STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15E667		06/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNHURST HEALTHCARE	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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 14, 15, 16, 17, & 18, 2015 Facility number: 000385 Provider number: 15E667 AIM number: 100291340 Census bed type: NF: 36 Total: 36 Census payor type: Medicaid: 36 Total: 36 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	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 laws. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the 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 regulations governing the operation of long term care facilities and the 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(s). These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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			opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	
F 0156 SS=C Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any			

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	charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.			

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	The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on observation and interview, the facility failed to ensure all of the names, addresses, and telephone numbers of the state department, ombudsman, area agency on aging, adult protective services, and information to apply for and use of Medicare and Medicaid benefits were posted and in a prominent place in the facility for 4 of 4 days observed during the annual survey. (June 14, 15, 17, and 18, 2015) Findings include: On 6/14/15 at 4:10 p.m., during the initial tour the posting information including all of the names, addresses, and telephone numbers of the state department, ombudsman, area agency on aging, adult protective services, and information to apply for and use of Medicare and Medicaid benefits were not observed in the facility. On 6/15/15 at 8:30 a.m., on 6/17/15 at 8:35 a.m., and on 6/18/15 at 8:30 a.m., no information was observed posted in the facility for all of the names, addresses,	F 0156	F156 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected by the lack of a wall poster notification. As per state and federal regulations the facility does inform each resident before or at the time of admission and periodically during their stay of services available to them in the facility. However, the wall posting of this information had been moved by a resident who has several diagnosis of mental difficulties and behaviors. Such behaviors are also care planned and available in the resident's medical record. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident has the potential to be affected by the lack of state/federal required postings. Each resident will be issued another paper copy of the wall poster information. New postings will be placed in wall frames and attached to the wall to prevent a	07/18/2015

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	and telephone numbers of the state department, ombudsman, area agency on aging, adult protective services, and information to apply for and use of Medicare and Medicaid benefits. On 6/17/15 at 4:54 p.m., during an interview the Director of Nursing indicated the information for the ombudsman and the Medicare/Medicaid information should be posted, but was not. On 6/18/15 at 3:46 p.m., during an interview the Administrator indicated the information for Medicare/Medicaid, the state complaint number, and other information should be posted in the hallways. 3.1-4(j)(3)(A) 3.1-4(j)(3)(C) 3.1-4(j)(3)(D) 3.1-4(j)(3)(G) 3.1-4(l)(1)		resident (or anyone) from removing. Each resident will be issued another paper copy of the wall poster information. 3) What measures will be put into place or what systemic changes will be made? As per state and federal regulations the facility does inform each resident before or at the time of admission and periodically during their stay of services available to them in the facility. However, the wall posting of this information had been moved by a resident who has several diagnosis of mental difficulties and behaviors. Such behaviors are also care planned and available in the resident's medical record. Once the missing wall poster was bought to the facility's attention by the state surveyor, on 6-15-15, the wall poster was immediately replaced on the same date. The survey member was also informed of a typed paper in a protective sleeve with exact wall poster information, that had been posted on the the housekeeping door (a door centrally located and in plain view of all staff, residents and visitors.). The survey team member was also made aware of the new posting. Quality Assurance: New postings will be placed in wall frames and attached to the wall to prevent a resident (or anyone) from removing. Once the aforementioned has been accomplished, the Maintenance	

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			Man and/or his designee, will check the placement of the wall poster every week and document that the facility is in compliance with this posting; this action will occur through the next 12 months. Each resident will be issued another paper copy of the wall poster information. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: New postings will be placed in wall frames and attached to the wall to prevent a resident (or anyone) from removing. Once the aforementioned has been accomplished, the Maintenance Man and/or his designee, will check the placement of the wall poster every week and document that the facility is in compliance with this posting; this action will occur through the next 12 months. 5) By what date the systemic changes will be completed. July 18, 2015	
F 0161 SS=E Bldg. 00	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to ensure the Surety	F 0161	F161 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any	07/18/2015

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	Bond amount was sufficient coverage for the daily balances of the Residents' Trust Fund for 33 of 37 residents reviewed for surety of personal funds. (January, 2015 and March, 2015) Findings include: On 6/17/15 at 11:13 a.m., the Business Office Manager provided the Residents' Trust Fund account monthly statements dated January, 2015 to May, 2015. The daily balance summary indicated the following daily balances: 1/5/2015 - $40,424.33 1/8/2015 - $40,446.33 1/12/2015 - $40,558.33 1/13/2015 - $40,493.03 3/4/2015 - $41,865.61 3/9/2015 - $41,932.55 On 6/17/15 at 11:32 a.m., during an interview the Administrator indicated the Surety Bond was for $40,000. The Surety Bond was provided on 6/17/15 at 11:25 a.m., by the Administrator. A review of the Surety Bond indicated the amount of $40.000, beginning on March 4th of 2015, and ending March 4, 2016. On 6/17/15 at 11:45 a.m., the		resident to be affected existed, no resident was identified as having been affected. The facility had not incurred a reason to make a claim on a surety bond. However once the information from the state surveyor was given to the facility, the LHFA immediately increased the surety bond amount to fifty thousand and presented the survey team with a document acknowledging such increase from the insurance company. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. The surety bond amount has been increased. 3) What measures will be put into place or what systemic changes will be made? On 6-17-15 the facility's surety bond was increased by ten thousand dollars. The Business Office Manager will ensure resident funds do not exceed the surety bond amount. This will be accomplished by monthly checks of these funds, documented and shared with the LHFA. Monthly checks on these funds will be accomplished for a period of 12 months. Any resident account exceeding forty eight thousand will be reported to the LHFA who will then make the determination if a need exists to raise the surety bond. 4) How the corrective	

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	Administrator indicated the previous Surety Bond was $40,000 coverage and the present Surety Bond should be increased to $50,000. 3.1-6(i)		actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: The Business Office Manager will ensure resident funds do not exceed the surety bond amount. This will be accomplished by monthly monitoring of these funds, documented and shared with the LHFA. Monthly checks on these funds will be accomplished for a period of 12 months. Any resident account exceeding forty eight thousand will be reported to the LHFA who will then make the determination if a need exists to raise the surety bond. 5) By what date the systemic changes will be completed. 7-18-2015	
F 0221 SS=D Bldg. 00	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review, and interview, the facility failed to ensure a resident with a physical restraint was assisted in maintaining the highest practicable level of physical well-being, in that a resident was not repositioned or released from a restraint as indicated by the resident's care plan and facility	F 0221	F221 1) What action(s) will be accomplished for those residents found to have been affected? Resident #30 had care performed by two licensed nurses at approximately 1050 am. During this care the resident was placed in bed, checked for incontinence and cleaned as appropriate. Total care was approximately 35 minutes ;after such care the	07/18/2015

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	policy, for 1 of 3 residents who met the criteria for restraint review. (Resident #30) Findings include: The clinical record of Resident #30 was reviewed on 6/17/15 at 10:35 a.m. Diagnoses for the resident included, but were not limited to, infantile cerebral palsy and movement disorder. An admission Minimum Data Set assessment dated 2/23/15, indicated Resident #30 was severely impaired in the ability to make decisions and needed extensive assist of 2 or more staff for toileting and transfer. A recapitulated physician's order for June, 2015, with an original order date of 2/26/15, indicated a lap tray was to be utilized on the resident's wheel chair at all times and the resident was to be released and repositioned every 2 hours and as needed. A lap tray attaches to the arms of a wheel chair and is considered a restraint if the tray is not required to treat a resident's medical symptoms, the resident cannot remove the tray intentionally in the same manner as the tray was applied, and prevents the resident from rising. On 6/17/15 at 10:00 a.m., Certified Nursing Assistant #8		resident was placed back up in the wheelchair, where the resident was positioned and made comfortable by the two licensed nurses. Nursing staff will be re-trained regarding adherence to facility policy. There are no residents in the facility that are restrained and unable to move. Restraints are only utilized after all other options have been attempted and then, if a restraining device must be used, the least restraining device is used. Any resident with a restraint device, whether utilized for restraining or other measures, could be affected. Facility policy for the release and re-positioning of restraints will be followed. "Policy states the resident is visually checked every hour and released and re-positioned every two hours when up in wheelchair" The two hour time frame is what is recommended and what is adhered too, however, in a health care setting there are times when care must be triaged (immediate needs met first) and with more then one resident in the facility the actual times dictated by the policy may vary. This resident (#30) was not found by the state survey member to have any complications related to restraint use; resident was dry,comfortable and safe. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident with a restraint	

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	indicated Resident #30 was unable to remove the lap tray from his wheelchair. A current care plan for Resident #30, dated 3/9/15, indicated a problem of, "The resident uses physical restraint and is at risk for adverse effects, lap tray to wc [wheelchair] all times up for optimal upright positioning r/t [related to] poor balance, hx [history] of rocking back and forth when up in wc, leans forward and to the right, profound intellectual disability, hx of falls and poor safety awareness." The goal was the resident will remain free of complications related to restraint use. Interventions included, "release and reposition at least every 2 hours and prn [as needed]." Treatment records for May and June, 2015, indicated treatments of, "Release and reposition every 2 hours as needed when up in wheelchair with lap tray, Lap buddy [lap tray] on wheelchair when up and positioning every 2 hours, and Turn and reposition every 2 hours." Medication Administration Records (MAR) for May and June, 2015, indicated a restraint lap tray was used on the wheelchair and the resident was to have visual checks every hour and be released and repositioned every 2 hours when up in the wheelchair with a lap tray.		device, whether utilized for restraining or other measures, could be affected. All of the aforementioned residents will be cared for according to facility policy. There are no residents in the facility that are restrained and unable to move. Restraints are only utilized after all other options have been attempted and then, if a restraining device must be used, the least restraining device is used. Resident #30 had care performed by two licensed nurses at approximately 1050 am. During this care the resident was placed in bed, checked for incontinence and cleaned as appropriate. Total care was approximately 35 minutes ;after such care the resident was placed back up in the wheelchair, where the resident was positioned and made comfortable by the two licensed nurses. Among resident #30's diagnosis are: profound intellectual disability-cerebral palsy and stereotypic movement disorder. This resident uses a restraining device for optimal upright positioning r/t poor balance. Resident has a history of rocking back and forth, leaning precariously to the right and left. The resident has poor safety awareness.The care planned goal for the use of this restraint is listed as 'the resident will remain free of complications related to restraint use.' This resident was not found by the state survey	

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	The May and June, 2015 treatment records and MARs had 1 slot for each shift for staff to initial. On 6/18/15 at 10:06 a.m., Licensed Practical Nurse #7 indicated staff placement of their initials in the slot each shift indicated the releasing and repositioning was done and staff did not document specifically what time intervals the resident was released, or how the resident was repositioned. During a continuous observation on 6/17/15 from 11:10 a.m. to 1:40 p.m., which included a meal service, Resident #30 was observed not to be released from his lap tray restraint nor repositioned in his wheelchair. He sat in the hallway, at times with his head down, right foot dangling off the footrest, and at times with his head up looking around. On 6/17/15 at 10:00 a.m., CNA #8 indicated Resident #30 got up in the morning for breakfast and stayed in the wheelchair with the lap tray until after lunch. She indicated the staff didn't take the resident to bed or back to his room until after lunch and other than talking to him, "didn't have to do anything else for him." On 6/16/15 at 12:00 p.m., the Executive Director provided an undated policy		member to have any complications related to restraint use; resident was dry,comfortable and safe. The facility and the resident's physician believe the lap tray device is utilized to treat the resident's medical condition/symptoms. 3) What measures will be put into place or what systemic changes will be made? Old restraint monitoring forms have been replaced with forms that now document 'every two hour release and re-position'. Please see exhibit 'I' (The two hour time frame will remain as staff is required to be aware of this recommended time frame.) Nursing staff will be re-trained regarding adherence to facility policy. Re-training will be accomplished one on one (supervisor and/or her designee to nursing staff member) every two weeks for one month. The facility will provide nursing staff in-services regarding restraints and their use, re-positioning and releasing expectations as per facility policy; every month for six months. Residents who utilize restraints will be monitored every two hours as per facility policy and this action shall be documented utilizing the new physical restraint form. (exhibit 'I') 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: The DON will be responsible to monitor this	

