STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS PLACE	4200 WYNTREE DR, NEWBURGH, , 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00386613 and IN00386761. Complaint IN00386613 - Substantiated. State deficiencies related to the allegations are cited at R0241. Complaint IN00386761 - Unsubstantiated due to lack of evidence. Survey date: December 28, 29, 2022 Facility number: 004903 Residential Census: 41 This State Residential Finding was cited in accordance with 410 IAC 16.2-5. Quality review completed on January 6, 2023.	R 0000		
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1)	R 0241	***Submission of this response and Plan of***	02/18/2023

(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:

(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.

Based on observation, interview, and record review, the facility failed to ensure that medications were administered according to manufacturer's guidance. Insulin was administered from a Humalog KwikPen without it being primed (eliminating air bubbles) prior to insulin being administered to residents for 2 of 2 residents reviewed for receiving insulin. (Resident D, Resident E)

Findings include:

1. On 12/28/22 at 9:21 A.M., QMA (Qualified Medication Aide) 1 was observed preparing insulin for Resident D. They failed to prime the Humalog Insulin KwikPen with 2 (two) units of insulin prior to administering insulin to Resident D.

On 12/29/22 at 10:15 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes

Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does Not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Resident D was not found to have any adverse reactions due to the deficient practice.
QMA 1 was re-educated by CSM on 12/29/2022 regarding proper use of the Insulin KwikPen (Attachment 1).

2.
On 1/13/2023 CSM conducted an audit of resident's who receive insulin via KwikPen (Attachment @). Med passoverserved, insulin pens primed and administered correctly. By 1/18/2023 CSM will

mellitus type II, insulin dependent.

Current physician orders included, but were not limited to, Lisopro (Humalog) KwikPen 100 U/ML (units/milliliter) per sliding scale SQ (subcutaneous) within 10-15 (ten-fifteen) minutes of mealtime/bedtime snack when used as a mealtime/bedtime insulin.

Resident D's blood sugar reading per the Dexcom (device that monitors blood sugar levels continuously) reading was 192. The sliding scale reference for a blood sugar of 192 was to administer 3 (three) units of Humalog insulin SQ .

During an interview on 12/28/22 at 9:21 A.M., QMA 1 indicated they do not prime the Humalog KwikPen because the Drops needle that was used would turn orange after priming the pen and once that happened, they could not use that same needle to administer insulin to the resident, then the needle would have to be replaced prior to administering medication.

2. On 12/29/22 at 7:42 A.M., RN (Registered Nurse) 4 was observed preparing insulin pen for Resident E. They failed to prime the Humalog Insulin KwikPen with 2 (two) units of insulin prior to administering insulin to Resident E.

have in-serviced current medication passers with credentials to administer insulin on the proper usage of the insulin KwikPen (Attachment 3).

3.
CSM was retrained on 12/29/2022 by pharmacy staff member on how to properly prime Humalog KwikPen. By 1/18/2023 CSM will have in-serviced all medication passers, with credentials to administer insulin, on the proper usage of the insulin KwikPen.

4.
TheExecutiveDirector is responsible for sustained compliance. The CSM or designee will monitor insulin administration of med passer, 3x a week for 4 weeks, 2x a week for 4 weeks; then once a week for 4 weeks. Results of the audit will be reviewed at monthly QI meetings x3 months. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.

5.
February 18th, 2023

On 12/29/22 at 10:30 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II.

Current physician orders included, but were not limited to, Humalog KwikPen administer 10 (ten) units SQ with meals.

Resident E's blood sugar reading per glucometer was 292. The sliding scale reference for a blood sugar of 292 was to administer 12 (twelve) units of Humalog insulin SQ in addition to the scheduled 10 (ten) units with meals, for a total of 22 (twenty-two) units of insulin

During an interview on 12/29/22 at 7:54 A.M., RN 4 indicated they had never primed the pen nor seen anyone else prime them. RN 4 further indicated they had not been told to prime Humalog KwikPen before administering insulin to residents.

During an interview on 12/29/22 at 9:00 A.M., the DON indicated she was aware that staff were not priming the Humalog insulin KwikPen. The DON indicated the reason for not priming was due to the cost.

A current Drop Safe safety pen needle manufacturer's guide, dated January 2021, provided by the DON (Director of Nursing) on 12/29/22 at 9:00

A.M., indicated to "perform a priming test if recommend by the pen injector device. A drop of liquid should appear on the needle tip visible through the viewing window."

A current Humalog KwikPen manufacturer's guide, dated March 2013, provided by the DON on 12/29/22 at 6:45 A.M., indicated to "prime before each injection. Priming ensures the Pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin."

When asked for a current insulin administering policy, the DON provided a current undated Insulin Administration Competency for QMA Checklist on 12/28/22 at 1:50 P.M. It indicated the steps to follow for administering insulin included, but were not limited to," ... dial a dose of 2 (two) units to prime. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top. Press the injection button all the way in an check to see that the insulin comes out of the needle. If no insulin comes out, repeat the test. If insulin still does not come out, get a new needle. Check the order for the correct dose. Make sure the window shows "0" and then select the dose. Select the

correct dose and dial until the number shows in the window.(2nd check) ... "

This State Residential Finding relates to Complaint IN00386613.

Based on observation, interview, and record review, the facility failed to ensure that medications were administered according to manufacturer's guidance. Insulin was administered from a Humalog KwikPen without it being primed (eliminating air bubbles) prior to insulin being administered to residents for 2 of 2 residents reviewed for receiving insulin. (Resident D, Resident E)

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On 12/29/22 at 10:15 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, insulin dependent.

Current physician orders included, but were not limited to, Lisopro (Humalog) KwikPen 100

U/ML (units/milliliter) per sliding scale SQ (subcutaneous) within 10-15 (ten-fifteen) minutes of mealtime/bedtime snack when used as a mealtime/bedtime insulin.

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This State Residential Finding

	relates to Complaint IN00386613.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE