

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/29/2014
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00148713.</p> <p>Complaint -IN00148713 Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey Dates: May 20, 21, 22, 23, 27, 28, and 29, 2014</p> <p>Facility number: 000220 Provider number: 155327 AIM number: 100267650</p> <p>Survey team: Patti Allen, SW-TC Marcy Smith, RN (May 20, 21, 22, 27, 28, and 29, 2014) Dorothy Plummer, RN Karyn Homan, RN</p> <p>Census bed type: SNF: 37 SNF/NF: 118 Total: 155</p> <p>Census payor type: Medicare: 25 Medicaid: 103 Other: 27</p>	F000000	<p>Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p>University Heights Health and Living, respectfully request consideration for paper compliance for this survey.</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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F000223 SS=A	<p>Total: 155</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on June 06, 2014; by Kimberly Perigo, RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents remained free from verbal abuse for 1 of 6 residents reviewed for abuse in that a verbal altercation occurred between a resident and visitor in a resident hallway. (Resident #8)</p> <p>Findings include:</p> <p>An Interview dated 5/20/14 at 2:15 p.m., Resident #8 indicated she had been</p>	F000223	<p>1. Corrective Action-University Heights Health and Living self reported the incident involving resident #8 on April 4th, 2014 to ISDH. Resident and visitor were separated. Investigation initiated. Physician and responsible parties notified. Psychosocial support was provided to the resident for 72 hours and she exhibited no lasting negative effects. Visitor was immediately educated on resident's rights and abuse by the Associate Administrator and nurse. Family care</p>	06/23/2014

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	<p>verbally abused by a visitor about two months ago. She indicated the visitor was another resident's family member. Resident #8 stated the visitor starting yelling at her using inappropriate language when she asked if the visitor's family member could be moved from in front of her door. Resident #8 had requested the visitor to be moved, due to this resident being confused and yelling for his family member. Resident #8 went into her room and closed the door to get away from the visitor. Resident #8 indicated the nurse from the nurses station had come down to find out what was wrong and called the Assistant Administrator. The Assistant Administrator came and talked to Resident #8 about 30 minutes after the incident occurred. Resident #8 stated she feels safe at this facility.</p> <p>An interview dated 5/29/14 at 11:25 a.m., LPN #7 indicated she heard the verbal altercation between Resident #8 and the visitor from the nurses station. LPN #7 was seated at the nurses station charting and heard yelling down the hallway. Prior to the yelling she had witnessed the visitor bringing their family member back from a walk and parked the family member's wheel chair in front of Resident #8's door. LPN #7 heard Resident #8 yelling that the visitor was on the phone</p>		<p>plan was held with visitor, where resident's rights and abuse was reinforced.</p> <p>University Heights Health and Living self reported the incident involving residents #9 and #199 on September 24, 2013 to ISDH. Residents' safety was ensured. Staff members were suspended pending investigation. Physician and responsible parties notified. Residents were monitored for negative psychosocial effects. Staff members (C.N.A #8 and #9) were returned to work after receiving disciplinary action for rude and discourteous behavior. Both C.N.A's have since been terminated.</p> <p>2. Other residents potential for impact: All residents with a BIMS of 10 or higher interviewed asking the QIS questions on abuse.</p> <p>3. What measures--All staff to be educated on preventing, identifying, and reporting abuse. Families/Responsible parties will be informed on their roles in maintaining resident's rights and preventing abuse.</p> <p>4. Monitored-Social services will interview five percent of residents with a BIMS of 10 higher using QIS abuse questions monthly, any positive responses will be investigated. Five percent of staff will be quizzed on abuse prevention, identifying, and reporting monthly. Results will be presented Continuous Quality Improvement Committee monthly until 100% compliancy is recorded for 2 consecutive months</p>				

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	<p>and then the verbal altercation began between the visitor and Resident #8. LPN #8 went down the hall and Resident #8 had returned to her room and the visitor went into her family member's room. So she continued to take the visitor's family member up to the nurse's station and called the Assistant Administrator. LPN #7 explained to the visitor resident rights and that she could not talk to residents like that.</p> <p>An interview dated 5/28/14 at 4:40 p.m., the Assistant Administrator indicated she received the call from LPN #7 that the verbal altercation occurred. The Assistant Administrator came in and ensured the safety of all the residents. She started the investigation by talking to Resident #8 and her roommate about the incident. The investigation was continued by talking to the visitor and staff.</p> <p>Resident #8's clinical record was reviewed on 5/28/14 at 11:00 a.m. Diagnoses included but were not limited to, cerebrovascular disease (disease of the blood vessels supplying the brain), encephalopathy (disease affecting the function of the brain), and dementia (loss of brain function effecting memory).</p> <p>The quarterly MDS assessment,</p>		<p>then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee.</p> <p>5. Compliance date - June 23, 2014</p>	

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	<p>completed on 3/21/14, assessed Resident #8 as cognitively intact.</p> <p>On 5/22/14 at 11:45 a.m., the Assistant Administrator provided the Indiana State Department of Health ... Incident Report Form, dated 4/5/14. The form indicated, "Brief Description of Incident: [Resident #8] was involved in a verbal altercation with another resident's family member.... Neither party made any physical threats. The verbal altercation was regarding the actions/yelling out of the [visitor's family member] and family."</p> <p>The Incident Form continued to indicate, the Administrator, Resident #8's physician, and family had been notified. Resident #8 and her roommate were assessed for any psycho-social distress with no negative findings. The form indicated Social Services will continue to assess the resident's for psycho-social distress for 72 hours. The visitor was addressed regarding resident rights and how she should talk to University Heights Health and Living residents. The visitor was instructed to get a nurse if another situation occurs rather than yelling back at a resident.</p> <p>The Incident Form continued to indicate, the facility provided a five day follow-up. In the follow-up it indicated that Resident</p>			

