

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 14, 15, 16, 17, 20, 21, and 22, 2013</p> <p>Facility number: 004268 Provider number: 155735 AIM number: 200504460</p> <p>Survey team: Karina Gates, Generalist, TC Courtney Mujic, RN (May 20, 21, and 22, 2013) Beth Walsh, RN</p> <p>Census bed type: SNF: 19 SNF/NF: 25 Residential: 31 Total: 75</p> <p>Census payor type: Medicare: 8 Medicaid: 18 Other: 49 Total: 75</p> <p>Residential Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Preparation and/or execution of this plan of correction does not constitute 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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	Quality review 5/30/13 by Suzanne Williams, RN			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a care plan was developed for a resident's anxiety, for 1 of 20 residents whose care plans were reviewed. (Resident #70)</p> <p>Findings include:</p> <p>Resident #70's clinical record was reviewed on 5/20/2013 at 12:32 pm. Diagnoses included but were not limited to; dementia with behaviors, osteoarthritis, and anxiety.</p>	F000279	<p>A care plan for Resident #70 was immediately updated to include anxiety to the clinical record. All residents have the potential to be affected. Social Service Director was inserviced on the importance of developing care plans. A checklist was developed to ensure residents who have medications for anxiety, also have a care plan in place for this.</p> <p>These checklists will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team</p>	06/21/2013

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	<p>An interview with the hospice company nurse on 5/21/2013 at 2:40 pm indicated she thinks the resident might have been molested in the shower earlier in life. The resident needs anxiety medication every morning and right before showers. The resident needs the medication in order for staff to be able to even get the resident up and dressed for the day, because otherwise when the resident is undressed or showered, the resident "goes ballistic, screaming and fighting."</p> <p>Review of the resident's clinical record indicated no care plan for anxiety.</p> <p>An interview with the Social Services Director on 5/22/13 at 11:54 am indicated Resident #70 did not have an anxiety care plan but should have had one. The Social Services Director indicated the resident will have an anxiety care plan from now on.</p> <p>3.1-35(a)</p>		<p>monthly for at least 6 months for ongoing needs and action. Social Service Director or designee will complete the audits.</p>	

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to update a pressure ulcer care plan with a new intervention and to update an activity care plan to reflect the resident's current medical condition and interests, for 2 of 20 residents reviewed for care plans. (Resident #10 and #81)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #10 was reviewed on 5/20/13 at 11:30 a.m. The diagnoses for Resident #10 included, but were not limited to: decreased mobility, stage 3</p>	F000280	<p>The Care Plan for resident #10 was immediately updated to include the air mattress as an intervention for Alteration in Skin Integrity. The Care Plan for resident #81 was immediately updated to include interventions identified during assessment and how history of falls impacted her activity involvement. All residents on health center have the potential to be affected. Employees were inserviced on 6/6/13 Care Plan Updating. Random checks will be completed for care plans. These audits will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until substantial compliance is</p>	06/21/2013			

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	<p>pressure ulcer, and Kaposi's sarcoma.</p> <p>A review of a Physician's Order, dated 4/29/13 at 11:45 a.m., indicated an air mattress was to delivered.</p> <p>A review of Resident #10's care plan for Alteration in Skin Integrity for a stage 3 pressure ulcer, included the following interventions: pressure/wound assessment per schedule, examine skin daily for signs of redness, discoloration, assess areas prone to breakdown especially over bony prominences, provide peri-care after each incontinent episode, turn and reposition every 2 hours and as needed, avoid sheering, monitor labs as ordered by physician, treatment per physician order, weekly skin assessment by licensed nurse, and notify physician and responsible party of changes in skin status. An intervention for an air mattress was not located on the care plan.</p> <p>During an interview with the wound nurse/unit manager #5, on 5/20/13 at 1:25 p.m., she indicated an air mattress was ordered for the pressure ulcer and that she was in charge of creating and updating pressure ulcer/skin care plans. She also indicated she usually puts the</p>		<p>achieved. Results of audits will be discussed with QA team monthly for at least 6 months for ongoing needs and action. DHS or designee will complete the audits skin integrity and Activity Director or designee will complete audits for Activity Care Plans</p>				