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	titled, "C.N.A. [Certified Nursing Assistant] Care of Patients while using restraints," and indicated it was the policy currently used by the facility. The policy indicated, "...All monitoring of a person with a restraint must be documented...A patient who is restrained must be released and repositioned at least every 2 hours...If your patient has any type of physical restraint, he has to be visually checked hourly and remove the restraint at least every 2 hours. While it's off, assess, turn, reposition and toilet the patient..." 3.1-26(h)		correction. Nursing staff will be re-trained regarding adherence to facility policy. Re-training will be accomplished one on one (supervisor and/or her designee to nursing staff member) every two weeks for one month. The facility will provide nursing staff in-services regarding restraints and their use, re-positioning and releasing expectations as per facility policy; every month for six months. Residents who utilize restraints will be monitored every two hours as per facility policy and this action shall be documented utilizing the new physical restraint form. (exhibit 'I') 5) By what date the systemic changes will be completed. 7-18-15	
F 0246 SS=D Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on record review and interview, the facility failed to ensure a resident received showers according to his plan of care for 1 of 4 residents who met the criteria for review of accommodation of needs. (Resident #38) Findings include:	F 0246	F246 1) What action(s) will be accomplished for those residents found to have been affected? As per state survey, one of four residents was found to have been affected. Resident # 38 medical diagnosis include psuedo-bulbar affect- senile dementia with delusions-schizoaffective disorder-personality disorder and is care planned for accusatory	07/18/2015

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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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	The clinical record of Resident #38 was reviewed on 6/16/15 at 11:07 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease and dementia. On 6/15/15 at 10:27 a.m., Resident #38 indicated, "Nobody ever gives me a shower." A care plan for the resident, dated 3/14/14, and current through 8/8/15, indicated Resident #38 was at risk for activities of daily living deficit related to dementia. Interventions included showers twice weekly. A current care plan dated 6/1/15, indicated the resident refused showers offered by DCS (direct care staff). An approach was, "DCS to offer showers on scheduled shower days. DCS to attempt x 3 to gain compliance. DCS to approach nursing charge and nursing office of refusals. Nurses/nursing office to approach to see if compliance can be obtained." A review of shower sheets for Resident #38 indicated the following: No showers 6/5/15 - 6/11/15 No showers 5/20/15 - 5/26/15 No showers 5/2/15 - 5/13/15		behaviors. For resident #38; The Assistant Director of Nursing (ADON), among a few other staff members, assists this resident with showers as there are specific employees only that this resident will allow to assist him or he will refuse bathing. Staff was also in-serviced as of 6-1-15 (prior to the facility's state survey) as the issue of shower documentation was recognized by the facility at that time. Staff was in serviced on resident rights to refuse showers/bathing. (This in servicing included night shift and the requirement to document all am care that is performed.) All care plans (including resident #38)have had the following intervention(s) added: Flex plan of care for all bathing per resident wishes. Care plans already indicate staff is to offer shower/bathing twice weekly and offer partial bathing on non scheduled shower days. Shower sheet documentation has been changed (now includes resident refusals) . Please see exhibit 'J' and staff will be in serviced on the use of this new form. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident has the possibility of being affected if showers/bathing are not being accomplished. As per state survey, one of four residents was found to have been affected. Resident # 38 medical diagnosis	

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	No showers 4/8/15 - 4/13/15 No showers 3/22/15 - 4/6/15. On 6/16/15 at 2:00 p.m., Licensed Practical Nurse #7 indicated shower sheets are supposed to be filled out by staff when a shower is given and also when the resident refuses. She indicated she had no further information regarding why Resident #38 did not receive his showers during the above time frames. No shower sheets or nurses' notes were found which indicated Resident #38 had received or refused a shower in the above time frames. On 6/18/15 at 12:15 p.m., the Executive Director provided a policy dated 2/25/15, titled Shower Sheets/Bathing & Responsibility, and indicated it was the policy currently used by the facility. The policy indicated, "All...patients are on a 'flex plan of care' for bathing...Shower Sheets must be completed for any type of bathing...must be completed for any refusals of bathing care..." 3.1-3(v)(1)		include psuedo-bulbar affect-senile dementia with delusions-schizoaffective disorder-personality disorder and is care planned for accusatory behaviors. All residents of this facility are on a Flex Plan of Care for showers/bathing. Staff was also in-serviced as of 6-1-15 (prior to the facility's state survey) as the issue of shower documentation was recognized by the facility at that time. Staff was in serviced on resident rights to refuse showers/bathing. (This in servicing included night shift and the requirement to document all am care that is performed.) All care plans have had the following intervention(s) added: Flex plan of care for all bathing per resident wishes. Care plans already indicate staff is to offer shower/bathing twice weekly and offer partial bathing on non scheduled shower days. Shower sheet documentation has been changed (now includes resident refusals) . Please see exhibit 'J' and staff will be in serviced on the use of this new form. The ADON will monitor the new shower/bathing forms and follow up with any shower concerns, on a daily basis. The DON and/or her designee will be responsible to follow up on any resident that has refused shower/bathing times 3. A log will be kept to document this correction and a copy of these documents will be given to the LHFA and the SSD (Social	

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			Service) on a weekly basis. 3) What measures will be put into place or what systemic changes will be made? Shower/bathing sheet documentation has been changed (now includes resident refusals) . Please see exhibit 'J' and staff will be in serviced on the use of this new form. The ADON will monitor the new shower/bathing forms and follow up with any shower concerns, on a daily basis. The DON or her designee will be responsible to follow up on any resident that has refused shower/bathing times 3. A log will be kept to document this correction and a copy of these documents will be given to the LHFA and the SSD (Social Service) on a weekly basis. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? The ADON will monitor the new shower/bathing forms and follow up with any shower concerns, on a daily basis. The DON or her designee will be responsible to follow up on any resident that has refused shower/bathing times 3. A log will be kept to document this correction and a copy of these documents will be given to the LHFA and the SSD (Social Service) on a weekly basis. 5) By what date the systemic changes will be completed. 7-18-15	
F 0282	483.20(k)(3)(ii)			

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SS=E Bldg. 00	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to provide range of motion services (Residents #19, #27, and #26), failed to release and reposition a resident with a physical restraint (Resident #30), and failed to provide showers (Resident #38), as indicated by the care plans. Findings include: 1. The clinical record of Resident #30 was reviewed on 6/17/15 at 10:35 a.m. Diagnoses for the resident included, but were not limited to, infantile cerebral palsy movement disorder. An admission Minimum Data Set assessment, dated 2/23/15, indicated Resident #30 was severely impaired in the ability to make decisions and needed extensive assist of 2 or more staff for toileting and transfers. A recapitulated physician's order for June, 2015, with an original order date of 2/26/15, indicated a lap tray was to be utilized on the resident's wheel chair at all times and the resident was to be	F 0282	F282 1) What action(s) will be accomplished for those residents found to have been affected? Any resident with a restraint device, whether utilized for restraining or other measures, could be affected. Resident Care Plans are monitored by (1) The MDS process as per the RAI Manual. (2) Quarterly Care Plan meetings. (3) Nursing Assistant's daily assignment sheets. (4) Behavior meetings and in-services (5) Nursing Assistant Activity of Daily Living Grid. (6) Electronic Mar (medical records) for nurses. For residents 19,26,27 and all other residents who receive Restorative Care: The Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly. Restorative goals have been changed to be in sync with these resident's schedules/preferences and rights. Resident's #26 has several self scheduled appointments with outside providers per month and daily visitors. The resident also has a documented history of accusatory behaviors and refusals of care. Resident's #27 and #19 also have a documented history of refusals of care. It is determined that this less restrictive restorative schedule	07/18/2015

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	released and repositioned every 2 hours and as needed. A lap tray attaches to the arms of a wheel chair and is considered a restraint if the tray is not required to treat a resident's medical symptoms, the resident cannot remove the tray intentionally in the same manner as the tray was applied, and prevents the resident from rising. On 6/17/15 at 10:00 a.m., Certified Nursing Assistant #8 indicated Resident #30 was unable to remove the lap tray from his wheelchair. A current care plan for Resident #30, dated 3/9/15, indicated a problem of, "The resident uses physical restraint and is at risk for adverse effects, lap tray to wc [wheelchair] all times up for optimal upright positioning r/t [related to] poor balance, hx [history] of rocking back and forth when up in wc, leans forward and to the right, profound intellectual disability, hx of falls and poor safety awareness." The goal was the resident will remain free of complications related to restraint use... Interventions included, "release and reposition at least every 2 hours and prn [as needed]." Treatment records for May and June, 2015, indicated treatments of, "Release and reposition every 2 hours as needed when up in wheelchair with lap tray, "Lap buddy [lap tray] on wheelchair		will better fit all the aforementioned resident's schedules/preferences and rights. ROM: The "goal" for Restorative (Fit) Care for our residents is 7 days per week, however that goal is not always reached due to various individual preferences,(including but not limited to), level of outside activity, staffing challenges and an assortment of other issues that may arise. The "goal " itself was not meant to be set in stone. It is therefore expected by the facility that our Restorative (Fit) Care residents are provided that care at varying levels week to week. However in order to comply with our survey process, the Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly. A) Resident #30 (lap table) Nursing staff will be re-trained regarding adherence to facility policy. (Please refer to exhibit Z) The resident did have care performed by two licensed nurses at approximately 1050 am. During this care the resident was placed in bed, checked for incontinence and cleaned as appropriate. Total care was approximately 35 minutes ;after such care the resident was placed back up in the wheelchair, where the resident was positioned and made comfortable by the two licensed nurses. Devices: There are no residents in the facility that are restrained	

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	when up and positioning every 2 hours," and "Turn and reposition every 2 hours." Medication Administration Records (MAR) for May and June, 2015, indicated a restraint lap tray was used on the wheelchair and the resident was to have visual checks every hour and be released and repositioned every 2 hours when up in the wheelchair with a lap tray. The May and June, 2015 treatment records and MARs had 1 slot for each shift for staff to initial. On 6/18/15 at 10:06 a.m., Licensed Practical Nurse #7 indicated staff placement of their initials in the slot each shift indicated the releasing and repositioning was done and staff did not document specifically what time intervals the resident was released, or how the resident was repositioned. During a continuous observation on 6/17/15 from 11:10 a.m. to 1:40 p.m., which included a meal service, Resident #30 was observed to not be released from his lap tray restraint nor repositioned in his wheelchair. He sat in the hallway, at times with his head down, right foot dangling off the footrest, and at times with his head up looking around. On 6/17/15 at 10:00 a.m., CNA #8 indicated Resident #30 got up in the		and unable to move. Restraints are only utilized after all other options have been attempted and then, if a restraining device must be used, the least restraining device is used. Facility policy for the release and re-positioning of restraints will be followed. "Policy states the resident is visually checked every hour and released and re-positioned every two hours when up in wheelchair" The two hour time frame is what is recommended and what is adhered too, however, in a health care setting there are times when care must be triaged (immediate needs met first) and with more then one resident in the facility the actual times dictated by the policy may vary. This resident was not found by the state survey member to have any complications related to restraint use; resident was dry,comfortable and safe. The facility and the resident's physician believe the lap tray device is utilized to treat the resident's medical condition/symptoms. B) Although the potential for any resident to be affected existed, no resident was identified as having been affected. ROM: The "goal" for Restorative (Fit) Care for our residents is 7 days per week, however that goal is not always reached due to various individual preferences,(including but not limited to), level of outside activity, staffing challenges and an assortment of other issues	