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F000224 SS=A	<p>#8 had not exhibited any negative psycho-social distress from the altercation. A follow-up care plan meeting had been set up with the visitor for further education on resident rights.</p> <p>3.1-27(b)</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure residents remain free from mistreatment for 2 of 6 residents reviewed for abuse. (Resident #9, and #199) (CNA #8 and #9)</p> <p>Findings include:</p> <p>An interview dated 5/22/14 9:50 a.m., a family member indicated she had received notification in the fall of 2013, from the facility her family member had been involved in an abuse incident. She was told two CNAs (certified nursing assistant) were speaking with unnecessary language to her family</p>	F000224	<p>1. Corrective Action-University Heights Health and Living self reported the incident involving resident #8 on April 4th, 2014 to ISDH. Resident and visitor were separated. Investigation initiated. Physician and responsible parties notified. Psychosocial support was provided to the resident for 72 hours and she exhibited no lasting negative effects. Visitor was immediately educated on resident's rights and abuse by the Associate Administrator and nurse. Family care plan was held with visitor, where resident's rights and abuse was reinforced.</p> <p>University Heights Health and Living self reported the incident involving</p>	06/23/2014			

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	<p>member. She continued to indicate she was told the staff members involved were disciplined.</p> <p>An interview dated 5/28/14 at 5:30 p.m., dietary aide #10 indicated she had witnessed CNA #8 push Resident #9 in a chair when the resident would not stay seated. Dietary Aide #10 indicated she immediately reported the incident to her manager the Food Services Director. She was unable to recall any more of the incident.</p> <p>An interview dated 5/28/14 at 5:32 p.m., the Food Services Director indicated as soon as Dietary Aide #10 reported the incident to him he notified the Administrator.</p> <p>An interview dated 5/28/14 at 5:40 p.m., the Administrator indicated he immediately suspended CNA #8 and CNA #9 pending an investigation of the incident. Nursing performed pain and skin assessments on Resident #9 and #199 with no negative findings. The families and physicians of both residents were notified and Social Services performed a psycho-social assessment of the residents for 72 hours following the incident with no negative findings.</p> <p>On 5/29/14 at 10:25 a.m., the</p>		<p>residents #9 and #199 on September 24, 2013 to ISDH. Residents' safety was ensured. Staff members were suspended pending investigation. Physician and responsible parties notified. Residents were monitored for negative psychosocial effects. Staff members (C.N.A #8 and #9) were returned to work after receiving disciplinary action for rude and discourteous behavior. Both C.N.A's have since been terminated.</p> <p>2. Other residents potential for impact: All residents with a BIMS of 10 or higher interviewed asking the QIS questions on abuse.</p> <p>3. What measures--All staff to be educated on preventing, identifying, and reporting abuse. Families/Responsible parties will be informed on their roles in maintaining resident's rights and preventing abuse.</p> <p>4. Monitored-Social services will interview five percent of residents with a BIMS of 10 higher using QIS abuse questions monthly, any positive responses will be investigated. Five percent of staff will be quizzed on abuse prevention, identifying, and reporting monthly. Results will be presented Continuous Quality Improvement Committee monthly until 100% compliancy is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee.</p> <p>5. Compliance date - June 23,</p>				

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	<p>Administrator provided a written statement from the dietary aide that witnessed the incident, dated 9/23/13. The statement indicated she had witnessed CNA #8 and #9 mocking the residents by telling them to sit down and shut up. She also witnessed CNA #8 physically shove Resident #9 down in the chair and yell sit down.</p> <p>Resident #199's clinical record was reviewed on 5/27/14 at 11:45 a.m. Diagnoses included but were not limited to, Alzheimer's disease (form of dementia that effects memory, thinking, and behavior), dementia (loss of brain function), anxiety, and depressive disorder.</p> <p>The annual MDS (Minimum Data Set) assessment, completed on 5/06/14, assessed Resident #199's cognitive function as severely impaired.</p> <p>Resident #9 clinical record was reviewed on 5/29/14 at 8:50 a.m. Diagnoses included but were not limited to, Alzheimer's disease (form of dementia that effects memory, thinking, and behavior), dementia (loss of brain function) with behavior disturbance, and anxiety.</p> <p>The discharge MDS assessment,</p>		2014	

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	<p>completed on 5/02/14, assessed Resident #9's cognitive function as being severely impaired.</p> <p>On 5/22/14 at 11:45 a.m., the Assistant Administrator provided the Indiana State Department of Health ... Incident Report Form, dated 9/24/14. The form indicated, "Brief description of Incident: It is alleged that the two Certified Nursing Assists [CNA #8 and CNA#9] were verbally inappropriate to two residents [Resident #9 and #199]. It was also reported that [CNA #8] touched [Resident #9] inappropriately, attempting to get [Resident #9] to sit down."</p> <p>Continued review of the Incident Form indicated, the facility ensured the safety of Resident #9 and #199, the two CNAs involved were immediately suspended pending the facilities investigation, a voicemail was left with the Indiana State Department of Health, and family and physicians of the residents were notified.</p> <p>Continued review of the Incident Form indicated, the facility provided a five day follow-up. The follow-up indicated their investigation was completed and both CNAs involved received disciplinary action for rude and discourteous behavior. Social Services had continued to assess Residents #9 and #199</p>			

