

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2024
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NAME OF PROVIDER OR SUPPLIER HERITAGE ASSISTED LIVING OF UNION CITY	STREET ADDRESS, CITY, STATE, ZIP COD 204 STAUDT DRIVE UNION CITY, IN 47390
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00447081 and IN00447127.</p> <p>Complaint IN00447081 - State deficiencies related to the allegations are cited at R0245.</p> <p>Complaint IN00447127 - State deficiencies related to the allegations are cited at R0245.</p> <p>Survey date: November 14, 2024</p> <p>Facility number: 015887</p> <p>Residential Census: 23</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed November 25, 2024.</p>	R 0000	<p>Please accept this POC as our credible statement to the corrections made to this deficient practice.</p> <p>We are requesting a paper compliance review.</p>	
R 0245 Bldg. 00	<p>410 IAC 16.2-5-4(e)(5) Health Services - Offense</p> <p>Based on interview and record review, the facility failed to ensure injectable medications were administered by qualified personnel for 2 of 3 residents reviewed for insulin administration (Resident B and Resident C).</p> <p>Findings include:</p> <p>1. During an interview, on 11/14/24 at 1:02 p.m., Resident B indicated the staff administered her medications, including insulin. She was uncertain which staff personnel were nurses and which were qualified medication aides (QMAs).</p>	R 0245	<p>QMA and LPNs wear name tags that identify their name and title. Effective 12/1/2024 staff are wearing color identifying uniforms. LPNs wear royal blue, QMAs red and assistant's green.</p> <p>Inservice was held with all nursing staff with all nursing staff outlining job descriptions and scope of practice. All nursing staff attended the Inservice training see attachment 1.</p>	12/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Fenton	Administrator	12/03/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>Resident B's clinical record was reviewed on 11/14/24 at 1:32 p.m. Diagnoses included long term current use of insulin and type 2 diabetes with hyperglycemia.</p> <p>Current physician orders included Admelog (rapid-acting insulin) 100 unit/ml (milliliters) - inject 12 units subcutaneously (in the fatty tissue under the skin) before meals (hold if blood sugar is less than 150 mg (milligrams)/dl (deciliters)) started 11/2/24, Admelog 100 units/ml - administer sliding scale before meals and at bedtime (If blood sugar is less than 60 or greater than 400 call the physician) started 11/2/24, and insulin degludec (long-acting insulin) - inject 46 units subcutaneously daily started 11/2/24.</p> <p>A facility resident assessment, dated 10/30/24, indicated Resident B required diabetic care oversight, maximum assistance with medication management, and injections four or more times a day.</p> <p>The Medication Administration Record (MAR) for 11/2/24 through 11/13/24 indicated when QMA 4 initialed Admelog and insulin degludec administration, an accompanying pass note indicated the DON had actually administered them.</p> <p>A progress note dated 11/14/24 at 12:26 p.m., as a late entry for 11/13/24 at 5:00 p.m., indicated the resident representative, the resident, and the physician were notified a QMA had administered the resident's insulin.</p> <p>During an interview, on 11/14/24 at 10:12 a.m., Licensed Practical Nurse (LPN) 3 indicated QMAs were not permitted to administer insulin unless specifically certified in insulin administration.</p>		<p>Residents B&C were assessed to ensure no adverse effects occurred. LPN notified the responsible party, physician, and resident. Residents who received insulin injections were interviewed and had no concerns. Review was made of any other residents receiving insulin injections and any new admissions will be reviewed for need of injections. For the next 90 days Inservice training will be given monthly to all LPNs and QMAs regarding job descriptions and scope of practice. All new hires will have job description and scope of practice training before working on the floor. See attachment 2</p> <p>DON or designee will be responsible for completing medication audit tool at least 4 times a week for 3 weeks, 3 times a week for 3 weeks, 2 times a week for 3 weeks at various times to ensure proper individuals are administering medications. Any identified concerns will be promptly addressed with the individual responsible. Audits will be reviewed in QUAPI meeting.</p> <p>Only qualified nursing staff will give injections per physician's order. Residents, responsible party was notified immediately when it was found thar QMA4 had been giving insulin per DON instructions. DON LPN6 was terminated due to</p>	