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	<p>mattress type on a care plan and will update it within a short timeframe of the mattress order. Unit Manager #5 also indicated Resident #10's skin care plan does not have the updated mattress on it, because it just slipped their mind.</p> <p>2. The clinical record for Resident #81 was reviewed on 5/21/13 at 10:30 a.m.</p> <p>The diagnoses for Resident #81 included, but were not limited to: Alzheimer's disease and senile dementia.</p> <p>The 4/8/13 significant change MDS (minimum data set) assessment indicated Resident #81's BIMS (brief interview for mental status) score was 5, indicating an impaired cognitive status. The assessment also indicated Resident #81 was a fall risk and had fallen since her last assessment on 3/8/13. The activities portion of this assessment indicated it was very important for Resident #81 to be around animals and somewhat important to do the following: have books, newspapers, and magazines to read, listen to music, keep up with news, get fresh air when the weather was good, and participate in religious activities.</p>			

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	<p>The 4/22/13 activity care plan for Resident #81 indicated an intervention was to explain the importance of social interaction and leisure activity time. The care plan did not indicate anything involving being around animals, reading, listening to music, keeping up with the news, going outside, or religious activities. It also did not address how her history of falls impacted her activity involvement.</p> <p>During an interview with the Activity Director on 5/21/13 at 11:21 a.m., she indicated Resident #81 did attend group activities, but often had to be taken out "due to behaviors" in that she "gets out of her chair. She's a fall risk." Regarding whether Resident #81 was taken outside at all over the past couple of weeks since the weather was nice, she indicated, "We have not taken her outside in April or May. We haven't taken her outside the last 2 weeks because I get nervous that she will fall." Regarding how she was trained to work with a resident who was a fall risk and cognitively impaired, she indicated, "I did not get specific training on how to deal with fall risk people outside. I am attending a training class in May specifically on dealing with difficult residents, specifically fall risks.</p>						

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	<p>(Name of another resident and Resident #81) are the 2 residents that make me nervous about falling and I'm nervous to take outside." Regarding whether she explained the importance of social interaction to Resident #81 as indicated in her activity care plan, the Activity Director responded, "No...I don't think she could understand that conversation."</p> <p>3.1-35(d)(2)(B)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure staff wore gloves while preparing food, washed hands prior to glove use and food preparation, wore a hairnet while in a food preparation area, and maintain the dishwasher at the proper temperature for cleaning dishes. This had the potential to affect 74 residents who ate meals from the kitchen of 75 residents in the facility.</p> <p>Findings include:</p> <p>1. During a random observation of the kitchen, a sign was observed, on 5/21/13 at 11:40 a.m., above the sink, near the gloves. The sign indicated, "Wash Your Hands before and after wearing gloves."</p> <p>On 5/21/13 at 11:52 a.m., Dietary Staff #2 was observed cutting vegetables and then Dietary Staff #2 touched the garbage can next to the sink. Dietary Staff #2 then donned</p>	F000371	<p>Dietary Employees were immediately inserviced on proper hand washing/glove usage/dishmachine temperatures and procedures. Plant Operations immediately placed a marker for staff to be aware of the areas where hairnets are required. Other departments were inserviced on proper hairnet usage. On 5/15/13, Dishmachine was changed over to a low temperature system. All staff were inserviced on how to properly test, record, and report findings to supervisor. All residents have the potential to be effected. Staff were also re-inserviced with return demonstration on 6/13/13. Random checks will be completed for proper dish machine procedures. These audits will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for at least 6 months for ongoing needs and action. Dining Services Director or designee will complete the audits.</p>	06/21/2013			

