

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2011
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NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE STREET FRANKLIN, IN46131
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00096046.</p> <p>Complaint IN00096046 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 19, 20, 21, 22, and 23, 2011</p> <p>Facility number: 001133 Provider number: 155593 AIM number: 200090430</p> <p>Survey team: Karina Gates, BHS TC Marcy Smith, RN Leia Alley, RN Courtney Mujic, RN Patty Allen, BSW</p> <p>Census bed type: SNF/NF: 137 SNF: 9 Residential: 114 Total: 260</p> <p>Census payor type: Medicare: 9 Medicaid: 137</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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F0282 SS=D	<p>Other: 114 Total: 260</p> <p>Sample: 24 Residential Sample: 8</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 9/30/11 by Suzanne Williams, RN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician's orders were followed in regard to routine Accucheck (test to determine the glucose level in the blood) testing, doctor notification of abnormal Accucheck results, and accurate insulin administration for 2 of 2 residents reviewed with diabetes mellitus in a total sample of 24. (Resident #123 and Resident #7)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #123 was reviewed on 9/23/11 at 9:45 a.m.</p> <p>Diagnoses for Resident #123 included, but were not limited to: diabetes mellitus,</p>	F0282	<p>It shall be the policy of the Indiana Masonic Home, Inc. to provide services in accordance with each resident's written plan of care.I) Accuchecks and insulin will be administered to those residents who require the same in accordance with physician orders.II) All applicable staff will be inserviced (per policy) on physician order transcription and order entry into E-MAR system. All applicable staff will be inserviced (per policy) on physician notification of abnormal accucheck results.III-IV) Physician order transcription, E-MAR entry, and physician notification of abnormal accucheck results will be randomly assessed on a weekly basis for 30 days and then monthly thereafter. Staff</p>	10/21/2011	

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	<p>hypertension, anxiety, and depression.</p> <p>A recapitulation of September, 2011 physician's orders indicated Accuchecks to be done 3 times daily (days, noon and evenings) effective June 6, 2011 and the physician was to be contacted if the results were above 451 effective July 1, 2011. The orders indicated the resident received Humalog Insulin to be given per sliding scale effective June 19, 2011, based on the results of the Accucheck test as follows: 151-250=4 Units, 251-350=8 Units, 351-450=12 Units, and 451 and higher=16 Units.</p> <p>The July, August, and September, 2011 MARs (Medication Administration Records) for Resident #123 indicated the resident's blood sugars were checked and in the range requiring insulin coverage per sliding scale on the following dates and times:</p> <p>7/25/11 at 4:00 p.m. = 496 16 Units should have been administered and only 12 were administered. 8/27/11 at 12:00 p.m. = 459 16 Units should have been administered and only 12 were administered. 9/19/11 at 12:00 p.m. = 491 16 Units should have been administered and only 12 were administered. 9/21/11 at 12:00 p.m. = 454 16 Units</p>		<p>education will be provided should deviation of policy be discovered. The Quality Assurance Committee will review the same at each regularly scheduled Committee meeting (for the next 12-months) to determine compliance or lack thereof. Monitored by: Director of Nursing Services Staff Education Coordinator Nurse Managers Compliance Date: 10/21/11</p>		

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	<p>should have been administered and only 12 were administered.</p> <p>The clinical record lacked any information indicating Resident #123's doctor was notified of the above 7/25/11, 8/27/11 and 9/21/11 blood sugar results in excess of 451.</p> <p>During interview with LPN #4 on 9/23/11 at 10:40 a.m., she indicated it looked like the wrong dose of insulin was given to Resident #123 on 7/25/11 at 4:00 p.m., 8/27/11 at 12:00 p.m., 9/19/11 at 12:00 p.m. and 9/21/11 at 12:00 p.m. and that Resident #123's doctor was not notified of the resident's blood sugar results in excess of 451.</p> <p>The current diabetic care plan effective 2/9/10 for Resident #123 indicated interventions were to administer medications as ordered, accuchecks per order, and obtain lab/diagnostic work as ordered and report results to MD (medical doctor).</p> <p>The Blood Glucose Measurement (Accuchecks) Policy provided by the DON (Director of Nursing) on 9/23/11 at 1:19 p.m. indicated a step in the procedure was to contact the physician or physician designee by phone or fax as appropriate with abnormal results.</p>			

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	<p>2. The clinical record for Resident #7 was reviewed on 9/22/11 at 11:30 a.m.</p> <p>Diagnoses for Resident #7 included, but were not limited to: diabetes mellitus, hypertension, anemia, and diabetic neuropathy.</p> <p>A recapitulation of September, 2011 physician's orders indicated effective 7/18/07 Resident #7 was to have an Accucheck (a blood test to determine the glucose level in the blood) twice daily (day and evening) and to contact the physician if the results were less than 60 or above 400.</p> <p>The August, 2011 and September, 2011 MAR for Resident #7 indicated an Accucheck was done only once on the following dates: 8/6/11, 8/12/11, 8/20/11, 8/21/11 and 9/20/11. There was no other documentation in the clinical record to indicate two Accuchecks were done on these dates. The July, 2011 MAR indicated an Accucheck result of 56 on 7/2/11 (day). There was no documentation in the clinical record to indicate Resident #7's physician was notified of this result.</p> <p>During interview with RN #5 on 9/22/11 at 12:35 p.m., she indicated she could not</p>			

