

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155448	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
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NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 15, 16, 17, 18, 19, and 20, 2015</p> <p>Facility number: 000361 Provider number: 155448 AIM number: 10026340</p> <p>Survey team: Jennifer Redlin, RN-TC Caitlyn Doyle, RN Heather Hite, RN Julie Ferguson, RN (3/15, 3/16, 3/18, 3/19, 3/20) Janelyn Kulik, RN (3/16)</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 14 Medicaid: 55 Other: 9 Total: 78</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after April 19, 2015. Lowell Healthcare requests a paper review IDR as the facility disagrees with the scope for F371.</p>	

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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F 282 SS=E Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed on March 26, 2015, by Janelyn Kulik, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure Physician's orders and care plans were followed as written related to skin discolorations not assessed and monitored for 2 of 3 resident's reviewed for skin (non-pressure related), of the 5 who met the criteria for skin (non-pressure related), labs not completed as ordered and following medication order parameters for 2 of 5 resident's reviewed for unnecessary medications. (Residents #71, #56, #75, #29)</p> <p>Findings include:</p> <p>1. Observation on 3/16/15 at 9:30 a.m., Resident #71 was observed to have two reddened discolorations to the underside</p>	F 282	<p>F282– Services by Qualified Persons Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: <i>Resident#71- The family and physician were notified of the new discolorations to theunderside of the left wrist. A head to toe assessment was completed on this resident with no other skin alterationsnoted. This resident has been monitoredfor bruising per the plan of care. Thisresident experienced no negative outcome as a result of this finding.</i> <i>Resident#29 – The family and physician were notified of the new discolorations to theback of both hands. A head to toeassessment was completed on this resident with no other skin alterationsnoted. This resident</i></p>	04/19/2015	

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	<p>of the left wrist. Interview with the resident at the time indicated she was unaware of how she got the areas.</p> <p>Observation on 3/17/15 at 8:56 a.m., Resident #71 was observed to be sitting in her wheelchair in her room. The resident was observed to have two reddened/purple discolorations to the underside of the left wrist.</p> <p>Record review for Resident #71 was completed on 3/17/15 at 9:15 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, and atrial fibrillation.</p> <p>A Care Plan dated 8/16/12, indicated: Resident at risk for abnormal/excessive bleeding due to use of anticoagulant medication. Approach included to observe for signs of bleeding: excessive bruising, or bruise increasing in size.</p> <p>Review of the March 2015 MAR (Medication Administration Record) indicated an order for -Anticoagulant Medication Use - Observe resident closely every shift for: bruises of unknown origin or spreading bruises. Monitor for signs and symptoms of bleeding. Notify the Physician of any change in condition. Document observed side effects in progress notes. The MAR</p>		<p><i>has been monitored for bruising per the plan of care. This resident now has a diagnosis of Senile Purpura. This resident experienced nonegative outcome as a result of this finding.</i></p> <p><i>Resident#56 – The family and physician were notified of the blood pressure medication administered. This resident's blood pressures are being monitored per physician's order. This resident experienced no negative outcome as a result of this finding.</i></p> <p><i>Resident#75 – The family and physician were notified of the missed labs. The ordered labs have been obtained and reported per policy. This resident experienced no negative outcome as a result of this finding.</i></p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by this finding. All residents receiving antiplatelet or anticoagulant therapy were assessed head to toe for any unknown bruising and/or new skin alterations. Any new bruising and/or new skin alterations were communicated to the family and physician and will be monitored by the facility. All residents with medication parameters were reviewed to ensure all medications were administered per physician's</p>				

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	<p>was signed off every shift this was completed.</p> <p>Review of the Nursing Progress Notes 3/10/15 to 3/17/17 indicated no documentation of discolorations to the left wrist.</p> <p>Interview with RN #2 on 3/17/15 at 10:09 a.m., indicated the CNAs should tell the nurse of any abnormal areas, including bruises observed during routine care or showers. She indicated the nurses do an assessment every shift for residents who receive Coumadin which included to observe for bruising. She further indicated if any bruising was observed they would document it in progress notes and do a skin event. She indicated the bruising should have been noticed and documented by now.</p> <p>Interview with the ADNS (Assistant Director of Nursing Services) on 3/17/15 at 10:16 a.m., indicated the residents discolorations should have been noticed and assessed by now especially since she had been put to bed the night before in a gown.</p> <p>Interview with NA#1(Nursing Assistant) on 3/19/15 at 2:58 p.m. indicated Resident #71 needed x 1 assist for dressing, transfers, and toileting. She</p>		<p>order. The physician and family were notified of any medications found to be administered outside of the parameters ordered. All residents with lab orders were reviewed to ensure the lab orders matched the orders at the facility and that all labs were obtained per physician's order. Any discrepancies and/or missing lab orders were verified and/or corrected and added to the lab tracking book. In addition, the DNS/designee will ensure that the Lab Technician is providing written communication regarding labs that were drawn on each visit by reviewing the Lab Requisition Sheet and comparing it to the Lab Technician worksheet. Physicians will be notified promptly by the DNS/designee in the event labs are not able to be obtained. Licensed nurses are responsible for completing ahead to toe skin assessment with each assigned Weekly Summary. Any noted skin alterations will be documented and addressed by the Charge Nurse at the time noted. Skin inspections are completed by the nurse aides during routine dressing, toileting, bathing and shower care. Any skin alterations noted will be reported immediately to the Charge Nurse for investigation and follow up. Shower sheets and Weekly Summaries will be reviewed during weekday clinical meetings by the</p>	

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	<p>indicated all resident's skin should have been looked at when resident care was completed which included to look for any abnormal areas including bruising. If any areas were observed they would then notify the nurse.</p> <p>2. Record review for Resident #56 was completed on 3/17/15 at 10:24 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, and depression.</p> <p>A Care Plan dated 6/17/12 indicated: Ineffective tissue perfusion related to hypertension. Approaches included to administer medications as ordered, monitor variations in blood pressure and notify Physician.</p> <p>Review of the March 2015 POS indicated to give metoprolol tartrate (blood pressure medication) 12.5 mg BID (twice a day): Hold if BP (blood pressure) less than 110/60.</p> <p>Review of the February 2015 MAR indicated: -February 4, 2015 at 9:00 a.m., BP was 106/76, the medication was administered. -February 6, 2015 at 9:00 a.m., BP was 107/87, the medication was administered. -February 11, 2015 at 9:00 a.m., BP was 106/70, the medication was administered.</p>		<p>DNS/NurseManagement Team and Charge Nurse on the weekend to ensure Weekly Summaries and shower sheets are accurately reflecting any resident skin alterations.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All nursing staff will be in-serviced on or before 4/19/2014. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to skin assessments, skin sheets, lab draws, and medication administration. Lab orders will be reviewed by the DNS/NurseManagement Team during weekday clinical meetings and if necessary by the Charge Nurse on the weekend to ensure the lab orders match the orders at the facility and that all labs are obtained per physician's order. DNS/designee will ensure that the Lab Technician is providing written communication regarding labs that were drawn on each visit by reviewing the Lab Requisition Sheet and comparing to the Lab Technician worksheet. Physicians will be notified promptly by the DNS/designee in the event labs are not able to be obtained. Any new physician orders with notification parameters will be reviewed by the DNS/Nurse</p>		

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	<p>-February 14, 2015 at 9:00 a.m., BP was 109/66, the mediation was administered.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/17/15 at 2:35 p.m., indicated according to the parameters the medication should not have been given on the above dates.</p> <p>3. The record for Resident #75 was reviewed on 3/17/15 at 2:10 p.m. The resident's diagnoses included, but were not limited to, hypertension, coronary artery disease, and atrial fibrillation.</p> <p>Review of a Physician's Order, dated 2/10/15, indicated a lab order for BMP (basic metabolic profile, electrolytes) every week on Wednesday.</p> <p>Review of the lab results indicated a BMP had not been completed on 3/11/15.</p> <p>Review of a Physician's Order, dated 3/6/15, indicated a lab order for BNP (a laboratory test to monitor heart failure) on 3/9/15 and 3/16/15.</p> <p>Review of the lab results indicated a BNP had not been completed on 3/16/15.</p> <p>Review of a Physician's Order, dated 3/14/15, indicated a lab order for BMP on 3/16/15, 3/18/15, and 3/20/15.</p>		<p>Management Team for accuracy during weekday clinical meetings, by the Charge Nurse on the weekends and again at the end of each month to ensure all medications were given within the correct parameters. The DNS/designee will review the MARs daily for all medications with parameters.</p> <p>Licensed nurses are responsible for completing ahead to toe skin assessment with each assigned Weekly Summary. Shower sheets and Weekly Summaries will be reviewed during weekday clinical meetings by the DNS/Nurse Management Team and Charge Nurse on the weekend to ensure Weekly Summaries and shower sheets are accurately reflecting any resident skin alterations.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be responsible for completing the CQI audit tools labeled "Bruises", "Lab/Diagnostics" and "Unnecessary Medications" weekly. These audits will be completed until 4 weeks of 100% compliance is achieved then monthly for at least 6 months.</p> <p>Findings will be submitted to the CQI Committee for review and</p>		

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	<p>Review of the lab results indicated a BMP had not been completed on 3/16/15.</p> <p>Review of the current care plan, dated 1/30/15, indicated the resident had ineffective tissue perfusion related to hypertension, coronary artery disease, atrial fibrillation, and anemia. Nursing interventions included labs as ordered.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/19/15 at 10:29 a.m. indicated the BMP was not completed as ordered on 3/11/15 and 3/16/15. She indicated the BNP had been completed on 3/18/15 instead of 3/16/15. She further indicated she was unsure why the labs had not been completed as ordered.</p> <p>Continued interview with the DNS on 3/19/15 at 1:12 p.m. indicated she had spoken with lab and the 3/11/15 BMP was not completed because lab had not put the order in their computer properly as a weekly standing order. She further indicated lab had come to draw the BMP and BNP on 3/16/15 but was unable to obtain the lab draw. She indicated lab had noticed the resident was also to have labs drawn on 3/18/15 so the lab</p>		<p>follow up. By what date the systemic changes will be completed: Compliance Date = 4/19/14.</p>		

