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	08/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK AT LUTHERWOODS	1301 N RITTER AVE INDIANAPOLIS, IN 46219

(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 IN00359804. Complaint IN00359804 - Substantiated. State deficiencies related to the allegations are cited at R0240 and R0407. Survey date: 8/11/21 Facility Number: 011587 Residential: 99 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 18, 2021	R 0000		
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to check blood sugars and administer insulin, as ordered, and clarify a pharmacy recommendation response for 3 of 3 residents reviewed for insulin administration. (Residents B, C, and D) Findings include: 1a. The clinical record for Resident B was reviewed on 8/11/21 at 11:45 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2. He discharged from the	R 0240	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **·Will reconcile pharmacy recommendation immediately.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	09/10/2021

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

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	facility on 7/15/21. The 1/15/21 service plan indicated he needed assistance with daily medications; coordination of outside pharmacy services; assistance with blood glucose monitoring; and routine insulin injections. The July, 2021 physician's orders indicated to check his blood sugar 4 times daily at 7:00 a.m., 11:00 a.m., 3:00 p.m., and 8:00 p.m., effective 3/27/21. The May, 2021 diabetic monitoring flowsheet indicated his blood sugar was either checked or refused or that he wasn't present for checking, a total of 103 out of 123 times the entire month. It did not indicated whether he refused or was unavailable for the other 20 scheduled blood sugar checks that month. The June, 2021 diabetic monitoring flowsheet indicated his blood sugar was either checked or refused or that he wasn't present for checking, a total of 73 out of 120 times the entire month. It did not indicated whether he refused or was unavailable for the other 47 scheduled blood sugar checks that month. The July, 2021 diabetic monitoring flowsheet indicated his blood sugar was either checked or refused or that he wasn't present for checking, a total of 30 times out of 56 times between 7/1/21 and 7/14/21. It did not indicated whether he refused or was unavailable for the other 26 scheduled blood sugar checks between 7/1/21 and 7/14/21. An interview was conducted with the DNS (Director of Nursing Services) on 8/11/21 at		**·Will meet with pharmacy consultant and determine outstanding recommendations that need to be reconciled by 9-10-21** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **·Nursing to be inserviced on proper procedure on pharmacy recommendations** 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; and **·DON/designee will begin using the pharmacy recommendation tool the week of 9/12/2021.** By what date the systemic changes will be completed. **·The DNS/ADNS will ensure compliance and All things will be completed by 9-10-21.**	

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	1:45 p.m. He indicated the flowsheets should say whether Resident B received, was unavailable for, or refused each ordered blood sugar check. 1b. The 2/12/21 outside physician's orders indicated, "Administer U500 sliding scare [sic] as directed." The 4/1/21 pharmacy recommendation, by Pharmacist 5, read, "CLINICALLY URGENT RECOMMENDATION: PROMPT RESPONSE REQUESTED. [Name of Resident B's] medication administration record (MAR) or prescriber order sheets (POS) includes items that need clarification: Please clarify his insulin orders--should he be receiving Humulin R with a sliding scale OR Humulin R 500 units/ml?? Recommendation: Please clarify the above mentioned items. Humulin R 500 is NOT appropriate for sliding scale use. Response Requested." In the blank space on the bottom half of the pharmacy recommendation was a written date of 4/7/21 with 2 initials, and the "Humulin R with a sliding scale" portion of the recommendation was circled. The May, 2021 physician's orders indicated he was to receive Humulin R, not Humulin R500, insulin per sliding scale, effective 3/27/21, and the July, 2021 physician's orders indicated he was to receive Humulin R500 per sliding scale, effective 5/12/21. An interview was conducted with the DNS (Director of Nursing Services) on 8/11/21 at 1:45 p.m. He reviewed the 4/1/21 pharmacy recommendation and indicated it looked like Resident B was receiving the Humulin R 500 insulin per sliding scale, but the pharmacy recommendation response looked like he should			

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	have been receiving the Humulin R. He was unsure who actually signed off on the pharmacy recommendation. An interview was conducted with Pharmacist 5, via telephone, in the presence of the ED (Executive Director) on 8/11/21 at 2:31 p.m. He indicated it looked to him like the Humulin R500 was the product that came out of their pharmacy for Resident B's sliding scale insulin. The R500 was a super concentrated form of insulin, and was not usually the standard. The R500 insulin was more susceptible to errors, so you had to be very careful with it. An interview was conducted with with the ED and DNS on 8/11/21 at 3:31 p.m. They both indicated they realized the pharmacy recommendation response indicating the order was for Humulin R was contradictory to the actual order indicating Humulin R500. The DON indicated he didn't know how or if the contradiction was clarified, especially since they were uncertain who responded to the recommendation. The ED provided the Pharmacy Consultant Medication Recommendations policy on 8/11/21 at 4:13 p.m. It read, "Upon receipt of the Consultant Pharmacist reviews, the communities Clinical Director and/or designee shall independently review each resident's medication regimen directly from the resident's medical record and with the Interdisciplinary Care Team, resident, or resident's Responsibility Party, as needed."2. The clinical record for Resident C was reviewed on 8/11/21 at 10:55 a.m. The Resident's diagnosis included, but were not limited to, Diabetes.			

