STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CHARM VILLAGE	7212 US HWY 31 S INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00213464. Complaint IN00213464 - Substantiated. State residential deficiencies related to the allegation are cited at R0241. Survey dates:November 21, 2016 Facility number: 003283 Provider number: 003283 AIM number: N/A Census bed type: Residential: 57 Total: 57 Sample: 5 This deficiency reflects State findings in accordance with 410 IAC 16.2-3.1. Quality review completed by #02748 on November 28, 2016.	R 0000	This plan of correction is submitted as required under either or both State and Federal Law. The submission of this plan of correction on 12/8/2016 does not constitute an admission of fault of liability to the government entity of any third party, on the part of The Wellington At Southport, as to the accuracy of the surveyor's findings of the conclusions drawn therefrom. Submission of this plan of correction also does not constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the communities policies and procedures should be considered to be subsequent remedial measures as that concept is employed in rule 47 of the Federal Rules of Evidence and any corresponding state rules of civil procedure should be inadmissible in any proceeding on that basis and the community reserves the right to object to the admission of this statement of deficiency or the plan of correction under any other theory of law. The community submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated company.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (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 observations, record reviews and interviews, the facility failed to ensure diabetic residents received their insulin at the time ordered by their physician, in 4 of 10 residents reviewed for missed morning insulin. (Resident #B, #D, #E, #F). Findings include: On 11/21/16, at 10:00 a.m., review of the facility insulin log indicated none of the morning (am) insulin had been given to above Residents as indicated by the physician order. Interview with LPN (Licensed Practical Nurse) #1 on 11/21/16 at 10:30 a.m., indicated she was called in to cover this day shift as well as her evening shift. Interview with the ED (executive director), indicated LPN#2 (advised was a brand new night nurse) had left after	R 0241	1. The corrective action for residents #B, #D, #E, #F identified in the alleged allegation on 11/21/2016 is all licensed nurses were immediately instructed to wear name tags for for identifying licensed persons on duty. In addition to wearing name tags, they were instructed they are not to leave until another nurse is present to administer insulins for all residents receiving insulin. LPN#1 did call the residents physician and received orders to go ahead and give the residents their insulin after blood sugar checks were done as a one time order. Resident's #B, #D, #E, #F were monitored for six hours plus and indicated no concerns, and no side effects observed from the late dose. 2. The alleged allegation may affect all residents who receive insulin. A monitoring flow sheet for administering insulin has been put into place and the Nursing Supervisor will check the Diabetic Monitoring Flow Sheet and MAR five times weekly for four weeks, then one time weekly thereafter. The Executive Director gave an in-service all nursing staff regarding the importance of wearing name tags to identify licensed persons on duty. In addition licensed nurses are not to leave unless another licensed nurse is present to administer insulin for all residents receiving insulin. 3. To ensure this alleged allegation does not recur the Executive Director has implemented staffing day shift with two licensed nurse and evening shift with two licensed nurses and night shift with one licensed nurse, along with the CNA's. The Nursing Supervisor will be responsible for ensuring these staffing needs and the Executive Director shall monitor compliance. 4. The Nursing Supervisor will monitor the administration of insulin for all residents receiving insulin via a monitoring flow sheet five times weekly for four weeks, then one time weekly thereafter. The Executive Director will co-sign the monitoring flow sheet as an additional quality assurance to assure residents are receiving their insulin. 5. The date the system changes will be completed by 12/21/2016.	12/21/2016

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	reporting off to the QMA (Qualified Medications Aide) at 7:00 a.m., not realizing they were not a nurse, (the QMA did not have their name tag on), nor did the QMA indicate to the LPN#2 they were not a nurse. This omission caused blood sugars not to be done and the morning (8:00 a.m.) insulin not given. Interview with LPN#1 at 10:40 a.m., indicated the physician(s) were called related to the residents effected, and received orders to go ahead and give the residents their insulin after blood sugar checks were done time 1. 1) On 11/21/16 at 1:10 p.m., Resident #F's clinical record review indicated Resident #F was to receive Humalog insulin 100 units/ml 20 units sq (below the skin) 3 times a day before meals (8 a.m., 12 noon,and 4 p.m.), and Levemir insulin 100 units/ml 50 units sq 2 times a day (8 a.m. and 8 p.m.). Blood sugar taken at 10:45 a.m. was 390 (reference: post meal blood sugar levels should be less than140). Interview with Resident #B at 4 p.m., indicated no concerns, and no side effects observed from the missed insulin dose. Resident # F's diagnoses include, but are not limited to: diabetes, hyperlipidemia.			

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	2) On 11/21/16 at 1:30 p.m., Resident #D's clinical record/MAR (Medication Administration Record) review indicated Resident #D' was to receive Novolog insulin 10 units sq every morning (8 a.m.). Blood sugar at 10: 45 a.m. was 399. Interview with Resident #D at 4:15 p.m., indicated no concerns and no side effects observed from the missed insulin dose. Resident #D's diagnoses include, but are not limited to: diabetes, congestive heart failure, high blood pressure. 3) On 11/21/16 at 1:55 p.m., Resident # B's clinical record/MAR (Medication Administration Record) review indicated Resident #B was to receive Humalog insulin 100 units/ml 12 units sq 3 times a day (7:30 a.m., 11:30 a.m., 4:30 p.m.) . Blood sugar taken at 10:45 a.m., was 227. Interview with Resident #B at 4:30 p.m., indicated no concerns and no side effects observed from the missed insulin dose. Resident#B's diagnoses include, but are not limited to: diabetes, cardiomyopathy. 4) On 11/21/16 at 2:15 p.m., Resident # E clinical record/ MAR (Medication Administration Record) indicated Resident #E was to received Levemir			

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	insulin via a flex touch pen 12 units sq every day (8 a.m.). Blood sugar taken at 10:45 a.m. was 124. Interview with Resident #E at 4:45 p.m. indicated no concerns and no side effects observed from missed insulin dose. Resident #E's diagnoses include, but are not limited to: diabetes, venous insufficiency. On 11/22/16 at approximately 9:15 a.m., the ED presented the policy on General Procedures for Providing the Administration of Subcutaneous Insulin Injection (no date given) on page 90 indicated these were the ones that were being used by the facility at this time. No other policies related to insulin administration related to physician orders were provided. This Residential tag is related to Complaint IN00213464.			