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	<p>gloves from a box near the sink, without washing hands, and resumed cutting vegetables.</p> <p>A policy, titled Dress Code and Personal Hygiene, no date, received from the Administrator, on 5/21/13 at 2:00 p.m., indicated, "3. All employees are required to wash their hands on these occasions:...f. After disposing or handling trash or food...l. Any other time deemed necessary."</p> <p>During an interview with the Dietary Manager, on 5/21/13 at 2:20 p.m., she indicated all staff should wash hands prior to glove use when handling food.</p> <p>The DoN (Director of Nursing) on 5/15/13 at 2:20 p.m., indicated only one resident was strictly NPO (nothing by mouth) and all other residents ate food from the kitchen.</p> <p>2. During a random observation, on 5/21/13 at 11:55 a.m., Corporate Staff #3 was observed buttering bread with their bare hands, and wearing a ring on the left hand. Corporate Staff #3 was then observed placing the bread on the stove.</p> <p>During an interview with the Dietary Manager, on 5/21/13 at 2:21 p.m.,</p>			

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	<p>she indicated anyone preparing food should follow federal regulations which include wearing gloves over hand jewelry, while preparing food.</p> <p>3. During a random observation, on 5/14/13 at 1:48 p.m., Office Staff #4 was in the middle of the kitchen, near the table/counter across from the stove, without a hairnet on. There was food in the vicinity.</p> <p>During an interview with Corporate Staff #3 and the Administrator, on 5/14/13 at 1:51 p.m., they indicated there was an imaginary line near the garbage cans and dishwashing area, that staff could come into the kitchen, without a hairnet on. They also indicated Office Staff #4 should have had a hairnet on, since Office Staff #4 was near the middle of the kitchen, away from the entrances and the imaginary line, near a food prep area.</p> <p>In a policy titled, Dietary Hair Restraint Policy and Procedures, received from the Administrator on 5/14/13 at 1:36 p.m., it indicated, "The walkway through the kitchen to the back door is not considered a food preparation area. Tray-line, dishwashing, cooking, and walk-in cooler area are restricted to personnel with hair restraints. For all</p>			

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	<p>other needs, Hair nets [sic] will be available at the entrance to the kitchen. Ask a Food Service staff person for assistance."</p> <p>4. During a random observation, on 5/14/13 at 12:45 p.m., the dishwasher was observed to reach a temperature of 176 degrees during the rinse cycle.</p> <p>During an interview with the Dietary Manager, on 5/14/13 at 12:46 p.m., she indicated the rinse temperature should reach 180 degrees during the rinse cycle and the dishwasher was high temperature dishwasher.</p> <p>In a policy, no title/no date, received from the Administrator on 5/14/13 at 1:36 p.m., it indicated dish machines will be properly used to ensure sanitation of dishes and utensils. The policy also indicated, "Procedure...1. High Temp-Wash temp should be 145-160 (symbol for degree) F (Fahrenheit); Rinse temp should be 180-194 [sic] F."</p> <p>A review of the dishwasher temperature logs indicated the following temperatures: 3/12/13-breakfast rinse temp 172, noon meal temp 170, 3/13/13-breakfast rinse temp 174,</p>						

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	<p>noon meal temp 174, 3/15/13-breakfast rinse temp 172, noon meal temp 174, 3/17/13-breakfast rinse temp 172, noon meal temp 172, 3/24/13-breakfast rinse temp 174, noon meal temp 174, 3/28/13-breakfast rinse temp 172, noon meal temp 174, 3/29/13-breakfast rinse temp 172, noon meal temp 172, 4/2/13-breakfast rinse temp 174, noon meal temp 170, 4/14/13-breakfast rinse temp 170, noon meal temp 168, 4/23/13-breakfast rinse temp 170, noon meal temp 172, 4/25/13-breakfast rinse temp 173, noon meal temp 173, 4/26/13-breakfast rinse temp 170, noon meal temp 174, 5/1/13-breakfast rinse temp 171, noon meal temp 174, 5/2/13-breakfast rinse temp 172, noon meal temp 172, 5/3/13-breakfast rinse temp 170, noon meal temp 175, 5/8/13-breakfast rinse temp 170, noon meal temp 174, 5/12/13-breakfast rinse temp 171, noon meal temp 174, and 5/13/13-breakfast rinse temp 171, noon meal temp 175. On the temperature logs, it indicated, "...Rinse Temperature At Least 180</p>			