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	morning for breakfast and stayed in the wheelchair with the lap tray until after lunch. She indicated the staff didn't take the resident to bed or back to his room until after lunch, and other than talking to him, "didn't have to do anything else for him." 2. a. On 6/14/15 at 5:39 p.m., Resident #26 was observed with a left hand contracture (condition of fixed high resistance to passive stretch of a muscle). On 6/17/2015 at 9 a.m., during a staff interview LPN #10 indicated Resident #26 would receive range of motion (ROM) with the Restorative aide. LPN #10 indicated the restorative aide was here 5 of the 7 days a week. On 6/18/2015 at 8:58 a.m., during an interview Resident #26 indicated he received ROM 1 time per week. He had his stroke in 2008. His hand was worse, because he was unable to extend his thumb out as his thumb laid between his fingers now. Resident #26's clinical record was reviewed on 6/17/2015 at 9:00 a.m. The resident's diagnoses included, but were not limited to, cardiovascular accident, neurogenic pain, limited mobility, and extremity weakness. The quarterly		that may arise. The "goal " itself was not meant to be set in stone. It is therefore expected by the facility that our Restorative (Fit) Care residents are provided that care at varying levels week to week. However in order to comply with our survey process, the Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly. C) Although the potential for any resident to be affected existed, no resident was identified as having been affected. Showers: Resident # 38 medical diagnosis include psuedo-bulbar affect- senile dementia with delusions-schizoaffective disorder-personality disorder and is care planned for accusatory behaviors. The Assistant Director of Nursing (ADON), among a few other staff members, assists this resident with showers as there are specific employees only that this resident will allow to assist him or he will refuse bathing. 6-1-15 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? A) Any resident with a restraint device, whether utilized for restraining or other measures, could be affected. All of the aforementioned residents will be cared for according to facility policy. There are no residents in the facility that are restrained and	

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	Minimum Data Set assessment, dated 4/3/15, indicated the resident had a Basic Interview Mental Status of 15, with a score of 8 to 15 as interviewable. The resident required extensive assistance of 1 to 2 persons for transfers and activities of daily living. The current care plan indicated passive range of motion to be completed 7 days per week with 20 repetition 1 time per day with rest break after 10 repetitions. The "FUNCTIONAL INDEPENDENCE TREATMENT MONTHLY SUMMARY FORM" indicated the following completion of PROM (passive range of motion): May, 2015 - no PROM was indicated as completed on 5/2, 5/3, 5/8, 5/12, 5/16, 5/17, 5/22, 5/26, and 5/29-31; June 1 to 16, 2015 - no PROM was indicated as completed on 6/5, 6/9, and 6/12-14. During an interview on 6/16/2015 at 4:41 p.m., the MDS Coordinator indicated the passive range of motion was not completed on the days that were left blank on the Functional Independence Treatment Monthly Summary Form. During an interview with the Minimum		unable to move. Restraints are only utilized after all other options have been attempted and then, if a restraining device must be used, the least restraining device is used. Resident #30 had care performed by two licensed nurses at approximately 1050 am. During this care the resident was placed in bed, checked for incontinence and cleaned as appropriate. Total care was approximately 35 minutes ;after such care the resident was placed back up in the wheelchair, where the resident was positioned and made comfortable by the two licensed nurses. Among resident #30's diagnosis are: profound intellectual disability-cerebral palsy and stereotypic movement disorder. This resident uses a restraining device for optimal upright positioning r/t poor balance. Resident has a history of rocking back and forth, leaning precariously to the right and left. The resident has poor safety awareness.The care planned goal for the use of this restraint is listed as 'the resident will remain free of complications related to restraint use. 'Nursing staff will be re-trained regarding adherence to facility policy. Re-training will be accomplished one on one (supervisor and/or her designee to nursing staff member) every two weeks for one month. The facility will provide nursing staff in-services	

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	Data Set (MDS) assessment Coordinator on 6/16/15 at 4:42 p.m., the MDS Coordinator indicated the facility only had one restorative nursing assistant to provide range of motion and restorative program services to the residents, and the residents were rotated on a daily basis with services provided 3-4 times a week, as not every resident could be provided services on a daily basis. The goal was to provide services to every resident 7 days a week, but the facility was unable to provide the level of service at this time. b. The clinical record review completed 6/16/15 at 3:48 p.m., indicated Resident #19 had diagnoses including, but not limited to, osteoporosis (a condition in which the bones become weak and brittle). During a Stage 1 interview on 6/15/15 at 11:42 a.m., Resident #19 was observed to have limited ability to turn their head from side to side and held their head turned to the right side during the interview. When prompted, the resident was able to turn their head slightly to the left. A review of the Nursing Functional Independence Treatment Program Careplan and Nursing Evaluation Active Range of Motion (AROM) dated 6/24/14,		regarding restraints and their use, re-positioning and releasing expectations as per facility policy; every month for six months. Residents who utilize restraints will be monitored every two hours as per facility policy and this action shall be documented utilizing the new physical restraint form. (exhibit 'I') B) In order to comply with our survey process, the Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly. All residents of this facility are on a Flex Plan of Care for showers/bathing. C) Showers: Staff was in-serviced as of 6-1-15 (prior to the facility's state survey) as the issue of shower documentation was recognized by the facility at that time. Staff was also in serviced on resident rights to refuse showers/bathing. (This in servicing included night shift and the requirement to document all am care that is performed.) All care plans have had the following intervention(s) added: Flex plan of care for all bathing per resident wishes. Care plans already indicate staff is to offer shower/bathing twice weekly and offer partial bathing on non scheduled shower days. Shower sheet documentation has been changed (now includes resident refusals) . Please see exhibit 'J' and staff will be in serviced on the use of this new form. 3) What measures will be put into place or what systemic changes will be	

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	and current through 5/7/15, indicated the resident had a partial loss of voluntary movement in which the resident leans their head to the right. Interventions included Active Range of Motion Program 7 days a week for 20 repetitions. A review of the Functional Independence Treatment Monthly Summary Form for May 2015, indicated Resident #19 did not receive AROM services on 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/20, 5/21, and 5/30/15. In June 2015, the resident did not receive AROM services 6/9, 6/12, 6/13, and 6/14/15. During an interview on 6/16/2015 at 4:41 p.m., the MDS Coordinator indicated the passive range of motion was not completed on the days that were left blank on the Functional Independence Treatment Monthly Summary Form. During an interview with the Minimum Data Set (MDS) assessment Coordinator on 6/16/15 at 4:42 p.m., the MDS Coordinator indicated the facility only had one restorative nursing assistant to provide range of motion and restorative program services to the residents, and the residents were rotated on a daily basis with services provided 3-4 times a week, as not every resident could be provided services on a daily basis. The goal was to		made? A) Old restraint monitoring forms have been replaced with forms that now document 'every two hour release and re-position'. Please see exhibit 'I' (The two hour time frame will remain as staff is required to be aware of this recommended time frame.) Nursing staff will be re-trained regarding adherence to facility policy. Re-training will be accomplished one on one (supervisor and/or her designee to nursing staff member) every two weeks for one month. The facility will provide nursing staff in-services regarding restraints and their use, re-positioning and releasing expectations as per facility policy; every month for six months. Residents who utilize restraints will be monitored every two hours as per facility policy and this action shall be documented utilizing the new physical restraint form. (exhibit 'I') B) In order to comply with our survey process, the Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly. The Restorative (Fit) Care employee will document any deviation from the residents restorative care program and s/he will turn this information in on a daily basis to the nurse that monitors this program. (MDS); that nurse will maintain this information. This document will be discussed in the morning meeting on a weekly basis. (Morning meeting	

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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
	provide services to every resident 7 days a week, but the facility was unable to provide the level of service at this time. c. A review of the clinical record for Resident #27 was completed on 6/16/2015 at 3:56 p.m. Diagnoses included, but were not limited to, depressive disorder. During a staff interview on 6/15/2015 at 2:23 p.m., Licensed Practical Nurse (LPN) #3, indicated Resident #27 had a contracture (condition of fixed high resistance to passive stretch of a muscle) to the left upper extremity. During an observation on 6/15/2015 at 2:24 p.m., Resident #27 was noted with the left wrist bent downward towards the forearm. The resident indicated he was not able to stretch out the wrist. A review of the careplan (completed on 06/16/2015 at 4:30 p.m.) titled, "Passive Range of Motion", dated 02/15/2015, indicated Resident #27 was to receive 15 repetitions of Passive Range of Motion to the left hand 1 time a day. A review of the "Functional Independence Treatment Monthly Summary Form," provided by the Minimal Data Set Coordinator (MDS		attendees approximately include the Director of Nursing Services, the MDS nurse, the Social Service Designee,the Dietary Manager, the ADON, Medical Records and the Maint. Manager) C) All residents of this facility are on a Flex Plan of Care for showers/bathing. Staff was also in-serviced as of 6-1-15 (prior to the facility's state survey) as the issue of shower documentation was recognized by the facility at that time. Staff was also in serviced on resident rights to refuse showers/bathing. (This in servicing included night shift and the requirement to document all am care that is performed.) All care plans have had the following intervention(s) added: Flex plan of care for all bathing per resident wishes. Care plans already indicate staff is to offer shower/bathing twice weekly and offer partial bathing on non scheduled shower days. Shower sheet documentation has been changed (now includes resident refusals) . Please see exhibit 'J' and staff will be in serviced on the use of this new form. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Resident Care Plans are monitored by (1) The MDS process as per the RAI Manual. (2) Quarterly Care Plan meetings. (3) Nursing Assistant's daily assignment sheets. (4) Behavior	

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	Coordinator) on 6/16/2015 at 4:40 p.m., indicated Resident #27 was to receive 15 reps (repetitions) to left hand daily as tolerated. There was no documentation, the repetitions were completed on April 2, 3, 14, 16, 18, 24, and 28, May 2, 3, 8, 12, 16, 17, 26, 29, 30, and 31, June 5, 9, 12, 13, and 14, 2015. During an interview on 6/16/2015 at 4:41 p.m., the MDS Coordinator indicated the passive range of motion was not completed on the days that were left blank on the Functional Independence Treatment Monthly Summary Form. During an interview with the Minimum Data Set (MDS) assessment Coordinator on 6/16/15 at 4:42 p.m., the MDS Coordinator indicated the facility only had one restorative nursing assistant to provide range of motion and restorative program services to the residents, and the residents were rotated on a daily basis with services provided 3-4 times a week, as not every resident could be provided services on a daily basis. The goal was to provide services to every resident 7 days a week, but the facility was unable to provide the level of service at this time. 3. The clinical record of Resident #38 was reviewed on 6/16/15 at 11:07 a.m. Diagnoses for the resident included, but		meetings and in-services (5) Nursing Assistant Activity of Daily Living Grid. (6) Electronic Mar (medical records) for nurses. Quality Assurance: A) The DON will be responsible to monitor this correction. Nursing staff will be re-trained regarding adherence to facility policy. Re-training will be accomplished one on one (supervisor and/or her designee to nursing staff member) every two weeks for one month. The facility will provide nursing staff in-services regarding restraints and their use, re-positioning and releasing expectations as per facility policy; every month for six months. Residents who utilize restraints will be monitored every two hours as per facility policy and this action shall be documented utilizing the new physical restraint form. (exhibit 'I') Quality Assurance: B) The Restorative (Fit) Care employee will document any deviation from the residents restorative care program and s/he will turn this information in on a daily basis to the nurse that monitors this program. (MDS); that nurse will maintain this information. This document will be discussed in the morning meeting on a weekly basis. (Morning meeting attendees approximately include the Director of Nursing Services, the MDS nurse, the Social Service Designee,the Dietary Manager, the ADON, Medical Records and the Maint. Manager)	

