STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR FORK CROSSING	1745 EAST 67TH STREET, ANDERSON, , 46013

(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 IN00367386, IN00367740 and IN00367766. Complaint IN00367386 - Substantiated. State Residential Findings related to the allegations are cited at R0243. Complaint IN00367740 - Substantiated. No deficiencies related to these allegations are cited. Complaint IN00367766 - Substantiated. No deficiencies related to these allegations are cited. Survey date: November 23 and 24, 2021 Facility number: 014080 Residential Census: 79 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed on December 1, 2021.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview the facility failed to ensure administered insulin and blood sugar checks were documented in the clinical record for 3 of 4 residents reviewed for medication administration. (Resident B, Resident C, and Resident D) This deficient practice has the potential to effect 7 of the 7 diabetic residents currently living in the facility. Findings include: 1. The clinical record for Resident B was reviewed on 11/23/2021 at 12:57 p.m. Diagnoses included, but were	R 0243	1. Residents B, C and D were all seen by community Nurse Practitioner for follow-up from missed insulin administration. He wrote Progress Note that determined residents suffered no adverse effects due to missed insulin and documentation. 2. Health & Wellness Director and/or her designee will audit all residents receiving insulin administration to ensure no further missed insulins and documentation of same. 3..Health & Wellness Director and /or her designee will provide all personnel administering insulins re-education on administration and documentation of same. Health & Wellness Director and/or her designee will conduct weekly random audits x 3 months to ensure compliance with insulin administration and documentation. 4. During monthly Quality Assurance meetings, Health & Wellness Director and/or her designee will bring results of any non-compliance from audits x 3 months. If 100% compliance audits will be discontinued.	12/17/2021

not limited to, dementia, anxiety, diabetes type 2 and hypertension.

Review of the physician orders indicated the resident had order, dated 4/15/2021, for Novolog (insulin) 100 unit/ml sliding scale. Blood sugars 80-130 = 14 units, 131-160 = 16 units, 161-200 = 18 units, 201-240 =20 units, 241-280 =22 units, 281-320 =24 units, 321-350 =26 units, 351-400 =28 units and 401=30 units. Blood sugars greater than 401= 30 units and call the physician-subcutaneous before meals and at bedtime.

Review of the Medication Administration Record (MAR) 11/1/2021 through 11/22/2021, indicated the clinical record lacked the following documentation:

a. 11/2/2021 at 11:30 a.m., blood sugar documented at 126, no insulin administration.

b. 11/3/2021 at 4:30 p.m., blood sugar documented at 238, no insulin administration.

c. 11/3/2021 at 8:00 p.m., blood sugar documented at 238, no insulin administration.

d. 11/4/2021 at 11:30 a.m., blood sugar documented at 421, no insulin administration.

e. 11/13/2021 at 8:00 p.m., no

blood sugar documented and no insulin administration.

f. 11/14/2021 at 8:00 p.m., blood sugar documented at 240 and no insulin administration.

g. 11/15/2021 at 8:00 p.m., blood sugar documented at 192 and no insulin administration.

h. 11/19 and 20/2021 at 8:00 p.m., no blood sugar check and no insulin administration.

j. 11/22/2021 at 8:00 p.m., blood sugar documented at 222 and no insulin administration.

k. On 11/21/2021 at 8:00 p.m. the blood sugar was documented twice; once at 400 and the other at 84.

2. The clinical record for Resident C was reviewed on 11/23/2021 at 2:01 p.m. Diagnoses included, but were not limited to,.diabetes type 2, stage 4 chronic kidney disease and hypertension.

Review of the physician orders indicated the resident had order, dated 10/1/2019, for Novolog (insulin) 100 units/ml sliding scale: blood sugars 200-250 = 2 units, 251-300 = 4 units, 301-400 = 6 units subcutaneous with meals.