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	<p>(symbol for degree) F. Food Safety First...****Notify Maintenance and Supervisor If Temperature Not Appropriate."</p> <p>During an interview with the Administrator on 5/14/13 at 1:45 p.m., she indicated Maintenance was working on the dishwasher and they had a work order out to [Name of Company] since March, but she was unsure what the work order was for.</p> <p>On 5/15/13, at 12:54 p.m., the Administrator indicated the work order was for a leaking issue. She also indicated the machine was switched to a chemical dishwasher the previous evening, when it was brought to the facility's attention that the dishwasher was not reaching appropriate temperatures. The Administrator indicated the temperature issue should have been brought to their attention when the temperatures were being recorded below 180 degrees F.</p> <p>A review of a Chemical and Beverage Service Report from [Name of Company], dated 5/15/13, indicated, "Installed third product pump to dispenser to dispense sanitizer, as the dish machine was not reaching proper temperature to sanitize</p>			

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R000000	dishware." The service report also indicated, "New high temp dish machine has been ordered through [Name of Company]." 3.1-21(i)(3) 5-5.1(f) The following state residential findings are cited in accordance with 410 IAC 16.2-5.	R000000	Preparation and/or execution of this plan of correction does not constitute 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.		

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R000029	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to treat a resident with consideration involving informing the resident of a newly diagnosed medical condition against the resident's power of attorney's (POA's) wishes, for 1 of 9 sampled residential residents. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record for Resident #21 was reviewed on 5/22/13 at 1:00 p.m.</p> <p>The diagnoses for Resident #21 included, but were not limited to: legally blind.</p> <p>A telephone interview was conducted with Resident #21's family member and POA (power of attorney), Family Member #10, on 5/17/13 at 12:05 p.m. He indicated Resident #21 was recently diagnosed with cancer and specifically requested to be the one who told Resident #21 of the diagnosis. He indicated he made this request to LPN #8 via telephone on 5/7/13 around 10:30 a.m. He indicated he came to the facility on 5/7/13 at 6:30 p.m. and Resident #21</p>	R000029	<p>Investigation of reported concerns of family member had been completed. POA form was immediately placed in residents chart. LPN #8 had been re-educated on how to better handle similiar situations. Resident Rights inservice conducted for staff in relation to consideration, respect, and recognition of their dignity and individuality by 6/21/13. Random audits will be completed by talking with residents and family members in person and by telephone. These audits will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team for at least 6 months for ongoing needs and action. ED or designee will complete the audits.</p>	06/21/2013	

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	<p>was slumped over in her chair with tears in her eyes and said, "I have cancer" and that LPN #8 told her. He indicated it took 45 minutes to calm her down as she was worried about it all day. He indicated this was abuse and cruelty to his mother.</p> <p>Review of the 5/7/13, 11:20 a.m. nurse's note written by LPN #8 indicated, "Resident son called. Resident has appt (appointment) May 29th @ 9:45 (symbol for "with") (name of doctor), to remove more from forehead & chin area d/t (due to test came back cancerous. Son will tell mother later today. Areas on nose will be done by a different doctor. No appt yet for that."</p> <p>An interview was conducted with LPN #8 on 5/22/13 at 1:50 p.m. regarding the above situation. She indicated on 5/7/13 Resident #21 "kept asking about the spots on her face...I told her she had a form of skin cancer." She indicated she informed Resident #21 within a couple of hours of Family Member #10 requesting he be the one to inform her of the cancer diagnosis. She indicated she was not aware Family Member #10 was Resident #21's POA, and had she known, she would not have informed Resident #21 of her cancer against</p>			

