STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00430621. Complaint IN00430621 - Federal/state deficiencies related to the allegations are cited at F760 and F761. Survey date: April 4, 2024. Facility number: 000044 Provider number: 155106 AIM number: 100274940 Census Bed Type: SNF/NF: 117 Total: 117 Census Payor Type: Medicare: 5 Medicaid: 70 Other: 42 Total: 117 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 15, 2024.	F 0000		
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to complete verification of the correct type of insulin prior to administration for 1 of 3 residents reviewed for	F 0760	We respectfully request a desk review in this matter. Thank you for your consideration. 1) What corrective action(s) will be	04/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
keith davis	Senior executive director	04/19/2024

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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	insulin use, resulting in the wrong type of insulin being given. (Resident B) Findings include: Resident B's clinical record was reviewed on 4/4/24 at 9:43 a.m. Diagnoses included type 2 diabetes mellitus without complications. His physicians orders included glargine-yfgn insulin (long-acting insulin) pen 40 units subcutaneously daily in the a.m. (started on 3/11/24) and Levemir (long- acting insulin) 55 units subcutaneously at bedtime (started on 2/20/24 - discontinued on 3/19/24). A 2/9/24 significant change Minimum Data Set (MDS) assessment indicated he was cognitively intact. His blood sugars on 3/16/24 were 180 mg/dL at 8:00 p.m., 184 mg/dL at 8:13 p.m., 150 mg/dL at 8:20 p.m., and 167 mg/dL at 8:33 p.m. A nurses note, dated 3/16/24 at 8:45 p.m. (recorded as a late entry on 3/17/24 at 3:09 p.m.), indicated a medication error was made. He received 55 units of Novolog insulin (short acting insulin) instead of 55 units of Levemir insulin. An accucheck was performed and read 180 mg/dL directly afterwards. He was brought to the nurses station for monitoring. The on-call physician was notified immediately and requested to have him sent to the emergency room (ER). His accuchecks were done frequently until the EMTs arrived. An ER note, dated 3/16/24 at 8:58 p.m., indicated he was transferred to the hospital after a medication error. He was treated with 55 units of subcutaneous Novolog insulin rather than 55		accomplished for those residents found to have been affected by the deficient practice; Resident B was monitored , sent to the E.R. and had no negative outcomes. RN 14 received immediate education on insulin pen administration utilizing the " insulin pen administration" skills validation. (See attachment A). 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents receiving insulin have the potential to be affected by the alleged deficient practice. DNS/designee will in service all licensed nurses on insulin pen administration utilizing the "insulin pen administration" skills validation (see attachment A) by 4/18/24. 3) what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; DNS/designee will in service all licensed nurses on insulin pen administration utilizing the "insulin pen administration" skills validation (see attachment A) by 4/18/24. DNS/designee to conduct rounds to ensure proper insulin pen administration is completed per MD order. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; POC Qapi tool (see	

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	units of Levemir insulin. His blood sugar was 150 mg/dL during transport to the hospital with EMS and 180 mg/dL upon arrival to the ER. He denied feeling like he had low blood sugar, and he was encouraged to eat and drink a soft drink. He was started on 5 % dextrose (solution used to provide your body with extra water and carbohydrates (calories from sugar)), however, his blood sugar continued to drop as low as 66 mg/dL and he was started on 10% dextrose. He had improvement and stability of his blood sugar (around 170's) in the ER. He was also given supplemental potassium for hypokalemia (low blood potassium), likely caused by the insulin. With the resolution of his hypoglycemia (low blood sugar), it was decided that it was safe for him to return to the facility from the ER. He resumed his regular insulin and staff should take caution with which insulin they gave him. A nurses note, dated 3/17/24 at 3:28 a.m., indicated the hospital was called to check his status. He had been admitted to have his blood sugars monitored. A nurses note, dated 3/17/24 at 11:17 a.m., indicated he was admitted to the hospital but there was no bed available, and he remained in the ER. He had dextrose running via IV. If his blood sugar remained within normal limits in the next couple of hours, he would be discharged back to the facility. A nurses note, dated 3/17/24 at 11:24 p.m., indicated he was at the facility, and he had an IV in his left arm. During an interview with RN 14, on 4/4/24 at 11:20 a.m., she indicated it had been her first time working on that medication cart. She went to give		attachment B) will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI committee overseen by the Executive Director. If a threshold of 95% is not achieved , an action plan will be developed to ensure compliance. 5) by what date the systemic changes for each deficiency will be completed; 4/18/24.	

