| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON AT EAGLE VALLEY, THE | 3060 VALLEY FARMS ROAD<br>INDIANAPOLIS, IN 46214 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00412810.<br><br>Complaint IN00412810- State Residential Findings related to the allegations are cited R0243.<br><br>Survey date: July 21, 2023<br><br>Facility number: 014045<br><br>Residential Census: 96<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on July 27, 2023. | R 0000 | | |
| R 0243<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(3)<br>Health Services - Deficiency<br>(3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:<br>(A) time;<br>(B) name of medication or treatment;<br>(C) dosage (if applicable); and<br>(D) name or initials of the person administering the drug or treatment.<br>Based on record review and interview, the facility failed to document the administration of insulin for 3 of 5 residents reviewed for medication administration (Residents B, C, and D).<br><br>Findings include:<br><br>1. During an interview with Resident B on 7/21/23 | R 0243 | · Resident B, C, and D's Medication Administration Records (MAR) were reviewed to ensure the medications and accu-checks were documented. Resident B's Novolog was administered by the Interim Wellness Director on July 10, | 08/11/2023 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Amy Yantiss | Executive Director | 08/11/2023 |

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| | at 11:12 a.m., she indicated she did not receive her insulin as ordered on 7/10/23. She went to her text messages on her phone to show she sent a text message to her daughter indicating she had not received her ordered insulin.<br><br>Resident B's Medication Administration Record (MAR) was reviewed on 7/21/23 at 1:30 p.m. She had an order for Novolog (an insulin) 7 units to be injected subcutaneously (under the skin) for blood sugar between 70 to 150 at noon. Her blood sugar was 146 at noon on 7/21/23. The MAR indicated a slash (/). The slash on the MAR legend indicated the medication was missed.<br><br>2. Resident C's MAR was reviewed on 7/21/23 at 1:40 p.m. He had an order for accu-check (finger stick to check his blood sugar) three times daily. There was an order for Humalog (insulin) 4 units to be injected subcutaneously three times daily before meals if blood sugars were between 80 to 140. If sugars were greater than 140, staff were to use his sliding scale insulin which was to be Humalog injected subcutaneously per sliding scale three times daily. The sliding scale indicated the following: if blood sugar was between 141 and 180 staff were to administer 4 units of Humalog, if blood sugar was between 181 and 220 staff were to administer 5 units, and if blood sugar was between 221 and 260 staff were to administer 6 units. On 7/10/23 he had slashes on his blood sugar order, Humalog and Humalog sliding scale insulin. The slashes indicated he missed his medications and accu-check.<br><br>3. Resident D's MAR was reviewed. She had orders for accu-checks three times daily with meals. If accu-check was greater than 200, staff were to use sliding scale insulin order and Humalog 7 units injected subcutaneously three | | 2023. A late entry was documented in Resident B's chart. Resident C's Humalog was administered, and accu-check was completed by the Interim Wellness Director on July 10, 2023. A late entry was documented in Resident C's chart. The Interim Wellness Director reviewed Resident D's medication with hospice and a sliding scale insulin order is not indicated at this time. Resident D refused her Humalog on July 10, 2023, and a late entry was entered into her chart.<br>· The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice.<br>· An in-service was conducted on August 10, 2023, with all team members certified to pass medication and/or administer insulin to review MAR documentation and medication administration policies and procedures.<br>· The Wellness Director or designee will review all Medication Administration Records for missed orders and administration five times per week for six months. | |

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| | times daily with meals. A sliding scale order was not found on the MAR. On 7/10/23 at 8a.m. There were slashes indicated she missed her insulin.<br><br>During an interview with the Interim Wellness Coordinator (WC) on 7/21/23 at 1:50 p.m., she indicated she thought Qualified Medication Aide (QMA) 8 was licensed to administer insulin. She indicated QMA 8 phoned her and told her that she could not administer insulin. The Interim WC indicated once she found out QMA 8 could not administer insulins, she went and administered all of the insulins on QMA 8's assignment. The Interim WC indicated she forgot to sign the accu-checks and insulins after she administered on the MARs.<br><br>A policy titled, "Routine Medications," with no date of origin was provided by the ED (Executive Director) on 7/21/23 at 2:30 p.m. It did not contain information regarding placing initials on the MAR to indicate the medication was administered.<br><br>This State Residential finding relates to Complaint IN00412810. | | | |