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	<p>following the incident and no findings a negative impact had been assessed. The form noted that Social Services would continue to assess both residents psycho-social well-being weekly for changes.</p> <p>On 5/29/14 at 10:25 a.m., the Administrator provided Employee Warning Form, dated 9/27/13. The form indicated that CNA #8 was given a first and final warning due to non-compliance with company policy and unethical conduct. CNA #8 will be immediately terminated if any further allegations of abuse occur.</p> <p>An interview dated 5/28/14 at 5:40 p.m., the Administrator indicated CNA #8 received a final written warning, stress management counseling, and an inservice on how to handle residents with reoccurring behaviors. CNA #8 was no longer allowed to work on the memory care unit.</p> <p>On 5/29/14 at 10:25 a.m., the Administrator provided Heart of Cardon Payroll Change Data Sheet, dated 9/22/13. This form indicated CNA #9 was terminated for rude and discourteous behavior. CNA #9's termination was effective 9/22/13.</p>			

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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 comprehensive assessments were accurately completed for 1 of 1 residents reviewed for residents receiving dialysis treatments. (Resident # 81)</p> <p>Findings include:</p>	F000278	<p>1. Corrective Action- Resident #81's MDS Assessment was updated to reflect dialysis treatment.</p> <p>2. Other residents potential for impact- An audit was completed for other residents received dialysis treatment to ensure the MDS had been coded correctly. Update MDS completed as needed.</p>	06/23/2014
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	<p>During a Stage 1 interview on 5/21/14 at 9:30 a.m., Resident #81 indicated she had been receiving dialysis treatments prior to coming to the facility in October 2013.</p> <p>The clinical record of Resident #81 was reviewed on 5/29/14 at 1:15 p.m. Resident #81 was admitted to the facility on 10/15/13 following a right leg below the knee amputation. Diagnoses included, but were not limited to, end stage renal disease, hypertension, congestive heart failure, diabetes, and peripheral vascular disease.</p> <p>A review of the recapitulation of physician's orders for May 2014, indicated Resident #81 had an order to receive dialysis treatments 3 times a week on Mondays, Wednesdays, and Fridays. The date of the original order for dialysis was 10/16/13.</p> <p>A quarterly Minimum Data Set (MDS) assessment, completed on 4/22/14, assessed Resident #81 as requiring extensive assistance of 2 staff for bed mobility, transfers, and toileting. Resident #81 was assessed as having a Basic Interview for Mental Status (BIMS) of 15, indicating Resident #81 was cognitively intact. The MDS did not assess Resident #81 as receiving dialysis</p>		<p>3. What measures – MDS Lead Coordinator has completed training with LPN #6 and RN #3 and other MDS personnel to ensure understanding of proper coding for those resident receiving dialysis. See attached.</p> <p>4. Monitored- Quality assurance MDS Lead Coordinator will submit a monthly audit to the Continuous Quality Improvement Committee that MDS has been updated correctly for any resident receiving dialysis. Results will be presented Continuous Quality Improvement Committee monthly until 100% compliancy is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee.</p> <p>5. Compliance date - June 23, 2014</p>	

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F000279 SS=D	<p>treatments. Section I, assessing "Genitourinary" was blank for Renal Insufficiency, Renal Failure, or End Stage Renal Disease. Section O, assessing "Special Treatments and Programs," was blank for dialysis. The assessment was signed by Registered Nurse (RN) #3 indicating the assessment was accurate and complete.</p> <p>During a review of the MDS assessments completed for Resident #81, the 14-Day MDS assessment completed on 10/27/13 and the MDS completed 1/7/14 did not assess Resident #81 as receiving dialysis treatments.</p> <p>During an interview with Licensed Practical Nurse (LPN) #6 and RN #3 on 5/29/14 at 3:35 p.m., LPN #6 indicated, "I must have overlooked the dialysis when I completed the MDS. I am not sure how it was missed on some assessments and was coded on the others."</p> <p>3.1-31(i)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p>			

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	<p>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 observation, interview, and record review, the facility failed to ensure care plans were developed for 2 of 2 residents reviewed who met the criteria for impaired range of motion (full movement potential of a joint) in that there were no care plans related to range of motion for these residents. (Residents #12 and #91)</p> <p>Findings Include:</p> <p>1. Resident #12's clinical record was reviewed on 5/28/14 at 2:00 p.m. Diagnoses included, but were not limited to, scoliosis (abnormal curving of the spine), depressive disorder, osteoarthritis</p>	F000279	<p>1. Corrective Actions: Resident #12's care plans were updated to include either limited range of motion to both lower extremities or refusal to participate. Resident #91's care plan was updated for the contracture in her right hand.</p> <p>2. Other Residents potential for impact: Nursing management will conduct an audit on facility residents with impaired range of motion and those at risk for developing impaired range of motion not currently receiving therapy or restorative nursing services. A care plan will be created for those with a limited range of motion. Residents identified with limited range of motion will be referred to therapy and restorative for evaluation and</p>	06/23/2014

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	<p>(joint disorder due to wear and tear of the joints), osteoporosis (disease in which bones become fragile), and cerebrovascular accident (loss of brain function due to disturbance in blood supply) with hemiplegia (inability to move one side of the body) to the left side.</p> <p>Documentation was lacking a care plan related to limited range of motion (full movement potential of a joint).</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 12/24/13, assessed Resident #12 as having functional impairment in range of motion to both sides of her lower extremities.</p> <p>The Therapy Screen assessment, completed 12/19/13, assessed Resident #12 as having poor functional range of motion in both lower extremities. This assessment also indicated Resident #12 refuses therapy.</p> <p>An interview dated 5/21/14 at 10:45 a.m., LPN #4 indicated Resident #12 has contractures (abnormal shortening of muscle tissue) in both of her legs and had refused to participate in therapy.</p> <p>Resident # 12 was observed 5/28/14 at 2:15 p.m., in bed with both legs drawn up</p>		<p>treatment.</p> <p>3. Measures/Changes: Lead MDS coordinator and/or Therapy Supervisor will educate nursing staff on how to identify residents possibly experiencing changes in full movement potential. Residents will be referred to therapy for an evaluation and restorative nursing. Unit Managers will develop a care plan to address limited range of motion.</p> <p>4. Monitored/Quality Assurance: Unit Managers and Lead MDS will report any noted changes in range of motion or functional impairment will be during morning clinical meeting. Residents will be referred to therapy for an evaluation and restorative nursing. The Lead MDS coordinator will submit an audit to the Continuously Quality Assurance Committee monthly until 100% compliancy is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee.</p> <p>5. Compliance date June 23, 2014</p>	