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	were not limited to, Alzheimer's disease and dementia. On 6/15/15 at 10:27 a.m., Resident #38 indicated, "Nobody ever gives me a shower." A current care plan for the resident, dated 3/14/14, indicated Resident #38 was at risk for activities of daily living deficit related to dementia. Interventions included showers twice weekly. A current care plan dated 6/1/15, indicated the resident refused showers offered by DCS (direct care staff). An approach was, "DCS to offer showers on scheduled shower days. DCS to attempt x 3 to gain compliance. DCS to approach nursing charge and nursing office of refusals. Nurses/nursing office to approach to see if compliance can be obtained." A review of shower sheets for Resident #38 indicated the following: No showers 6/5/15 - 6/11/15 No showers 5/20/15 - 5/26/15 No showers 5/2/15 - 5/13/15 No showers 4/8/15 - 4/13/15 No showers 3/22/15 - 4/6/15 On 6/16/15 at 2:00 p.m., Licensed		Quality Assurance: C) The ADON will monitor the new shower/bathing forms and follow up with any shower concerns, on a daily basis. The DON or her designee will be responsible to follow up on any resident that has refused shower/bathing times 3. A log will be kept to document this correction and a copy of these documents will be given to the LHFA and the SSD (Social Service) on a weekly basis. 5) By what date the systemic changes will be completed. 7-18-15	

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	Practical Nurse #7 indicated shower sheets are supposed to be filled out by staff when a shower is given and also when the resident refuses. She indicated she had no further information regarding why Resident #38 did not receive his showers during the above time frames. On 6/18/15 at 12:15 p.m., the Executive Director provided a policy dated 2/25/15, titled Shower Sheets/Bathing & Responsibility, and indicated it was the policy currently used by the facility. The policy indicated, "All...patients are on a 'flex plan of care' for bathing...Shower Sheets must be completed for any type of bathing...must be completed for any refusals of bathing care..." No shower sheets or nurses' notes were found which indicated Resident #38 had received or refused a shower in the above time frames. On 6/18/15 at 12:15 p.m., the Executive Director provided a policy dated 2/25/15, titled Shower Sheets/Bathing & Responsibility, and indicated it was the policy currently used by the facility. The policy indicated, "All...patients are on a 'flex plan of care' for bathing...Shower Sheets must be completed for any type of bathing...must be completed for any refusals of bathing care..."			

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	3.1-35(g)(2)			
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure that residents with a limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 3 of 3 residents reviewed for range of motion. (Residents #26, #27, #19) Findings include: 1. A review of the clinical record for Resident #27 was completed on 06/16/2015 at 3:56 p.m. Diagnoses included, but were not limited to, depressive disorder. During a staff interview on 6/15/2015 at 2:23 p.m., Licensed Practical Nurse (LPN) #3, indicated Resident #27 had a contracture (condition of fixed high resistance to passive stretch of a muscle)	F 0318	F318 1) What action(s) will be accomplished for those residents found to have been affected? For residents 19,26,27 and all other residents who receive Restorative Care: The Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly. Restorative goals have been changed to be in sync with these resident's schedules/preferences and rights. The facility will place an employment advertisement for an additional Restorative Care employee. Resident #26 diagnosis include; muscle spasms which includes affect to the muscles of the hand (thumb) and has a doctor's order to wear a special glove for this hand but this resident refuses to follow doctor orders. Resident's #26 has several monthly self scheduled appointments with several outside providers which renders this resident unavailable to restorative care as the resident is not inside the facility during those times.The	07/18/2015

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	to the left upper extremity. During an observation on 6/15/2015 at 2:24 p.m., Resident #27 was noted with the left wrist bent downward towards the forearm. The resident indicated he was not able to stretch out the wrist. A review of the careplan (completed on 06/16/2015 at 4:30 p.m.) titled, "Passive Range of Motion" dated 02/15/2015, indicated Resident #27 was to receive 15 repetitions of Passive Range of Motion to the left hand 1 time a day. A review of the "Functional Independence Treatment Monthly Summary Form," provided by the Minimal Data Set Coordinator (MDS Coordinator) on 6/16/2015 at 4:40 p.m., indicated Resident #27 was to receive 15 reps the (repetitions) to left hand daily as tolerated. There was no documentation, the repetitions had been completed on April 2, 3, 14, 16, 18, 24, and 28, May 2, 3, 8, 12, 16, 17, 26, 29, 30, and 31, June 5, 9, 12, 13, and 14, 2015. During an interview on 6/16/2015 at 4:41 p.m., the MDS Coordinator indicated the passive range of motion was not completed on the days that were left blank on the Functional Independence Treatment Monthly Summary Form.		resident also has daily visitors and goes outside of the facility with the visitors daily. The resident also has a documented history of accusatory behaviors and non-compliance with care and refusals of care. Resident's #27 and #19 also have a documented history of refusals of care. The Restorative (Fit) Care goals were revised. It is determined that this less restrictive restorative schedule will better fit all the aforementioned resident's schedules/preferences and rights. Although the potential for any resident to be affected existed, no resident was identified as having been affected. The "goal" for Restorative (Fit) Care for our residents is 7 days per week, however that goal is not always reached due to various individual preferences,(including but not limited to), level of outside activity, staffing challenges and an assortment of other issues that may arise. The "goal " itself was not meant to be set in stone. It is therefore expected by the facility that our Restorative (Fit) Care residents are provided that care at varying levels week to week. However in order to comply with our survey process, the Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly. 2) How the facility	

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	The policy titled, "The Interdisciplinary Plan of Care *General Policy and Definitions", provided by the Director of Nursing (DON) on 6/18/2015 at 2:55 p.m., indicated "...Patients receive care and treatment based on assessment of their needs...." During an interview with the Minimum Data Set (MDS) assessment Coordinator on 6/16/15 at 4:42 p.m., the MDS Coordinator indicated the facility only had one restorative nursing assistant to provide range of motion and restorative program services to the residents. The residents were rotated on a daily basis with services provided 3-4 times a week, as not every resident could be provided services on a daily basis. The goal was to provide services to every resident 7 days a week, but the facility was unable to provide the level of service at this time. 2. On 6/14/15 at 5:39 p.m., Resident #26 was observed with a left hand contracture (condition of fixed high resistance to passive stretch of a muscle). On 6/17/2015 at 9 a.m., during a staff interview LPN #10 indicated Resident #26 would receive range of motion (ROM) with the Restorative aide. The restorative aide was here 5 of the 7 days a		will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. Resident # 26 is care planned for accusatory behavior and refusals of care and has diagnosis of including but not limited to; schizophrenia, PTSD, anxiety and bipolar disease. (Please see exhibit 'H') The BIMS (brief instrument of mental status) score may show interview ability but the facility feels (with respect) that the complete state of this resident's medical diagnosis and medications utilized for those diagnosis must somehow be taken into consideration when considering the reliability of resident statements. However in order to comply with our survey process, Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly. The facility will place an employment advertisement for an additional Restorative Care employee. 3) What measures will be put into place or what systemic changes will be made? Systemic Change Restorative (Fit) Care goals were revised from the goal of 7 days per week to a goal of 4-7 days weekly for all residents on this program. The facility will place an employment advertisement for an additional Restorative Care	

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	week. On 6/18/2015 at 8:58 a.m., during an interview Resident #26 indicated he received ROM 1 time per week. He had his stroke in 2008. His hand was worse, because he was unable to extend his thumb out as his thumb now laid between his fingers. Resident #26's clinical record was reviewed on 6/17/2015 at 9:00 a.m. The resident's diagnoses included, but were not limited to, cardiovascular accident, neurogenic pain, limited mobility, and extremity weakness. The quarterly Minimum Data Set assessment, dated 4/3/15, indicated the resident had a Basic Interview Mental Status of 15, with a score of 8 to 15 as interviewable. The resident required extensive assistance of 1 to 2 persons for transfers and activities of daily living. The care plan indicated passive range of motion to be completed 7 days per week with 20 repetition 1 time per day with rest break after 10 repetitions. The "FUNCTIONAL INDEPENDENCE TREATMENT MONTHLY SUMMARY FORM" indicated the following completion of PROM (passive range of motion):		employee. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: The Restorative (Fit) Care employee will document any deviation from the residents restorative care program and s/he will turn this information in on a daily basis to the nurse that monitors this program. (MDS); that nurse will maintain this information. This document will be discussed in the morning meeting on a weekly basis. (Morning meeting attendees approximately include the Director of Nursing Services, the MDS nurse, the Social Service Designee,the Dietary Manager, the ADON, Medical Records and the Maint. Manager) 5) By what date the systemic changes will be completed. 7-18-15	

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	May, 2015 - no PROM was indicated as completed on 5/2, 5/3, 5/8, 5/12, 5/16, 5/17, 5/22, 5/26, and 5/29-31; June 1 to 16, 2015 - no PROM was indicated as completed on 6/5, 6/9, and 6/12-14. During an interview on 6/16/2015 at 4:41 p.m., the MDS Coordinator indicated the passive range of motion was not completed on the days that were left blank on the Functional Independence Treatment Monthly Summary Form. The policy titled, "The Interdisciplinary Plan of Care *General Policy and Definitions", provided by the Director of Nursing (DON) on 6/18/2015 at 2:55 p.m., indicated "...Patients receive care and treatment based on assessment of their needs...." During an interview with the Minimum Data Set (MDS) assessment Coordinator on 6/16/15 at 4:42 p.m., the MDS Coordinator indicated the facility only had one restorative nursing assistant to provide range of motion and restorative program services to the residents. The residents were rotated on a daily basis with services provided 3-4 times a week, as not every resident could be provided services on a daily basis. The goal was to			

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	provide services to every resident 7 days a week, but the facility was unable to provide the level of service at this time. 3. The clinical record review completed 6/16/15 at 3:48 p.m., indicated Resident #19 had diagnoses including, but not limited to, osteoporosis (a condition in which the bones become weak and brittle). During a Stage 1 interview on 6/15/15 at 11:42 a.m., Resident #19 was observed to have limited ability to turn their head from side to side and held their head turned to the right side during the interview. When prompted, the resident was able to turn their head slightly to the left. A review of the Nursing Functional Independence Treatment Program Careplan and Nursing Evaluation Active Range of Motion (AROM) dated 6/24/14, and current through 5/7/15, indicated the resident had a partial loss of voluntary movement in which the resident leans head to the right. Interventions included Active Range of Motion Program 7 days a week for 20 repetitions. A review of the Functional Independence Treatment Monthly Summary Form for May 2015, indicated Resident #19 did			

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	not receive AROM services on 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/20, 5/21, and 5/30/15. In June 2015, the resident did not receive AROM services 6/9, 6/12, 6/13, and 6/14/15. During an interview on 6/16/2015 at 4:41 p.m., the MDS Coordinator indicated the passive range of motion was not completed on the days that were left blank on the Functional Independence Treatment Monthly Summary Form. The policy titled, "The Interdisciplinary Plan of Care *General Policy and Definitions", provided by the Director of Nursing (DON) on 6/18/2015 at 2:55 p.m., indicated "...Patients receive care and treatment based on assessment of their needs...." During an interview with the Minimum Data Set (MDS) assessment Coordinator on 6/16/15 at 4:42 p.m., the MDS Coordinator indicated the facility only had one restorative nursing assistant to provide range of motion and restorative program services to the residents. The residents were rotated on a daily basis with services provided 3-4 times a week, as not every resident could be provided services on a daily basis. The goal was to provide services to every resident 7 days a week, but the facility was unable to			

