

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/25/2013
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NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 18, 19, 20, 21, 22, & 25, 2013</p> <p>Facility number: 000385 Provider number: 15E667 AIM number: 100291340</p> <p>Survey team: Patti Allen, BSW-TC Marcy Smith RN, (3/20, 3/21, 3/22, & 3/25, 2013) Leia Alley, RN Dinah Jones, RN</p> <p>Census bed type: NF: 39 Total: 39</p> <p>Census payor type: Medicaid: 39 Total: 39</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 03, 2013; by Kimberly Perigo, RN.</p>	F000000	<p>Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with the regulations governing the operation of long term care facilities; that this Plan of Correction in its entirety ,constitutes this provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with federal and state regulations and to correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the opinion that it was in participation of or that corrective</p>	
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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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			was necessary.	

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>A) Based on observation and interview, the facility failed to maintain a respectful, dignified environment for 3 of 3 randomly observed staff to resident interactions. (Resident #14, #25, and #33) (Activity Assistant #1)</p> <p>B) Based on observation, interview, and record review, the facility failed to ensure 2 residents were treated with dignity and respect in a sample of 30 residents reviewed for dignity and respect. This had the potential to affect 38 of 38 residents residing in the facility. (Resident #8 and Resident #31) (QMA #1)</p> <p>Findings Include:</p> <p>A) During an observation on 3/21/13 at 3:00 p.m., Activity Assistant #1 was noted near the facility nurses station. She walked at a very fast pace. Resident #25 stopped and started to talk to Activity Assistant #1. As Resident #25 talked, Activity Assistant #1 walked in and out of other</p>	F000241	F241 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents had the potential to be affected by this deficiency. Although the facility agrees that the tone of voice that the survey team member heard the activity director assistant use was not in any way a tone of voice that is appropriate when speaking to a resident; the residents involved (#44, #14 and #33) were spoken to by nursing staff, directly after this event being reported to the facility, and no residents voiced any complaint regarding the activity or the activity directors assistant and her tone of voice or what may have been said. Staff involved were given verbal counseling immediately after the surveyors brought this to the facility's attention. Staff is not permitted to enter a resident's room without knocking first and waiting for a reply. This section of F241 was not brought to the facility's attention during the survey however as of this date (4-10-2013) the facility's ADON is making Dignity rounds to monitor staff compliance of this issue.	04/24/2013			

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	<p>residents' rooms. They carried on a conversation as follows...</p> <p>Resident #25 stopped the Activity Assistant and asked, "What are we having to eat?" The Activity Assistant replied, "donuts."</p> <p>Resident #25 asked, "anything else?" The Activity Assistant then replied, "nope, just donuts."</p> <p>Resident #25 asked, "anything to drink?" The Activity Assistant replied in a harsh, gruff tone, " WELL YA, we will be having something to drink!" and just kept walking away from the nurses station towards the dining room area.</p> <p>Activity Assistant #1 was then seen a few moments later, going up behind Resident #33 and stating in a harsh tone, "I will push you down there but YOU have to pick up your feet!"</p> <p>Activity Assistant #1 was then observed calling to Resident #14, stating " Come on [Resident #14's name], come on, come down to the dining room," in a manor that was demeaning, similar to how one may call to a child.</p>		<p>Staff involved have also received written counseling. Exhibit K 2)</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents had the potential to be affected by this deficiency. Facility staff are frequently in serviced on resident rights and dignity. Dignity rounds to monitor staff compliance of the issue of staff forgetting to 'knock and then wait' , before entering a resident's room will continue daily for two (2) months, then bi-weekly for three (3) months, then once monthly for six (6) months. Dignity rounds will be made and documented by either the DON, the ADON or the day, evening or night charge nurse. Nursing staff will be in-serviced on 4-10-2013 and 4-19-2013 on the issues of dignity and resident rights. (exhibits 'A' and 'B") Nursing staff will continue to be in -serviced, via in house education, on resident rights and dignity twice per month for the next three (3) months (starting 4-2013) then once per month for three (3) months, then monthly for six (6) months.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The residents involved (#44, #14 and #33) were spoken to by nursing staff, directly after this event being reported to the</p>		

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	<p>During an interview with the Executive Director (ED) on 3/22/13 at 2:30 p.m., she suggested perhaps the Activity Assistant was upset about something, because she was normally very personable.</p> <p>A review of a facility document on 3/25/13 at 3:30 p.m., titled "Quality of Life", dated 3/24/06 indicated staff are to make sure "Residents perceive that their dignity is intact and respected and do not experience feelings of being belittled, de-valued or humiliated."</p>		<p>facility, and no residents voiced any complaint regarding the activity or the activity directors assistant and her tone of voice or what may have been said. Staff involved were given verbal counseling immediately after the surveyors brought this to the facility's attention. Staff is not permitted to enter a resident's room without knocking first and waiting for a reply. This section of F241 was not brought to the facility's attention during the survey however as of this date (4-10-2013) the facility's ADON is making Dignity rounds to monitor staff compliance of this issue. Facility staff are frequently in serviced on resident rights and dignity. Dignity rounds to monitor staff compliance of the issue of staff forgetting to 'knock and then wait' , before entering a resident's room will continue daily for two (2) months, then bi-weekly for three (3) months, then once monthly for six (6) months. Dignity rounds will be made and documented by either the DON, the ADON or the day, evening or night charge nurse. Nursing staff will be in-serviced on 4-10-2013 and 4-19-2013 on the issues of dignity and resident rights.(exhibits 'A' and 'B") Nursing staff will continue to be in -serviced, via in house education, on resident rights and dignity twice per month for the next three (3) months then once per month for three (3) months, then monthly for six (6)</p>		

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	B) During an interview with Resident #31 on 3/18/13 at 1:15 p.m., QMA [Qualified Medication Aide] #1 knocked on Residents #8 and #31's door and pushed it open without waiting for the residents to respond. She entered the room and indicated she didn't know anyone was in the room with the residents. After entering the room, the QMA closed the door, and called out to Resident #8, who was lying in bed with her		months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Quality assurance: Dignity rounds will be made and documented by either the DON, the ADON or the day, evening or night charge nurse. The DON or her designee will maintain copies of these dignity rounds. Nursing staff will be in-serviced on 4-10-2013 and 4-19-2013 on the issues of dignity and resident rights.(exhibits 'A' and 'B") Nursing staff will continue to be in -serviced, via in house education, on resident rights and dignity twice per month for the next three (3) months then once per month for three (3) months, then monthly for six (6) months. 5) By what date the systemic changes will be completed? April 24th, 2013.		

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	<p>eyes closed, that she [QMA #1] had her [Resident #8] medications and it was time for her to get up for lunch.</p> <p>A second, unidentified, staff member pushed the door open without knocking. The unidentified staff member closed the door without entering.</p> <p>During an interview with Resident #31 on 3/18/13 at 1:15 p.m., she indicated the staff, "do that [enter without knocking] all the time and we are used to it."</p> <p>During an interview, on 3/25/13 at 3:30 p.m., the Executive Director provided a document entitled, "Quality of Life" dated, 3/24/06 and reviewed, 2/20/10. She indicated it was not considered a policy but a guideline for the staff to follow. The document indicated, "staff knocks on room doors and requests permission to enter."</p> <p>3.1-3(t)</p>				

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that 1 of 1 residents in a sample of 30 residents reviewed for oral health was accurately assessed</p>	F000272	F272 The facility respectfully requests an Informal Dispute Resolution for F 272, with reasons given as follows: 1) What corrective actions will be accomplished for those residents	04/24/2013

