

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155356	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/23/2015
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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL CARE UNIT OF ST JOSEPH	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 17, 18, 19, 20, &amp; 23, 2015</p> <p>Facility number: 000247 Provider number: 155356 AIM number: N/A</p> <p>Census bed type: SNF: 8 NF: 2 SNF/NF: 2 Other: 3 Total: 15</p> <p>Census payor type: Medicare: 8 Medicaid: 2 Other: 5 Total: 15</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on November 23, 2015 by 17934.</p>	F 0000	This Facility requests Paper Compliance	
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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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F 0282 SS=E Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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 observation, interview and record review, the facility failed to ensure physician orders were followed for insulin administration for 4 of 4 observations of insulin administration. This deficient practice had the potential to effect 11 of the 15 residents on the unit. (Resident #90, Resident #82, Resident #84, Resident #85)</p> <p>Findings include:</p> <p>1. On 11/19/15 at 12:15 p.m., RN #2 was observed to enter the room of Resident #90. RN #2 was observed to have a vial of Novolog insulin and an unfilled insulin syringe with her. RN #2 was observed to review the insulin order on her computer and draw up the insulin into the syringe while inside the resident's room. RN #2 was the only facility nurse in the resident's room at this time and did not have another facility nurse verify the insulin type or dose she was administering to the resident. RN #2 was observed to administer the insulin to the resident at 12:15 p.m. After</p>	F 0282	<p><b><u>Corrective Action for Affected Residents:</u></b></p> <p>1. The deficient practice was immediately addressed and corrected by educating the nurses that were caring for the 11 residents that were affected by the deficiency.</p> <p>2. All charts of the affected Residents were reviewed and noted to have received the appropriate dosing per physician order. There was no negative patient outcome as a result of the deficient practice. No additional actions were required.</p> <p>3. All nurses will be educated on the Facility Policy and Procedure (Policy # NUR 117 – Medication Administration and Documentation in Admin-Rx and Non Admin-Rx) regarding following Physician order when administering Insulin.</p> <p>a. Per Policy, "In the administration process, co-signature is required for insulin administration and editing the dose for the amount being given".</p> <p><b><u>Corrective Action for Potentially Affected Residents:</u></b></p> <p>1. All nurses will be educated</p>	12/23/2015			

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	<p>administering the insulin to the resident, RN #2 was observed to document in the computer, the insulin had been given.</p> <p>2. On 11/19/15 at 12:20 p.m., RN #1 was observed to prepare insulin to administer to Resident #82. RN #1 was not observed to have another facility nurse verify the insulin or dose she had drawn up in the syringe. RN #1 was the only facility nurse in the room. RN #1 indicated she was going to give the roommate (Resident #84) her insulin. Without leaving the room, RN #1 drew up insulin into the syringe and indicated to Resident #84 she had 3 units. No facility nurse was observed to verify the insulin or dose RN #1 drew up and administered to Resident #84.</p> <p>3. On 11/19/15 at 12:25 p.m., RN #2 was observed in Resident #85's room and indicated she was going to give insulin to Resident #85. RN#2 indicated to the resident his blood sugar was 199 and he was to get 4 units of coverage. RN #2 was observed to administer the insulin to Resident #85. RN #2 was not observed to verify the type of insulin or dose with another facility RN. RN #2 was then observed to document the administered insulin dose in the computer.</p> <p>On 11/20/15 at 9:50 a.m. the Interim</p>		<p>on the Facility Policy and Procedure (Policy # NUR 117 – Medication Administration and Documentation in Admin-Rx and Non Admin-Rx) regarding following Physician order when administering Insulin.</p> <p>a. The nurses will sign that they have read and understand the policy.</p> <p>2. All charts of the potentially affected Residents were reviewed and noted to have received the appropriate dosing per physician order. There was no negative patient outcome as a result of the deficient practice. No additional actions were required.</p> <p>3. Random audits during meal times will be implemented to ensure that a 2nd nurse verifies the appropriate order and dose to be administered; and cosigns the insulin administration in real time.</p> <p>a. Two random audits per meal time per day X 14 days (84 audits), followed by 5 random audits 3 times a week X 2 weeks (30 audits), eventually 10 random audits for 8 weeks will be done to ensure compliance.</p> <p>b. The audits will monitor physician order to ensure right patient, right medication, right dose, right route, right frequency, and the two RN double check is performed immediately prior to insulin administration as evidenced by Time Insulin Administered compared to Time of Co-Sign by 2nd RN.</p> <p>4. The audits will be monitored</p>		