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	provide the level of service at this time. 3.1-42(a)(2)			
F 0323 SS=D Bldg. 00	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. Based on observation, interview, and record review, the facility failed to ensure potentially hazardous chemicals and disinfecting wipes were secured, the medication carts were locked, spilled water was removed, and failed to provide adequate supervision to prevent an accident (Resident #4). Findings include: 1.) During the initial tour of the facility on 6/14/15 from 4:10 p.m. to 4:40 p.m., the following observations were made: a. The janitor's closet located near the kitchen door was unlocked. A sign on the door indicated, "Keep door locked." On the floor of the closet were two bottles of Reply R.T.U. spray buff cleaner and a spray bottle of Reply R.T.U. was on the shelf just inside the	F 0323	F323 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected. Resident's # 33 and # 31 were being transported in wheelchairs by nursing staff, these residents were not at risk of falls at the time that water was observed to be on the floor. To provide immediate correction of water spills on the floor: The facility will provide absorption material placed strategically in the dining room to ensure such material is ready for immediate use for any other spill. Resident #4 is not mentioned as being near the water on the floor in the dining area. Resident #4 diagnosis include; dementia due to brain injury, bi-polarism and schizoaffective disorders. Resident #4 was assessed for the need of a self release wheelchair	07/18/2015

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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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	door. The label indicated, "May cause eye irritation." A spray bottle with "Ammonia" handwritten on the bottle was hanging from the shelf, along with another spray bottle marked "Disinfectant for nursing staff. Keep in janitor's closet." A spray can of mirror and glass cleaner was sitting on the shelf. The label indicated, "...Contents under pressure may explode if heated...." A third spray bottle marked, "Bio plex deodorizer" was hanging on the shelf. The handwritten label indicated," 5/5/15, keep in janitor's closet." b. Two of two medication carts were unlocked and a set of keys were laying on the top of one of the carts. No staff were observed near the carts. c. Two tubs of Super Sani-Wipes were sitting on top of the medication carts in the hallway and another tub was sitting on top of a medication cart located in the activity room. The label on the wipes indicated, "...Precautionary Statements-Hazard to humans and Domestic Animals. Danger: Causes irreversible eye damage. Do not get in eyes or on clothing. Avoid contact with skin...." d.) An unlabeled bottle of hand and body lotion was observed on a shelf in the		belt by the ADON, the physician and the physician's nurse (AEB nursing note dated 5-19-15 please refer to exhibit A) This nursing note also documents that prior to the placement of the self release belt, there were issues with the resident attempting to transfer without assistance of staff. The self release belt assessment would differ from a restraint assessment. Due to resident #4 being able to remove the self release belt at will and without staff assistance it is not considered a restraint. Regarding locked areas : Investigation does not relate any events of a resident being affected by such a practice. To the LHFA's knowledge there has not been an event of such nature in this facility for the last nine years. Self locking door handles will replace the regular door handles in four areas of the facility. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident had the potential to be affected by this practice. Corrective action is as follows: A) The lock on the janitors closet will to changed to a lock that automatically locks when the door is closed. The Maintenance Manager and/or his designee will perform twice daily monitoring of the janitors closet and resident bathrooms, for six months. This monitoring will be documented. -	

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	bathroom by room 15 with the label indicating was not for consumption. e.) An unlabeled tube of opened toothpaste and an air freshener spray with a manufacture's label on the air freshener, indicating warning, flammable and an eye irritant, was observed on top of the medication cart located at the entrance to the dining room. During an interview with Licensed Practical Nurse (LPN) #6 on 6/14/15 at 4:35 p.m., LPN #6 indicated the janitor's closet was supposed to be locked and the medication carts should be locked as well. 2.) During the dining observation on 6/14/2015 from 4:30 p.m. to 6:45 p.m., the following was observed: After several bags of ice were carried through the dining room by the dietary staff, water was observed in the middle of the traffic area of the dining room floor. Resident #33 by CNA #2 and Resident #31 by CNA #3 were observed wheeled in to the dining room through the water on this floor. After 4 minutes, CNA #2 was observed to set out a wet floor sign and then mopped up the water. 3.) The clinical record record review for Resident #4, completed 6/16/15 at 10:52		The employee(s) who worked during the survey visit will be counseled on their responsibility to maintain a safe environment for our residents by ensuring cleaning supplies are kept under lock and key at all times unless being utilized. -Housekeeping staff will have re-training on equipment safety via in services related to their department three times monthly for two months; followed by two times monthly for a period of four months. B) Nursing staff will be monitored by the Director of Nursing. (DON). The DON will make rounds on the carts during medication passes and in at least 30% of resident rooms and resident common areas twice daily to monitor nursing staff and their handling of nursing carts/equipment and resident personal supplies and resident safety. These rounds will be documented as being accomplished daily. -For coverage of this monitoring practice when the DON is not available the DON will schedule this monitoring to be accomplished by a nursing staff designee. (Including all shifts) -Nurses who were scheduled as charge nurses on the floor during evening shift on 6-14-15 will be counseled. -The facility will schedule pharmacy monitored medication passes with the aforementioned nursing staff. Pharmacy will also be schedule to provide the same service for the	

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	a.m., indicated the resident had diagnoses including, but not limited to, dementia due to brain injury. A Fall Risk Assessment completed 5/7/15, indicated the resident was at a high risk for falls. A physician's order dated 5/9/15, indicated a chair alarm for patient safety as Resident #4 continued to get up out of wheel chair without assistance and had an unsteady gait. An Interdisciplinary Team (IDT) Note dated 5/18/15, indicated the resident experienced a fall on 5/17/15 at 7:30 p.m. The note indicated the resident's alarm sounded and the resident stood up without assistance and fell to the floor before staff could assist the resident. New interventions for the fall included a self release belt trial. A current care plan dated 5/19/15, indicated the resident was at a high risk of falls related to poor balance, poor safety awareness, history of falls, incontinence, and leans forward in the wheelchair. Interventions included, but were not limited to, toileting every 2-3 hours, encourage activities, anticipate needs, and encourage to use cal light.		day shift. -The aforementioned nursing staff will be in serviced/re-trained on medication pass safety which will include the safe storage of medication and providing a locked medication/treatment cart unless the cart is in use and in line of sight. The in services/re-training will be accomplished every week for 3 months and monthly thereafter for a total of six months. -Other licensed nursing staff will be in serviced on the same, once a month for six months. -The facility is currently addressing a possible Nurse Manager on Duty for weekend purposes. C) Resident's # 33 and # 31 were being transported in wheelchairs by nursing staff, these residents were not at risk of falls at the time that water was observed to be on the floor. During meal times (while residents are being transported and the then meals set up) the facility does not believe 4 minutes should be considered an inordinate amount of time for the nursing assistants to recognize and take care of a spill; however the facility will provide absorption material placed strategically in the dining room to ensure such material is ready for immediate use for any other spill. The facility will also provide additional 'hand sanitizing stations' in the dining area. (D) Resident #4 was assessed for the need of a self release wheelchair belt by the	

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	A physician's order dated 5/19/15, indicated the resident had a self release belt for safety and positioning while up in the wheelchair. An IDT Note dated 5/20/15, indicated the resident experienced a fall on 5/19/15 at 5:30 p.m. New interventions included an adjustment to the self release belt. During an interview with the Minimum Data Set (MDS) assessment Coordinator and Licensed Practical Nurse #1 on 6/18/15 at 9:59 a.m., the MDS coordinator indicated the self release belt was too loose when the belt was first applied to the chair and was across the thighs of the resident instead of across the hips, and the resident was able to remove the belt and stand up before staff could reach the resident. The MDS coordinator indicated no assessment was completed prior to the placement of the self release belt and the resident was not assessed for accurate fit and placement of the belt after the belt was attached to the chair. On 3/18/15 at 11:39 a.m., the Executive Director provided a policy addendum titled Self Releasing Chair Belt, dated 4/5/13, and indicated the policy was the one currently used by the facility. The policy indicated the residents would be		ADON, the physician and the physician's nurse (AEB nursing note dated 5-19-15 please refer to exhibit A) This nursing note also documents that prior to the placement of the self release belt, there were issues with the resident attempting to transfer without assistance of staff. The self release belt is not considered a 'restraint' by this facility due to it is being utilized only as a reminder to the resident to ask for assistance before attempting to exit the wheelchair and due to the resident being able to remove the self release belt at will and without staff assistance. The self release belt assessment would differ from a restraint assessment. The MDS Coordinator states that she reported not being the one to assess this resident for use of a self releasing belt and that the belt did have to be adjusted for this resident. Again the self release belt, ill fitting or properly fitting, is utilized only as a reminder to the resident to ask for assistance before attempting to exit the wheelchair and due to the resident being able to remove the self release belt at will and without staff assistance it is not considered a restraint. 3) What measures will be put into place or what systemic changes will be made? The systemic changes are as follows: (A)-The lock on the janitors closet will to changed to a lock that automatically locks	

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	assessed at the time of admission regarding information to minimize the use of seclusion/restraints. 3.1- 45(a)(1) 3.1-45(a)(2)		when the door is closed. -Twice daily monitoring of the janitors closet and resident bathrooms, for six months. This monitoring will be documented. (B) Nursing staff will be monitored by the Director of Nursing. -Direct monitoring of the nursing staff during medication passes by the DON. (AEB documented nursing rounds) -Retraining of nurses by the pharmacy medication pass monitoring team -Counseling for the nursing staff involved -In servicing/re-training for all licensed nursing staff (as above) (C)-The facility will provide absorption material placed strategically in the dining room to ensure such material is ready for immediate use for any other spill. The facility will also provide additional 'hand sanitizing stations' in the dining area. (D) Resident #4 was assessed for the need of a self release wheelchair belt by the ADON, the physician and the physician's nurse (AEB nursing note dated 5-19-15 please refer to exhibit A) The self release belt is not considered a 'restraint' by this facility due to it is being utilized only as a reminder to the resident to ask for assistance before attempting to exit the wheelchair and due to the resident being able to remove the self release belt at will and without staff assistance. The self release belt assessment would differ from a restraint assessment. This nursing note	

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			also documents that prior to the placement of the self release belt, there were issues with the resident attempting to transfer without assistance of staff. The MDS Coordinator states that she reported not being the one to assess this resident for use of a self releasing belt and that the belt did have to be adjusted for this resident. Again the self release belt, ill fitting or properly fitting, is utilized only as a reminder to the resident to ask for assistance before attempting to exit the wheelchair and due to the resident being able to remove the self release belt at will and without staff assistance it is not considered a restraint. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: A) The lock on the janitors closet will to changed to a lock that automatically locks when the door is closed. The Maintenance Manager will monitor (and/or his designee) will perform twice daily monitoring of the janitors closet and resident bathrooms, for six months. This monitoring will be documented. - The employee(s) who worked during the survey visit will be counseled on their responsibility to maintain a safe environment for our residents by ensuring cleaning supplies are kept under lock and key at all times unless being utilized.	