Review of the MAR 11/1/2021 through 11/22/2021, indicated the clinical record lacked the

following documentation for the sliding scale:

a. 11/6/2021 at 12:30 p.m., no blood sugar check and no insulin administration.

b. 11/12/2021 at 9:00 a.m., no blood sugar check and no insulin administration.

c. 11/12/2021 at 12:30 p.m., no blood sugar check and no insulin administration.

Review of the physician orders indicated the resident had an order, dated 10/1/2019, for Novolog 100 units//ml 4 units subcutaneous one time a day at breakfast.

Review of the physician orders indicated the resident had an order, dated 10/2/2019, for Novolog 100 units/ml, 8 units subcutaneous one time a day with lunch.

Review of the physician orders indicated the resident had an order, dated 10/2/2019, for Novolog 100 units/ml, 6 units subcutaneous one time a day with dinner.

Review of the MAR 11/1/2021 through 11/22/2021, indicated the clinical record lacked the following documentation for the daily scheduled insulin:

a. 11/4/2021 at 9:00 a.m., no insulin administration

documented.

b. 116. 2021 at 12:30 p.m., no insulin administration documented.

c. 11/12/2021 at 9:00 a.m., no insulin administration documented.

d. 11/12/2021 at 12:30 p.m., no insulin administration documented.

3. The clinical record for Resident D was reviewed on 11/23/2021 at 2:39 p.m. Diagnoses included but were not limited to, diabetes type 2, cerebral infarction and hypothyroidism.

Review of the physician orders indicated the resident had an order, dated 9/25/2020, for Lantus (insulin) 100 units/ml, 8 units subcutaneous one time a day.

Review of the MAR 11/1/2021 through 11/22/2021, indicated the clinical record lacked the following documentation for the daily scheduled insulin:

a. 11/17/2021 at 8:00 a.m., no documentation insulin was administered.

During an interview on 11/24/2021 at 11:30 a.m., the Director of Nursing indicated she was unaware of the missing medication administration

documentation and that the matter would be addressed.

Review of a current policy, dated September 2019, titled "Medication Administration Policy" indicated the following:

"Background Information

Community shall provide medication administration services to Assisted Living residents according to Indiana State Department of Health regulations and current standards of Nursing Practice A licensed nurse shall be involved in identification and documentation of administration of medications provide to residents. ...

Recordkeeping

1. An accurate written record of medications administered will be maintained by the Community. The medication record will include:

a. The identity and signature of the person administering the medication.

b.The medication administered within one hour off the scheduled time.

c.Medication administrated p.r.n. [as needed] are recorded immediately, including the date, time, dose, medication, and administration method. ...

2. The Community will audit the accuracy and completeness of the medication administration records, controlled substance list, medication errors and medication disposable records on a quarterly base [sic] or as needed. ..."

This state residential finding relates to complaint IN00367386.

Based on record review and interview the facility failed to ensure administered insulin and blood sugar checks were documented in the clinical record for 3 of 4 residents reviewed for medication administration. (Resident B, Resident C, and Resident D) This deficient practice has the potential to effect 7 of the 7 diabetic residents currently living in the facility.

Findings include:

1. The clinical record for Resident B was reviewed on 11/23/2021 at 12:57 p.m. Diagnoses included, but were not limited to, dementia, anxiety, diabetes type 2 and hypertension.

Review of the physician orders indicated the resident had order, dated 4/15/2021, for Novolog (insulin) 100 unit/ml sliding scale. Blood sugars 80-130 = 14 units, 131-160 = 16 units, 161-200 = 18 units, 201-240 =20 units, 241-280 =22 units, 281-320 =24 units, 321-350 =26 units, 351-400 =28 units and 401=30 units. Blood sugars greater than 401= 30 units and call the physician- subcutaneous before meals and at bedtime.

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2. The clinical record for Resident C was reviewed on 11/23/2021 at 2:01 p.m. Diagnoses included, but were not limited to,.diabetes type 2, stage 4 chronic kidney disease and hypertension.

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blood sugar check and no insulin administration.

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	records, controlled substance list, medication errors and medication disposable records on a quarterly base [sic] or as needed. ..." This state residential finding relates to complaint IN00367386.			

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