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	The clinical record contained a physician's order, dated 2/16/21, which indicated she was to receive accucheck (blood sugar check) 4 times daily at 7 a.m., 11 a.m., 4 p.m., and 8 p.m. The Diabetic Monitoring Flowsheets for July and August 2021 were reviewed on 8/11/21 at 12:45 p.m. There were no blood sugars recorded for the following dates and times: 7/2/21- 7 a.m., 11 a.m., 4 p.m., and 8 p.m., 7/3/21- 7 a.m., 7/4/21- 7 a.m. and 11 a.m., 7/5/21- 8 p.m., 7/6/21- 4 p.m. and 8 p.m., 7/8/21- 8 p.m., 7/9/21 - 7 a.m., 7/10/21- 7 a.m., 11 a.m., 4 p.m., and 8 p.m., 7/11/21- 7 a.m., 11 a.m., 4 p.m., and 8 p.m., 7/12/21- 7 a.m. and 8 p.m., 7/14/21- 8 p.m., 7/16/21- 8 p.m., 7/17/21- 7 a.m., 11 a.m., and 4 p.m., 7/18/21- 7 a.m., 11 a.m., and 4 p.m., 7/21/21- 11 a.m. and 4 p.m., 7/22/21- 11 a.m., and 4 p.m., 7/23/21- 8 p.m., 7/24/21- 7 a.m., 11 a.m., 4 p.m., and 8 p.m., 7/25/21- 7 a.m., 11 a.m., 4 p.m., and 8 p.m., 7/28/21 3 p.m. and 8 p.m., 7/29/21 11 a.m., 4 p.m., and 8 p.m., 7/30/21- 8 p.m., 7/31.21- 7 a.m., 11 a.m., 8 p.m., 8/1/21- 8 p.m., 8/2/21- 8 p.m., 8/3/21- 8 p.m., 8/4/21- 8 p.m., 8/5/21- 7 a.m., 11 a.m., and 8 p.m., 8/6/21- 8 p.m., 8/7/21- 7 a.m. and 8 p.m.,			

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	8/8/21- 8 p.m., 8/9/21- 8 p.m., and 8/10/21- 4 p.m. and 8 p.m. A physician's order, dated 6/8/21, indicated that she was to receive Novolog (insulin) 8 units injected 3 times daily with meals at 8 a.m., 12 p.m., and 5 p.m. The July and August 2021 MAR (Medication Administration Record) was reviewed on 8/11/21 at 2:28 p.m. There are no initials indicating that the scheduled dose of Novolog 8 units were administered or had been on the following days and times: 7/2/21 - 5 p.m., 7/3/21 - 8 a.m. and 12 p.m., 7/4/21 - 8 a.m. and 12 p.m., 7/10/21 - 8 a.m., 12 p.m., and 5 p.m., 7/11/21 - 8 a.m., 12 p.m., and 5 p.m., 7/17/21 - 8 a.m., 12 p.m., and 5 p.m., 7/18/21 - 8 a.m., 12 p.m., and 5 p.m., 7/24/21 - 8 a.m., 12 p.m., and 5 p.m., 7/25/21 - 8 a.m., 12 p.m., and 5 p.m., and 7/29/21 - 5 p.m. A physician's order, dated 3/18/21, indicated she was to receive Novolin N 30 units injected 2 times daily at 7 a.m. and 5 p.m. The July and August MAR were reviewed on 8/11/21 at 2:28 p.m. There were no initials indicating the scheduled dose of Novolog 30 units were administered on the following days and times: 7/3/21 - 7 a.m., 7/4/21 - 7 a.m., 7/10/21 - 7 a.m. and 5 p.m.,			