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	<p>provide any information indicating Accuchecks were done twice daily as ordered on 8/6/11, 8/12/11, 8/20/11, 8/21/11 and 9/20/11 or any information indicating #7's physician was notified of the Accucheck result of 56 on 7/2/11.</p> <p>The current diabetic care plan effective 6/2/11 for Resident #7 indicated interventions were to administer medications as ordered, accuchecks per order, and obtain lab/diagnostic work as ordered and report results to MD.</p> <p>The Blood Glucose Measurement (Accuchecks) Policy provided by the DON (Director of Nursing) on 9/23/11 at 1:19 p.m. indicated steps in the procedure were routine Accuchecks and results will be on the medication sheet and to contact the physician or physician designee by phone or fax as appropriate with abnormal results .</p> <p>3.1-35(g)(2)</p>				

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure 2 bottles of eye drops were disposed of after expiration, affecting 2 of 11 residents receiving eye drops from the Northridge and Arch Lane medication carts. (Residents #51 and #135)</p> <p>Findings included:</p> <p>During a review of the Northridge medication cart on 9/21/11 at 2:50 p.m. with Licensed Practical Nurse (LPN) #1, the following was observed:</p> <p>A bottle of Artificial Tears eye drops for Resident #51 was marked with an expiration date of 5/31/11. During an</p>	F0425	<p>All expired or improperly labeled medications will be removed. It shall then be the policy of the Indiana Masonic Home, Inc. to:I) Provide/obtain routine emergency drugs and biologicals to its residents. The same will remain dated and fresh.II) Provide pharmaceutical services to meet the needs of each resident.III) Employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the Facility. This includes periodic monitoring of expired or improperly labeled medications.IV) The Quality Assurance Committee will review the same at each regularly scheduled Committee meeting (for the next 12-months) to</p>	10/21/2011			

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	<p>interview with LPN #1 on 9/21/11 at 2:50 p.m., she indicated the eye drops should have been disposed of.</p> <p>During a review of the Arch Lane medication cart on 9/22/11 at 9:00 a.m. with LPN #2, the following was observed:</p> <p>A bottle of Travatan 0.004% eye drops for Resident #135 was marked as opened on 7/11/11. During an interview with LPN #2 on 9/22/11 at 9:00 a.m. she indicated she did not know when Travatan eye drops expired after they were opened.</p> <p>Review of an undated facility policy received from the Director of Nursing (DON) on 9/22/11 at 9:00 a.m., titled "Expiration Dates of Perishable Medications," indicated Travatan eye drops expired "6 Weeks after Opening."</p> <p>3.1-25(a)</p>		<p>determine compliance or lack thereof. All expired or improperly labeled medications will be removed. It shall then be the policy of the Indiana Masonic Home, Inc. to: I) Dispose of drugs and biologicals after their expiration in accordance with facility policy. II) All applicable staff will be inserviced (per policy) on identifying expiration dates of drugs and biologicals. III-IV) Expiration date monitoring (per audit of medication storage areas) will be randomly assessed on a weekly basis. The Quality Assurance Committee will review the same at each regularly scheduled Committee meeting (for the next 12-months) to determine compliance or lack thereof. Monitored by: Director of Nursing Staff Education Coordinator Nurse Managers Compliance Date: 10/21/11</p>		

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F0431 SS=D	<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 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>Based on observation, interview and record review, the facility failed to ensure bottles of eye drops and vials of insulin were labeled with open dates for 2 bottles of insulin, affecting 2 of 8 residents receiving insulin (Residents #123 and #53) and 2 of 6 residents receiving eye drops from the third floor west cart and</p>	F0431	It shall be the policy of the Indiana Masonic Home, Inc. to maintain drug records and label/store drugs and biologicals in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions.) Medications in multi-dose containers will be	10/21/2011

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	<p>first floor Northridge cart. (Residents #56 and #44)</p> <p>Findings included:</p> <p>During a review of the third floor West cart on 9/22/11 at 8:45 a.m. with LPN #3, the following was observed:</p> <p>A vial of Lantus insulin for Resident #123 was not marked with an open date.</p> <p>During an interview with LPN #3 on 9/22/11 at 8:45 a.m. she indicated vials of insulin were always supposed to be marked with the date they were opened.</p> <p>During a review of the first floor Northridge medication cart on 9/21/11 at 2:55 p.m. with LPN #1, the following was observed:</p> <p>A vial of Lantus insulin for Resident #53 was not marked with an open date.</p> <p>A bottle of Ketorlac 0.4% eye drops for Resident #56 was not marked with an open date.</p> <p>A bottle of Vigamox 0.5% eye drops for Resident #44 was not marked with an open date.</p> <p>During an interview with LPN #1 on 9/21/11 at 2:55 p.m., she indicated bottles</p>		<p>labeled with the date the container was opened.II) All applicable staff will be inserviced (per facility policy) on labeling a multi-dose container with the date container was opened.III-IV) Date opened labeling will be randomly assessed (per audit) on a weekly basis.Monitored by:</p> <p>Director of Nursing Staff Education Coordinator Nurse Managers Compliance Date: 10/21/11</p>		

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	<p>of eye drops and vials of insulin were always supposed to be marked with the date they were opened.</p> <p>An undated facility policy, received from the Director of Nursing on 9/22/11 at 9:00 a.m. and deemed current, titled "Expiration Dates of Perishable Medications," indicated "*Date When Opened" next to Travatan and opened insulin.</p> <p>3.1-25(o)</p>				