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	<p>on the Minimum Data Set assessment tool. (Resident #31)</p> <p>Findings include:</p> <p>During an observation and interview with Resident #31 on 3/18/13 at 2:45 p.m., the resident was observed to be edentulous [without natural teeth]. She indicated during an interview, at the time of the observation, that she had both upper and lower dentures but preferred to wear only her upper denture.</p> <p>A record review of a quarterly Minimum Data Set [MDS] assessment tool, dated 9/1/12, on 3/22/13 at 3:00 p.m., indicated in Section L, oral/dental status was not assessed.</p> <p>A record review of an entry MDS assessment tool dated 11/27/12, on 3/22/13 at 3:05 p.m., indicated in Section L, oral/dental status was not assessed.</p> <p>A record review of a significant change MDS, dated 12/03/12, on 3/11/13 at 3:00 p.m. indicated, Section L, oral/dental status was assessed as, " Z. none of the above present," indicating the resident did not wear dentures.</p>		<p>found to have been affected by the deficient practice? All residents had the potential to be affected by this deficiency. The facility provides our nurses with a weekly oral health assessment tool for all residents. The facility also enlists Primesource Healthcare Systems who see our residents for oral care and assessment by a dentist, on a scheduled six (6) month basis. Residents also have the option of visiting a dentist of their choice. MDS records for those residents found to have been affected, have been amended as applicable. The record for resident #31, dated 11-27-12, was an "entry record" and there was found to be no code for dental for an "entry record" on the MDS form. Please refer to exhibit "B2". (This resident had returned from hospital). The record entry for resident #31 dated 9-1-12 was marked "-", meaning that there was "no problem". The "-" mark did not mean that a dental assessment had been accomplished. Resident #31 has been re-scheduled to see the dentist, on 4-12-13. Please see exhibit C. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The record for resident #31 was an "entry record" and there was found to be no code for dental for an "entry record" on the</p>		

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	3.1-31(a)		MDS form. Please refer to exhibit "B2". (This resident had returned from hospital). The record entry for resident #31 dated 9-1-12 was marked "-", meaning that there was "no problem". The "-" mark did not mean that a dental assessment had been accomplished. All 'tagged' entries that have been questioned by our state surveyors have been amended as applicable and re-submitted as of 4-10-2013. All new residents are assessed for oral health as part of the nursing admission assessment. The facility provides our nurses with a weekly oral health assessment tool for all residents. The facility also enlists Primesource Healthcare Systems who see our residents for oral care and assessment by a dentist, on a scheduled six (6) month basis. Residents also have the option of visiting a dentist of their choice. The facility will adopt a dental health assessment form that will be attached to the nursing MDS forms, on an every three (3) month basis. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? MDS records for those residents found to have been affected, have been amended as applicable. The facility will adopt a dental health assessment form that will be attached to the nursing MDS		

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			<p>forms, on an every three (3) month basis. All new residents are assessed for oral health as part of the nursing admission assessment. The facility provides our nurses with a weekly oral health assessment tool for all residents. The facility also enlists Primesource Healthcare Systems who see our residents for oral care and assessment by a dentist, on a scheduled six (6) month basis. Residents also have the option of visiting a dentist of their choice.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? MDS records for those residents found to have been affected, have been amended as applicable. The facility will adopt a dental health assessment form that will be attached to the nursing MDS forms, on an every three (3) month basis. The MDS nurse will head the quality assurance measures as aforementioned and the way that MDS is coded has now been amended. (The record for resident #31 was an "entry record" and there was found to be no code for dental for an "entry record" on ther MDS form. Please refer to exhibit "B2". (This resident had returned from hospital). The record entry for resident #31 dated 9-1-12 was marked "-", meaning that there</p>	

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			was "no problem". The "-" mark did not mean that a dental assessment had been accomplished.) 5) By what date the systemic changes will be completed? April 24th, 2013	

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F000278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 7 residents in a sample of 7 clinical records reviewed for admission diagnoses, was coded as having a terminal diagnosis. (Resident #21)</p> <p>Findings include:</p>	F000278	F278 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents had the potential to be affected by this deficiency. Resident #21 who was admitted 10/9/2012, has a "Physicians Certification Of Terminal Illness For Medicare Hospice Benefit",	04/24/2013			

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	<p>A clinical record review of the admission record for Resident #21 on 3/19/13 at 2:45 p.m., indicated the resident was admitted on 10/9/12, with diagnoses including but not limited to: acute kidney failure, angina pectoris, hyperlipidemia, long term use of anticoagulant, general muscle weakness, senile dementia, delirium tremens, congestive heart failure, adult antisocial disorder, subdural hematoma, and dementia.</p> <p>A review of a Minimum Data Set [MDS] assessment dated 10/15/12, indicated, section J1400. Prognosis, "does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (requires physician documentation)." The response coded was, "0. No", indicating the resident did not have a terminal illness.</p> <p>A review on 3/19/13 at 3:00 p.m., of a document entitled, "Physician's Certification of Terminal Illness For Medicare Hospice Benefit" dated 10/9/12, indicated a hospice diagnosis of senile dementia. The document indicated, with a life expectancy of six months or less, the resident qualified for hospice services</p>		<p>which was given to our state surveyors, from the resident's medical record. The Physician's certification was signed by the doctor for Season's Hospice, on 10/10 2012. Hospice may not admit a resident for their services without this form and the doctor's signature. J1400 (Page J-24) of the CMS RAI Version 3.0 Manuel states that "...Under the hospice program benefit regulations , a physician is required to document in the medical record a life expectancy of less then six (6) months, so that if a resident is on hospice the expectation is that the documentation is in the medical record. The MDS nurse has amended and resubmitted the record for this resident regarding J1400 (as of 4-8-2013.) 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The MDS nurse has amended and resubmitted the record for this resident regarding J1400 (as of 4-8-2013.) The MDS nurse has also audited her records to ensure this J1400 reply was not duplicated on other hospice residents. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Resident #21 who was admitted 10/9/2012, has a "Physicians Certification Of Terminal Illness</p>				

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	<p>upon admittance to the facility. The document was signed and dated by the physician on 10/10/12. A document entitled, "Hospice Certification and Plan of Treatment" dated 10/9/12, indicated the resident had a prognosis of less than a 6 month life expectancy. The plan of treatment indicated the start of hospice care was to be 10/9/12. The code status was indicated as, "CPR [cardiopulmonary resuscitation] will not be initiated."</p> <p>A review on 3/20/13 at 3:30 p.m., of a care plan initiated on 10/17/12, indicated the resident had a problem of end of life care related to a diagnosis of end stage dementia. Interventions included but not limited to: hospice services, collaborate nursing facility care with hospice services, and do not resuscitate status.</p> <p>In an interview on 3/20/12 at 10:30 p.m., the Minimum Data Set [MDS] Coordinator indicated the resident did not have a terminal diagnosis when she was admitted to the facility. She indicated, "you would never be able to get a doctor to pin down when a patient is going to die. They would never make a statement that someone is going to die in six, seven</p>		<p>For Medicare Hospice Benefit", which was given to our state surveyors, from the resident's medical record. The MDS nurse has amended and resubmitted the record for resident #21, regarding J1400 (as of 4-8-2013.) All hospice residents will be reviewed by the MDS nurse and the hospice nurse to ensure continuity of care and correct documentation of the hospice status. Review may be done in person, by telephone or by written communications between the MDS nurse and the hospice nurse. The MDS nurse will document such reviews in the resident's medical record and will code accordingly on section J1400. The MDS nurse has also audited her records to ensure this J1400 reply was not duplicated on other hospice residents. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Quality Assurance: The MDS nurse has amended and resubmitted the record for resident #21, regarding J1400 (as of 4-8-2013.) The MDS nurse has also audited her records to ensure this J1400 reply was not duplicated on other hospice residents. Hospice residents will be reviewed by the MDS nurse and the hospice nurse to ensure continuity of care and correct documentation of the hospice status. Review may be</p>		