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	<p>indicated they would try again to get the BMP and BNP on 3/18/15. She indicated the lab had not notified any staff they had been unable to obtain the lab draw on 3/16/15.</p> <p>4. On 3/15/15 at 11:44 a.m., Resident # 29 was observed with medium size, dark purple discolorations to the back of both hands.</p> <p>On 3/18/15 at 8:12 a.m., the resident was observed in the main dining room eating breakfast and the dark purple discolorations remained on the back of the resident's hands.</p> <p>The record for Resident #29 was reviewed on 3/16/15 at 3:20 p.m. The resident's diagnoses included, but were not limited to, manic disorder, anxiety, cataract, diabetes mellitus, atrial fibrillation (irregular heart beat), edema (swelling), and anemia.</p> <p>The "Nursing Weekly Summary" dated 3/12/15 at 6:48 a.m.," indicated there were no alteration in the resident's skin integrity.</p> <p>Review of the Nursing Progress Notes from 3/12/15 through 3/18/15, indicated there was no documentation related to the resident's discolorations to the back of</p>			

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	<p>the hands.</p> <p>Review of the "Shower Report" dated 3/12/15 and 3/16/15, indicated the resident did not have any problem areas related to skin integrity.</p> <p>The plan of care dated 7/18/13, indicated the resident was at risk for bleeding/bruising related to use of antiplatelet medications. The interventions included, but were not limited to, observe for increased bleeding bruising, headaches, diarrhea, fatigue, dizziness, stomach pains, black tarry stools, ringing in the ears.</p> <p>Interview with CNA #1 and CNA #2 both indicated on 3/18/15 at 8:48 a.m., any marks or bruises on a resident, the nurse would be notified, documented on the kiosk and written on the shower sheet.</p> <p>Interview with DON (Director of Nursing) on 3/18/15 at 10:11 a.m., indicated the resident always had a dark colorations on back of her hands. She further indicated that resident did not have a diagnosis of Purpura.</p> <p>3.1-35 (g)(2)</p>			

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F 309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 2 of 3 residents reviewed for non pressure related skin conditions of the 5 residents who met the criteria for non pressure related skin conditions. (Resident #71 and #29)</p> <p>Findings include:</p> <p>1. Observation on 3/16/15 at 9:30 a.m., Resident #71 was observed to have two reddened discolorations to the underside of the left wrist. Interview with the resident at the time indicated she was unaware of how she got the areas.</p> <p>Observation on 3/16/15 at 3:16 p.m., Resident #71 was observed to be sitting in her wheelchair in her room. The resident was observed to have two reddened discolorations to the underside of the left wrist.</p>	F 309	<p>F309– Provide Care/Services for Highest Well Being Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: Resident#71- The family and physician were notified of the new discolorations to theunderside of the left wrist. A head totoe assessment was completed on this resident with no other skin alterationsnoted. This resident has been monitoredfor bruising per the plan of care. Thisresident experienced no negative outcome as a result of this finding. Resident#29 – The family and physician were notified of the new discolorations to theback of both hands. A head to toeassessment was completed on this resident with no other skin alterationsnoted. This resident has been monitoredfor bruising per the plan of care. Thisresident now has a diagnosis of Senile Purpura. This resident experienced nonegative outcome as a result of this finding. Howother residents having the potential to be affected by the</p>	04/19/2015			

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	<p>Observation on 3/17/15 at 8:56 a.m., Resident #71 was observed to be sitting in her wheelchair in her room. The resident was observed to have two reddened/purple discolorations to the underside of the left wrist.</p> <p>Record review for Resident #71 was completed on 3/17/15 at 9:15 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, and atrial fibrillation.</p> <p>The Quarterly MDS (Minimum Data Set) assessment completed on 1/8/15 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 13 which indicated the resident was cognitively intact. The assessment included the resident was an extensive 2+ assist for transfers and dressing.</p> <p>A Care Plan dated 8/16/12, indicated: Resident at risk for abnormal/excessive bleeding due to use of anticoagulant medication. Approach included to observe for signs of bleeding: excessive bruising, or bruise increasing in size.</p> <p>Review of the March 2015 MAR (Medication Administration Record) indicated an order for -Anticoagulant Medication Use - Observe resident</p>		<p>same deficientpractice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected bythis finding. All residents receivingantiplatelet or anticoagulant therapy were assessed head to toe for any unknownbruising and/or new skin alterations. Any new bruising and/or new skin alterations were communicated to thefamily and physician and will be monitored by the facility. Licensed nurses are responsible for completinga head to toe skin assessment with each assigned Weekly Summary. Any noted skin alterations will be documentedand addressed by the Charge Nurse at the time noted. Skin inspections are completed by the nurseaides during routine dressing, toileting, bathing and shower care. Any skin alterations noted will be reportedimmediately to the Charge Nurse for investigation and follow up. Shower sheets and WeeklySummaries will be reviewed during weekday clinical meetings by the DNS/NurseManagement Team and Charge Nurse on the weekend to ensure Weekly Summaries andshower sheets are accurately reflecting any resident skin alterations.</p> <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient</p>		

