STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY DEVELOPMENT CORPORATION OF MISHAWAKA, IN	500 LINCOLNWAY EAST, MISHAWAKA, , 46544

(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 Complaint IN00382275. Complaint IN00382275- Substantiated. State Residential Findings related to the allegations are cited at R0036. Survey dates: June 20 & 21, 2022 Facility number: 012688 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/30/22.	R 0000		
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal	R 0036	Policy regarding Insulin Administration and Blood Glucose Parameters developed. All nursing staff educated on policy. All residents physicians contacted	07/14/2022

	representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview , the facility failed to ensure 1 of 3 residents, reviewed for insulin administration, had documentation indicating a physician had been notified and responded to a resident's extremely high blood sugar reading. (Resident D) Finding includes: On 6/20/22 at 11:22 A.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: hypertension and diabetes. A Service plan, dated 4/29/22, indicated the nursing staff would administer all medication, including insulin and glucose monitoring. A Resident Note, dated 5/18/22 at 12:05 P.M., indicated the resident was observed on the floor, in his room. Urine was on		regarding preferred contact method for glucose readings outside of ordered parameters Blood Glucose readings on all residents receiving blood glucose testing will be audited 3 times weekly for 4 weeks, then, 2 times weekly for 2 weeks. If 100% compliance will then be done on an as needed basis	

the floor and the residents pants were wet. The Note indicated the resident had reported, to the staff, he was getting out of his chair when he fell. He denied pain or discomfort. The resident's family physician and the Director of Nursing (DON) was notified of the fall.

A Resident Note, dated 5/18/22 at 12:15 P.M., documented by LPN 2 indicated the resident's " ...blood sugar read high on meter, glucose box states it will read blood glucose up to 600. Insulin given per sliding scale. PCP [Primary Care Physician] notified. Receptionist states she will send message back. Awaiting a call back. DON [Director of Nursing] aware ...."

A Resident Note, dated 5/18/22 at 3:53 P.M. indicated "...Resident evening blood sugar 509. No call back from PCP [Primary Care Physician] office at this time...." This Resident Note was documented by LPN 2.

The next Resident Note, dated 5/19/22 at 10:22 A.M. P.M., indicated "...F/U [Follow up fall conts [continues]. No s/o [complaints of] pain or discomfort voiced ..."

A Resident Note, dated 5/30/22 indicated "...the resident was admitted to hospital due to [symbol of arrow going up]

blood glucose...."

The Medication Administration Record (MAR), for the month of May, indicated the resident had blood sugar readings over 400, prior to dinner. The dates and readings were as follows: 5/1-443, 5/2-480, 5/3-406, 5/4-417, 5/5-454, 5/6-598, 5/7-462, 5/9-468, 5/10-406, 5/11-571, 5/12-462, 5/13-437, 5/14-412, 5/15-512, 5/16-425, 5/17-478, 5/18-509, 5/19-531, 5/20-508, 5/22-532, 5/23-498, 5/24-484, 5/25-426, 5/26-487 ,5/27-444 and 5/28-530. The MAR indicated "...Call MD if BG [blood glucose] is less than 70 or more than 400...."

During an interview, on 6/20/22 at 11:52 A.M., the DON indicated when a resident had a physician's order to call if below or above a certain blood sugar number, the staff would fax the physician with the results. The DON indicated they do not keep a record of the faxes sent to the physicians. The DON indicated there was no procedure and/or documentation to ensure Resident B's physician received the notices of high blood sugars or the HIGH glucometer reading. The DON indicated the last sliding scale order, the facility had, did not include the parameters which were stated on the May MAR. The DON indicated the pharmacy would provide documentation

	demonstrating they were in error by putting the parameters on the MAR. The documentation was never obtained by the facility, from the pharmacy, during the survey. A user instruction manual for testing blood sugars, undated, was received by LPN 2 and indicated it was the one currently used by the facility. The manual, page 31, indicated the following: " ...HI Message The meter displays results between 20-600 mg/dL [milligrams per deciliter]. "HI" appears when the blood sugar level is greater than 600 mg/dL and indicates severe hyperglycemia (much higher than normal glucose levels). If "HI" is displayed again upon testing, please contact the patient's healthcare provider immediately ...."			

On 6/21/22 at 11:10 A.M., the Administrator provided a policy titled, "Insulin Administration", dated 7/11/21, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: * Indicate in the resident assessment and service plan who is responsible for blood sugar monitoring and insulin injections. Physicians orders for insulin and blood glucose checks will be followed by the RN, LPN or QMA with insulin certification...."

This State tag relates to complaint IN00382275.

Based on record review and interview , the facility failed to ensure 1 of 3 residents, reviewed for insulin administration, had documentation indicating a physician had been notified and responded to a resident's extremely high blood sugar reading. (Resident D)

Finding includes:

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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