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	<p>days or even a month."</p> <p>A review of the resident's clinical record on 3/20/13 at 10:40 a.m., indicated the resident died at the facility on 11/03/12 at 7:05 p.m. The physician and family were notified of the resident's death.</p> <p>3.1-31(d)</p>		<p>done in person, by telephone or by written communications between the MDS nurse and the hospice nurse. The MDS nurse will document such reviews in the resident's medical record and will code accordingly on section J1400. This remedy is assigned no stop date. 5) By what date the systemic changes will be completed? April 24th, 2013.</p>		

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F000279 SS=E	<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 care plans for residents receiving antipsychotic medications addressed the need for monitoring for signs and symptoms of abnormal, involuntary movements and performing the AIMS (Abnormal Involuntary Movements Scale) assessment quarterly, for 3 of 10 residents who met the criteria for review of unnecessary medications (Residents #14, #29 and #26) and a care plan for a resident experiencing weight loss was developed for 1 of 2 residents who met the criteria for</p>	F000279	F279 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents had the potential to be affected by this deficiency. Care plans have been adjusted on all residents as of 4-11-2013 to include specific possible signs and symptoms of abnormal involuntary movements related to the use of antipsychotic medications. The facility now utilizes a single sheet AIMS assessment that is done every three (3) months on every resident. Please see exhibit D. (Previously the AIMS assessment	04/24/2013			

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	<p>review of significant weight loss in a total sample of 19.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #14 was reviewed on 3/21/13 at 11:19 a.m.</p> <p>Diagnoses for Resident #14 included, but were not limited to, dementia with agitation and behavioral disturbances, anxiety, and a history of alcohol abuse.</p> <p>A recapitulated physician's order for December, 2012, with an original order date of 9/16/11, indicated Resident #14 was to receive Zyprexa, 7.5 mg. every night at bedtime.</p> <p>A recapitulated physician's order for March, 2013, with an original order date of 2/7/13, indicated the Zyprexa was decreased to 5.0 mg. every night for Resident #14.</p> <p>Zyprexa is an anti-psychotic medication used to treat bi-polar disorder, schizophrenia and depression. An adverse side effect of taking Zyprexa can be the development of abnormal, involuntary movements, called tardive dyskinesia. (2010 Nursing Spectrum Drug</p>		<p>form contained eight (8) separate dates for the assessment on one single form. This form had to be "carried over". The current form does not "carry over".) Please see exhibit E that is attached to exhibit D. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Care plans have been adjusted on all residents as of 4-11-2013 to include specific possible signs and symptoms of abnormal involuntary movements related to the use of antipsychotic medications. The facility now utilizes a single sheet AIMS assessment that is done every three (3) months on every resident. Please see exhibit D. (Previously the AIMS assessment form contained eight (8) separate dates for the assessment on one single form. This form had to be "carried over". The current form does not "carry over".) Please see exhibit E. AIMS assessments will also be reviewed in weekly care plan meetings and documented as being reviewed in the care plan notes. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Care plans have been adjusted on all residents as of 4-11-2013 to include specific possible signs and symptoms of abnormal involuntary movements related to</p>				

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	<p>Handbook)</p> <p>Medication Administration Records for Resident #14 indicated he had received the Zyprexa daily in April, 2012 through February, 2013.</p> <p>A care plan for Resident #14, originally dated 12/1/11, and updated through 5/19/13, indicated a problem of, "Resident is at risk for side effects [related to] routine antipsychotic...medications..." The goal was "Resident will have no adverse side effects thru next review." Approaches included, "(4) Document side effects and notify MD...(5) Observe for dry mouth, drowsiness, dizziness, insomnia, depression, confusion and decreased appetite... (7) AIMS every 6 months and as needed..."</p> <p>No approaches were found in this care plan to indicate Resident #29 should be monitored for signs/symptoms of tardive dyskinesia or that the AIMS (Abnormal Involuntary Movement Scale) assessment should be done quarterly.</p> <p>2. The clinical record of Resident #29 was reviewed on 3/22/13 at 9:55 a.m.</p>		<p>the use of antipsychotic medications. The facility now utilizes a single sheet AIMS assessment that is done every three (3) months on every resident. Please see exhibit D. The new AIMS single form will be attached to all quarterly MDS nursing packets. The nursing staff will be in-serviced regarding the use of the new AIMS form, in-services will take place twice per month for two months , then once per month for three (3) months. (Previously the AIMS assessment form contained eight (8) seperate dates for the assessment on one single form. This form had to be "carried over". The current form does not "carry over".) Please see exhibit E. AIMS assessments will also be reviewed in weekly care plan meetings and documented as being reviewed in the care plan notes. The care plan for resident #30 regarding therapeutic diet, was given to our state surveyors. Please see exhibit H. This care plan for resident #30 addresses weight and states that the residents weight will be monitored with the physician notified of 5% weight loss in one month or 10% weight loss in 180 days. The physician was notified and the resident is a hospice, end of life palliative care resident who's weight loss is to be expected. However, an updated care plan for this residents nutrition has been done. 4) How</p>				

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	<p>Diagnoses for Resident #29 included, but were not limited to, depression, schizophrenia, bipolar disorder, anxiety, post traumatic stress disorder, and history of alcohol abuse.</p> <p>Recapitulated physician's orders for March, 2013, indicated Resident #29 was to receive Seroquel XR 150 mg. every morning (original order date 7/13/12), Seroquel 50 mg. every day at noon (original order date 7/16/12), and Seroquel XR 400 mg. every night at bedtime.(original order date 9/11/11)</p> <p>Seroquel is an anti-psychotic medication used to treat depression, bipolar disorder and schizophrenia. An adverse side effect of taking Seroquel can be abnormal, involuntary movements, called tardive dyskinesia. (2010 Nursing Spectrum Drug Handbook)</p> <p>Medication Administration Records for Resident #29 for March, 2012, through March, 2013, indicated he received Seroquel as ordered.</p> <p>A care plan for Resident #29, with an original date of 8/19/09, updated 11/19/12, and reviewed current, indicated he was, " at risk for side</p>		<p>the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Quality Assurance: The AIMS for all residents have been accomplished at this time and will continue to be completed every three (3) months. The new AIMS single form will be attached to all quarterly MDS nursing packets. This correction has no end date. The nursing staff will be in-serviced regarding the use of the new AIMS form, in-services will take place twice per month for two months, then once per month for three (3) months. The updated AIMS have been reported to the physician and the physician has made his recommendations regarding the use of antipsychotic medications. As an example please see exhibits F and G. (For the resident examples in Exhibits F and G, please note there were no changes made at this time. The physician believes the abnormal involuntary movements from this particular resident are directly related to autism and mental retardation.) AIMS assessments will also be reviewed weekly in care plan meetings and documented as being reviewed in the care plan notes. The MDS nurse will monitor these actions and be responsible to document. This correction will have no end date. Attendees in care plan meeting</p>		

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	<p>effect r/t [related to] psychotropic medication use [diagnoses] schizophrenia, bipolar, behaviors, depression..." The goal was that he would have no adverse reaction to this medication through his next review. Approaches included (1) Assess for side effects of headache, dizziness, agitation, sedation, syncope and nausea..."</p> <p>No approaches were found in this care plan to indicate Resident #29 should be monitored for signs/symptoms of tardive dyskinesia or that the AIMS assessment should be done quarterly.</p> <p>3. The clinical record of Resident #26 was reviewed on 3/21/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #26 included, but were not limited to, depression, anxiety, dementia, and bipolar disorder. She was admitted to the facility on 7/12/12.</p> <p>A recapitulated physician's order for March, 2013, with an original date of 8/29/12, indicated Resident #26 was to receive Abilify, (an anti-psychotic medication, used to treat schizophrenia, bipolar disorder and depression) 2 mg. every day. An adverse side effect of this medication</p>		<p>include the Director of Nursing, the MDS nurse, the Social Service Director, the Activity Director, the Dietary Manager, the resident and or the family member and the Administrator. The Dietary Manager monitors weights once per month or more frequently as needed or ordered. This will continue with the nutritional care plans copied when updated for weight loss and given to the Administrator. These will also be discussed and documented as applicable during the weekly care plan meetings.</p> <p>5) By what date the systemic changes will be completed? April 24th, 2013</p>		