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	<p>to her body and when asked to straighten her legs she was unable to.</p> <p>An interview dated 5/28/14 at 4:05 p.m., DoN (Director of Nursing) indicated Resident #12 did not have a care plan related to her limited range of motion in her legs or refusal of preventative measures to maintain range of motion. She to indicated the facility would develop a care plan.</p> <p>2. Resident #91's clinical record was reviewed on 5/23/14 9:10 a.m. Diagnoses included, but were not limited to, dementia (decline in mental ability), depressive disorder, and anxiety.</p> <p>Documentation was lacking a care plan related to limited range of motion (full movement potential of a joint).</p> <p>The annual MDS (Minimum Data Set) assessment, completed on 5/07/14, assessed Resident #91 as having functional impairment in range of motion to one side of her upper extremities and one side of her lower extremities.</p> <p>The Therapy Screen assessment, completed 5/01/14, assessed Resident #91 as having poor functional range of motion in her left upper extremity and decreased range of motion in her bilateral</p>			

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F000282 SS=D	<p>lower extremities.</p> <p>An interview dated 5/21/14 10:35 a.m., LPN #14 indicated Resident #91 has a contracture (abnormal shortening of muscle tissue) in her right hand.</p> <p>Resident #91 was observed 5/21/14 2:25 p.m., to have the fingers on her right hand drawn to the center of the palm of her hand. She still was able to use her right hand to feed herself, but was unable to stretch her hand out.</p> <p>An interview dated 5/28/14 at 4:05 p.m., the DoN indicated that Resident #91 did not have a care plan related to her limited range of motion. She continued to indicate that the facility would develop a care plan.</p> <p>3.1-35(a)</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.</p> <p>Based on observation, interview, and record review, the facility failed to provide showers 2 times a week as indicated on the written plan of care for 2 of 9 residents who met the criteria for</p>	F000282	<p>1. Corrective Action: Necessary ADL (shower, hair washed, nail care) care was provided to residents (#70 and 140). C.N.A assignment sheets and care plans were reviewed to</p>	06/23/2014

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	<p>review of activities of daily living (ADLs). (Resident # 70 and Resident #140)</p> <p>Findings include:</p> <p>1. During a Stage 1 observation on 5/21/14 at 12:03 p.m., Resident #140 was sitting in a room looking through a paperback book. The hair of Resident #140 was greasy looking. Her fingernails were long, chipped, and had a brown substance under the nails. Unshaven facial hair was noted on the neck and chin of Resident #140.</p> <p>The clinical record of Resident #140 was reviewed on 5/27/14 at 3:30 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, hypertension, dysphagia (difficulty swallowing), and anxiety.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed on 3/21/14, assessed Resident #140 as requiring extensive assistance of 2 staff members for bed mobility, transfers, and toileting and extensive assistance of 1 staff member for dressing, eating, and personal hygiene. Resident #140 was unable to complete a Brief Interview for Mental Status (BIMS), and was assessed as having severe cognitive impairment.</p>		<p>ensure proper ADL assistance was noted.</p> <p>2. Other residents potential for impact: A visual assessment of residents who require assistance with ADL's was conducted. Residents who require assistance with ADL's are receiving the appropriate care to ensure their care needs are met.</p> <p>3. What Measures: Unit Managers will re-educate nursing staff (C.N.A and nurses) on completing shower sheet. If a resident refuses a shower then the nurse will document the occurrence. Residents ADL needs will be monitored to ensure they are receiving the necessary services for grooming and hygiene.</p> <p>4. Monitored/Quality Assurance: Unit Managers will audit showers/refusals and report weekly in morning meeting and monthly to the Continuous Quality Improvement Committee. Audit results will be presented Continuous Quality Improvement Committee monthly until 100% compliance is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee. All resident visual observations will be monitored weekly and compliancy presented to the Continuous Quality Improvement Committee.</p> <p>5. Compliance date - June 23, 2014</p>	

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	<p>During an observation of Resident #140 on 5/27/14 at 11:00 a.m., Resident #140 was sitting in a room looking through a paperback book. The hair of Resident #140 was greasy looking. Her fingernails were long and chipped. Unshaven facial hair was noted on the neck and chin of Resident #140.</p> <p>During an observation of Resident #140 on 5/27/14 at 3:30 p.m., Resident #140 was sitting in a room looking through a paperback book. The hair of Resident #140 was greasy looking. Her fingernails were long and chipped. Unshaven facial hair was noted on the neck and chin of Resident #140.</p> <p>On 5/27/14 at 2:30 p.m., the Director of Nursing (DoN) provided copies of shower sheets for Resident #140 for April and May 2014. The DoN provided a copy of an undated nurse aide assignment sheet and indicated the assignment sheet was current for Resident #140. The assignment sheet indicated Resident #140 should have received showers on Wednesdays and Saturdays during the day shift. A review of the shower sheets indicated Resident #140 had missed showers on 4/12, 4/19, 4/30, and 5/10/14.</p> <p>During an interview with the DoN on</p>			

