PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING		12/29/2022		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
					YNTREE DR		
BELL OA	KS PLACE			NEWBU	JRGH, IN 47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
R 0000							
Bldg. 00							
g. 00	This visit was for th	e Investigation of Complaints	R O	000			
	IN00386613 and IN	_	R 0000				
	11 100500015 und 11 1	100300701.					
	Complaint IN00386	6613 - Substantiated. State					
	•	to the allegations are cited at					
	R0241.	to the anegations are elect at					
	10211.						
	Complaint IN00386	5761 - Unsubstantiated due to					
	lack of evidence.	7701 Chadastantiated due to					
	nack of evidence.						
	Survey date: Decem	ober 28, 29, 2022					
	Burvey date. Beech	1001 20, 29, 2022					
	Facility number: 004903						
	racinty number.	7703					
	Residential Census: 41						
	Residential Consus.						
	This State Residenti	ial Finding was cited in					
	This State Residential Finding was cited in accordance with 410 IAC 16.2-5. Quality review completed on January 6, 2023.						
	Quality Teview conf	protoco on varioury o, 2023.					
R 0241	410 IAC 16.2-5-4(e)(1)					'
	Health Services - (, , ,					
Bldg. 00		ition of medications and the					
Blag. 00	` '	ential nursing care shall be					
		resident 's physician and					
	_						
	-	d by a licensed nurse on					
	the premises or or						
	, ,	all be administered by					
	medication aides.	ersonnel or qualified					
		on, interview, and record	R 02	241	Submission of this reasons		02/19/2022
	review, the facility f		K U2	2 4 1	Submission of this response and Plan of Correction is NO		02/18/2023
	-	dministered according to				ıa	
		e			legal admission that a		
	manufacturer's guidance. Insulin was administered from a Humalog KwikPen without it being primed			deficiency exists or, that this Statement of Deficiencies wa			
		viki cii without it being primeu			Statement of Deliciencies Wa	io 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING			12/29/2022	
				_			
NAME OF I	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
			4200 WYNTREE DR				
BELL OAKS PLACE				NEWBU	JRGH, IN 47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	IE	DATE
		obles) prior to insulin being			correctly cited, and is also N	OT	
	`	idents for 2 of 2 residents			to be construed as an admis		
		ring insulin. (Resident D,			against interest by the	31011	
	Resident E)	mg mounn. (resident B,			residence, or any employees		
	resident E)				agents, or other individuals		
	Findings include:				drafted or may be discussed		
	i mamgs merade.				the response or Plan of	***	
	1 On 12/28/22 at 0	·21 A M OMA (Qualified			Correction. In addition,		
	1. On 12/28/22 at 9:21 A.M., QMA (Qualified Medication Aide) 1 was observed preparing				preparation and submission	of	
	insulin for Resident D. They failed to prime the				this Plan of Correction does		
					constitute an admission or		
	Humalog Insulin KwikPen with 2 (two) units of insulin prior to administering insulin to Resident				agreement of any kind by the	•	
	D.				facility of the truth of any fac		
	D.				alleged or the correctness of		
	On 12/29/22 at 10:15 A.M., Resident D's clinical				any conclusions set forth in		
	record was reviewed. Diagnoses included, but				allegation by the survey age		
	were not limited to, diabetes mellitus type II,				anegation by the survey age	ncy.	
	insulin dependent.				/b>		
	insum dependent.				Resident D was not found to		
	Current physician orders included, but were not				have any adverse reactions		
		(Humalog) KwikPen 100 U/ML			due to the deficient practice.		
	(units/milliliter) per sliding scale SQ				QMA 1 was re-educated by		
	(subcutaneous) within 10-15 (ten-fifteen) minutes				CSM on 12/29/2022 regarding		
	of mealtime/bedtime snack when used as a				proper use of the Insulin		
	mealtime/bedtime i				KwikPen (Attachment 1).		
	modelino insuini.				,		
	Resident D's blood sugar reading per the Dexcom				2. On 1/13/2023 CSM		
	(device that monitors blood sugar levels				conducted an audit of		
	continuously) reading was 192. The sliding scale				resident's who receive insuli	n	
	reference for a blood sugar of 192 was to				via KwikPen (Attachment @)		
	administer 3 (three) units of Humalog insulin SQ.				Med pass overserved, insulin		
	` <i>'</i>				pens primed and administere		
	During an interview	v on 12/28/22 at 9:21 A.M.,			correctly. By 1/18/2023 CSM		
	QMA 1 indicated they do not prime the Humalog				have in-serviced current		
	KwikPen because the Drops needle that was used				medication passers with		
	would turn orange after priming the pen and once				credentials to administer		
	that happened, they could not use that same needle to administer insulin to the resident, then				insulin on the proper usage	of	
					the insulin KwikPen		
the needle would have to be replaced prior to				(Attachment 3).			