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	<p>can include the development of abnormal involuntary movements, called tardive dyskinesia. (2010 Nursing Spectrum Drug Handbook)</p> <p>Medication Administration Records for September, 2012, through February, 2013, indicated she received Abilify, 2 mg., every day.</p> <p>A care plan for Resident #26, dated 7/20/12 and updated through 4/15/13, indicated a problem of, "Resident at risk for side effects as she is on psychotropic medications per orders. antidepressant, antianxiety and antipsychotic..." The goal was, "Resident will remain free from side effects through next review." Approaches included, "... (2) Observe and document mood/behaviors..."</p> <p>No approaches were found in the care plan to indicate Resident #26 should be monitored for signs/symptoms of tardive dyskinesia or that the AIMS assessment should be done quarterly.</p> <p>During an interview on 3/25/13 at 11:50 a.m., the MDS (Minimum Data Set) Coordinator indicated the AIMS assessment was the tool the facility used to monitor residents on anti-psychotic medications for</p>			

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	<p>signs/symptoms of tardive dyskinesia. She indicated monitoring residents on anti-psychotic medications for signs and symptoms of the development of tardive dyskinesia, and assessing the residents, quarterly, using the AIMS tool, were not approaches she incorporated into the residents' care plans. She indicated these approaches were part of the residents' plans of care but, "I just don't put them on the care plans. I've never done it before. I'll start doing it now." She indicated she had added an undated approach to all anti-psychotic medication resident care plans on 3/25/13, to indicate, "quarterly assessments and as needed."</p> <p>4. Resident #30's clinical record was reviewed on 3/21/13 at 9:30 a.m.</p> <p>Resident #30's diagnoses included but were not limited to cardiomegaly (an enlarged heart), hypertension, degenerative joint disease, and psychosis.</p> <p>A Minimum Data Set (MDS) done on 10/14/12 indicated a Care Area Assessment (CAA) and Care Plan was needed for Resident #30's nutritional status.</p>				

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	<p>A review of the clinical record indicated Resident #30 had a significant weight loss. Resident #30's weight on 9/4/12 was 160 pounds. Resident #30's weight on 3//3/13 was 135 pounds. Resident #30 had a weight loss 25 pounds, 18.5 percent of his body weight, in 180 days.</p> <p>The facility dietary manager and Resident #30's medical doctor were aware of the weight loss and were monitoring Resident #30, who was placed on end of life hospice services as of 9/26/12.</p> <p>During an interview with the facility DON (Director of Nursing) and ADON (Assistant Director of Nursing) on 3/21/13 at 12:00 p.m., further information was requested in regards to a nutrition care plan for Resident #30.</p> <p>During an interview with the facility DON and ADON on 3/22/13 at 2:00 p.m., they indicated no such care plan was available for Resident #30.</p> <p>A facility policy titled "Care Plan Meetings", dated 10/18/10, indicated "Triggers on the CAA will be compared to the care plans to ensure</p>			

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	all CAA are properly included in the care plan section." 3.1-35(a)				

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F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure care plans were implemented for 3 of 19 residents reviewed for of implementation of care plans in a total sample of 19. (Resident #26, #29 and #30)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #26 was reviewed on 3/21/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #26 included, but were not limited to depression, anxiety, dementia, and bipolar disorder.</p> <p>a. An updated care plan for Resident #26, originally dated 7/19/12, indicated a problem of "Resident verbalizes and/or demonstrates feelings of sadness/anxiety/depression." Goals were "(1) Resident will express or show some sign of happiness or pleasure...(2) Resident will verbalize and/or demonstrate decreased anxiety levels..." Approaches included "(1) Encourage to verbalize feelings...(5) Attempt to identify sources of anxiety and help to resolve</p>	F000282	<p>F282 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The facility does not practice giving anti-anxiety medications without performing suggested interventions. Interventions were written out specifically within the care plans for residents # 26,29 and 30. For reference and as an example, resident #29 has the following diagnosis: Hx GI bleed, Hx Hep B & C, depression, dysphagia, HX pancreatitis, dysarthria, HTN, Schizophrenia, bipolar disease, edema, chronic constipation, colitis, GERD, recurrent ileus, severe gastroparesis, hyperlipidemia, anxiety, post traumatic stress disorder, insomnia, peripheral vascular disease with peripheral neuropathy, HX CVA, slurred speech, seizure disorder, chronic neck pain, HX pulmonary embolus, hemiparesis, chronic left shoulder pain, hemorrhoids, limited mobility, hiatal hernia, urinary retention with occasional incontinence, barretts esophagitis, anemia, thyromegaly, COPD, spasticity and hypokalemia. This resident wears a brace to a lower</p>	04/24/2013			

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	<p>where appropriate...(7) Provide redirection of thought patterns...(8) Encourage coping mechanisms [e.g. talking, walking, crying]..."</p> <p>A recapitulated physician's order for March, 2013, with an original date of 8/29/12, indicated Resident #26 could receive Ativan 0.5 mg. (milligrams) every 4 hours as needed for agitation or anxiety. Ativan is an anti-anxiety medication.</p> <p>Medication Administration Records (MAR) for December, 2012, indicated Resident #26 received Ativan on 12/3/12 at 11:15 p.m., 12/4/12 at 8:13 p.m., 12/6/12 at 7:51 p.m., and 12/10/12 at 8:24 p.m. Follow up documentation on the MAR, after the above as needed administrations of Ativan, indicated the Ativan was "With good effect."</p> <p>A nurse's note for 12/4/12 at 10:00 p.m., indicated "Resident requested prn [as needed] Ativan. Med[ication] given per order helpful per resident..."</p> <p>The MAR for January, 2013, indicated #26 received Ativan on 1/11/13 at 7:42 p.m., 1/14/13 at 9:43 p.m., 1/24/13 at 12:48 p.m. and 7:36 p.m. Follow up documentation on the MAR, after the administrations of Ativan, indicated the Ativan was "With good effect."</p>		<p>extremity, uses a cervical collar for chronic neck pain prn and has foot drop and hemiparesis as a result of a stroke and also requires all activities of daily living be accomplished by facility staff. The resident receives botox injections for muscle spasticity and to prevent contractures. The facility utilizes an electronic medication pass and there was no room in the electronic document for interventions that were utilized. The facility has requested an enhancement for the electronic medication pass system that will allow specific interventions to be documented by the nurse administering the medications. Please see unmarked exhibit entitled Behavior Monitoring. The facility does not practice giving anti-anxiety medications without performing suggested interventions however the nurses have been verbally counseled as to their responsibility to document interventions prior to administering PRN medications. Such documentation will be located in the nursing notes, on behavior sheets, on the 24 hour report, or in other parts of the medical record; until such time that the enhancement to the electronic medication pass has been completed. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be</p>				

