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	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLES FORD MEMORIAL HOME INC	920 S MAIN ST NEW HARMONY, IN 47631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00440674. Complaint IN00440674 - No deficiencies related to the allegations are cited. Survey dates: December 17, 2024 Facility number: 001123 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 18, 2024.	R 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective January 10, 2025, to the state findings of the State Residential Licensure with Complaint (IN00440674) Survey conducted on December 17, 2024.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on observation, record review, and interview, the facility failed to properly administer insulin per manufacturer's instructions for 1 of 5 residents reviewed for medication administration. (Resident 10) Finding includes: On 12/17/2024 at 11:51 A.M., Registered Nurse (RN) 2 administered 4 units of insulin lispro to Resident 10. RN 2 failed to prime the insulin pen prior to administration. On 12/17/2024 at 2:00 P.M., Resident 10's clinical	R 0247	R 247 *The corrective action taken for those residents found to have been affected by the deficient practice is that Registered Nurse 2 was provided with in-service training on the proper technique for priming insulin to ensure correct administration. Residents identified as resident 10 is now receiving their insulin in accordance with acceptable standards of practice of insulin administration.*	01/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Knopf Koch	HFA, Executive Director	12/31/2024

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	record was reviewed. Resident 10 had diagnosis that included, but was not limited to, diabetes mellitus type II. Physician orders for Resident 10 included, but were not limited to: Insulin Lispro Injection Solution 100 unit/mL (units per milliliter) - Inject as per sliding scale: if 141 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301+ = 10 units. If above 301, recheck in 2 hours. Do not repeat insulin & call physician if still above 301 after the 10 units, subcutaneously before meals and at bedtime, dated 8/7/24 On 12/17/2024 12:10 P.M., RN 2 indicated they never primed insulin pens. On 12/17/2024 at 2:00 P.M. the Director of Nursing (DON) provided an insulin administration policy. This policy did not address the use of insulin pens only insulin given with a syringe. On 12/17/2024 at 2:09 P.M., the manufacturer's insert for Insulin Lispro KwikPen was reviewed. It indicated "if you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle and repeat priming steps 6 to 8."		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that all residents currently receiving insulin are at risk of being affected by this deficient practice. Registered Nurse 2 and all nursing staff received in-service training on the correct method for priming insulin to prevent potential errors in insulin administration. All residents who have orders for insulin are now receiving their insulin in accordance with acceptable standards of practice of insulin administration.* *The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed their insulin administration policy and procedure to ensure it meets acceptable standards of practice. Nursing staff have been in serviced on the updated insulin administration policy and procedure.* *The corrective action taken to monitor to ensure that the deficient practice will not recur is that we have developed a Quality Assurance tool to ensure compliance. This tool will be completed by the Director of Nursing and or their designee. Nursing staff will be monitored for compliance on a weekly basis for*	

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			the first month. After the initial month, monitoring will be conducted monthly for the following three months. Quarter monitoring will then be implemented and maintained up to one year to ensure ongoing compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to follow the facility policy by dating food once removed from original packaging according to sanitation and safe food handling standards for 1 of 1 kitchen observations. (Kitchen) Finding includes: During an observation on 12/17/24 at 9:35 A.M., the following items were observed in the walk-in freezer, removed from original packaging, and lacked any labeling including dates or description of items inside the bag: bag of waffles bag of chicken patties bag of chocolate cookie dough with pink chips bag of strawberries bag of grapes bag of french fries bag of blueberries bag of potato cubes During an interview on 12/17/24 at 1:53 P.M., the dietary director indicated she would not be able to tell when an item was opened or expired by looking at the items in the freezer without dates	R 0273	R 273 *The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey all residents, staff and visitors have the potential to be affected by this deficiency. All undated items and items without label that were identified in the walk-in freezer were promptly removed and disposed of to ensure resident safety and compliance with proper food handling practices.* *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is although no specific residents were identified during the survey all residents, staff and visitors have the potential to be affected by this deficiency. All undated items and items without label that*	01/10/2025

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	labeled on them. On 12/17/24 at 11:15 A.M., the dietary director provided an undated policy titled "Opening and Dating Policy" that indicated "To ensure food safety for residents... Once the product is received it is dated with the receiving date. Once a product is open it gets an open date. Once opened and dated with an open date product must have an expiration date."		*were identified in the walk-in freezer were promptly removed and disposed of to ensure resident safety and compliance with proper food handling practices. Additionally, the walk-in freezer was inventoried to identify and address all items missing a label, open date, or expiration date.* *The measures that have been put into place to ensure that the deficient practice does not recur is that the FOOD SAFETY: STORAGE OF FOOD POLICY has been amended to meet acceptable standards for food safety practices (attached). All dietary staff have received in-service training on the amended FOOD SAFETY: STORAGE OF FOOD POLICY in accordance with the acceptable standards for food handling.* *The corrective action taken to monitor to ensure that the deficient practice will not recur is that a Quality Assurance tool has been developed and implemented to monitor the safe food practices in the dietary department to ensure that all food items are properly wrapped/covered and dated with open dates/expiration dates in accordance with safety food practices. This tool shall be completed by the Dietary Manager and/or their designee weekly for four weeks, then monthly for three*	

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			months and then quarterly for three quarters to ensure on-going compliance. Any discrepancies will be immediately corrected to ensure food safety.	