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	<p>closely every shift for: bruises of unknown origin or spreading bruises. Monitor for signs and symptoms of bleeding. Notify the Physician of any change in condition. Document observed side effects in progress notes. The MAR was signed off every shift this was completed.</p> <p>Review of the Nursing Progress Notes 3/10/15 to 3/17/17 indicated no documentation of discolorations to the left wrist.</p> <p>Review of the Weekly Nursing Summary and Skin Assessment completed on 3/12/15 at 10:24 a.m., indicated the resident had no bruises.</p> <p>Review of the Shower Reports completed on 3/3/15, 3/6/15, and 3/13/15 indicated no discolorations to the left wrist were documented.</p> <p>A Nursing Note on 3/16/15 at 12:30 p.m., indicated the resident was picked up from the facility for an appointment. No new skin issues noted.</p> <p>A Nursing Note on 3/16/15 at 2:07 p.m., indicated no signs or symptoms of adverse reactions related to Coumadin noted. No signs or symptoms of bleeding or bruising.</p>		<p>practice does not recur: All nursing staff will be in-serviced on or before 4/19/2014. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to skin assessments and observations of skin conditions during routine care and bathing. Licensed nurses are responsible for completing a head to toe skin assessment with each assigned Weekly Summary. Any noted skin alterations will be documented and addressed by the Charge Nurse at the time noted. Skin inspections are completed by the nurse aides during routine dressing, toileting, bathing and shower care. Any skin alterations noted will be reported immediately to the Charge Nurse for investigation and follow up. Shower sheets and Weekly Summaries will be reviewed during weekday clinical meetings by the DNS/Nurse Management Team and Charge Nurse on the weekend to ensure Weekly Summaries and shower sheets are accurately reflecting any resident skin alterations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will</p>		

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	<p>Interview with RN #2 on 3/17/15 at 10:09 a.m., indicated the CNAs should tell the nurse of any abnormal areas, including bruises observed during routine care or showers. She indicated the nurses do an assessment every shift for residents who receive Coumadin which included to observe for bruising. She further indicated if any bruising was observed they would document it in progress notes and do a skin event. She indicated the bruising should have been noticed and documented by now.</p> <p>Interview with the ADNS (Assistant Director of Nursing Services) on 3/17/15 at 10:16 a.m., indicated the residents discolorations should have been noticed and assessed by now especially since she had been put to bed the night before in a gown.</p> <p>Interview with NA#1(Nursing Assistant) on 3/19/15 at 2:58 p.m. indicated Resident #71 needed x 1 assist for dressing, transfers, and toileting. She indicated all resident's skin should have been looked at when resident care was completed which included to look for any abnormal areas including bruising. If any areas were observed they would then notify the nurse.</p> <p>2. On 3/15/15 at 11:44 a.m., Resident #</p>		<p>be responsible for completing the CQI audit tooltitled "Bruises" weekly until 4 weeks of 100% compliance is achieved thenmonthly for at least 6 months. Findings will be submitted to the CQICommittee for review and follow up. Bywhat date the systemic changes will be completed: Compliance Date = 4/19/14.</p>		

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	<p>29 was observed with medium size, dark purple discolorations to the back of both hands.</p> <p>On 3/18/15 at 8:12 a.m., the resident was observed in the main dining room eating breakfast and the dark purple discolorations remained on the back of the resident's hands.</p> <p>The record for Resident #29 was reviewed on 3/16/15 at 3:20 p.m. The resident's diagnoses included, but were not limited to, manic disorder, anxiety, cataract, diabetes mellitus, atrial fibrillation (irregular heart beat), edema (swelling), and anemia.</p> <p>The "Nursing Weekly Summary" dated 3/12/15 at 6:48 a.m.," indicated there were no alteration in the resident's skin integrity.</p> <p>Review of the Nursing Progress Notes from 3/12/15 through 3/18/15, indicated there was no documentation related to the resident's discolorations to the back of the hands.</p> <p>Review of the "Shower Report" dated 3/12/15 and 3/16/15, indicated the resident did not have any problem areas related to skin integrity.</p>				