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	<p>A nurse's note for 1/11/13, no time documented, indicated "Resident requested prn Ativan at bedtime effective..."</p> <p>A nurse's note for 1/14/13 at 11:00 p.m. indicated, "Res[ident] asked for...prn Ativan to help her relax...given...effective..."</p> <p>No documentation in Resident #26's record was found to indicate any attempts were made to encourage her to verbalize her feelings, identify the source of her anxiety, redirect the resident or encourage coping mechanisms, as outlined in her care plan.</p> <p>2. The clinical record of Resident #29 was reviewed on 3/22/13 at 9:55 a.m.</p> <p>Diagnoses for Resident #29 included, but were not limited to, depression, schizophrenia, bipolar disorder, anxiety, post traumatic stress disorder, and history of alcohol abuse.</p> <p>A recapitulated physician's order for March, 2013, with an original date of 11/6/12, indicated Resident #29 could receive Ativan, 0.5 mg twice a day as needed. Ativan is an anti-anxiety medication.</p>		<p>taken? All residents had the potential to be affected by this deficiency. Interventions were written out specifically within the care plans for residents # 26,29 and 30. Nurses have been verbally counseled as to their responsibility to document interventions prior to administering PRN medications. Such documentation will be located in the nursing notes, on behavior sheets, on the 24 hour report, or in other parts of the medical record; until such time that the enhancement to the electronic medication pass has been completed. The facility has requested an enhancement for the electronic medication pass system that will allow specific interventions to be documented by the nurse administering the medications. Nursing staff will be in-serviced on the enhancement to our system. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nurses have been verbally counseled as to their responsibility to document interventions prior to administering PRN medications. Such documentation will be located in the nursing notes, on behavior sheets, on the 24 hour report, or in other parts of the medical record; until such time that the enhancement to the electronic medication pass has</p>		

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	<p>A care plan for Resident #29, with an original date of 1/8/10, indicated he had "Potential for restlessness, fatigue, insomnia, irritability d/t [due to] generalized anxiety disorder..." The goal was that he would have "decreased episodes of anxiety..." Approaches included, "...(2) Encourage to ventilate feelings, give positive, realistic feedback...(3) encourage res[ident] to call family...(6) Attempt to find out reason for anxiety...(7) Re-assure res[ident] as needed..."</p> <p>The MAR for February, 2013, indicated Resident #29 received Ativan, 0.5 mg. on 2/7 at 7:35 a.m., 2/8 at 4:29 p.m., 2/9 at 12:45 a.m., 2/13 at 10:47 a.m. and 7:05 p.m., 2/14 at 12:50 p.m., 2/16 at 9:26 a.m. and 8:54 p.m., 2/22 at 5:52 p.m., 2/23 at 9:49 a.m., and 2/24 at 9:25 a.m.</p> <p>A nurse's note for 2/7/13 at 10:00 p.m. indicated, "Resident ask staff for Ativan c/o [complaints of] anxiety and nurse administered medication per doctors order with effective results."</p> <p>A nurse's note dated 2/8/13, no time given, indicated, "c/o anxiety this am so prn Ativan given effective..."</p> <p>A nurse's note, dated 2/16/13 at 10:30</p>		<p>been completed. Systemic changes: The facility has requested an enhancement for the electronic medication pass system that will allow specific interventions to be documented by the nurse administering the medications. Nursing staff will be in-serviced on the enhancement to our system. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Nursing staff have been verbally counseled as to their responsibility to document interventions prior to administering PRN medications. Such documentation will be located in the nursing notes, on behavior sheets, on the 24 hour report, or in other parts of the medical record; until such time that the enhancement to the electronic medication pass has been completed. Nursing staff will also be in-serviced on performing interventions prior to administering PRN medications x2 before the enhancement to our electronic record is provided.</p> <p>Systemic changes: The facility has requested an enhancement for the electronic medication pass system that will allow specific interventions to be documented by the nurse administering the medications. Please see unmarked exhibit entitled Behavior Monitoring. Nursing staff will be in-serviced on the</p>				

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	<p>p.m., indicated, "Resident requested Ativan this evening for anxiety medication was effective..."</p> <p>No other documentation was found in the resident's clinical record regarding the February, 2013, MAR administrations of prn Ativan.</p> <p>No documentation in Resident #29's record was found to indicate any attempts were made to identify the source of his anxiety, encourage him to ventilate his feelings, encourage him to call his family and to reassure him as needed, as outlined in his care plan.</p> <p>During an interview with the Director of Nursing on 3/22/13 at 8:35 a.m., she indicated "They're supposed to offer something else, like trying to divert the resident's attention or something."</p> <p>3. Resident #30's clinical record was reviewed on 3/21/13 at 9:30 a.m.</p> <p>Resident #30's diagnoses included but were not limited to cardiomegaly (an enlarged heart), hypertension, degenerative joint disease, and psychosis.</p>		<p>enhancement to our system. Nursing staff will also be inserviced on performing interventions prior to administering PRN medications x2 before the enhancement to our electronic record is provided. The electronic enhancement to our EZ Mar will provide an on going documentation record that is readily available should future questions arise. The DON or her designee will weekly monitor compliance of the staff for written interventions prior to the facility's electronic medication record enhancement. 5) By what date the systemic changes will be completed? April 24th, 2013</p>		

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	<p>Resident #30 had a written physicians order, dated 1/10/13, stating "Administer 2L O2 PRN When Sats 80 DX: Pneumonia" [Administer 2 Liters of Oxygen as needed when oxygen saturation in the body is below 80% for a diagnoses of Pneumonia].</p> <p>The clinical record review lacked evidence of oxygen saturation levels being assessed.</p> <p>During an interview with the facility DON (Director of Nursing) and ADON (Assistant Director of Nursing) on 3/21/13 at 12:00 p.m., further information was requested in regards to monitoring of the oxygen saturation levels for Resident #30.</p> <p>During an interview with the facility DON and ADON on 3/22/13 at 2:00 p.m., they indicated no such monitoring had been done.</p> <p>During an interview with the facility Executive Director on 3/25/13 at 3:15 p.m., she indicated there was no policy in regards to following physicians orders, just that they address this during facility meetings.</p> <p>3.1-35(g)(2)</p>			

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F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 record review and interview, the facility failed to ensure residents were free of unnecessary medications for 7 of 10 residents who met the criteria for review of unnecessary medications in a sample of 19. (Residents #26, #14, #4, #29, #8, #25, and #2)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #26 was reviewed on 3/21/13 at 9:00 a.m.</p>	F000329	F329 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The facility does not practice giving anti-anxiety medications without performing suggested interventions. Interventions were written out specifically within the care plans for residents # 26, 29 and 30. For reference and as an example, resident #29 has the following diagnosis: Hx GI bleed, Hx Hep B & C, depression, dysphagia, HX pancreatitis, dysarthria, HTN, Schizophrenia,	04/24/2013			

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	<p>Diagnoses for Resident #26 included, but were not limited to, depression, anxiety, dementia, and bipolar disorder.</p> <p>a. An updated care plan for Resident #26, originating 7/19/12, indicated a problem of "Resident verbalizes and/or demonstrates feelings of sadness/anxiety/depression." Goals were "(1) Resident will express or show some sign of happiness or pleasure...(2)Resident will verbalize and/or demonstrate decreased anxiety levels..." Approaches included "(1) Encourage to verbalize feelings...(5) Attempt to identify sources of anxiety and help to resolve where appropriate...(7) Provide redirection of thought patterns...(8) Encourage coping mechanisms [e.g. talking, walking, crying]."</p> <p>A recapitulated physician's order for March, 2013, with an original date of 8/29/12, indicated Resident #26 could receive Ativan 0.5 mg. (milligrams) every 4 hours as needed for agitation or anxiety. Ativan is an anti-anxiety medication.</p> <p>Medication Administration Records (MAR) for December, 2012, indicated Resident #26 received Ativan on</p>		<p>bipolar disease, edema, chronic constipation, colitis, GERD, recurrent ileus, severe gastroparesis, hyperlipidemia, anxiety, post traumatic stress disorder, insomnia, peripheral vascular disease with peripheral neuropathy, HX CVA, slurred speech, seizure disorder, chronic neck pain, HX pulmonary embolus, hemiparesis, chronic left shoulder pain, hemorrhoids, limited mobility, hiatal hernia, urinary retention with occasional incontinence, barretts esophagitis, anemia, thyromegaly, COPD, spasticity and hypokalemia. This resident wears a brace to a lower extremity, uses a cervical collar for chronic neck pain prn and has foot drop and hemiparesis as a result of a stroke and also requires all activities of daily living be accomplished by facility staff. The resident receives botox injections for muscle spasticity and to prevent contractures. The facility utilizes an electronic medication pass and there was no room in the electronic document for interventions that were utilized. The facility has requested an enhancement for the electronic medication pass system that will allow specific interventions to be documented by the nurse administering the medications. The facility does not practice giving anti-anxiety medications without performing suggested interventions however</p>				

