STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N STATE ROAD 135 GREENWOOD, IN 46142

(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
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure the administration of rapid acting insulin (a prescription medication, injected into the fat layer under the skin, used in the treatment of type 1 and 2 diabetes mellitus that begins to take effect after approximately 5 to 15 minutes after injection) was administered to the correct resident for 1 of 3 residents reviewed for insulin administration. (Resident B, Resident C) Finding includes: During an interview on 11/22/22 at 10:15 a.m., RN 1 (Registered Nurse) indicated she was the nurse that administered insulin aspart (rapid acting insulin) to Resident B. The insulin was meant to be administered to Resident C, but she got confused when she looked at the pictures on the MAR (Medication Administration Record) because Resident B and Resident C's pictures are right next to each other, and they were also in the same room. Resident B returned from dinner approximately 45 minutes later and indicated to her that he felt "low." She rechecked Resident B's blood sugar and looked at the picture on the MAR again, and that was when she realized she had administered insulin to the wrong resident.	F 0684	A. The RN who mistakenly gave resident C's ordered insulin to resident B received inservice training on the "General Dose Preparation and Medication Administration" policy on 11/16/2022. Resident B's medication is given as ordered B. All residents have the potential to be affected. Inservice training was provided to all staff that administer medications related to policy for "General Dose Preparation and Medication Administration" on 12/12/2022. A review of medication errors was completed 12/13/2022. C. Inservice training was provided to all staff that administer medications related to policy for "General Dose Preparation and Medication Administration" on 12/13/2022. D. Observational Rounds Medication Administration tool will be completed by DNS/Designee daily x4 weeks, weekly x4 week and monthly for 6 months.	12/14/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
R. Shane McFall	Executive Director	12/12/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	She should have paid more attention to the pictures on the MAR to identify the correct resident. Resident C received the correct dose of insulin when he returned from dinner. The clinical record for Resident B was reviewed on 11/22/22 at 10:18 a.m. The diagnoses included, but were not limited to, urinary tract infection, dementia, and heart failure. An Admission MDS (Minimum Data Set) assessment, dated 7/18/22, indicated Resident B was not cognitively intact. A progress note, dated 10/21/22 at 8:31 p.m., indicated before dinner Resident B accidently received insulin aspart 14 units. When Resident B returned from dinner around 6:30 p.m., Resident B stated he was not feeling well, his blood sugar was 58, and at that time the writer realized she administered insulin to wrong resident. Resident B was alert and oriented, 2 glass of orange juice with 7-8 packs of sugar were administered. After 20 minutes the blood sugar was 63, ensure plus with 4 more sugars packets was administered to Resident B. After 20 minutes the blood sugar was 71. The DON (Director of Nursing) and on call Nurse Practitioner were notified. After 30 minutes the blood sugar was 71. A 12 oz (ounce) soda given to Resident B. Also received order from the Nurse Practitioner to give Glucagon 1 MG (milligrams) and keep checking blood sugar every 15 minutes until blood sugar is above 100, then continue checking blood sugar every hour for 24 hours. After 15 minutes of Glucagon administration blood sugar was 119. Nurse Practitioner and DON made aware. Resident B was alert and able to swallow. Thirty minutes later blood sugar was 141. Hospice informed and family informed.		Medication Administration QAPI tool will be completed monthly for 3 months, then Quarterly for 3 quarters. If 95% compliance is not achieved, an action plan will be developed.	

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	The clinical record for Resident B lacked a diagnosis for diabetes mellitus. The clinical record for Resident B lacked a physician's order for insulin aspart. On 11/22/22 at 11:15 a.m. The Director of Nursing provided a nursing skills competency, titled "Insulin Pen Administration," dated 6/2018. A review of the skills competency indicated, 1. Verify resident... On 11/22/22 at 7:12 a.m. The Director of Nursing provided a copy of a facility policy, titled General Dose Preparation and Medication Administration, dated 12/1/2017, and indicated this was the current policy used by the facility. A review of the policy indicated facility staff should verify each time a medication is administered that it is the current medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident... This Federal tag relates to Complaint IN00394996. 3.1-37(a)			