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	<p>5/27/14 at 5:15 p.m., the DoN indicated a shower sheet was completed each time a resident received a shower and the lack of a shower sheet indicated the resident did not receive a shower that day. The DoN indicated all of the shower sheets for Resident #140 for April and May 2014 had been provided. The DoN indicated Resident #140 did not regularly go to the beauty shop and nursing staff were responsible for ensuring Resident #140 had clean hair.</p> <p>During an observation of Resident #140 on 5/28/14 at 11:45 a.m., Resident #140 was sitting in the main dining room with eyes closed. The hair of Resident #140 was greasy looking. Her fingernails were long and chipped. Unshaven facial hair was noted on the neck and chin of Resident #140.</p> <p>A review of careplans for Resident #140 indicated Resident #140 needed assistance with ADLs related to the diagnosis of Alzheimer's disease. The goal indicated Resident #140 would be well groomed daily. Interventions, with a start date of 8/27/12, indicated Resident #140 would receive partial baths and have hair combed daily. Resident #140 was to receive 2 baths a week.</p> <p>During an interview with the DoN on</p>			

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	<p>5/28/14 at 3:30 p.m., the DoN indicated the facility did not have a specific policy for providing ADLs and the only documentation of the provision of a shower was the shower sheet.</p> <p>2. During a Stage 1 observation on 5/21/14 at 2:32 p.m., Resident #70 was up in the bathroom with a staff member. The hair of Resident #70 was greasy looking and uncombed.</p> <p>The clinical record of Resident #70 was reviewed on 5/27/14 at 4:00 p.m. Diagnoses included, but were limited to, Alzheimer's disease, atrial fibrillation, osteoarthritis, anxiety, and depression.</p> <p>A Quarterly MDS assessment completed on 4/15/14 assessed Resident #70 as requiring extensive assistance of 2 staff members for toileting, extensive assistance of 1 staff member for bed mobility and transfers, and limited assistance of 1 staff member for dressing, eating and personal hygiene. Resident #70 completed the Brief Interview for Mental Status (BIMS) with a score of 1, indicating severe cognitive impairment.</p> <p>During an observation of Resident #70 on 5/27/14 at 10:55 a.m., Resident #70 was lying in bed with eyes closed. The hair of</p>			

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	<p>Resident #70 was greasy looking and unkempt.</p> <p>On 5/27/14 at 2:30 p.m., the DoN provided copies of shower sheets for Resident #70 for April and May 2014. The DoN provided a copy of an undated nurse aide assignment sheet, and indicated the assignment sheet was current for Resident #70. The assignment sheet indicated Resident #70 should have received showers on Tuesdays and Fridays during the evening shift. Resident #70 had a total of 8 shower sheets. A review of the shower sheets indicated Resident #70 had refused showers on 5 of the 8 times a shower was offered. No shower sheets were provided for 4/4, 4/18, 4/22, 4/25, 4/29, 5/6, 5/9 and 5/20/14.</p> <p>During an interview with the DoN on 5/27/14 at 5:15 p.m., the DoN indicated a shower sheet was completed each time a resident received a shower and the lack of a shower sheet indicated the resident did not receive a shower that day. The DoN indicated all of the shower sheets for Resident #70 for April and May 2014 had been provided. The DoN indicated Resident #70 did not regularly go to the beauty shop and nursing staff were responsible for ensuring Resident #70 had clean hair.</p>			

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F000312 SS=D	<p>A review of careplans for Resident #70 indicated Resident #70 needed extensive assistance with ADLs. Interventions, with a start date of 3/8/13, indicated Resident #70 would be assisted with a full bath/shower 2 times a week and would have oral, hair, and nail care twice a day.</p> <p>During an interview with the DoN on 5/28/14 at 3:30 p.m., the DoN indicated the facility did not have a specific policy for providing ADLs and the only documentation of the provision of a shower was the shower sheet.</p> <p>3.1-35(g)2</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, interview, and record review, the facility failed to provide showers 2 times a week and failed to ensure 2 residents had clean hair for 2 of 9 residents reviewed who met the criteria for review of activities of daily</p>	F000312	<p>1. Corrective Action: Necessary ADL (shower, hair washed, nail care) care was provided to residents (#70 and 140). C.N.A assignment sheets and care plans were reviewed to ensure proper ADL assistance was noted.</p>	06/23/2014

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	<p>living (ADLs). (Resident # 70 and Resident #140)</p> <p>Findings include:</p> <p>1. During a Stage 1 observation on 5/21/14 at 12:03 p.m., Resident #140 was sitting in a room looking through a paperback book. The hair of Resident #140 was greasy looking. Her fingernails were long, chipped, and had a brown substance under the nails. Unshaven facial hair was noted on the neck and chin of Resident #140.</p> <p>The clinical record of Resident #140 was reviewed on 5/27/14 at 3:30 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, hypertension, dysphagia (difficulty swallowing), and anxiety.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed on 3/21/14, assessed Resident #140 as requiring extensive assistance of 2 staff members for bed mobility, transfers, and toileting and extensive assistance of 1 staff member for dressing, eating, and personal hygiene. Resident #140 was unable to complete a Brief Interview for Mental Status (BIMS) and was assessed as having severe cognitive impairment.</p>		<p>2. Other residents potential for impact: A visual assessment of residents who require assistance with ADL's was conducted. Residents who require assistance with ADL's are receiving the appropriate care to ensure their care needs are met.</p> <p>3. What Measures: Unit Managers will re-educate nursing staff (C.N.A and nurses) on completing shower sheet. If a resident refuses a shower then the nurse will document the occurrence. Residents ADL needs will be monitored to ensure they are receiving the necessary services for grooming and hygiene.</p> <p>4. Monitored/Quality Assurance: Unit Managers will audit showers/refusals and report weekly in morning meeting and monthly to the Continuous Quality Improvement Committee. Audit results will be presented monthly until 100% compliancy is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee. All resident visual observations will be monitored weekly and compliancy presented to the Continuous Quality Improvement Committee. Audit results will be presented monthly until 100% compliancy is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by</p>	