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	<p>The plan of care dated 7/18/13, indicated the resident was at risk for bleeding/bruising related to use of antiplatelet medications. The interventions included, but were not limited to, observe for increased bleeding bruising, headaches, diarrhea, fatigue, dizziness, stomach pains, black tarry stools, ringing in the ears.</p> <p>The Annual Minimum Data Set assessment dated 2/19/15, indicated the resident was a 2 person assist with transfers, dressing, toileting and bathing.</p> <p>A Physician's Order on 3/18/15 at 10:20 a.m., indicated a diagnosis of Purpura(a red or purple discoloration on the skin that do not blanch with pressure applied).</p> <p>Interview with CNA #1 and CNA #2 both indicated on 3/18/15 at 8:48 a.m., any marks or bruises on a resident, the nurse would be notified, and it would have been documented on the kiosk and written on the shower sheet.</p> <p>Interview with DON (Director of Nursing) on 3/18/15 at 10:11 a.m., indicated the resident always had a dark colorations on back of her hands. She further indicated that resident did not have a diagnosis of Purpura.</p>			

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F 312 SS=D Bldg. 00	<p>A policy on Skin Management Program updated 2/2015, and received as current from the DON on 3/18/15 indicated, "...Procedure:...3. any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tear, blisters, and rashes...."</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to provide Activities of Daily Living (ADL) assistance to a dependant resident related to not providing incontinency care in a timely manner for 1 of 3 residents reviewed for ADL's. (Resident #35)</p> <p>Finding includes: On 3/18/15 during a continuous observation from 8:30 a.m. until 10:30 a.m., Resident #35 was observed to have</p>	F 312	<p>F312- ADL Care Provided for Dependent Residents Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: <i>Resident#35- has continued to receive ADL care per plan of care. This residentexperienced no negative outcome as a result of this finding.</i> Howother residents having the potential to be affected by the same deficientpractice will be</p>	04/19/2015

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	<p>come from the main dining room with the CNA pushing the resident in her wheelchair, to her room and placed in front of her TV. During that continuous observation, the resident sat in her wheelchair in front of her TV and no one entered the room.</p> <p>At 10:42 a.m., the resident was observed to have a small amount of stool and saturation of urine in her brief when changed in the shower room by CNA #2.</p> <p>The record for Resident #35 was reviewed on 3/18/15 at 11:00 a.m. The diagnoses included, but were not limited to, anemia, Alzheimer's Disease and dementia.</p> <p>The Annual MDS (Minimum Data Set) assessment dated 2/12/15 indicated the resident was always incontinent of bladder and bowel, was on toileting program, was cognitively impaired, was a 2 person assist with transfers, toileting and personal hygiene.</p> <p>The plan of care dated 6/15/12 indicated the resident had potential for skin breakdown related decreased mobility, urinary incontinence and impaired cognition. The interventions included, but were not limited to, assist the resident with toileting and peri care after each</p>		<p>identified and what corrective action(s) will be taken: Any resident requiring incontinent care and/or assistance with toileting have the potential to be affected by this finding. The care plan and resident profile were reviewed for all residents requiring incontinent care and/or assistance with toileting to ensure each resident specific need was accurately addressed. Resident needs specific to toileting and incontinent care were updated as identified and communicated to all direct care staff. Changes in residents requiring ADL assistance is reviewed quarterly during the care plan review process and/or with any significant change in resident condition. The DNS/designee will be responsible for conducting rounds on each shift to ensure residents are receiving incontinent care per individual plan of care.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All nursing staff will be in-serviced on or before 4/19/2014. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to toileting assistance toileting programs and timely incontinent care. The care plan and resident profile were reviewed for all residents requiring incontinent</p>	

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	<p>incontinent episode.</p> <p>Another plan of care dated 11/26/14 indicated the resident was incontinent due to decreased mobility and impaired cognition. The interventions included, but were not limited to, check the resident every 2 hours for incontinence and assist with elimination and incontinent care.</p> <p>Interview on 3/18/15 at 10:31 a.m. with CNA #2 indicated that someone would check on the resident every hour and she was a 2 person assist with toileting.</p> <p>The policy titled, "Bladder Program" was received on 3/18/15 at 11:24 a.m. by the ADON (Assistant Director of Nursing) as current and indicated, "...Procedure...Scheduled toileting program:...develop an individualized resident specific program, update the care plan..."</p> <p>3.1-38 (2)(c) 3.1-38 (3)(A)</p>		<p>care and/or assistance withtoileting to ensure each resident specific need was accurately addressed. Resident needs specific to toileting andincontinent care were updated as identified and communicated to all direct carestaff. Changes in residents requiringADL assistance is reviewed quarterly during the care plan review process and/orwith any significant change in resident condition. The DNS/designee will be responsible forconducting rounds on each shift to ensure residents are receiving incontinentcare per individual plan of care.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action willbe monitored though the facility CQI program. The DNS/designee will be responsible for completing the CQI audit toolslabeled "Resident Care Rounds" to assure resident's toileting and incontinentcare needs are addressed in a timely manner per their individual care plan. These will be completed daily until 4 weeks of100% compliance is achieved then monthly for at least 6 months. Findings will be submitted to the CQI Committeefor review and follow up.</p> <p>Bywhat date the systemic</p>		