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	DON (Director of Nursing) was interviewed. She indicated two facility nurses were to verify the correct type of insulin and the correct dose of insulin were prepared prior to administration to the resident. She indicated both nurses who verified the insulin type and dose were to document the verification in the computer system. She indicated both nurses would need to be at the same computer at the same time to verify this information. The Interim DON was made aware of the insulin administration observed on 11/19/15 without two nurses having verified the insulin type and dose prior to administration to the resident. The Interim DON reviewed the following resident's computerized MAR (medication administration record) to review which two nurses documented they verified the observed insulin administrations on 11/19/15. She indicated the following: Resident #85 had insulin administered by RN #2 at 12:31 p.m. and was cosigned as verified by RN #3. Resident #84 had insulin administered by RN #1 at 12:18 p.m. and was cosigned as verified by RN #2. Resident #82 had insulin administered by RN #1 and was cosigned as verified by RN #2. Resident #90 had insulin administered by RN #2 and was cosigned as verified by RN #3. The Interim DON indicated 11 of the 16 residents on the		by the Director of Nursing. <b><u>Measures for prevention:</u></b>  1. All nurses will be educated on the Facility Policy and Procedure (Policy # NUR 117 – Medication Administration and Documentation in Admin-Rx and Non Admin-Rx) regarding following Physician order when administering Insulin. a. The nurses will sign that they have read and understand the policy. b. All new hire nurses will be educated regarding this policy during their new hire orientation to the unit. 2. Random audits during meal times will be implemented to ensure that a second nurse witnesses the appropriate order and dose to be administered; and cosigns the insulin administration in real time. a. When applicable, two random audits per meal time per day X 14 days, followed by 5 random audits 3 times a week X 2 weeks ; eventually 10 random audits for 8 weeks will be done to ensure compliance. b. The audits will monitor physician order to ensure right patient, right medication, right dose, right route, right frequency, and the two RN double check is performed immediately prior to insulin administration as evidenced by Time Insulin Administered compared to Time of Co-Sign by 2nd RN.				

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	<p>unit were diabetic and received insulin.</p> <p>On 11/20/15 at 11:00 a.m., the Interim DON provided a copy of the current facility policy and procedure for "Medication Administration and Documentation..." This policy was dated 9/2015 and included. but was not limited to, the following: "...Medications are only administered by physician order...All staff members are required to utilize computerized medication administration system when electronic charting is functional... Insulin...In the administration process, co-signature is required for insulin administration and editing the dose for the amount being given...."</p> <p>On 11/23/15 at 10 a.m., the Interim DON provided a copy of the physician order for Resident #85. The physician order included, but was not limited to, the following: "...Humulin R (regular)...Must be double checked; and documented by 2 licensed clinicians...."</p> <p>On 11/23/15 at 11:35 a.m., the Interim DON was interviewed. She provided the following information: The clinical record of Resident #84 indicated the following physician order, dated 11/19/15 at 7:15 a.m.: "...Insulin...All dosages must be double checked and documented</p>		<p>3. The audits will be monitored and maintained by the Director of Nursing.</p> <p><b><u>Monitoring of Corrective Action- Quality Assurance</u></b></p> <p>1. The Director of Nursing will address any deviations from the policy immediately with the concerned staff nurse.</p> <p>2. The results of the audit will be shared with staff during Monthly Department Meeting.</p> <p>3. The audit results will be reviewed during the Quarterly Quality Assurance Meeting.</p>		

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F 0441 SS=D Bldg. 00	<p>by 2 licensed clinicians...." The clinical record of Resident #82 indicated the following physician order, dated 11/14/15: "...Insulin...All dosages much be double checked and documented by 2 licensed clinicians...." The clinical record of Resident #90 indicated the following physician order, dated 11/8/15: "...Insulin...All dosages much be double checked and documented by 2 licensed clinicians...."</p> <p>3.1-35(g)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as</p>			