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	<p>During an observation of Resident #140 on 5/27/14 at 11:00 a.m., Resident #140 was sitting in a room looking through a paperback book. The hair of Resident #140 was greasy looking. Her fingernails were long and chipped. Unshaven facial hair was noted on the neck and chin of Resident #140.</p> <p>During an observation of Resident #140 on 5/27/14 at 3:30 p.m., Resident #140 was sitting in a room looking through a paperback book. The hair of Resident #140 was greasy looking. Her fingernails were long and chipped. Unshaven facial hair was noted on the neck and chin of Resident #140.</p> <p>On 5/27/14 at 2:30 p.m., the Director of Nursing (DoN) provided copies of shower sheets for Resident #140 for April and May 2014. The DoN provided a copy of an undated nurse aide assignment sheet and indicated the assignment sheet was current for Resident #140. The assignment sheet indicated Resident #140 should have received showers on Wednesdays and Saturdays during the day shift. A review of the shower sheets indicated Resident #140 had missed showers on 4/12, 4/19, 4/30, and 5/10/14.</p> <p>During an interview with the DoN on 5/27/14 at 5:15 p.m., the DoN indicated a</p>		<p>Administrator or designee. 5. Compliance date - June 23, 2014</p>	

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	<p>shower sheet was completed each time a resident received a shower and the lack of a shower sheet indicated the resident did not receive a shower that day. The DoN indicated all of the shower sheets for Resident #140 for April and May 2014 had been provided. The DoN indicated Resident #140 did not regularly go to the beauty shop and nursing staff were responsible for ensuring Resident #140 had clean hair.</p> <p>During an observation of Resident #140 on 5/28/14 at 11:45 a.m., Resident #140 was sitting in the main dining room with eyes closed. The hair of Resident #140 was greasy looking. Her fingernails were long and chipped. Unshaven facial hair was noted on the neck and chin of Resident #140.</p> <p>A review of careplans for Resident #140 indicated Resident #140 needed assistance with ADLs related to the diagnosis of Alzheimer's disease. The goal indicated Resident #140 would be well groomed daily. Interventions, with a start date of 8/27/12, indicated Resident #140 would receive partial baths and have hair combed daily. Resident #140 was to receive 2 baths a week.</p> <p>During an interview with the DoN on 5/28/14 at 3:30 p.m., the DoN indicated</p>			

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	<p>the facility did not have a specific policy for providing ADLs and the only documentation of the provision of a shower was the shower sheet.</p> <p>2. During a Stage 1 observation on 5/21/14 at 2:32 p.m., Resident #70 was up in the bathroom with a staff member. The hair of Resident #70 was greasy looking, and uncombed.</p> <p>The clinical record of Resident #70 was reviewed on 5/27/14 at 4:00 p.m. Diagnoses included, but were limited to, Alzheimer's disease, atrial fibrillation, osteoarthritis, anxiety, and depression.</p> <p>A Quarterly MDS assessment completed on 4/15/14, assessed Resident #70 as requiring extensive assistance of 2 staff members for toileting, extensive assistance of 1 staff member for bed mobility and transfers, and limited assistance of 1 staff member for dressing, eating, and personal hygiene. Resident #70 completed the Brief Interview for Mental Status (BIMS) with a score of 1, indicating severe cognitive impairment.</p> <p>During an observation of Resident #70 on 5/27/14 at 10:55 a.m., Resident #70 was lying in bed with eyes closed. The hair of Resident #70 was greasy looking and</p>			

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	<p>unkempt.</p> <p>On 5/27/14 at 2:30 p.m., the DoN provided copies of shower sheets for Resident #70 for April and May 2014. The DoN provided a copy of an undated nurse aide assignment sheet and indicated the assignment sheet was current for Resident #70. The assignment sheet indicated Resident #70 should have received showers on Tuesdays and Fridays during the evening shift. Resident #70 had a total of 8 shower sheets. A review of the shower sheets indicated Resident #70 had refused showers on 5 of the 8 times a shower was offered. No shower sheets were provided for 4/4, 4/18, 4/22, 4/25, 4/29, 5/6, 5/9, and 5/20/14.</p> <p>During an interview with the DoN on 5/27/14 at 5:15 p.m., the DoN indicated a shower sheet was completed each time a resident received a shower and the lack of a shower sheet indicated the resident did not receive a shower that day. The DoN indicated all of the shower sheets for Resident #70 for April and May 2014 had been provided. The DoN indicated Resident #70 did not regularly go to the beauty shop and nursing staff were responsible for ensuring Resident #70 had clean hair.</p>			

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F000323 SS=E	<p>A review of careplans for Resident #70 indicated Resident #70 needed extensive assistance with ADLs. Interventions, with a start date of 3/8/13, indicated Resident #70 would be assisted with a full bath/shower 2 times a week and would have oral, hair, and nail care twice a day.</p> <p>During an interview with the DoN on 5/28/14 at 3:30 p.m., the DoN indicated the facility did not have a specific policy for providing ADLs and the only documentation of the provision of a shower was the shower sheet.</p> <p>3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 3-1-38(a)(3)(E)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Base on observation, interview, and record review, the facility failed to ensure that water temperatures were kept at a safe and comfortable level for 5 of 5 rooms reviewed for water temperatures</p>	F000323	<p>1. Corrective Action - A hot water mixing valve for the line supplying 400 Hall was replaced 05.16.14 and again with another valve on 05.23.14. Resident #8 and #93 water temperature has been</p>	06/23/2014