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	Resident B his insulin in his belly. She didn't look at the pen to verify it was his, or the right insulin, prior to administering it to him. As she administered the insulin, she realized the pen was orange (Novolog) rather than green (Levemir). She immediately stopped administering the insulin, went to the computer to look up the insulins and got the other two nurses that were working. They got him up in his wheelchair and rechecked his blood sugar. She thought his blood sugar was 150 mg/dL or 180 mg/dL. They called the on-call physician and they didn't answer, so they called the endocrinologist, who told them to just continue to monitor him. The on-call physician called back and told them to send him to the ER. He was transported to the ER and he stayed stable. The facility provided her education related to the medication error. During an interview with RN 14, on 4/4/24 at 1:00 p.m., she indicated she had grabbed the resident's storage bag containing his insulin from the medication cart. His name was on the storage bag, but someone must have put someone else's insulin pen in his bag. She wasn't sure whose insulin pen she used. During an interview with Resident B, on 4/4/24 at 1:02 p.m., he indicated he was sent to the hospital because a nurse gave him an immediate release insulin when he was supposed to get a long-acting insulin, but she caught it right away. They got him up, put him in his wheelchair and took him to the nurses station. They took his blood sugar, and kept checking on him. A current facility policy, revised on 1/1/22, tilted "General Dose Preparation and Medication Administration," provided by the DON on 4/4/24 at 1:18 p.m., indicated the following:			

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	"...Procedure...3.7 Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record...4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in facility's medication administration schedule...." 3.1-48(c)(2) This citation relates to Complaint IN00430621.			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

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	except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to date resident's insulin vials and insulin flex pens after opening in accordance with facility policy (Resident G, C, D, E, F, and H) for 2 of 3 medication carts observed. (H hall and K/I medication carts) During a medication administration observation, on 4/4/24 at 11:55 a.m., with RN 14, she administered 22 units of Lispro (short acting insulin) insulin to Resident G. Neither the insulin vial, nor the container, had an open date on it. RN 14 checked other in-use insulins stored in the H hall medication cart and the following in-use insulins lacked open dates: 1. Resident C's Lispro insulin vial. 2. Resident D's Lispro insulin vial and a glargine-yfgn (long acting insulin) insulin pen with 180 of 300 units used from the pen. 3. Resident E's insulin aspart (short acting insulin) insulin pen with 280 units of 300 units used from the pen. 4. Resident F's glargine-fygn insulin pen with 280 units of 300 units used from the pen. RN 12 indicated they would normally date the insulin vials and pens after opening. During an observation of the K/I hall medication cart, accompanied by LPN 23, on 4/4/24 at 12:45 p.m., Resident H's in-use insulin glargine pen had no open date on it, 160 units of insulin had been	F 0761	We respectfully request desk review in this matter. Thank you for your consideration. 1) what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents G,C,D,E,F and H and medication cart H and K/I was immediately audited and corrected by unit manager. Any updated insulin vials and flex pens were destroyed. DNS/designee will in service all licensed nurses on labeling and dating opened insulin pens utilizing "insulin pen administration" skills validation by 4/18/24. 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; all residents receiving insulin have the potential to be affected. DNS/designee will in service all licensed nurses on labeling and dating opened insulin pens utilizing "insulin pen administration" skills validation by 4/18/24. DNS/designee to audit all carts for appropriate labeling and dating of insulin pens by 4/18/24. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;	04/18/2024

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	used from the 300 unit pen. LPN 23 indicated she would normally date the insulin as soon as she pulled it from the refrigerator. A current facility policy, revised on 1/1/22, tilted "General Dose Preparation and Medication Administration," provided by the DON on 4/4/24 at 1:18 p.m., indicated the following: "...Procedure...3.12 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins...) ...." 3.1-25(j) This citation relates to Complaint IN00430621.		DNS/designee will in service all licensed nurses on labeling and dating opened insulin pens utilizing "insulin pen administration" skills validation by 4/18/24. DNS/designee to observe each med cart daily to ensure insulin vials and insulin flex pens are dated when opened. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; POC Qapi tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 5) by what date the systemic changes for each deficiency will be completed; 4/18/24.	