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			-Housekeeping staff will have re-training on equipment safety via in services related to their department three times monthly for two months; followed by two times monthly for a period of four months. B) Nursing staff will be monitored by the Director of Nursing. (DON). The DON will make rounds on the carts during medication passes and in at least 30% of resident rooms and resident common areas twice daily to monitor nursing staff and their handling of nursing carts/equipment and resident personal supplies and resident safety. These rounds will be documented as being accomplished daily. -For coverage of this monitoring practice when the DON is not available the DON will schedule this monitoring to be accomplished by a nursing staff designee. (Including all shifts) -Nurses who were scheduled as charge nurses on the floor during evening shift on 6-14-15 will be counseled. -The facility will schedule pharmacy monitored medication passes with the aforementioned nursing staff. Pharmacy will also be schedule to provide the same service for the day shift. -The aforementioned nursing staff will be in serviced/re-trained on medication pass safety which will include the safe storage of medication and providing a locked medication/treatment cart unless	

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			the cart is in use and in line of sight. The in services/re-training will be accomplished every week for 3 months and monthly thereafter for a total of six months. -Other licensed nursing staff will be in serviced on the same, once a month for six months. -The facility is currently addressing a possible Nurse Manager on Duty for weekend purposes. C) Resident's # 33 and # 31 were being transported in wheelchairs by nursing staff, these residents were not at risk of falls at the time that water was observed to be on the floor. During meal times (while residents are being transported and the then meals set up) the facility does not believe 4 minutes should be considered an inordinate amount of time for the nursing assistants to recognize and take care of a spill; however the facility will provide absorption material placed strategically in the dining room to ensure such material is ready for immediate use for any other spill. The facility will also provide additional 'hand sanitizing stations' in the dining area. (D) Resident #4 was assessed for the need of a self release wheelchair belt by the ADON, the physician and the physician's nurse (AEB nursing note dated 5-19-15 please refer to exhibit A) The self release belt assessment would differ from a restraint assessment. This nursing note also documents that	

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			prior to the placement of the self release belt, there were issues with the resident attempting to transfer without assistance of staff. The self release belt is not considered a 'restraint' by this facility due to it is being utilized only as a reminder to the resident to ask for assistance before attempting to exit the wheelchair and due to the resident being able to remove the self release belt at will and without staff assistance. The MDS Coordinator states that she reported not being the one to assess this resident for use of a self releasing belt and that the belt did have to be adjusted for this resident. Again the self release belt, ill fitting or properly fitting, is utilized only as a reminder to the resident to ask for assistance before attempting to exit the wheelchair and due to the resident being able to remove the self release belt at will and without staff assistance. It is not considered a restraint. 5) By what date the systemic changes will be completed. 7-18-15	
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse			

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	consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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.			
	Based on observation, interview, and record review, the facility failed to identify and monitor targeted behaviors of delusions, insomnia, and mood stabilization for a resident receiving antipsychotic medications for these behaviors, for 1 of 5 residents reviewed for unnecessary medication use. (Resident #38) Findings include: The clinical record review, completed on 6/17/15 at 10:05 a.m., indicated Resident #38 had diagnoses including, but not limited to, delusional disorder and obsessive compulsive disorder. A Quarterly Minimum Data Set (MDS) assessment completed 5/1/15, assessed the resident as having a BIMS (Brief	F 0329	F329 1) What action(s) will be accomplished for those residents found to have been affected? As per state survey, one of five residents was found to have been affected. Resident # 38 medical diagnosis include psuedo-bulbar affect- senile dementia with delusions-schizoaffective disorder-personality disorder and is care planned for accusatory behaviors. Due to the diagnosis of schizoaffective disorder this patient's gradual dose reduction of anti-psychotic medications is contraindicated by the GDR guidelines. (per resident's physician). Documentation of delusions were located in psych notes made by Dr. J. Harrison. Please see exhibit Q. For resident #38 and any resident currently taking anti-psychotic medications: The facility has identified that the forms now utilized for documentation for	07/18/2015

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	Interview for Mental Status) of 15 out of 15, indicating the resident did not have a cognitive deficit. The resident was not assessed as having hallucinations, delusions, nor physical behaviors during the assessment period. The resident was assessed as having verbal behaviors directed toward others, rejection of care, and other behaviors directed toward others as occurring 4-6 days of the assessment period. A care plan dated 4/8/14, and updated 5/8/15, indicated the resident had non-purposeful pacing, making threats and accusatory remarks to the staff. Resident #38 had care plans dated 5/27/15, for cussing staff and peers and making insulting remarks, a care plan dated 6/1/15, for refusal of linen changes on shower days and refusing showers and then saying the staff would not give him a shower, and a care plan dated 6/4/15, for frequently interrupting communications between others. Interventions included, but were not limited to, giving medications as ordered, offering showers 3 times, teaching the resident to wait until the conversation was completed before interrupting, counseling the resident to treat others with respect, and report and document all behaviors.		diagnosis such as mentioned are not specific enough. The facility is investigating a change of forms. For the present the facility will utilize the form (marked exhibit 'K')-"Behavior Intervention Monthly Flow Record". This form includes areas for monitored behaviors. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? As per state survey, one of five residents was found to have been affected. Any resident prescribed anti-psychotic medications could be affected by this issue. The facility has identified that the forms now utilized for documentation for diagnosis such as mentioned are not specific enough. The facility is investigating a change of forms. For the present the facility will utilize the form (marked exhibit 'K')-"Behavior Intervention Monthly Flow Record" Licensed nursing staff will be in serviced on the use of this 'new' form. 3) What measures will be put into place or what systemic changes will be made? *Medications utilized for insomnia, depression and delusions (*not all inclusive) will now be monitored with the new form. (Please see exhibit 'K' bottom of page marked "medications/dosage") Licensed staff will begin training for using the new document 7-6-15. The new forms will be kept in a behavior log book where that staff	

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	A recapitulation of physician's orders dated 6/1/15 - 6/30/15, indicated the resident was prescribed risperidone (an antipsychotic medication used to treat schizophrenia) 0.5 mg (milligrams) every morning and 1.5 mg at bedtime (the last dosage change was an increase on 5/1/15) prescribed for the treatment of delusional disorder, divalproex sodium (an anti-seizure medication) 1250 mg at bedtime as a mood stabilizer (the last dosage change was an increase on 2/12/15), and Trazodone (an antidepressant) 125 mg (last dosage change was 2/12/15) for the treatment of insomnia. During an interview with the Social Services Director (SSD) on 6/17/15 at 11:14 a.m., the SSD indicated the facility utilized behavior sheets for the documentation of behaviors and did not maintain a behavior log. The SSD indicated the staff filled out a behavior sheet whenever the resident had a behavior. The SSD provided the behavior sheets for May and June 2015. A review of the sheets indicated the resident had 6 incidents of cursing at the staff, 3 incidents of disruptive vocalizations/behaviors, 1 incident of spitting in the face of a staff member, and 1 incident of threatening to hit the staff		will be able to document behaviors associated for the anti-psychotic medications. The Social Service Designee will audit these forms once per week for the next three months and then audit once a month for three months. The Social Service Designee will add the behaviors as documented by licensed staff to her notes for each individual patient. The facility is investigating an electronic charting system that would include the monitoring of behaviors for anti-psychotic medication use. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Qaulity Assurance: *Medications utilized for insomnia, depression and delusions (*not all inclusive) will now be monitored with the new form. (Please see exhibit 'K' bottom of page marked "medications/dosage") Licensed staff will begin training for using the new document 7-6-15. The new forms will be kept in a behavior log book where that staff will be able to document behaviors associated for the anti-psychotic medications. Monitoring: The Social Service Designee will audit these forms once per week for the next three months and then audit once a month for three months. The Social Service Designee will add the behaviors as documented by	

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	member. The documentation lacked monitoring of insomnia, delusions, and moods. During an interview with Certified Nursing Assistant (CNA) #14 on 6/17/15 at 12:20 p.m., CNA #14 indicated the nursing assistants documented on the ADL (Activities of Daily Living) sheets when the resident experienced wandering behaviors and used the behavior sheets if the wandering happened more than once in a shift. CNA #14 indicated the resident wandered almost all day every day. During an interview with the SSD and the Minimum Data Set (MDS) assessment Coordinator on 6/18/15 at 11:30 a.m., the MDS Coordinator indicated the ADL sheets completed by the CNAs needed to be updated, as the resident no longer wandered aimlessly. The MDS Coordinator indicated the resident was purposeful when ambulating, and the staff needed re-education for wandering behaviors. The SSD indicated the behavior sheets were reviewed monthly but no day to day tracking of behaviors was completed. On 6/18/15 at 10:45 a.m., the Executive Director (ED) provided a policy titled Emotional Outbursts (Temper Tantrums)		licensed staff to her notes for each individual patient. The facility is investigating an electronic charting system that would also include the monitoring of behaviors for anti-psychotic medication use. The facility also discusses anti-psychotic drug use, the medical diagnosis for such use, the increase or decreased behaviors related to such use and the GDR (gradual dosage reduction) in monthly Quality Assurance meetings. The facility is investigating an electronic charting system that would include the monitoring of behaviors for anti-psychotic medication use. 5) By what date the systemic changes will be completed. 7-18-15	

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	dated 12/27/13, and indicated the policy was the one currently used by the facility. The policy indicated, "...All behaviors and interventions will be documented in the resident's medical record...." 3.1-48(a)(3)			
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. 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: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to			

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	exceed the community standard. 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. Based on observation, record review, and interview, the facility failed to ensure nurse staffing data was posted for 2 of 3 days observed. (6/14/15 and 6/15/15) Findings include: On 6/14/15 at 4:15 p.m., during the initial tour, the nurse staffing data for 6/14/15, was observed not to be posted. On 6/15/15 at 8:35 a.m., the nurse staffing data for 6/15/15, was observed not to be posted. On 6/17/15 at 4:54 p.m., during an interview the Director of Nursing indicated the night shift nurse was to fill out the nurse staffing data and post it.	F 0356	F356 1) What action(s) will be accomplished for those residents found to have been affected? No resident was found to have been affected by the posting of the nurse staffing data. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? No resident was found to have been affected by the posting of the nurse staffing data. No resident was reported as having inquired regarding such a posting. The Director of Nursing states (6-30-15) that she gave the properly filled out nurse staffing paperwork to the surveyor and that furthermore, the *information relayed was correct. (*dates) With the exception of the nursing staff information for 6-15-15 Please refer to exhibit B 3) What measures will be put into place or what systemic changes will be made? Night shift licensed nursing staff has the responsibility for this documentation and therefore they will be in serviced/re-trained on this paperwork, once per week for the next 2 months and monthly thereafter for four months. 4) How the corrective actions will be monitored and what quality assurance program will be put	07/18/2015

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			into place; who will monitor? Quality Assurance: The DON and or her designee will check the placement of the nurse staffing posting, daily, to ensure proper placement and to also confirm that dates and information is correct. This monitoring will be documented. Night shift licensed nursing staff has the responsibility for this documentation and therefore they will be in serviced/re-trained on this paperwork, once per week for the next 2 months and monthly thereafter for four months. The DON will receive copies of this paperwork on a daily basis. 5) By what date the systemic changes will be completed. 7-18-15	
F 0364 SS=E Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to ensure recipes were followed while preparing pureed food and failed to check the temperature of food before placing it on the steam table for 5 of 5 residents who received pureed meals from the kitchen in the facility population of 36. Findings include:	F 0364	F364 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected. The facility had a change of management in the dietary department and the residents have had increased positive comments regarding the food that is being served. 2) How	07/18/2015

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	1) During an observation on 6/14/14 at 5:35 p.m., Cook #1 pureed the sloppy joe for the evening meal. Cook #1 put sloppy joe meat in for 5 sandwiches and then poured an unmeasured amount of hot water from a pitcher. During the pureeing process Cook #1 added an unmeasured amount of a white powder substance and more unmeasured amounts of hot water from the pitcher. Cook #1 did not have a recipe out to refer to. Cook #1 the pureed the corn for the evening meal. Cook #1 put 5 servings of corn in and poured an unmeasured amount of hot water from a pitcher. During the pureeing process Cook #1 added an unmeasured amount of a white powder substance. Cook #1 did not have a recipe out to refer to. 2) When Cook #1 had completed the pureeing process, she placed the sloppy joe and corn on the steam table without checking the temperatures. During interview, after the pureeing process, with Dietary Manager she indicated the facility does have recipes to follow when preparing pureed food and she was aware the recipes were not used. She indicated the sloppy joe and corn would have had a better flavor and more		the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. The facility had a change of management in the dietary department and the residents have had increased positive comments regarding the food that is being served. Corrective action has been taken in the form of verbal counseling (regarding the importance of following recipes and checking the temperature of the food prior to placing it on a steam table) to those cooks involved in the event. Cooks involved will also be issued written counseling. 3) What measures will be put into place or what systemic changes will be made? The Dietary Manager is to ensure that recipes for meals are available and are followed by her staff. The Dietary Manager will ensure that this correction is monitored and documented, by herself and/or her designee, on a daily basis for all three served meals. Dietary staff will be in serviced/re-trained on checking food temps prior to pacing the food on the steam table and also in serviced/re-trained on following recipes. In servicing/ re-training will be every two weeks for three months and then every month for four months. (seven month total)	

