

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/29/2022
NAME OF PROVIDER OR SUPPLIER SUGAR FORK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00394818. Complaint IN00394818 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 28 & 29, 2022 Facility number: 014080 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 5, 2022.	R 0000			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in	R 0117	1. We received the missing certification for CPR and First aid 10 minutes after surveyors pulled out of parking lot.	12/30/2022	

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number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on interview and record review, the facility failed to ensure a staff member was certified in cardiopulmonary resuscitation (CPR) on 4 of 7 night shifts for the week reviewed.

Findings include:

During review of the employee schedule, provided by the

2. An audit of staff needing re-certification has been completed and we have a class scheduled for 12-28-2022.

3. On-going audits will be conducted monthly to ensure compliance with CPR and First Aid for direct care staff.

4. Results of monthly audits will be brought to monthly Quality Assurance meetings x 3 months.

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Business Office Manager (BOM) on 11/29/22 at 10:30 a.m., there was no staff member in the facility that was certified in CPR for third shift, 10:00 p.m. to 6:00 a.m. on 11/22/22, 11/23/22, 11/24/22, and 11/25/22.

During an interview, on 11/29/22 at 11:05 a.m., the BOM indicated the CPR/First Aide certification binder provided had the only certifications for staff.

No further information was provided.

Based on interview and record review, the facility failed to ensure a staff member was certified in cardiopulmonary resuscitation (CPR) on 4 of 7 night shifts for the week reviewed.

Findings include:

During review of the employee schedule, provided by the Business Office Manager (BOM) on 11/29/22 at 10:30 a.m., there was no staff member in the facility that was certified in CPR for third shift, 10:00 p.m. to 6:00 a.m. on 11/22/22, 11/23/22, 11/24/22, and 11/25/22.

During an interview, on 11/29/22 at 11:05 a.m., the BOM indicated the CPR/First Aide certification binder provided had the only certifications for staff.

No further information was

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	provided.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to	R 0123	1. Executive Director re-educated nurse on requirement for renewing license and if license expired she cannot work until re-instated. 2. Audit completed on all licensed staff and no other concerns identified. 3. Executive Director and/or her designee will conduct monthly audits to ensure compliance with licensed staff. 4. Results of monthly audits will be brought to monthly Quality Assurance meetings for any non-compliance.	12/30/2022

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ensure a Licensed Practical Nurse had an active license to administer care for 1 of 37 employees reviewed for active licensure and certification.

Findings include:

During an interview on 11/28/22 at 10:46 a.m., the Administrator indicated they had promoted Licensed Practical Nurse (LPN) 2 to the position of Director of Nursing. LPN 2 had notified her that there had been an issue with her nursing license renewal (due October 31, 2022). The facility felt it had been due to a lag in record updates with the Indiana Professional Licensing Agency as LPN 2 had indicated she had resolved the issue preventing her license from being renewed.

During Employee Record Review, LPN 2's nursing license had expired on 10/31/22 on the MyLicense.IN.gov website, accessed on 11/29/22 at 11:32 a.m.

During an interview, on 11/29/22 at 9:46 a.m., LPN 2 indicated she had made a payment to renew her nursing license on 10/30/22. She received an email from the Indiana Professional Licensing Agency on 10/31/22, indicating the agency was unable to process her renewal and provided information on who to contact to resolve the

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issue. She indicated she had not reviewed the email until 11/11/22 because she had not checked her email following her renewal submission. She contacted the other entity on 11/11/22 and acted to resolve the issue on 11/18/22. She had worked in the facility as a Wellness Nurse on the following dates: November 1, 3, 4, 7, 8, 12, 13, 17, 18, 21, 22, 25, 26, and 27, 2022.

No further information was provided prior to exit from the facility.

Based on record review and interview, the facility failed to ensure a Licensed Practical Nurse had an active license to administer care for 1 of 37 employees reviewed for active licensure and certification.

Findings include:

During an interview on 11/28/22 at 10:46 a.m., the Administrator indicated they had promoted Licensed Practical Nurse (LPN) 2 to the position of Director of Nursing. LPN 2 had notified her that there had been an issue with her nursing license renewal (due October 31, 2022). The facility felt it had been due to a lag in record updates with the Indiana Professional Licensing Agency as LPN 2 had indicated she had resolved the issue preventing her license from

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No further information was provided prior to exit from the facility.

R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b)	R 0296	1. Nurse was re-educated on proper insulin administration.	12/30/2022
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(b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff.

Based on observation, interview, and record review, the facility failed to assure an employee was properly trained to administer insulin and to prime the insulin pen's needle per manufacturers guidelines 1 of 1 resident observed for insulin administration. (Resident 25)

Findings include:

During medication administration observation, on 11/28/22 at 11:05 a.m., Licensed Practical Nurse (LPN) 2 prepared to administer insulin to Resident 25. LPN 2 applied a new needle to the Humalog Insulin Pen (to treat diabetes) and dialed the order dose of 6 units. LPN 2 wiped an area to the resident's left lower abdomen and inserted the insulin pen into her skin. LPN 2 pressed the injector button and removed the pen from the skin and wiped the area with the alcohol swab.

During an interview, following the observation, LPN 2 indicated she had not primed the insulin needle and had no knowledge this was to be done

2. All staff administering insulin received re-education on manufacturer's requirements for insulin administration.

3. Monthly audits will be conducted x 3 months to ensure proper administration of insulin.

4. Results of monthly audits will be brought to monthly Quality Assurance Meetings x 3 months.

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or to hold the pen in place following injection.

During an interview, on 11/29/22 at 1:43 p.m., the Director of Nursing (DON) indicated the insulin needle should have been primed prior to injection and the administration of insulin using a Humalog pen should be completed per manufacturer's guidelines.

Review of a manufacturer's document titled "Instructions For Use Humalog Kwikpen," provided by the DON on 11/29/22 at 9:37 a.m., indicated the following:

"...Priming your Pen...Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly....Step 6: To prime your Pen, turn the Dose Knob to select 2 units. ...Step 8 : ...Push the Dose Knob in until it stops, and "0" is seen in the Dose Window...Giving your injection...Step 11: Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle...."

Based on observation, interview, and record review, the facility failed to assure an employee was properly trained

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to administer insulin and to prime the insulin pen's needle per manufacturers guidelines 1 of 1 resident observed for insulin administration. (Resident 25)

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During an interview, following the observation, LPN 2 indicated she had not primed the insulin needle and had no knowledge this was to be done or to hold the pen in place following injection.

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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
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