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	<p>12/3/12 at 11:15 p.m., 12/4/12 at 8:13 p.m., 12/6/12 at 7:51 p.m., and 12/10/12 at 8:24 p.m. Follow up documentation on the MAR, after the administrations of Ativan, indicated the Ativan was, "With good effect."</p> <p>Nurses' notes for 12/4/12 at 10:00 p.m., indicated "Resident requested prn [as needed] Ativan. Med[ication] given per order helpful per resident..."</p> <p>The MAR for January, 2013, indicated #26 received Ativan on 1/11/13 at 7:42 p.m., 1/14/13 at 9:43 p.m., 1/24/13 at 12:48 p.m. and 7:36 p.m. Follow up documentation the the MAR, after the administrations of Ativan, indicated the Ativan was, "With good effect."</p> <p>Nurses' notes for 1/11/13, no time documented, indicated "Resident requested prn Ativan at bedtime effective..."</p> <p>Nurses' notes for 1/14/13 at 11:00 p.m. indicated, "Res[ident] asked for...prn Ativan to help her relax...given...effective..."</p> <p>No documentation in Resident #26's record was found to indicate any attempts were made to identify the source of her anxiety, redirect the</p>		<p>the nurses have been verbally counseled as to their responsibility to document interventions prior to administering PRN medications. Such documentation will be located in the nursing notes, on behavior sheets, on the 24 hour report, or in other parts of the medical record; until such time that the enhancement to the electronic medication pass has been completed. Care plans have been adjusted on all residents as of 4-11-2013 to include specific possible signs and symptoms of abnormal involuntary movements related to the use of antipsychotic medications. The facility now utilizes a single sheet AIMS assessment that is done every three (3) months on every resident. Please see exhibit D. (Previously the AIMS assessment form contained eight (8) separate dates for the assessment on one single form. This form had to be "carried over". The current form does not "carry over".) Please see exhibit E. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents had the potential to be affected by this deficiency. Interventions were written out specifically within the care plans for residents # 26, 29 and 30. Nurses have been verbally counseled as to their</p>		

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	<p>resident, encourage coping mechanisms or that any other alternative, non-pharmacological interventions were tried prior to these administrations of prn Ativan.</p> <p>During an interview with the Director of Nursing on 3/22/13 at 8:35 a.m., she indicated "They're supposed to offer something else, like trying to divert the resident's attention or something."</p> <p>b. A recapitulated physician's order for March, 2013, with an original date of 8/29/12, indicated Resident #26 was to receive Abilify, (an anti-psychotic medication, used to treat schizophrenia, bipolar disorder and depression) 2 mg. every day. Adverse side effects of this medication can include abnormal involuntary movements, called tardive dyskinesia. (2010 Nursing Spectrum Drug Handbook)</p> <p>Medication Administration Records for Resident #26 for September, October, November and December, 2012, and January and February, 2013, indicated she received Abilify, 2 mg. every day.</p> <p>There was no documentation to indicate a quarterly AIMS (Abnormal</p>		<p>responsibility to document interventions prior to administering PRN medications. Such documentation will be located in the nursing notes, on behavior sheets, on the 24 hour report, or in other parts of the medical record; until such time that the enhancement to the electronic medication pass has been completed. The facility has requested an enhancement for the electronic medication pass system that will allow specific interventions to be documented by the nurse administering the medications. Nursing staff will be in-serviced on the enhancement to our system. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nurses have been verbally counseled as to their responsibility to document interventions prior to administering PRN medications. Such documentation will be located in the nursing notes, on behavior sheets, on the 24 hour report, or in other parts of the medical record; until such time that the enhancement to the electronic medication pass has been completed. Systemic changes: The facility has requested an enhancement for the electronic medication pass system that will allow specific interventions to be documented by the nurse administering the medications. Nursing staff will be</p>		

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	<p>Involuntary Movement Scale) assessment had been done for Resident #26 between August, 2012, and March 25, 2013. The AIMS is an assessment tool the facility uses to evaluate each resident taking anti-psychotic medications for the appearance and/or worsening of such signs and symptoms as abnormal facial, extremity, and trunk movements, and the residents' incapacitation due to, and awareness of, these abnormal movements.</p> <p>During an interview with the MDS (Minimum Data Set) Coordinator on 3/25/13 at 12:25 p.m., she indicated she was not able to find any other AIMS assessments done for Resident #26 between August, 2012 and February, 2013.</p> <p>2. The clinical record of Resident #14 was reviewed on 3/21/13 at 11:19 a.m.</p> <p>Diagnoses for Resident #14 included, but were not limited to, dementia with agitation and behavioral disturbances, anxiety and a history of alcohol abuse.</p> <p>A recapitulated physician's order for December, 2012, with an original order date of 9/16/11, indicated</p>		<p>in-serviced on the enhancement to our system. Care plans have been adjusted on all residents as of 4-11-2013 to include specific possible signs and symptoms of abnormal involuntary movements related to the use of antipsychotic medications. The facility now utilizes a single sheet AIMS assessment that is done every three (3) months on every resident. Please see exhibit D. (Previously the AIMS assessment form contained eight (8) separate dates for the assessment on one single form. This form had to be "carried over". The current form does not "carry over".) Please see exhibit E. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Nursing staff have been verbally counseled as to their responsibility to document interventions prior to administering PRN medications. Such documentation will be located in the nursing notes, on behavior sheets, on the 24 hour report, or in other parts of the medical record; until such time that the enhancement to the electronic medication pass has been completed. Nursing staff will also be in-serviced on performing interventions prior to administering PRN medications x2 before the enhancement to our electronic record is provided.</p>				

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	<p>Resident #14 was to receive Zyprexa, 7.5 mg. every night at bedtime.</p> <p>A recapitulated physician's order for March, 2013, with an original order date of 2/7/13, indicated the Zyprexa was decreased to 5.0 mg. every night for Resident #14.</p> <p>Zyprexa is an anti-psychotic medication used to treat bi-polar disorder, schizophrenia and depression. An adverse side effect of taking Zyprexa can be having abnormal, involuntary movements, called tardive dyskinesia. (2010 Nursing Spectrum Drug Handbook)</p> <p>Medication Administration Records for Resident #14 indicated he had received the Zyprexa daily in April, 2012 through February, 2013.</p> <p>Documentation was found in Resident #14's record which indicated an AIMS assessment had been done 2/18/12 and 11/15/12.</p> <p>Further information was requested from the MDS (Minimum Data Set) Coordinator. on 3/21/13 at 1:30 p.m., regarding whether any AIMS assessments were done between 2/18/12 and 11/15/12. At 3:00 p.m. on 3/21/13, the MDS Coordinator</p>		<p>Systemic changes: The facility has requested an enhancement for the electronic medication pass system that will allow specific interventions to be documented by the nurse administering the medications. Nursing staff will be in-serviced on the enhancement to our system. This will provide an on going documentation record that is readily available should future questions arise. The DON or her designee will weekly monitor compliance of the staff for written interventions prior to the facility's electronic medication record enhancement.</p> <p>The nursing staff will be in-serviced regarding the use of the new AIMS form, in-services will take place twice per month for two months, then once per month for three (3) months. The updated AIMS have been reported to the physician and the physician has made his recommendations regarding the use of antipsychotic medications. As an example please see exhibits F and G. (For the resident examples in Exhibits F and G, please note there were no changes made at this time. The physician believes the abnormal involuntary movements from this particular resident are directly related to autism and mental retardation.) AIMS assessments will also be reviewed weekly in care plan meetings and documented as being reviewed in the care plan notes. The MDS</p>				