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F 329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure resident's were free from unnecessary medications related to labs not completed as ordered and following medication order parameters for 2 of 5 resident's reviewed for unnecessary medications. (Residents #57 and #75)</p> <p>Findings include:</p>	F 329	<p>changes will be completed: Compliance Date = 4/19/14.</p> <p>F329– Drug Regimen is Free From Unnecessary Drugs Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: <i>Resident#56 – The family and physician were notified of the blood pressure medicationadministered. This resident experienced no negative outcome as a result of thisfinding.</i></p>	04/19/2015

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	<p>1. Record review for Resident #56 was completed on 3/17/15 at 10:24 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia, and depression.</p> <p>A Care Plan dated 6/17/12 indicated: Ineffective tissue perfusion related to hypertension. Approaches included to administer medications as ordered, monitor variations in blood pressure and notify Physician.</p> <p>Review of the March 2015 POS indicated to give metoprolol tartrate (blood pressure medication) 12.5 mg BID (twice a day): Hold if BP (blood pressure) less than 110/60.</p> <p>Review of the February 2015 MAR indicated: -February 4, 2015 at 9:00 a.m., BP was 106/76, the medication was administered. -February 6, 2015 at 9:00 a.m., BP was 107/87, the medication was administered. -February 11, 2015 at 9:00 a.m., BP was 106/70, the medication was administered. -February 14, 2015 at 9:00 a.m., BP was 109/66, the medication was administered.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/17/15 at 2:35 p.m., indicated according to the parameters the medication should not</p>		<p><i>Resident#75 – The family and physician were notified of the missed labs. The ordered labs have been obtained and reported per policy. This resident experienced no negative outcome as a result of this finding.</i></p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by this finding. All residents with medication parameters were reviewed to ensure all medications were administered as ordered. The physician and family were notified of any medications found to be administered outside of the ordered parameters. All residents with lab orders were reviewed to ensure the lab orders matched the orders at the facility and that all labs were obtained per physician's order. Any discrepancies and/or missing lab orders were verified and/or corrected and added to the lab tracking book. In addition, the DNS/designee will ensure that the Lab Technician is providing written communication regarding labs that were drawn on each visit by reviewing the Lab Requisition Sheet and comparing to the Lab Technician worksheet. Physicians will be notified promptly by the DNS/designee in the event labs are not able to be</p>		

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	<p>have been given on the above dates.</p> <p>2. The record for Resident #75 was reviewed on 3/17/15 at 2:10 p.m. The resident's diagnoses included, but were not limited to, hypertension, coronary artery disease, and atrial fibrillation.</p> <p>Review of the March 2015 Physician Order Summary indicated the following orders:</p> <ul style="list-style-type: none"> -Lasix (furosemide, a diuretic medication) 20 mg (milligrams) once a day on Monday, Tuesday, Wednesday, Thursday, and Friday. -Zaroxolyn (metolazone, a diuretic medication) 2.5 mg daily. <p>Review of a Physician's Order, dated 2/10/15, indicated a lab order for BMP (basic metabolic profile, electrolytes) every week on Wednesday.</p> <p>Review of the lab results indicated a BMP had not been completed on 3/11/15.</p> <p>Review of a Physician's Order, dated 3/6/15, indicated a lab order for BNP (a laboratory test to monitor heart failure) on 3/9/15 and 3/16/15.</p> <p>Review of the lab results indicated a BNP had not been completed on 3/16/15.</p> <p>Review of a Physician's Order, dated</p>		<p>obtained.</p> <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</p> <p>All nursing staff will be in-serviced on or before4/19/2014. This in-service will beconducted by the DNS/designee and will include review of the facility policyrelated to lab draws and medication administration. Lab orders will be reviewed by the DNS/NurseManagement Team during weekday clinical meetings and if necessary by the ChargeNurse on the weekend to ensure the lab orders match the orders at the facilityand that all labs are obtained per physician's order. In addition, the DNS/designee will ensurethat the Lab Technician is providing written communication regarding labs thatwere drawn on each visit by reviewing the Lab Requisition Sheet and comparingto the Lab Technician worksheet. Physicians will be notified promptly by the DNS/designee in the eventlabs are not able to be obtained. Any new physician orders with notificationparameters will be reviewed by the DNS/Nurse Management Team for accuracyduring weekday clinical meetings, by the Charge Nurse on the weekends and against the end of each month to ensure all medications were given within thecorrect parameters. The</p>	

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	<p>3/14/15, indicated a lab order for BMP on 3/16/15, 3/18/15, and 3/20/15.</p> <p>Review of the lab results indicated a BMP had not been completed on 3/16/15.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/19/15 at 10:29 a.m. indicated the BMP was not completed as ordered on 3/11/15 and 3/16/15. She indicated the BNP had been completed on 3/18/15 instead of 3/16/15. She further indicated she was unsure why the labs had not been completed as ordered.</p> <p>Continued interview with the DNS on 3/19/15 at 1:12 p.m. indicated she had spoken with lab and the 3/11/15 BMP was not completed because lab had not put the order in their computer properly as a weekly standing order. She further indicated lab had come to draw the BMP and BNP on 3/16/15 but was unable to obtain the lab draw. She indicated lab had noticed the resident was also to have labs drawn on 3/18/15 so the lab indicated they would try again to get the BMP and BNP on 3/18/15. She indicated the lab had not notified any staff they had been unable to obtain the lab draw on 3/16/15.</p> <p>3.1-48(a)(3)</p>		<p>DNS/designee will review the MARs daily for all medications with parameters.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be responsible for completing the CQI audit tools titled "Lab/Diagnostics" and "Unnecessary Medications" weekly. These will be completed until 4 weeks of 100% compliance is achieved then at least monthly for 6 months. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date = 4/19/14.</p>		

