D did not have a physician's order for insulin. She indicated she called LPN #1 and LPN #1 confirmed she had given Resident #D insulin and had not given Resident #E her insulin. LPN #2 indicated, after she talked to the nurse, she administered 8 units of Novolog insulin to Resident #E.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706		
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	<p>On 6/22/11 at 2:50 p.m., the Administrator indicated the incident was investigated by the DON, who was currently out of the country, but they were not able to find the investigation. The Administrator indicated it had been determined there were identifying pictures in the MAR at the time of the incident.</p> <p>The current policy for medication errors, revised 1/06, provided by the Assistant Director of Nursing, was reviewed on 6/22/11 and indicated "It is the policy of this provider to ensure residents residing in the facility are free of medication errors..."</p> <p>3.1-25(b)(9)</p>				