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	<p>indicated no other AIMS assessments had been done on Resident #14. She indicated the facility policy was to do them every 6 months. She indicated the resident had been taking Zyprexa every evening from February, 2012, to November, 2012 with out having an AIMS assessment done to see if he had developed any abnormal, involuntary movements.</p> <p>During an interview with the Director of Nursing on 3/21/13 at 3:55 p.m. she indicated, "I just realized we were supposed to be doing AIMS every 3 months. Our consultant didn't even tell us that."</p> <p>3. The clinical record of Resident #4 was reviewed on 3/21/13 at 3:05 p.m.</p> <p>Diagnoses for Resident #4 included, but were not limited to, mental retardation, organic brain syndrome, depression, dementia, and schizophrenia.</p> <p>A recapitulated physician's order for February, 2013, with an original date of 10/11/11, indicated Resident #4 was to receive Seroquel, 75 mg., 2 times per day for behaviors.</p> <p>Another physician's order for Resident #4, dated 2/7/13, indicated</p>		<p>nurse will monitor these actions and be responsible to document. This correction will have no end date. Gradual dosage reductions (GDR) for antipsychotic medication usage are discussed monthly in the facility's Quality Assurance meetings (QA). The facility met with QA on 4-11-2013. Attendees are the physician, a psychiatrist, the lead pharmacist, the DON, the ADON, the Administrator and the SSD. Examples are: resident #3 had a failed reduction secondary to seizures as noted at the bottom of a physician progress note. 5) By what date the systemic changes will be completed? April 24th, 2013</p>		

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	<p>Seroquel was to be decreased to 50 mg., 2 times per day.</p> <p>Seroquel is an anti-psychotic medication used to treat depression, bipolar disorder and schizophrenia. An adverse side effect of taking Seroquel can be abnormal, involuntary movements, called tardive dyskinesia. (2010 Nursing Spectrum Drug Handbook)</p> <p>Medication Administration Records for March, 2012, through February, 2013, indicated Resident #4 received Seroquel as ordered.</p> <p>A review of his clinical record indicated an assessment using the Abnormal Involuntary Movement Scale (AIMS) had been done on 5/7/12 and 8/3/12. There was no indication a quarterly AIMS had been done after 8/3/12.</p> <p>Further information was requested from the MDS (Minimum Data Set) Coordinator on 3/22/13 at 9:15 a.m. On this day at 11:00 a.m. the MDS Coordinator indicated no AIMS had been done after 8/3/12.</p> <p>4. The clinical record of Resident #29 was reviewed on 3/22/13 at 9:55 a.m.</p>						

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	<p>Diagnoses for Resident #29 included, but were not limited to, depression, schizophrenia, bipolar disorder, anxiety, post traumatic stress disorder, and history of alcohol abuse.</p> <p>a. Recapitulated physician's orders for March, 2013, indicated Resident #29 was to receive Seroquel XR 150 mg. every a.m.(original order date 7/13/12), Seroquel 50 mg. every day at noon (original order date 7/16/12), and Seroquel xr 400 mg. every night at bedtime.(original order date 9/11/11)</p> <p>Medication Administration Records for Resident #29 for March, 2012, through March, 2013, indicated he received Seroquel as ordered.</p> <p>Documentation in the clinical record indicated only 1 AIMS assessment, dated 10/4/12, had been done for Resident #29 from March, 2012, through 3/ 22/13.</p> <p>During an interview with the MDS Coordinator on 3/25/13 at 3:50 p.m., she indicated she was only able to find the AIMS assessment dated 10/4/12. She was not able to find any others done between March, 2012 and March 2013 to evaluate Resident</p>			

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	<p>#26 for the development of abnormal involuntary movements as a result of his receiving Seroquel.</p> <p>b. A recapitulated physician's order for March, 2013, with an original date of 11/6/12, indicated Resident #29 could receive Ativan, 0.5 mg twice a day as needed. Ativan is an anti-anxiety medication.</p> <p>A care plan for Resident #29, with an original date of 1/8/10, indicated he had "Potential for restlessness, fatigue, insomnia, irritability d/t [due to] generalized anxiety disorder..." The goal was that he would have decreased episodes of anxiety... Approaches included, "... (2) Encourage to ventilate feelings, give positive, realistic feedback... (3) encourage res[ident] to call family... (6) Attempt to find out reason for anxiety... (7) Re-assure res[ident] as needed..."</p> <p>A Medication Administration Record for February, 2013, indicated Resident #29 received Ativan, 0.5 mg. on 2/7 at 7:35 a.m., 2/8 at 4:29 p.m., 2/9 at 12:45 a.m., 2/13 at 10:47 a.m. and 7:05 p.m., 2/14 at 12:50 p.m., 2/16 at 9:26 a.m. and 8:54 p.m., 2/22 at 5:52 p.m., 2/23 at 9:49 a.m., and 2/24 at 9:25 a.m.</p>						

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	<p>No documentation in Resident #29's record was found to indicate any attempts were made to identify the source of his anxiety, redirect the resident, encourage coping mechanisms or that any other alternative, non-pharmacological interventions were tried prior to these administrations of prn Ativan.</p> <p>c. Recapitulated physician's orders for March, 2013, indicated Resident #29 was to receive Seroquel (an anti-psychotic medication used to treat schizophrenia, bipolar disorder and depression) XR 150 mg. every a.m.(original order date 7/13/12), Seroquel 50 mg. every day at noon (original order date 7/16/12), and Seroquel XR 400 mg. every night at bedtime.(original order date 9/11/11)</p> <p>There was no documentation in Resident #29's record to indicate a Gradual Dose Reduction had been considered or attempted for the Seroquel the resident was receiving, between March, 2012 and 3/25/13.</p> <p>During an interview with the Executive Director on 3/25/13, at 5:00 p.m., she indicated she was not able to find where any Gradual Dose Reductions had been considered or attempted for</p>				

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	<p>Resident #29 between March, 2012 and March, 2013. She indicated, "I can't believe we missed this. We always go over the need for Gradual Dose Reductions at our Quality Assurance meetings."</p> <p>An untitled facility policy, dated 2/2011, received from the Executive Director on 3/25/13 at 3:30 p.m., indicated, "...when monitoring all psychopharmacological medications...the facility should review the continued need for them, at least quarterly (i.e. a 3 month period) and document the rationale for continuing the medication, including evidence that the following had been evaluated...Whether the resident experienced any medication-related adverse consequences during the previous quarter..."</p> <p>5. A clinical record review on 3/22/13 at 11:03 p.m., indicated Resident #8 had diagnoses including but not limited to:paranoid schizophrenia, glaucoma, insulin dependent diabetes mellitus, hypertension, history of lower extremity cellulitis with graft, and insomnia.</p> <p>A review of the resident's care plan indicated a problem of risk for side effects related to psychotropic</p>						

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	<p>medications. The goal of the care plan was the resident would remain free from side effects of the psychotropic medication effects. An intervention indicated in the care plan was for an Abnormal Involuntary Movement Scale [AIMS] assessment to be completed every six months and as needed.</p> <p>AIMS [Abnormal Involuntary Movement Scale] assessment dates were, 2/28/13 and 6/1/12. indicating the assessments were nine months apart indicating only 2 of 4 required AIMS assessments had been completed.</p> <p>6. On 3/21/13 at 2:37 p.m., a clinical record review for resident #25 indicated diagnoses including but not limited to: mentally retarded developmentally disabled, hypertension, seizures, psychosis with aggression, chronic renal insufficiency, hyperlipidemia, gout, depression, cardiac dysrhythmia, hypothyroid, inappropriate sexual behaviors, paranoid schizophrenia, and hallucinations.</p> <p>A review of the resident's care plan indicated a problem for potential side effects of psychotropic medication use. A goal indicated the resident</p>				