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	7/11/21 - 7 a.m. and 5 p.m., 7/17/21 - 7 a.m. and 5 p.m., 7/18/21 - 7a.m. and 5 p.m., 722/21 - 7 a.m., 7/24/21 - 7 a.m. and 5 p.m., 7/25/21 - 7 a.m. and 5 p.m., and 7/29/21 - 5 p.m. 3. The clinical record for Resident D was reviewed on 8/11/21 at 11:10 a.m. The Resident's diagnosis included, but were not limited to, Diabetes. The clinical record contained a Physician's order, dated 1/26/21, which indicated she was to receive accuchecks (blood sugar testing) 4 times a day at 6 a.m., 11 a.m., 3 p.m., and 8 p.m. The July and August 2021 MAR were reviewed on 8/11/21 at 1:30 p.m. There were no initials indicating the scheduled blood sugar testing had been completed on the following dates and times: 7/1/21- 8 p.m., 7/3/21 - 6 a.m., 11 a.m., and 3 p.m., 7/4/21- 6 a.m., 11 a.m., 3 p.m., and 8 p.m., 7/6/21 - 8 p.m., 7/7/21 - 8 p.m., 7/10/21 - 6 a.m., 11 a.m., 3 p.m., and 8 p.m., 7/11/21 - 6 a.m., 11 a.m., 3 p.m., and 8 p.m., 7/17/21- 6 a.m., 11 a.m., and 3 p.m., 7/18/21 - 6 a.m., 11 a.m., and 3 p.m., 7/24/21 - 6 a.m., 11 a.m., and 3 p.m., 7/25/21 - 6 a.m., 11 a.m., 3 p.m., and 8 p.m., and 8/5/21 - 8 p.m. A physician's order, dated 4/19/21 and updated on 7/15/21, indicated she was to receive Novolog 35 units scheduled 3 times daily with			

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	meals and sliding scale Novolog doses 3 times daily with meals based on blood sugar results. The clinical record did not contain documentation of the administration of the sliding scale insulin being administered. The July and August 2021 MAR did not contain initials indicating the scheduled Novolog 35 units daily with meals had been administered on the following dates and times: 7/10/21 - 4 p.m., and 7/11/21 - 6 a.m., 11 a.m., and 4 p.m., 7/17/21 - 7 a.m. and 3 p.m., 7/18/21 - 7 a.m. and 3 p.m., 7/23/21- 7 a.m., 7/24/21 - 7 a.m. and 3 p.m., 7/25/21 - 7 a.m., 11 a.m., and 3 p.m., 7/26/21 - 7 a.m. and 3 p.m., and 8/4/21 - 6 p.m. On 8/11/21 at 12:37 p.m., the ED (Executive Director) provided the Glucose Meter Cleansing and Testing Policy, reviewed 1/2016, which read "...1. Verify orders...41. Document results of glucose." On 8/11/21 at 12: 38 p.m., the ED provided the Subcutaneous Injection Policy, reviewed 9/2012, which read "...19. Document pertinent information..." This State tag relates to Complaint IN00359804.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to			

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	analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review the facility failed to cleanse the hub of an insulin pen and the stopper of an insulin vial prior to administering insulin for 2 of 3 residents reviewed for insulin administration (Resident C and D). Findings include: 1. The clinical record for Resident C was reviewed on 8/11/21 at 10:55 a.m. The Resident's diagnosis included, but were not limited to, Diabetes. On 8/11/21 at 10:55 a.m., LPN (Licensed Practical Nurse) 2 was observed administering insulin to Resident C. She removed the Novolog insulin pen from the storage pouch. She performed hand hygiene and put on disposable gloves. She then put the needle on the pen and primed the pen. She did not clean the hub of the insulin pen prior to attaching the needle. She administered Novolog 8 units. During an interview on 8/11/21 at 11:15 a.m., LPN 2 indicated she normally did cleanse the stopper of the insulin vial prior to withdrawing the insulin.	R 0407	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **·Skills validation/check off for nurses** **·In-service all nurses for diabetic clinic-technique and documentation** **·Notify PCP of any changes to resident's times for blood sugar checks/changes of insulin times.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **·Med review for diabetic residents to ensure diabetic times coincide with specific residents needs in coordination with PCP by 9-10-21** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	09/10/2021

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	2. The clinical record for Resident D was reviewed on 8/11/21 at 11:10 a.m. The Resident's diagnosis included, but were not limited to, Diabetes. On 8/11/21 at 11:10 a.m., LPN 2 was observed administering insulin to Resident D. She removed the vial of Novolog from the storage pouch. She performed hand hygiene and put on disposable gloves. She used an insulin syringe to draw 41 units on Novolog into a syringe. She did not cleanse the vial stopper prior to drawing the insulin from the vial. She then cleansed her arm and administered the insulin. During an interview on 8/11/21 at 11:15 a.m., LPN 2 indicated she did normally cleanse the vial stopper with alcohol prior to drawing the insulin. On 8/11/21 at 12:38 p.m., the ED (Executive Director) provided the Subcutaneous Injection Policy, reviewed 09/2012, which read "...Procedure Steps...3. Prepare medication: Cleanse top of the rubber vial, withdraw dose with syringe, replace needle cap in applicable..." This State tag relates to Complaint IN00359804.		recur; **·validating skills, educating nurses about documentation when there is a refusal** 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; and **·CQI tool developed to ensure that all diabetic orders are being followed correctly and all residents are receiving insulin as directed by the MD. QA tool will be completed 3 times weekly X 4 weeks, then 2 times weekly for 4 weeks and weekly thereafter until 2 consecutive months of compliance is achieved. CQI tool will begin week of 9/12/2021.** By what date the systemic changes will be completed. **·The DNS/ADNS will ensure compliance and All things will be completed by 9-10-21.**	