

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER River Terrace Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Presbyterian Ave Madison, IN 47250	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34231</p> <p>Based on interview and record review, the facility failed to ensure a resident (Resident B) received Lantus (long-acting diabetic medication) as ordered by the physician for 1 of 3 residents reviewed for pharmacy services.</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 12/9/24 at 8:05 p.m. The resident's diagnosis included, but was not limited to, diabetes.</p> <p>The Care Plan, dated 11/18/24, indicated the resident was at risk for hypoglycemia/hyperglycemia due to diabetes mellitus and staff were to administer the resident's medications as ordered.</p> <p>The Admission Order, dated 11/14/24, indicated the resident was to receive Lantus insulin, 20 units subcutaneous at bedtime.</p> <p>The EDK (emergency drug kit) record indicated, on 11/14/24 at 9:33 p.m., a Lantus Solostar insulin pen was removed for Resident B.</p> <p>The November 2024 Medication Administration Record indicated the resident received 20 units of the Lantus insulin at bedtime on 11/14/24.</p> <p>The progress note, dated 11/16/24 at 11:57 a.m., indicated the resident was sweating and her blood sugar was 504. The physician was notified with a new, one time, order for 8 units of Novolog (short acting insulin) insulin and 20 units of Lantus insulin. The resident was also to resume the normal timing of her Lantus at bedtime.</p> <p>The resident's Medication Administration Record lacked documentation of the administration of the Lantus insulin on 11/15/24. The record was documented that the resident did not receive the insulin due to the medication being unavailable.</p> <p>During an interview on 12/10/24 at 12:01 p.m., RN (Registered Nurse) 6 indicated she admitted the resident on 11/14/24. She pulled the Lantus from the EDK to administer, which had several doses in it. She placed the insulin pen in a bag, put the resident's name on it and then placed pen in the top left drawer.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/10/24 at 12:22 p.m., the ADON (Assistant Director of Nursing) indicated she had gone to the EDK and the Lantus was not available. She called pharmacy to have it sent stat and it was delivered after she left on 11/16/24. She did not notify the physician as he usually had a standing order that if a resident was not symptomatic then the medication can be administered when it arrived from pharmacy. She checked the medication cart and could not find any Lantus. She had been in and out of the resident's room several times and the resident was not symptomatic. The family was in the room all night and never asked about it.</p> <p>During an interview on 12/10/24 at 1:03 p.m., the DON (Director of Nursing) indicated the resident had moved rooms. The residents' medications were moved to the other cart but staff did not move the insulin. The resident did have insulin available for administration on 11/15/24.</p> <p>On 12/10/24 at 2:00 p.m., a current copy of the document titled Medication Administration - General Guidelines dated 11/18 was provided. It included, but was not limited to, Policy .Medications are administered as prescribed in accordance with good nursing principles and practices .Procedure .If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room and facility (e.g., other units) are searched</p> <p>The Past noncompliance began on 11/15/24 between 7:00 p.m. and 11:30 p.m. The deficient practice was corrected by 11/18/24 after the facility implemented a systemic plan that included the following actions: All nurses were educated on room moves which included room moves that involved changing medication carts (11/18/24); Ongoing audits were implemented to ensure all medications are moved when residents moved rooms (11/18/24).</p> <p>This Citation relates to Complaint IN00447558</p> <p>3.1-25(g)(2)</p>		