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	<p>During an interview, on 11/14/24 at 10:46 a.m., the Administrator in Training (AIT) indicated QMA 4 had come to her after administering an insulin injection on 11/11/24. QMA 4 had told her she was uncomfortable giving insulin, as it was not in her scope of practice, but had been told by the Director of Nursing (DON) to give the insulins. The AIT immediately began an investigation. The AIT indicated unless a QMA was specifically trained, they could not give an insulin injection. The DON was no longer employed by the facility.</p> <p>Review of the QMA's certification for qualified medication aide from the state of Indiana, provided by the Administrator on 11/14/24 at 10:50 a.m., indicated QMA 4's certification was effective as of 1/6/22. QMA 4 was not a certified insulin administrator.</p> <p>A facility document, provided by the AIT on 11/14/24 at 12:41 p.m., indicated Resident B received insulin injections from QMA 4.</p> <p>2. During an interview, on 11/14/24 at 1:10 p.m., Resident C indicated the nurses administered her insulins and medications. She did not know what a QMA was or if a QMA gave her medications.</p> <p>Resident C's clinical record was reviewed on 11/14/24 at 1:46 p.m. Diagnoses included diabetes type 2 and dementia.</p> <p>Physician's orders included insulin glargine (long-acting insulin) 100 units/ml - inject 17 units subcutaneously daily started 11/9/24 and insulin glargine 100 units/ml - inject 15 units subcutaneously daily started 2/19/24 and discontinued 11/8/24.</p>		<p>the findings of QMA 4 giving insulin despite that QMA 4 had told DON that she felt uncomfortable because giving insulin was out of her scope. LPN 6 also entered a pass note falsifying that she had given insulin. ISDH and the Attorney General were notified of LPN 6 knowingly instructed QMA 4 to give insulin and then falsified documentation.</p> <p>QMA 4 was given training on her job description and scope of practice. QMA 4 was instructed to never give any type of injections or do anything outside of her scope of practice she is to report it to Administrator. QMA 4 was also given a final written warning. See Attachment 4</p>	

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	<p>A resident assessment, dated 10/1/24, indicated the resident required diabetic care oversight, maximum assistance with medication management, and injections daily. She had memory or cognitive impairment.</p> <p>The MAR for 11/1/24 through 11/13/24 indicated when QMA 4 initialed insulin glargine administration an accompanying pass note indicated the DON had administered them.</p> <p>A progress note, dated 11/14/24 at 12:31 p.m., late entry for 11/13/24 at 1:00 p.m., indicated the resident representative, the resident, and the physician were notified a QMA had administered the resident's insulin.</p> <p>A facility document, provided by the AIT on 11/14/24 at 12:41 p.m., indicated Resident C received insulin injections from QMA 4.</p> <p>During an interview, on 11/14/24 at 1:50 p.m., QMA 4 indicated she had given long-acting insulin to Resident C.</p> <p>A job description, signed by QMA 4 on 1/5/24, provided by the AIT on 11/14/24 at 1:17 p.m., indicated the following: "The primary duty of the Certified Medication Technicians to provide personal care to residents in a manner conducive to their safety and comfort consistent with policies and procedures while complying with state, federal and all other applicable health care standards ...Dispenses medication to residents as per physicians' orders, quality assurance standards and state regulations ...Maintains records and flow sheets accurately and timely"</p> <p>A job description, signed by LPN 6 (former DON) on 7/11/24, provided by the AIT on 11/14/24 at</p>			

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	<p>1:17 p.m., indicated the following: "ESSENTIAL JOB FUNCTIONS ...Prepares, administers and records medications in accordance with facility policy ...complies with state, federal, and all other applicable health care and safety standards"</p> <p>During an interview, on 11/14/24 at 1:50 p.m., QMA 4 indicated the (former) DON was not always in the facility in the mornings, so QMA 4 would give a couple of long-acting insulins when the DON asked her to do so. She administered insulin a few times when the DON was there. She thought the DON saw her give an insulin one time. The DON knew the insulins were due. The DON would, at times, be out of the building doing an assessment and would say to QMA 4 "You got this. You know what you are doing," when she wanted QMA 4 to give the insulins. She reminded the DON it was not in her scope of practice. The QMA was afraid the resident's blood sugar would spike up if they did not get their insulin since there was no one to give it except her. She had given Resident B short-acting insulin. She did not want her residents in danger and told the AIT a couple of days ago.</p> <p>During an interview, on 11/14/24 at 2:38 p.m., LPN 6 (the former DON) indicated she had been under the impression that QMA 4 was certified to give insulins. She should have checked. QMA 4 told her she had been trained under the two prior DONs. She had been there prior to LPN 6 being employed by the facility, and LPN 6 indicated she assumed the QMA "was good to go." LPN 6 had worked in Ohio for 10 years, and Ohio did not utilize QMAs. LPN 6 had just recently learned a QMA needed a special certification for the administration of insulin. Another QMA who worked in the facility and was not certified called her in at random hours to administer insulin. She</p>			

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	<p>had thought since QMA 4 had worked at the facility prior to LPN 6's employment, she (QMA 4) had been administering insulin. When she had become the DON sometime around the middle to end of September 2024, QMA 4 moved to cover the previous day shift schedule of LPN 6. She had switched LPN 7 into QMA 4's day shift schedule because she knew QMA 4 could not receive orders and needed someone who could take the orders as it was difficult to cover the nurse's duties and the DON duties.</p> <p>"Qualified Medication Aide Scope of Practice" (4/14/22) was retrieved on 11/15/24 at 1:01 p.m. from the Indiana Department of Health website at https://www.in.gov/health/files/QMAScopeofPractice.pdf. The guidance indicated " ... The following tasks shall NOT be included in the QMA scope of practice: Administer medication by the injection route"</p> <p>A current, undated facility policy, provided by the Corporate Nurse Consultant on 11/14/24 at 4:19 p.m., titled "Medication Policy," indicated the following: " ...If a resident is unable to administer his/her own injections, a licensed professional must be employed for this purpose"</p> <p>This citation relates to Complaints IN00447081 and IN00447127.</p>			