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	nourishment if staff would have followed the facility recipe, measured the correct amount of the ingredients, and added what the recipe called for. It is the facility policy to check the temperature of the food before placing it on the steam table, because the pureeing process could cause the temperature to drop. Reviewed the facility recipe for the sloppy joe on 6/15/15 at 10:30 a.m. The Dietary Manager indicated when preparing for 5 servings the recipe calls for 15 ounces of meat, 2/3 cups of meat broth, 5 slices of bread, 1 and 2/3 tablespoons of margarine. Dietary staff did not refer to the recipe or add any ingredient other than sloppy joe mixture, unmeasured amount of hot water, and unmeasured amount of a white powder substance. Reviewed the facility recipe for the corn on 6/15/15 at 10:30 a.m.. The Dietary Manager indicated when preparing for 5 servings the recipe calls for 2 and 1/2 cups of vegetables, 5 pats oleo, and 2/3 cup of vegetable broth. Dietary staff did not refer to the recipe or add any ingredient other than corn, unmeasured amount of hot water, and unmeasured amount of a white powder substance. 3.1-21(a)(2)		4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: The Dietary Manager is to ensure that recipes for meals are available to be followed by her staff. The Dietary Manager will ensure that this correction is monitored and documented, by herself and/or her designee, on a daily basis for all three served meals. Dietary staff will be in serviced/re-trained on checking food temps prior to pacing the food on the steam table and also in serviced/re-trained on following recipes. In servicing/ re-training will be every two weeks for three months and then every month for four months. (six month total) The facility will also utilize our food vendor(s) for additional re-training of the dietary staff. 5) By what date the systemic changes will be completed. 7-18-15	

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F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure 18 of 35 residents received food prepared, distributed and served under sanitary conditions and failed to ensure resident water pitchers had lids. Findings Include: 1.)During the service of evening meal on 06-14-15 at 5:10 p.m., the following were observed: Dietary Cook #1 was observed to handle the buns for the sloppy joe sandwich and orange slices with gloved hands. Dietary Cook #1 was observed performing multiple tasks of touching plates, touching trays/tray cards, handles of serving utensils, touching the cart that held the completed meal trays, serving pans, and then going back to handling sandwich buns and orange slices with out changing gloves.	F 0371	F371 1) What action(s) will be accomplished for those residents found to have been affected? The potential for any resident to be affected existed. Res # 29 was given a water pitcher lid immediately during the survey. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? The potential for any resident to be affected existed. Water pitcher lids had been ordered, prior to the survey, however the new lids received did not fit the water pitchers. New pitchers with lids were ordered approx. 6-15-15. New pitchers were received and in use in the facility on 6-20-15. The Dietary Manager has been instructed to maintain a supply of extra water pitcher lids. 3) What measures will be put into place or what systemic changes will be made? Dietary staff will be in serviced/re-trained on proper glove use. In servicing/ re-training will be every two weeks for three months and	07/18/2015

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	During an interview with the Dietary Manager on 06-14-15 at 6:30 p.m., she indicated it was the facility policy to prevent the contamination of food with infectious organisms. Dietary staff are expected to observe the following infection control practices; use a spatula or tongs, or wear disposable gloves when handling food, do not touch food with bare hand, and do not perform multiple activities while wearing gloves that will be used in food handling. She indicated all her staff were fairly new, but received training on facility policies. They are gone over during orientation. She indicated she expects all the dietary staff to wash hands, use a spatula or tongs, or wear disposable gloves when handling food, and change gloves when changing task while in the food preparation areas. 2.) During a Stage 1 interview with Resident #29 on 6/15/15 at 9:45 a.m., Resident #29 indicated the water pitcher in the room did not have a lid and hadn't had a lid for "some time now." The resident indicated staff had ordered replacement lids but the lids were not the right size when the delivery arrived. The resident indicated the staff was good at providing fresh water but was not good at locating a lid for the pitcher.		then every month for four months. (seven month total) Dietary staff will be in serviced/re-trained on infection control. In servicing/ re-training will be every two weeks for three months and then every month for four months. (seven month total) (Please see example exhibit 'G') Cooks involved in the event will also be issued written counseling. New pitchers were received and in use in the facility on 6-20-15. The Dietary Manager has been instructed to maintain a supply of extra water pitcher lids. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: The Dietary Manager is to ensure that proper glove use is followed by the dietary department. The Dietary Manager will ensure that this correction is monitored and documented, by herself and/or her designee, on a daily basis. Monitoring and documentation by the Dietary Manager will have no end date. Dietary staff will be in serviced/re-trained on proper glove use. In servicing/ re-training will be every two weeks for three months and then every month for four months. (seven month total) Dietary staff will be in serviced/re-trained on infection control. In servicing/ re-training will be every two weeks for three months and then every month for four months.	

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	During an interview with with Certified Nursing Assistant (CNA) #13 on 5/17/15 at 3:30 p.m., CNA #13 indicated the kitchen sends out the clean pitchers and lids and then the staff places them in the resident rooms. CNA #13 indicated some of the water pitchers didn't have lids when the staff passed fresh water and ice at the beginning of the shift. During an interview with the Dietary Manager on 6/18/15 at 3:00 p.m., the Dietary Manager indicated the facility had 36 plus water pitchers and had only 10 lids for the water pitchers. The dietary manager indicated new lids had been ordered but the wrong lids were delivered and the facility was waiting for the right lids to be delivered. 3.1-21(i)(3)		(seven month total) (Please see example exhibit 'G') 5) By what date the systemic changes will be completed. 7-18-15	
F 0431 SS=E Bldg. 00	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.			

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	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. 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. 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.			
	Based on observation, interview, and record review, the facility failed to ensure the disposal of expired medications/nutrients, timely signing out of narcotics, and clean equipment for one of one medication rooms observed and for one of two medication carts observed. Findings include: 1. During an observation of an unlocked crash cart located in the dining room on 6/14/2015 at 5:14 p.m., supplies were observed to be expired. 3 sterile water containers located in a drawer of the	F 0431	F431 1) What action(s) will be accomplished for those residents found to have been affected? Any resident had the possibility to be affected on this issue. The crash cart expired contents were replaced immediately when the issue was brought to the attention of the facility. This included sterile water, (used only to prime the suction machine), one yankauer suction tube pack (orally suctioning a resident is not considered a sterile procedure.) An additional yankauer tubing pack and a sterile water, all well within their expiration dates, were also located on the cart. 2)	07/18/2015

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	crash cart contained the expiration dated of 09/2013. 1 yankauer suction tube package located in a drawer of the crash cart, indicated an expiration date of 05/2013. 1 500 milliliter container of sterile water located on the bottom shelf of the crash cart indicated an expiration date of 04/2015. During an interview on 06/18/2015 at 10:31 a.m., Licensed Practical Nurse (LPN) #7, indicated the night shift nurses maintain the crash cart. During an interview on 06/18/2015 at 10:44 a.m., the Director of Nursing (DON), indicated the initials on the 'Daily Suction Machine Check - Dining Room' form indicate the nurses have checked the suction machine and suction cart in the dining room for that date, including the supplies and the supplies expiration dates located in the cart. The DON indicated if there are expired supplies, the nurses are supposed to remove and dispose of the expired supplies and replace them with non-expired supplies. The policy and procedure titled "Crash Cart", provided by the Executive Director (ED) on 06/18/2015 at 11:40 a.m., indicated "...1. A night shift nurse will be delegated to check the crash cart at the		How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident had the possibility to be affected on this issue. The crash cart expired contents were replaced immediately when the issue was brought to the attention of the facility. This included sterile water, (used only to prime the suction machine), one yankauer suction tube pack (orally suctioning a resident is not considered a sterile procedure.) An additional yankauer tubing pack and a sterile water, all well within their expiration dates, were also located on the cart. The crash cart is also covered with drawers turned to the wall. There are no sharps, no medications and nothing of a safety issue that is contained on or in the crash cart. The facility's crash cart policy will be amended to reflect that the crash cart is not locked. Night shift licensed staff are responsible to check the crash cart and they have been re-inserviced (between 6-22-15 and 6-25-15) on their responsibilities, including but not limited to, removing expired items and replacing these items. Night shift licensed staff have been in-serviced (between 6-22-15 and 6-25-15) on infection control (cleaning of) medication carts and medication room, storage of medications and cleaning equipment of such	

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(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
	beginning of the clinical day and initial the checklist to ensure that the contents of the crash cart are present...3. The crash cart will remain locked unless it is necessary to use any supplies that are in the crash cart during an emergency situation...." 2. On 6/16/2015 at 10:30 a.m., the following was observed in the medication room. a. Pro stat sugar free wild cherry punch nutricia (whole bag of individual packets) had an expiration date of 4/17/15. b. One vial of glucose control level 1 was expired on 10/31/2012. On 6/18/15 at 11:00 A.M. an interview with Licensed Practical Nurse (LPN) #3, indicated the night nurses are responsible to check expiration dates of all medications and once a month Pharm America (pharmacy) service comes in and checks expiration dates on medications 3. On 6/16/2015 at 10:48 a.m., during the narcotic medication count, Clonazepam 1mg tablet was not signed out for Resident #12 for the 8:00 a.m. dose making the count inaccurate. At the time of the observation LPN #6 indicated she		areas. 3) What measures will be put into place or what systemic changes will be made? The facility's pharmacy and/or their designee will do an audit of the medication carts and the medication room once per month; this will include checking these areas for expired products. Night shift licensed staff are responsible to check the crash cart and this staff have been re-in serviced (between 6-22-15 and 6-25-15) on their responsibilities, including but not limited to, removing expired items and replacing these items. Night shift licensed staff are responsible to check the medication room, the medication and treatment carts and the medication cart equipment; this staff have been re-in serviced (between 6-22-15 and 6-25-15) on their responsibilities concerning this correction. Night shift licensed staff have been in-serviced (between 6-22-15 and 6-25-15) on infection control (cleaning of) medication carts and medication room, storage of medications and cleaning equipment of such areas. The facility narcotic count is not unlike any other facility narcotic count, the licensed nurse knows that the narcotic count sheet is required to be signed, as the medication is given. The nurse involved in the event will be counseled. The nurse involved in this event will also undergo re-training in the	

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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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	forgot to sign the narcotic medication out when she gave the medication. On 6/16/2015 at 11:18 a.m., during an interview with the DON (Director of Nursing), she indicated the procedure for passing narcotics (narcs) was to sign out the medication on the narc count sheet, and then, to sign them out in the computer. On 6/16/15 at 12:00 p.m., the Administrator provided a policy titled, Guidelines Policy for Medication Administration dated May 2005 and Updated September 2012, and NARCOTIC COUNT SIGN OFF SHEET, and indicated it was the policy currently used by the facility. This policy indicated the following: "...Procedure 19 ensure accurate documentation of all medications..." The Narcotic Count Sign Off Sheet indicated the nurse or the QMA (Qualified Medication Aide) should understand and hereby accept complete responsibility for signatures and the condition of the narcotics that are under double lock on this medication cart and inside the locked medication room refrigerator.		form of a re-training packet-including policy for documentation, narcotic administration and the medication pass. This nurse will be included in the up coming pharmacy medication pass audit. (The narcotic count was found to be correct after this nurse had signed out her medications.) 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Quality Assurance: The facility's pharmacy and/or their designee will do an audit of the medication carts and the medication room once per month; this will include checking these areas for expired products. These checks are documented by the auditor and a copy of their findings will be given to the DON. The DON or her designee will be responsible to monitor these corrective actions and follow up as applicable. The facility narcotic count is not unlike any other facility narcotic count, the licensed nurse knows that the narcotic count sheet is required to be signed as the medication is given. The nurse involved in the event will be counseled. The nurse involved in this event will also undergo re-training in the form of a re-training packet-including policy for documentation, narcotic administration and the medication pass. This nurse will be included in the up coming pharmacy	