	administering medi				<u> </u>		
	_		1				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î í	ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		B. WI		00	COMPLETED 12/29/2022	
					ADDRESS SITE OF THE SOR	12/20/2022
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD /YNTREE DR	
BELL OA	AKS PLACE				URGH, IN 47630	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY C	DR LSC IDENTIFYING INFORMATION		TAG	3. CSM was retrained on	DATE
	2. On 12/29/22 at 7:42 A.M., RN (Registered Nurse) 4 was observed preparing insulin pen for				12/29/2022 by pharmacy staf	f
					member on how to properly	'
		failed to prime the Humalog			prime Humalog KwikPen. By	,
	Insulin KwikPen v	with 2 (two) units of insulin prior			1/18/2023 CSM will have	
	to administering ir	nsulin to Resident E.			in-serviced all medication	
				passers, with credentials to		
		:30 A.M., Resident E's clinical			administer insulin, on the	
		red. Diagnoses included, but			proper usage of the insulin	
	were not limited to, diabetes mellitus type II.				KwikPen.	
	Current physician orders included, but were not				4. The Executive Director is	
	limited to, Humalog KwikPen administer 10 (ten)				responsible for sustained	
	units SQ with meals.				compliance. The CSM or	
	B 11 . El 11				designee will monitor insulir	
	Resident E's blood sugar reading per glucometer				administration of med passe	r,
	was 292. The sliding scale reference for a blood				3x a week for 4 weeks, 2x a	
	sugar of 292 was to administer 12 (twelve) units of Humalog insulin SQ in addition to the scheduled				week for 4 weeks; then once week for 4 weeks. Results of	
	10 (ten) units with meals, for a total of 22				the audit will be reviewed at	
	(twenty-two) units of insulin				monthly QI meetings x3	
					months. The QI Committee v	vill
	During an interview on 12/29/22 at 7:54 A.M., RN				determine if continued audit	ing
	4 indicated they had never primed the pen nor				is necessary based on three	
	seen anyone else prime them. RN 4 further				consecutive months of	
	indicated they had not been told to prime Humalog KwikPen before administering insulin to				compliance. Monitoring will	be
	residents.	n before administering insulin to			ongoing.	
	residents.				5. February 18th, 2023	
	During an intervie	ew on 12/29/22 at 9:00 A.M., the			3. February Totil, 2023	
	_	e was aware that staff were not				
		log insulin KwikPen. The DON				
	indicated the reaso	on for not priming was due to				
	the cost.					
	A current Drop Sa	ife safety pen needle				
	_	ide, dated January 2021,				
		ON (Director of Nursing) on				
12/29/22 at 9:00 A.M., indicated to "perform a priming test if recommend by the pen injector						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING		12/29/2022		
NAME OF PROVIDER OR SUPPLIER BELL OAKS PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 4200 WYNTREE DR NEWBURGH, IN 47630				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG			TAG	DEFICIENCY)	DATE		
	_						
	needle tip visible th	rough the viewing window."					
	device. A drop of liquid should appear on the needle tip visible through the viewing window." A current Humalog KwikPen manufacturer's guide, dated March 2013, provided by the DON on 12/29/22 at 6:45 A.M., indicated to "prime before each injection. Priming ensures the Pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin." When asked for a current insulin administering policy, the DON provided a current undated Insulin Administration Competency for QMA Checklist on 12/28/22 at 1:50 P.M. It indicated the steps to follow for administering insulin included, but were not limited to," dial a dose of 2 (two) units to prime. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top. Press the injection button all the way in an check to see that the insulin comes out of the needle. If no insulin comes out, repeat the test. If insulin still does not come out, get a new needle. Check the order for the correct dose. Make sure the window shows "0" and then select the dose. Select the correct dose and dial until the number shows in the window.(2nd check) " This State Residential Finding relates to Complaint IN00386613.						

State Form Event ID: EKH511 Facility ID: 004903 If continuation sheet Page 4 of 4