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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	11/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00243561 and IN00244639. Complaint IN00243561 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00244639 - Substantiated. Federal/State deficiencies are cited at F333. Survey dates: November 11 and 13, 2017 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census Bed Type: SNF/NF: 121 SNF: 6 Total: 127 Census Payor Type: Medicare: 10 Medicaid: 82 Other: 35 Total: 127 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on November 16, 2017.	F 0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, the response and plan of correction constitutes Lincoln Hills Health Center's allegation of compliance in accordance with Section 7305 in the State Operations Manual.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 0333 SS=D Bldg. 00	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a significant medication error did not occur when a resident (Resident B) was due 5 units of insulin but was administered 50 units for 1 of 3 residents reviewed for medication administration. Findings include: The clinical record for Resident B was reviewed on 11/11/17 at 5:03 p.m. Diagnosis included, but was not limited to, diabetes. The resident was admitted to the facility on 10/13/17. The mediation administration record, dated 10/13/17, indicated the resident was to receive humalog insulin, subcutaneous, per sliding scale for the following blood sugar readings: 151-200 = 3 units 201-250 = 3 units 251-300 = 5 units 301-350 = 5 units 351 or above = 7 units The nurse's note, dated 10/28/17 at 9:06 p.m., indicated at 6:45 p.m. the resident's blood sugar was taken with a result of 269 and 50 units of insulin was administered by LPN (Licensed Practical Nurse) 7. The physician was notified at 6:54 p.m. with new orders to re-check the residents blood sugar in 15 minutes. At 7:10 p.m.	F 0333	The facility will continue to ensure that its residents are free from any significant medication errors. Per MD orders, Resident B's blood sugar was rechecked every 15 minutes until Resident was subsequently sent to the ER for evaluation. The resident's blood sugar stabilized in the ER. LPN 7 was educated on 10/30/17 regarding sliding scale insulin administration policies and procedures. All residents with a diagnosis of diabetes that receive sliding scale insulin have the potential to be affected by this alleged deficient practice. Licensed nursing personnel were reeducated regarding sliding scale insulin administration policy.	11/14/2017

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	the residents blood sugar was 219 and the physician was notified with a new order to check the residents blood sugar every 15 minute for 30 minutes. At 7:33 p.m., the residents blood sugar was 158 and at 7:47 p.m., the blood sugar was 120. The physician was notified and a new order was received to send the resident to the emergency room for evaluation. During an interview on 11/11/17 at 5:25 p.m., LPN 7 indicated she was new to the hall and was trying to be very careful by matching up what was drawn up in the syringe to the medication administration record (MAR). The resident's blood sugar was 269 and the MAR read to give 50 units. After administering the 50 units of insulin, it was noticed that everyone else was documenting 5 units or 3 units. The "u" looked like a zero so it appeared to read 50 units. "It just did not click. If someone would have asked me if I would give 50 units of fast acting insulin, I would have said no. I do realize it was a huge mistake...my common sense should have taken over." On 11/13/17 at 2:20 p.m., the Director of Nursing provided a current copy of the document titled "Administration of Medications". It included, but was not limited to, the following: "...Important Points: 1. Always adhere to the five rights of medication administration, right drug, right resident, right dose, right time, right route, plus right documentation...Procedure...5. Check medication label with order sheet when removing from drawer...and immediately before administering..." On 11/13/17 at 2:25 p.m., the Director of Nursing provided a current copy of the document titled "Diabetes Mellitus - Routine Care". It included, but was not limited to, the following: "Purpose:		Sliding scale insulin administration audits will be conducted by nursing managers on all units. During these audits, nursing managers will check for accuracy of sliding scale insulin administration. These audits will be conducted weekly times four weeks and then monthly. If any inconsistencies are found they will be addressed immediately by nursing management. The results of these audits will be reported to the DON and Administrator. The DON and Administrator will ensure that additional training and or counseling is provided as necessary. A summary of the audits above will be reported to the QAA committee. The QAA committee will review results of all audits. Audits will be ongoing until 100% compliance has been achieved and maintained for one quarter. DON and Administrator to monitor.	

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	To provide nursing staff with guidelines for implementing care for the person with Diabetes...General Information...Medication...1. Routine insulin...should be given as ordered..." The hospital history and physical, dated 10/28/17 at 8:17 p.m., included, but was not limited to, the following: "...Plan of Care...Recurrent pneumonia...Accidental insulin overdose..." This Federal tag relates to Complaint IN00244639 3.1-48(c)(2)			