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	<p>isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure glucometers were sanitized between resident use for 1 of 2 glucometer usage observations. This deficient practice had the potential to affect 12 of the 15 residents on the unit who received glucometer checks. (Resident #78, Resident #88)</p> <p>Findings include:</p> <p>1. On 11/19/15 at 11:40 a.m., RN #1 was observed to use a lancet to obtain blood from Resident #78 and perform a blood</p>	F 0441	<p><b><u>Corrective Action for Affected Residents:</u></b></p> <p>1. The deficient practice was immediately addressed and corrected by educating the nurses that were caring for the 12 residents that were affected by the deficiency.</p> <p>2. All nurses will be educated on the Facility Policy and Procedure (Policy # PTC 110-NOVA Statstrip Whole Blood Glucose Monitoring System) regarding sanitizing glucometers between patient use. Please see attached Policy which indicates to clean the surface of the meter after every patient test by using</p>	12/23/2015

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	<p>glucometer check. RN #1 was then observed to leave Resident #78's room and go into the hall with the glucometer. RN #1 placed the glucometer, which she had not cleaned after use on Resident #78, on an isolation cart in the hall. RN #1 indicated she was going to obtain a glucometer check on Resident #88, who was in contact isolation. Prior to RN #1 entering the room of Resident #88, she was interviewed. RN #1 indicated she had not cleaned the glucometer after she used it on Resident #78. RN #1 indicated she typically does not clean glucometers between use on different residents. RN #1 indicated she usually only cleaned a glucometer after it had been used on a resident who was in isolation.</p> <p>On 11/19/15 at 2:44 p.m., a copy of the current facility policy and procedure for "Statstrip Whole Blood Glucose Monitoring System", with a revision date of 1/2015, was received from the Interim DON (Director of Nursing). This policy included, but was not limited to, the following: "...Safety Instructions...Meters are cleaned between patients...Maintenance: Clean the surface of the meter after every patient test: Use a PDI (type of germicidal disinfecting cloths) Super Sani-cloth disinfectant wipe. Squeeze out excess cleaning solution or blot on a dry paper towel to</p>		<p>Sani Cloth wipes – surface must be wet for 2 minutes to kill organisms.</p> <p><b><u>Corrective Action for Potentially Affected Residents:</u></b></p> <ol style="list-style-type: none"> <li>All nurses will be educated on the Facility Policy and Procedure ( Policy # PTC 110-NOVA Statstrip Whole Blood Glucose Monitoring System) regarding sanitizing glucometers between patient use. The nurses will sign that they have read and understand the policy.</li> <li>Random Direct Observation audits will be performed to ensure that the nurse sanitizes the glucometer between patient use. <ol style="list-style-type: none"> <li>When applicable, two random audits per meal time per day X 14 days, followed by 5 random audits 3 times a week X 2 weeks ; eventually 10 random audits for 8 weeks will be done to ensure compliance.</li> </ol> </li> <li>The audits will be monitored by the Director of Nursing.</li> </ol> <p><b><u>Measures for prevention:</u></b></p> <ol style="list-style-type: none"> <li>All nurses will be educated on the Facility Policy and Procedure (Policy # PTC 110-NOVA Statstrip Whole Blood Glucose Monitoring System) regarding sanitizing glucometers between patient use. The nurses will sign that they have read and understand the policy.</li> <li>All new hire nurses will be educated regarding this policy during their new hire orientation to the unit.</li> <li>Random Direct Observation</li> </ol>	

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	<p>remove excess cleaning solution before cleaning the surface of the meter. REMINDER: surface must be wet for 2 minutes to kill organisms. Follow with a water dampened cloth to remove cleaning residue and dry..."</p> <p>On 11/20/15 at 9:45 a.m., the Interim DON was interviewed. She indicated glucometers should always be cleaned between use on all residents. She indicated when a glucometer was cleaned, it should be cleaned with a PDI wipe and should be kept wet for at least 2 minutes.</p> <p>3.1-18(b)(1)</p>		<p>audits will be performed to ensure that the nurse sanitizes the glucometer between patient use.</p> <p>a. When applicable, two random audits per meal time per day X 14 days, followed by 5 random audits 3 times a week X 2 weeks ; eventually 10 random audits for 8 weeks will be done to ensure compliance.</p> <p>4. The audits will be monitored and maintained by the Director of Nursing.</p> <p><b><u>Monitoring of Corrective Action- Quality Assurance</u></b></p> <p>1. The Director of Nursing will address any deviations from the policy immediately with the concerned staff nurse.</p> <p>2. The results of the audit will be shared with staff during Monthly Department Meeting.</p> <p>3. The audit results will be reviewed during the Quarterly Quality Assurance Meeting.</p>	