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	<p>Family Member #10's wishes.</p> <p>An interview was conducted with the ED (Executive Director) on 5/22/13 at 1:50 p.m. During this interview, the ED found a copy, in Resident #21's financial file, of a Power of Attorney form indicating Family Member #10 was Resident #21's POA since 10/10/89. She indicated this was the first time she'd seen this form and that it should have been in Resident #21's chart. She also indicated LPN #8 could have called Resident #21's POA prior to informing her of the cancer. She indicated she spoke with LPN #8 on how she could have handled the situation differently.</p>			
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R000042	<p>410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.</p> <p>Based on observation and interview, the facility failed to ensure the Indiana State Department of Health survey results were readily accessible for viewing. This had the potential to affect all 31 residents who live in the residential facility.</p> <p>Findings include:</p> <p>During an observation of the building on 5/22/2013 at 3:50 pm, the survey results could not be found. An interview with LPN #6 at this time indicated there used to be a sign posted which directed those wanting to view survey results to go to the healthcare portion of the building.</p> <p>An interview with the Administrator on 5/22/2013 at 4:30 pm indicated there was a sign posted in the assisted living (residential) building which instructed visitors they could look at the survey results in the healthcare center (skilled nursing) building. The Administrator indicated the Ombudsman came last week, right</p>	R000042	<p>Indiana Department of Health Survey was available in the Health Center portion of the building with a sign on Assisted Living indicating where it could be found. A separate survey binder was created and immediately placed on the Assisted Living portion of the building. ED or designee will inform residents in Assisted Living where to find the survey binder during resident council and through on-going discussion with residents and family members. A new sign was created to indicate the survey could be found on Assisted Living. Random audits will be completed for placement of the sign and binder on Assisted Living. These audits will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for at least 6 months for ongoing needs and action. ED or designee will complete the audits.</p>	06/21/2013	

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	before the annual survey began, and told the Administrator she needed to have a copy of the survey results also available in the residential building.				

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R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on interview and record review, the facility failed to promptly follow through with a resident's orders for dental treatment for a resident having mouth pain, for 1 of 5 residents reviewed for provision of health services in a sample of 9. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record for Resident #21 was reviewed on 5/22/13 at 1:00 p.m.</p> <p>The diagnoses for Resident #21 included, but were not limited to: legally blind.</p> <p>A telephone interview was conducted with Resident #21's family member and POA (power of attorney), Family Member #10, on 5/17/13 at 12:05 p.m. He indicated there was a delay in Resident #21 receiving dental treatment, and the resident was in pain during the delay.</p>	R000241	Resident #21 dental care needs had been addressed at the time of survey. All residents on Assisted Living have the potential to be affected. Review of all resident needs will be reviewed during daily clinical meetings as needed for timely follow up of concerns. These meeting are held daily M-F with weekend concerns reviewed on Mondays by the Clinical Management Team. This will be an ongoing process for the campus. Results of findings will be discussed with QA team monthly for at least 6 months for ongoing needs and action.	06/21/2013			

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	<p>The 2/2/13, 8:30 p.m. nurse's note written by LPN #9 indicated, "Res (resident) c/o (complains of) pain (symbol for "right") lower jaw. States her gum has been hurting approx (approximately) 1 wk (week). Unable to see anything that would cause pain."</p> <p>The 2/2/13, 9:30 p.m. nurse's note written by LPN #9 indicated, "Notified (name of physician's office)/notification mailbox of res c/o's (complaints)."</p> <p>The 2/2/13, 9:40 p.m. nurse's note written by LPN #9 indicated, "Notified son (name of Family Member #10) of res's c/o. He request (sic) we set up dental appt (appointment) et (and) transportation for res."</p> <p>The 2/2/13, 9:47 p.m. nurse's note written by LPN #9 indicated, "(Name of physician's office) returned call et was notified of res's condition et what son had requested for res to see a dentist about it. Rec'd (received) N/O (new order) for dental eval (evaluation) et tx (treatment)."</p> <p>The 2/2/13, 9:47 p.m. Physician/Prescriber 's order indicated, "Dental eval & tx."</p>			