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F 371 SS=D Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>Based on observation, interview and record review, the facility failed to distribute food under sanitary conditions related to fluids uncovered during serving of the room trays from the Diners Club cart for the first floor. This affected 2 of the 10 room trays observed for room tray distribution on the first floor. (Diners Club Cart)</p> <p>Finding includes:</p> <p>During an observation of lunch service on 3/15/15 at 12:29 p.m. from the diner club cart for the first floor hallway, RN #1 poured prune juice from a pitcher from the tray cart, placed the cup on a lunch tray, and carried the tray with uncovered drink down the hallway to room 105.</p> <p>During the same lunch service observation on 3/15/15 at 12:40 p.m. from the first floor hallway from the Diners Club tray cart, LPN #1 removed a</p>	F 371	<p>LowellHealthcare requests a paper review IDR as the facility disagrees with the scope for F371. F371– Food Procure, Store/Prepare/Serve - Sanitary Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: Allfood and drinks are being distributed and served using sanitaryconditions. All food and drinks leavingthe dining room are covered. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this finding. Staff responsible for food preparation,distribution and meal service is utilizing proper technique and sanitarypractices. All food and fluids are beingproperly handled and appropriately covered when leaving the kitchen perpolicy. An all staff in-service will</p>	04/19/2015

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	<p>lunch tray from the cart and carried the tray with the uncovered drink down the hallway to the main dining room to a resident.</p> <p>Interview with RN #1 on 3/15/15 at 12:36 p.m., indicated the beverage should have been covered after placed on the room tray.</p> <p>Interview with LPN #1 on 3/15/15 at 12:42 p.m., indicated the beverage should have been covered before it came out of the cart. She further indicated the kitchen should have covered the beverage before having been placed on the cart.</p> <p>The policy titled "General Food Preparation and Handling" provided by the Director of Nursing on 3/17/15 at 8:00 a.m. as current and indicated, "...Procedure:...20. Any utensils or dishware transported to other areas will either be covered or placed in covered containers/enclosed carts...."</p> <p>3.1-21(i)(3)</p>		<p>beconducted on or before 4/19/15 by the DNS/designee. This in-service will include review of the policy related to General Food Handling and Distribution. Staff will be re-educated regarding the importance of serving and distributing food in a sanitary manner including covering all food and fluids as they leave the kitchen. Dietary will provide individual covered fluids for all room trays and will cover all food and drinks before the trays go in the food cart. The Dietary Manager/designee will review all trays to assure all items are covered per policy.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An all staff in-service will be conducted on or before 4/19/15 by the DNS/designee. This in-service will include review of the policy related to General Food Handling and Distribution. Staff will be re-educated regarding the importance of serving and distributing food in a sanitary manner including covering all food and fluids as they leave the kitchen. Dietary will provide individual covered fluids for all room trays and will cover all food and drinks before the trays go in the food cart. The Dietary Manager/designee will review the all trays to assure all items are covered per policy. How the</p>		

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F 441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and		corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility CQI program. The Dietary Manager/designee will be responsible for completing the CQI audit tool labeled "Dining Room Manager Observation List" daily. This will be completed until 4 weeks of 100% compliance is achieved then monthly for at least 6 months. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date = 4/19/14.		

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	<p>corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to maintain a sanitary environment, related to uncovered urinals, bath basins, and toothbrushes stored in residents bathrooms and rooms for 2 resident rooms on one of two floors in the facility. This had the potential to affect 4 residents who reside in those rooms.(Rooms #315 & 318)</p> <p>1. During an observation of room 315 B on 3/16/15 at 10:00 a.m., a urinal half full with a yellow liquid was observed sitting on the bedside table with the cap off.</p> <p>During the Environmental tour on 3/20/15 at 10:20 a.m., with the Executive</p>	F 441	<p>F441– Infection Control, Prevent Spread, Linens Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: <i>Asanitary environment is being maintained in resident rooms with urinals beingcovered in room 318 and 315.</i> <i>Asanitary environment is being maintained in resident rooms with toothbrushesbeing covered in room 318.</i> Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: Infection control rounds were</p>	04/19/2015