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	<p>would remain free from adverse effects of the psychotropic medications.</p> <p>A clinical record review on 3/22/13 at 10:33 a.m., indicated AIMS [Abnormal Involuntary Movement Scale] assessments were conducted 3/12/12 and 8/31/12 for the previous 12 month period, indicating only 2 of 4 required AIMS assessments had been completed.</p> <p>7. On 3/22/13 at 2:30 p.m., a clinical record review for resident #2 indicated diagnoses including but not limited to: neuropathy, depression, dementia, mild mentally retarded, renal insuff, medical non-compliance, and agitation.</p> <p>A review of the resident's care plan indicated a problem for potential side effects of psychotropic medication use. A goal indicated the resident would remain free from adverse effects of the psychotropic medications.</p> <p>A clinical record review on 3/25/13 at 10:33 a.m., indicated AIMS [Abnormal Involuntary Movement Scale] assessments were conducted 10/02/12 and 01/31/13 for the previous 12 month period, indicating only 2 of 4 required AIMS</p>			

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	<p>assessments had been completed.</p> <p>During an interview with the MDS (Minimum Data Set) Coordinator on 3/25/13 at 3:25 p.m., she indicated she was not able to find any other AIMS assessments done for Resident #2 between March, 2012 and March, 2013.</p> <p>An untitled facility policy, dated 2/2011, received from the Executive Director on 3/25/13 at 3:30 p.m., indicated, "...when monitoring all psychopharmacological medications...the facility should review the continued need for them, at least quarterly (i.e. a 3 month period) and document the rationale for continuing the medication, including evidence that the following had been evaluated...Whether the resident experienced any medication-related adverse consequences during the previous quarter..."</p> <p>3.1-48(a)(6)</p>				

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F000356 SS=D	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the daily staffing data had been posted in a prominent place.</p> <p>Findings include:</p>	F000356	F356 An Informal Dispute Resolution is being requested humbly for this tag, with reasons given as follows: 1) What corrective actions will be accomplished for those residents found to have been affected by	04/24/2013			

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	<p>On 3/18/13 at 11:50 a.m., the staffing data requirements of the facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift, registered nurse, licensed practical nurses or licensed vocational nurses, certified nurse aides, resident census were posted on a door behind the nurses station, not visible to residents or visitors.</p> <p>On 3/19/13 at 09:50 a.m., the staffing data for 3/19/13 were posted on a door behind the nurses station, not visible to residents or visitors.</p> <p>On 3/20/13 at 9:00 a.m., the staffing data for 3/20/13 were posted on a door behind the nurses station, not visible to residents or visitors.</p> <p>On 3/21/13 at 9:00 a.m., the staffing data for 3/21/13 were posted on a door behind the nurses station, not visible to residents or visitors.</p> <p>On 3/21/13 at 2:00 p.m., interview with the Assistant Director of Nursing indicated that the posting of staffing data was not visible to the residents or visitors.</p>		<p>the deficient practice? A new staff scheduling sheet was placed in the hall by the time clock as soon as our survey team member questioned it's location. (The previous location was the medication room door that is in full view of any interested party.)</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The facility does not believe any residents or family was affected by this practice as the facility has always posted the staffing hours in full view of interested parties. (IE: the medication room door.)Please see photos as exhibits I. However, a new staff scheduling sheet was placed in the hall by the time clock as soon as our survey team member questioned it's location. Please see exhibit J The previous staffing sheet included names and hours of work for each nursing staff member assigned to resident care. Please see exhibit K</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility has replaced the staffing hour sheet as per the surveyors suggestion. This was accomplished before the survey team members exited the facility.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient</p>				

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			practice will not recur/what quality assurance program will be put into place? An Informal Dispute Resolution is being requested for this tag humbly,with reasons given as follows: The facility does not believe any residents or family was affected by this practice as the facility has always posted the staffing hours in full view of interested parties. (IE: the medication room door.)Please see photos as exhibits I. However, a new staff scheduling sheet was placed in the hall by the time clock as soon as our survey team member questioned it's location. Please see exhibit J The new staffing sheet is updated daily. The previous staffing sheet included names and hours of work for each nursing staff member assigned to resident care. Please see exhibit K 5) By what date the systemic changes will be completed? April 24th, 2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/25/2013
NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000456 SS=D	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on observation and interview, the facility failed to ensure the kitchen stove was in good repair during 2 of 2 kitchen observations which had the potential to affect 39 residents receiving meals from the kitchen in the population of 39 and to affect staff who worked in the dietary department.</p> <p>Findings include:</p> <p>During the dietary walk through on 3/18/13 at 1:15 p.m., with the A.M. Cook and Dietary Manager the following were observed:</p> <p>1) In the kitchen there was a six burner stove, one burner was non-functional, four burners would not light from the automatic igniter, the burners had to be lit by a lighter.</p> <p>During an interview with the A.M. Cook at that time, she indicated the burners would not light from the automatic igniter, the burners had to be lit. I use this and picked up a blue handled lighter. The one burner has not worked at all, the four burners</p>	F000456	<p>F456 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The survey team was given documentation by Grease Cutters that the stove had been looked at. The documentation states that: the stove was in good condition on 2-21-2013. This documentation further states that "stove and hood in good working order". Please see exhibit 'I' The parts for the stove were on order from ECO Lab. On 4-11-2013 the facility received the ordered parts however the wrong parts were sent. Please see exhibit photos J.</p> <p>The facility regrets that employees made statements to the contrary. Dietary employees will be in-serviced by the maintenance person regarding the use and care of the stove and reporting problems immediately to the maintenance person. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents had the potential to be affected by this deficiency. The survey team was given documentation by Grease Cutters that the stove had been looked at.</p>	04/24/2013	

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	<p>have had to be lit since I started in January of 2013.</p> <p>During an interview with the dietary manager at the end of the walk through, she indicated the maintenance is responsible for the maintenance of the stove and she would get with him. She indicated the above mentioned observations, had the potential to affect 38 residents receiving meals from the kitchen.</p> <p>On 3/21/13 10:00 A.M., during observation of noon meal parathion the cook was observed using the blue handle lighter to light the burners because they would not light from the automatic igniter.</p> <p>Following the observation interview with Dietary Manger she indicated that the maintenance man had the part order for the non-functional burner, and was not sure what he was going to do about the burner. She indicated that she would check with the maintenance man.</p> <p>On 3/21/13 12:30 p.m., interview of the Maintenance Supervisor indicated and he had work on the stove in the summer. He indicated he was not certified to work on appliances. He indicated Grease Cutters kitchen</p>		<p>The documentation states that: the stove was in good condition on 2-21-2013. This documentation further states that "stove and hood in good working order". Please see exhibit 'I' The parts for the stove were on order from ECO Lab. On 4-11-2013 the facility received the ordered parts however the wrong parts were sent. Please see exhibit photos J. The facility regrets that employees made statements to the contrary. Dietary employees will be in-serviced by the maintenance person regarding the use and care of the stove and reporting problems immediately to the maintenance person. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility regrets that employees made statements to the contrary of the document provided to the surveyors. Dietary employees will be in-serviced by the maintenance person regarding the use and care of the stove and reporting problems immediately to the maintenance person. The in-services will take place once a month for the use and care of the stove and once per month on reporting issues immediately regarding the kitchen appliances. (Two in-services per month). The in-services will continue for three (3) months and annually thereafter. 4) How the corrective</p>		

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	<p>exhaust system cleaning and work order came out did the exhaust and they looked at the stove. The documentation did clean the exhaust, did not verify the stove was looked at. He was aware of the burner not working and he has the part ordered, and he will check on the 4 burners not lighting.</p> <p>3.1-19(bb)</p>		<p>action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? The stove will be repaired immediately upon receipt of the correct parts. The facility is informed that the new stove part will be available on 4-15-2013. The maintenance person will in-service the dietary staff as mentioned and be responsible for the documentation and the retention of these in-service records. 5) By what date the systemic changes will be completed? April 24th, 2013</p>		