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	<p>The 2/4/13 Physician/Prescriber's order indicated, "Monitor oral cavity for abscess Q (every) shift until seen by dentist."</p> <p>The 2/4/13 Nurse Practitioner progress note indicated, "Rt (right) side jaw pain. N.O. (new order) dental eval & tx. Watch temp (temperature)."</p> <p>The 2/15/13 Physician/Prescriber's order indicated, "Z-pack (antibiotic) 500 mg on Day 1, and 250 mg po (by mouth) on days 2-5. Warm compresses to (symbol for "right") side of jaw BID (twice daily) until swelling goes down. Call MD if (symbol for "no") improvement."</p> <p>The next nurse's note, written by LPN #8, was dated 2/18/13 at 2:10 p.m. and indicated, "Called (name of dentist)'s office to make appt. Resident has appt tomorrow 2/19/13 @ 2 p.m. Notified son. Our bus will transport."</p> <p>An interview was conducted with LPN #8 on 5/22/13 at 1:50 p.m. regarding Resident #21's dental condition. She indicated, "I remember her complaining of a sore gum and I got her an appointment." LPN #8 looked through Resident #21's chart and</p>			

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	<p>pointed to the above referenced 2/18/13 nurse's note.</p> <p>An interview was conducted with the ED (Executive Director) on 5/22/13 at 1:50 p.m. regarding the sixteen day delay in scheduling a dental appointment for Resident #21. She indicated she spoke with the Staffing Coordinator, responsible for scheduling the appointment and who no longer worked at the facility, and apparently the delay involved the facility not being able to choose a dentist for her. The ED stated, "I would expect attempts to be made to get an appointment for a resident in pain."</p> <p>Resident #21's 10/11/13 admission face sheet indicated, "Dentist - Campus Provider."</p>			

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R000306	<p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.</p> <p>Based on observation, interview, and record review, the facility failed to discard expired insulin for 1 of 1 resident receiving insulin, from the Memory Care Medication Cart. (Resident #6)</p> <p>Findings include:</p> <p>During a random observation of the Memory Care Medication Cart, on 5/22/13 at 1:35 p.m., a Novolog (insulin) 3 milliliter Flexpen, for Resident #6 was observed with a sticker, on it that indicated it was opened on 4/14/13. The sticker also indicated, "discard after 28 days."</p>	R000306	The medication was immediately discarded. Nursing staff inserviced on 6/6/13 regarding proper expiration dates and proper disposal of insulin pens and vials. Expiration Dates placed in front of MAR. Pharmacist will audit medication carts monthly. Random audits will be completed for checking medication carts for expired medications. These audits will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for at least 6 months for ongoing needs and action. DHS or designee will complete the audits.	06/21/2013			

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	<p>During an interview with QMA #6, on 5/22/13 at 1:37 p.m., she indicated insulin pens were good for 30 days and she would discard the Novolog Flexpen. She also indicated Resident #6 was administered the insulin on 5/21/13.</p> <p>A review of the May MAR (medication administration record), indicated the Novolog 3 milliliter Flexpen was used on 5/21/13.</p> <p>A review of a policy titled, Tips to Improve Insulin Safety, received from the DoN (Director of Nursing) on 5/21/13 at 3:05 p.m., indicated, "The following expiration dates begin after removing from refrigerator or opening whichever comes first, despite how it is stored...Novolog Pen Expiration-28 days."</p> <p>A review of the website, http://www.novolog.com/insulindiabetes/novologflexpen.aspx, on 5/23/13 at 11:28 a.m., indicated, "it can be used for up to 28 days without refrigeration."</p>				