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	<p>having the potential to effect all rooms in the 100 hall, 200 hall, 300 hall and 400 hall in that the water temperature was too high.</p> <p>Findings include:</p> <p>During an observation dated 5/21/14 at 11:00 a.m., Room 408's water from the bathroom faucet was too hot to hold fingers under.</p> <p>An interview dated 5/21/14 11:10 a.m., Resident #8 indicated she has to turn the faucet on in just the right location so the water is not too hot. She continued to say, "The faucet needs to be in the middle of the red and blue bubble." As she was demonstrating where she turns the faucet handle.</p> <p>During an observation dated 5/21/14 at 11:15 a.m., the facility's Maintenance Supervisor used a thermometer to test a sampled number of rooms temperatures; Room 401, 124 degrees Fahrenheit (unit of measurement of temperature) Room 402, 125 degrees Fahrenheit Room 406, 128 degrees Fahrenheit Room 408, 126 degrees Fahrenheit Room 415, 121 degrees Fahrenheit</p> <p>An interview dated 5/21/14 11:17 a.m., Res #93 indicated he liked his water</p>		<p>resolved and is in between the acceptable temperature ranges allowed high/low.</p> <p>2. Other residents potential for impact – Waters temperatures have been checked throughout the facility 5 times per week on each hall to ensure water temperatures are within range of 100-120 degrees. Until temperatures are consistently within range for 2 weeks, then monitoring will resume weekly.</p> <p>3. What Measures – Water temperatures will be checked 5 times per week for two weeks and until there is 100 % compliance. In the event water temperature is outside safe range UHHL will take the following action: Residents/Staff in the affected area will be asked not to use the water until it returns to safe temperature, Administrator will be notified, Maintenance will inspect the system and identify the problem, Maintenance will create a temporary solution until the issue has been resolved, When a temperature is noted below 100 degrees Fahrenheit or above 120 degrees Fahrenheit 15 minute checks will be conducted to ensure a safe temperature, Once temperature has been within range for a period of 1 hour, 15 minute checks will continue 1 additional hour. Maintenance director will educate all University Heights Associates on water temperature practice.</p> <p>4. Monitored- Quality assurance</p>	

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	<p>temperature. He stated he liked it hot and his was, "good and hot."</p> <p>An interview dated 5/21/14 at 11:20 p.m., the Maintenance Supervisor indicated these temperatures are to warm. He will go and turn down the temperature of the water. He stated he had adjusted it that morning when he came in because it was reading 99 degrees Fahrenheit, not warm enough. He has been monitoring the water closely, because he had changed the 400 hall mixing valve (valve that blends hot water with cold water to ensure constant, safe shower and bath outlet temperatures) last Friday. The 100, 200, 300, and 400 halls are all on the same mixing valve. The 500, 600, 700, and 800 halls are all on the same mixing valve. The 900 hall is on it's own mixing valve.</p> <p>During an observation dated 5/21/14 at 1135 a.m., the facility's Maintenance Supervisor used a thermometer to recheck the sampled room temperatures; Room 401, 104 degrees Fahrenheit Room 402, 104 degrees Fahrenheit Room 406, 103 degrees Fahrenheit Room 408, 104 degrees Fahrenheit Room 415, 102 degrees Fahrenheit</p> <p>On 5/29/14 at 905 a.m., the Assistant Administrator provide the facility's policy</p>		<p>– Maintenance Director will submit audits monthly to the Continuously Quality Assurance Committee the results of findings. Audit results will be presented monthly until 100% compliancy is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee.</p> <p>5. Compliance date June 23, 2014</p>	

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F000431 SS=D	<p>on Water Temperature, dated 5/29/14, and indicated the policy was the one currently used by the facility. The document indicated that safe water temperature is 100-120 degrees Fahrenheit.</p> <p>3.1-19(r)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>			

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	<p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on interview, observation, and record review, the facility failed to ensure insulin pens and insulin vials were discarded after 28 days of use in 2 of 4 medication carts reviewed for medication storage. (200 Hall Medication Cart and 400 Hall Medication Cart)</p> <p>Findings include:</p> <p>1. During a review of the 400 Hall Medication Cart on 5/28/14 at 10:37 a.m., a pen containing insulin detemir (Levemir) insulin, with a fill date of 4/1/14, was found in the drawer. The pen was 1 of 8 pens in the drawer that did not have a date opened on it. The pharmacy tag attached to the pen indicated the pen belonged to Resident #17. Registered Nurse (RN) #1 indicated the pen was opened in excess of 28 days and should be discarded. A vial of insulin glargine (Lantus), with a date opened of 3/30/14, was also found in the drawer. RN #1 indicated the vial belonged to Resident #23 and should be discarded. Licensed</p>	F000431	<p>1. Corrective Action- Insulin pens and insulin vials on the 200 and 400 Hall were audited to ensure nothing was outdated and insulin pens and insulin vials have an open date on them. Resident #17 and 23 were assessed and no adverse reactions were noted, Resident #17 and 23 has a date opened insulin that has not expired. RN #1, LPN #5 and LPN #4 were educated on the importance and policy to date opened insulin pens and vials and educated not to use them if they were expired.</p> <p>2. Other residents potential for impact- An audit was completed on all other medication carts any insulin pens and vials older than 28 days were discarded and open vials/pens had a date they were opened.</p> <p>3. What measures – Unit Manger or other nurse manager will educate licensed nursing staff on insulin storage and expiration dates. Staff will provide return demonstration of how storage and ensure insulin is within date. Medication carts will be audited no less than weekly by assigned cart</p>	06/23/2014