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	<p>Director, Maintenance Supervisor, and Housekeeping & Laundry Supervisor, an empty urinal was observed sitting on the bedside table in room 315 B uncovered. Two residents resided in this room.</p> <p>2. During an observation of room 318 B on 3/16/15 at 11:16 a.m., a urinal with a yellow liquid in it was hanging on the garbage can next to bed B, two urinals were uncovered hanging on the bathroom garbage can, and a toothbrush was uncovered sitting directly on the sink.</p> <p>During the Environmental tour on 3/20/15 at 10:20 a.m., with the Executive Director, Maintenance Supervisor, and Housekeeping & Laundry Supervisor, a urinal filled with yellow liquid was observed hanging on the garbage can next to bed B, two urinals were uncovered hanging on the bathroom garbage can, a bath basin was uncovered and unlabeled sitting on the back of the toilet, and a toothbrush was uncovered sitting directly on the sink. Two residents resided in this room and shared the bathroom.</p> <p>At the time of the tour, the Executive Director acknowledged the above issues in regards to infection control.</p> <p>3.1-18(a)</p>		<p>completed by CustomerCare Reps to ensure all personal items were covered. Rounds will be conducted by the IDT Monday –Friday and by the Weekend Supervisor on weekends. These rounds will ensure that a safe, sanitary environment is maintained in resident living areas and that infection control practices are in place for resident personal items.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on or before 4/19/2014. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to infection control. Customer Care Rounds will be conducted by the IDT Monday – Friday and by the Weekend Supervisor on weekends. These rounds will ensure that a safe, sanitary environment is maintained in resident living areas and that infection control practices are in place for resident personal items.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will</p>		

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F 502 SS=D Bldg. 00	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were obtained in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident #75)</p> <p>Finding includes:</p> <p>The record for Resident #75 was reviewed on 3/17/15 at 2:10 p.m. The resident's diagnoses included, but were not limited to, hypertension, coronary artery disease, and atrial fibrillation.</p> <p>Review of a Physician's Order, dated 2/10/15, indicated a lab order for BMP (basic metabolic profile, electrolytes) every week on Wednesday.</p>	F 502	<p>be responsible for completing the CQI audit tool labeled "Resident Care Rounds" daily. This will be completed until 4 weeks of 100% compliance is achieved then monthly for at least 6 months. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date = 4/19/14.</p> <p>F502- Administration What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: <i>Resident #75 – The family and physician were notified of the missed labs. The ordered labs have been obtained and reported per policy. This resident experienced no negative outcome as a result of this finding.</i> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this finding. All residents with lab orders were reviewed to ensure the lab orders matched the orders at the facility</p>	04/19/2015	

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	<p>Review of the lab results indicated a BMP had not been completed on 3/11/15.</p> <p>Review of a Physician's Order, dated 3/6/15, indicated a lab order for BNP (a laboratory test to monitor heart failure) on 3/9/15 and 3/16/15.</p> <p>Review of the lab results indicated a BNP had not been completed on 3/16/15.</p> <p>Review of a Physician's Order, dated 3/14/15, indicated a lab order for BMP on 3/16/15, 3/18/15, and 3/20/15.</p> <p>Review of the lab results indicated a BMP had not been completed on 3/16/15.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/19/15 at 10:29 a.m. indicated the BMP was not completed as ordered on 3/11/15 and 3/16/15. She indicated the BNP had been completed on 3/18/15 instead of 3/16/15. She further indicated she was unsure why the labs had not been completed as ordered.</p> <p>Continued interview with the DNS on 3/19/15 at 1:12 p.m. indicated she had spoken with lab and the 3/11/15 BMP was not completed because lab had not put the order in their computer properly as a weekly standing order. She further</p>		<p>and that all labs were obtained timely and per physician's order. Any discrepancies and/or missing lab orders were verified and/or corrected and added to the lab tracking book. In addition, the DNS/designee will ensure that the Lab Technician is providing written communication regarding labs that were drawn on each visit by reviewing the Lab Requisition Sheet and comparing to the Lab Technician worksheet. Physicians will be notified promptly by the DNS/designee in the event labs are not able to be obtained.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>All nursing staff will be in-serviced on or before 4/19/2014. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to lab draws. Lab orders will be reviewed by the DNS/Nurse Management Team during weekday clinical meetings and if necessary by the Charge Nurse on the weekend to ensure the lab orders match the orders at the facility and that all labs are obtained per physician's order. DNS/designee will ensure that the Lab Technician is providing written communication regarding labs that were drawn on each visit by reviewing the Lab Requisition Sheet and comparing to the Lab Technician worksheet.</p>				

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	<p>indicated lab had come to draw the BMP and BNP on 3/16/15 but was unable to obtain the lab draw. She indicated lab had noticed the resident was also to have labs drawn on 3/18/15 so the lab indicated they would try again to get the BMP and BNP on 3/18/15. She indicated the lab had not notified any staff they had been unable to obtain the lab draw on 3/16/15.</p> <p>3.1-49(a)</p>		<p>Physicians will be notified promptly by the DNS/designee in the event labs are not able to be obtained.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be responsible for completing the CQI audit tool titled "Lab/Diagnostics" weekly. These will be completed until 4 weeks of 100% compliance is achieved then monthly for at least 6 months. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed: Compliance Date = 4/19/14.</p>		