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	<p>practical nurse (LPN) #4 indicated Resident #17 and Resident #23 had current physician's orders for the insulins. LPN #4 indicated all insulin pens and vials should be marked with the date the insulin was first opened and should be discarded after 28 days.</p> <p>2. During a review of the 200 Hall Medication Cart on 5/28/14 at 3:30 p.m., an insulin aspart pen (NovoLog) was found in the drawer and the date opened was smeared and unreadable. The pen was in a clear bag with a pharmacy label indicating the contents belonged to Resident #78. The medication was "GlucaGen," (a medication used to treat low blood sugars). The Assistant Director of Nursing (ADON) and LPN #5 indicated the NovoLog pen belonged to Resident #78 and Resident #78 had a current physician's order for NovoLog. Resident #78 had a Lantus pen in the drawer with a date opened of 4/28/14. LPN #5 indicated Resident #78 had a current physician's order for Lantus. A Lantus pen with a date opened of 4/29/14, belonging to Resident #242, was found in the drawer. LPN #5 indicated Resident #242 had a current physician's order for Lantus. LPN #5 indicated she thought pens and vials could be used for 30 days.</p>		<p>captain.</p> <p>4. Monitored- Cart captains will turn in weekly audits to the Director of Nursing on Friday. Pharmacy will audit the medications carts quarterly. Audits will be reviewed and presented to the Continuous Quality Improvement Committee. Results will be presented monthly until 100% compliancy is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee.</p> <p>5. Compliance date - June 23, 2014</p>	

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F000441 SS=E	<p>A Nursing 2014 Drug Handbook, 34th edition, copyright 2014, was found in the bottom drawer of the 200 Hall Medication Cart. After looking in the handbook, LPN #5 indicated the insulin pens should have been discarded after 28 days.</p> <p>On 5/29/14 at 10:22 a.m., the Director of Nursing (DoN) provided an undated policy and procedure titled "Drug Storage," and indicated the policy was the one currently used by the facility. In the section titled "...Procedures...11. ...Insulin and other multi-dose injectable vials must be discarded after <u>28 days</u> or according to manufacturer's recommendations..." In the section titled "Refrigerator storage...7. Insulin ... and other multi-dose vials requiring refrigeration need to be dated when opened. All vials should be discarded within <u>28 days of the open date...</u>"</p> <p>3.1-25(j)</p> <p>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</p>			

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	<p>development and transmission of disease and infection.</p> <p>(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 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, record review, and interview, the facility failed to ensure staff hand washed and/or sanitized their hands, according to facility policy, during medication administration. This had the potential to affect 25 residents residing on the 400 hall, and 17 residents residing</p>	F000441	<p>1. Corrective Action: LPN #1 and #2 were re-educated on hand washing and medication administration practices immediately. All nurses will practice proper infection control when administering medications. Residents #195, 199 170, 164 and 182 were assessed and have not had</p>	06/23/2014

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	<p>on the 300 hall. (Residents #195, #199, #170 and #164 and #182, LPN #1 and LPN #2)</p> <p>Findings include:</p> <p>1. During an observation of medication administration, on the 300 hall, on 5/28/14, at 8:12 a.m., Licensed Practical Nurse (LPN) #2 prepared and gave medications to Resident #195. She then returned to the medication cart and prepared and gave medications to Resident #199. She was not observed to sanitize or wash her hands between those medication administrations. Information was requested from LPN #2 regarding whether she ever washed her hands or used hand sanitizer when she prepared and administered medications. She indicated, at that time, she didn't have any hand sanitizer on the medication cart. At that time, she went to a sink and washed her hands.</p> <p>2. During an observation of medication administration on 5/28/14 at 8:24 a.m., on the 400 hall, LPN #1 prepared and gave medications to Resident #170. She then returned to the medication cart and asked the Unit Manager of the 400 hall, who was observing, if she (LPN #1) could borrow her (Unit Manager) hand sanitizer, because there wasn't any on the</p>		<p>any adverse outcomes or become ill.</p> <p>2. Other residents potential for impact: Nursing staff were provided the hand washing and medication administration policy.</p> <p>3. What Measures: The Staff Development Coordinator will educate the nursing staff on hand washing policy and procedure. Staff will provide return demonstration of hand washing to ensure they are able to complete proper hand washing. Staff Development Coordinator or other nurse manager will educate all nurses on the safe and effective infection control practices that must be followed while administering medication. Nurses will be required to demonstrate competency during a medication pass for staff development coordinator or designee.</p> <p>4. Monitored/Quality Assurance: Medication administration will be audited and return demonstrations by 5% nursing staff on a monthly basis. Audits will be reviewed and presented to the Continuous Quality Improvement Committee. Results will be presented monthly until 100% compliancy is recorded for 2 consecutive months then quarterly. If 95% compliancy is not achieved then a plan of action will be developed and monitored by Administrator or designee.</p> <p>5. Compliance date - June 23, 2014</p>	

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	<p>medication cart. The Unit Manager gave LPN #1 some sanitizer, and indicated, at that time, the nurses were supposed to keep hand sanitizer in their pockets, to use when preparing and administering medications to residents.</p> <p>3. During an observation of insulin (a medication injected with a needle just below the surface of the skin to help lower blood sugar) administration on 5/28/14 at 11:29 a.m., LPN #1 drew insulin into a syringe for Resident #164, used sanitizer on her hands, put gloves on, injected the insulin, removed her gloves and again used the hand sanitizer, and went on to prepare and give medications to Resident #182. She was not observed to wash her hands at any time during those medication administrations.</p> <p>On 5/28/14 at 11:39 a.m., the Director of Nursing provided an undated Medication Administration: General Policies & Procedures policy, and indicated the policy was the one currently used by the facility. The policy indicated, "15. Hands shall be washed after a med pass is completed with one resident and before commencing a med pass with the next resident. a) Hands may be cleaned with an alcohol-based gel or foam cleanser in between residents during med pass...c) In</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/29/2014	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227			
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	<p>all cases when gloves are used in the process of administering medications, hands should be washed with soap and water prior to and after the gloving."</p> <p>On 5/29/14 at 10:25 a.m., the Director of Nursing indicated 25 residents resided on the 400 hall and 17 residents resided on the 300 hall.</p> <p>3.1-18(1)</p>						