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	4. On 6/16/2015 at 10:48 a.m., the pill crusher on the medication cart was observed with a build up of rusty brown substance along the sides of the medication crusher. Also, a brownish powder build up was observed in the on all of the metal surfaces including the pill crushing area. 3.1-25(n) 3.1-25(o)		medication pass audit. (The narcotic count was found to be correct after this nurse had signed out her medications.) The DON and/or her designee will be responsible to monitor these corrective actions and follow up as applicable. The DON and/or her designee will perform unscheduled narcotic counts and narcotic sign out checks for this nurse;(This nurse presently works full time day shift);two times per week for one month and then a minimum of once per week times five months. **unscheduled narcotic counts and narcotic sign out checks for all three shifts will also be accomplished. These counts will include all three shifts; once per week for six months. 5) By what date the systemic changes will be completed. 7-18-15	
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents			

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	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. (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. (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 measures to prevent the spread of infection were used to clean blood glucose monitors (Residents #21, #8, #39, #18 and #5) and to transport clean resident clothing. Findings include: 1. a. During an observation of glucose testing on 6/15/16 at 4:20 p.m., Licensed Practical Nurse (LPN) #11 placed 2	F 0441	F441 1) What action(s) will be accomplished for those residents found to have been affected? Any resident had the potential to be affected by such practices. For any resident receiving blood glucose monitoring: Changes to the disinfecting of the glucometer machine are as follows: The machine(s) will be cleaned with a sani cloth for two minutes; allowed to air dry for two minutes. The medications carts have been provided with timers. (Please see exhibit 'M') Licensed staff were in-serviced on the changes to the	07/18/2015

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	glucose meters on a paper towel on top of the medication cart, donned gloves, and wiped each of the meters for 5 seconds with the same disinfecting wipe and then placed the meters on to the same paper towel. LPN #11 changed gloves and went into the dining room and performed a glucose check on Resident #21, who was sitting at a table with 4 other residents. LPN #11 returned to the medication cart, removed gloves, wiped the glucose meter with a disinfecting wipe for 2 seconds and placed the meter back onto the paper towel. b. LPN #11 then donned gloves, picked up the second meter, and went to check the blood sugar of Resident #8. After checking the blood sugar of Resident #8, LPN #11 returned to the medication cart, removed gloves, wiped the glucose meter with a disinfecting wipe for 2 seconds and then placed the meter back on to the same paper towel. c. LPN #11 applied gloves, picked up the first meter, and went to the activity room to check the glucose of Resident #39. After completing the glucose test, LPN #11 returned to the medication cart, removed gloves, wiped the meter with a disinfectant wipe for 2 seconds, and placed the meter back onto the same paper towel.		procedure between 6-22-15 and 6-25-15. Once the facility was made aware of a problem, the (1) glucometer disinfecting policy was changed and (2) the laundry staff was counseled. Laundry staff will have re-training on the proper handling of clean and dirty linens and transportation carts for linens will be covered. (Please see example exhibit 'N') 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Any resident had the potential to be affected by such practices. Once the facility was made aware of a problem, the (1) glucometer disinfecting policy was changed and (2) the laundry staff was counseled. Changes to the disinfecting of the glucometer machine are as follows: The machine(s) will be cleaned with a sani cloth for two minutes; allowed to air dry for two minutes. (Please see exhibit 'M') Licensed staff were in-serviced on the changes to the procedure between 6-22-15 and 6-25-15. The laundry staff involved were counseled. 3) What measures will be put into place or what systemic changes will be made? Once the facility was made aware of a problem, the (1) glucometer disinfecting policy was changed and (2) the laundry staff was counseled. Changes to the disinfecting of the glucometer machine are as follows: The machine(s) will be cleaned with a	

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	d. Resident # 18 rolled up to the medication cart, and asked to have glucose tested. Several residents were sitting in the dining room adjacent to the hallway where the medication cart was located. LPN #11 donned gloves, picked up one of the meters from the paper towel, and performed the glucose test in the hallway next to the medication cart. Once the glucose testing was completed, LPN #11 removed gloves and performed hand sanitizing using a sanitizing gel located on top of the medication cart. On 6/15/15 at 5:30 p.m., LPN #11 indicated the dwell time (length of time the disinfectant needs to be in contact with the device) was not known. e. On 6/16/15 at 4:18 p.m., observation of glucose testing was completed. Registered Nurse (RN) #12 took the glucose meter, disinfecting wipes, and gloves into the room of Resident #5. RN #12 placed the glucose meter on a paper towel on the bedside table, performed hand washing, donned gloves, and proceeded to wipe the meter with a disinfecting wipe for 30 seconds. RN #12 then placed the meter back onto the paper towel, changed gloves, waited 30 seconds, and then performed the glucose		sani cloth for two minutes; allowed to air dry for two minutes. Licensed staff were in-serviced on the changes to the procedure between 6-22-15 and 6-25-15. Licensed staff will be in-serviced on cleaning and disinfecting the glucose meters at the rate of three nurses per month for two months and then two nurses per month for four months. In-services may be as 'one-on-one' documented re-training ,by actual stand by monitoring during meter use and/or paper in servicing. (Please see example exhibit 'L'and 'M')**This monitoring/re-training will include the licensed staff (all shifts) Laundry staff will have re-training on the proper handling of clean and dirty linens and transportation carts for linens will be covered. (Please see example exhibit 'N') Re-training of laundry staff will be documented by the department manager and /or his designee daily for three weeks, as 'one on one' documentation of techniques while transporting linens. Re-training will include in servicing laundry staff for the next six months; once per month in unison with 'one on one' observation. An addendum to the facility's policy on linens has been added. (Please see exhibit "O") 4) How the corrective actions will be monitored and what quality	

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	test. After the test was completed, RN #12 wiped the meter with a second disinfecting wipe for 20 seconds, and then wrapped the meter in the same paper towel and exited the room. When asked about the dwell time (the amount of time required for the chemicals in the wipes to be in contact with the object requiring cleaning/disinfecting), RN #12 looked at the label on the container of wipes and indicated the dwell time should have been 2 minutes. During an interview with the Executive Director (ED) and the Director of Nursing (DON) on 6/16/15 at 5:17 p.m., the ED and the DON indicated the current policy of the facility was to let the glucose meter sit for 2 minutes after cleansing the meter and this was considered the dwell time. During a review of the label of the disinfecting wipes on 6/17/15 at 9:44 a.m., the label indicated, "...To Disinfect and Deodorize: To disinfect nonfood contact surfaces only; Use a wipe to remove heavy soil as needed. Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous		assurance program will be put into place; who will monitor? Quality Assurance: Licensed staff will be in-serviced on cleaning and disinfecting the glucose meters at the rate of three nurses per month for two months and then two nurses per month for four months. **In-services may be as 'one-on-one' documented re-training ,by actual stand by monitoring during meter use and/or paper in servicing. (Please see example exhibit 'L'and 'M') This monitoring/re-training will include the licensed staff (all shifts) The DON and/or her designee will have the responsibility to monitor these corrections. Medical Records will be responsible to track all in-services for correction purposes to ensure appropriate staff is reached. Re-training of laundry staff will be documented by the department manager and /or his designee daily for three weeks, as 'one on one' documentation of techniques while transporting linens. Re-training will include in servicing laundry staff for the next six months; once per month in unison with 'one on one' observation. An addendum to the facility's policy on linens has been added. (Please see exhibit "O") Laundry personnel include day and evening shifts. 5) By what date the systemic changes will be completed. 7-18-15	

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	two (2) minute wet contact time. Let air dry...Precautionary Statements-Hazard to humans and Domestic Animals. Danger: Causes irreversible eye damage. Do not get in eyes or on clothing. Avoid contact with skin. Wash thoroughly with soap and water after handling...SPECIAL INSTRUCTIONS FOR CLEANING AND DECONTAMINATION AGAINST HIV-1, HEPATITIS B VIRUS (HBV) AND HEPATITIS C VIRUS (HCV) OF SURFACES/OBJECTS SOILED WITH BLOOD/BODY FLUIDS Personal protection: When using this product, wear disposable protective gloves...." On 6/16/15 at 5:05 p.m, the ED provided the policy Cleaning and Disinfection of the Blood Glucose Monitors dated 2/14/2012/4/27/2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...TO CLEAN AND DISINFECT THE BLOOD GLUCOSE METER 1.) Wash your hands for 30 seconds and put on gloves. 2.)...remove a wipe from the container and follow product label instructions to disinfect the meter...4.) Place the cleaned meter on a clean surface, such as a brown paper towel **and allow it to dry for a complete 2 minutes.** VERY IMPORTANT: the meter must remain untouched after			

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	disinfecting, for 2 (two) minutes...." 2. a. On 6/15/15 at 8:27 a.m., Laundry Aid # 4 was observed transporting uncovered clean linen in a cart down the hallway to the linen closet at the bottom of the stairs. b. On 6/16/2015 at 2:25 p.m., Laundry Aide #4 was observed transporting clean linen down the hallway, uncovered in a cart to the linen closet. c. On 6/17/15 the following observations occurred: 12:33 PM Housekeeper #20 carried clean resident clothing on hangers resting against front and back of her uniform. 12:35 PM Housekeeper #20 carried another load of clean resident clothing on hangers resting against the front and back of her uniform. On 6/18/15 at 11:10 a.m., during an interview Laundry Aide #4 indicated linen should be covered when transporting the linen to the closets. On 6/18/15 at 10:45 a.m., the Administrator provided a policy titled, (Linen-Handling Supply), dated 7/2013, and indicated it was the policy currently used by the facility. This policy indicates			

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	the following "....Transportation Clean linen must be protected during transport to prevent contamination...." 3.1-18(a) 3.1-19(g)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe, sanitary, and comfortable environment for residents in that the facility was found to be unclean and in disrepair. Findings include: 1.) During an observation on 06/15/2015 at 10:46 a.m., a window seal next to the restroom in resident room #17, was observed to have 6 areas damaged on the outer edge with the veneer surface missing and the wood underneath exposed. In the middle of the window seal on the outer edge a sharp point was observed where the veneer was damaged. During the initial tour observation on 6/14/2015 from 4:10 p.m. to 4:40 p.m., the following was observed:	F 0465	F465 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. Environmental issues as noted will be repaired. -The area of concern in #18 bathroom have been cleaned -The areas of concern for the weigh scales have been cleaned - The fence in the back will be repaired within the time limit given by state. -The sliding glass doors have been cleaned inside and are scheduled	07/18/2015

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	2.) The bathroom near room 18 was observed to have a brown colored substance around the stool and on the floor with a foul odor noted. 3.) The weight scales in the dinning room were observed to be covered with brown/black substances and had scattered pieces of black material missing on the platform. 4.) The fence in the backyard was observed to be falling down. The green paint on the fence was observed to be peeling off and missing in scattered areas of the fence. During the dining observation on 6/14/2015 from 4:30 p.m. to 6:45 p.m., the following was observed: 5.) The sliding glass doors in the back of the dining room and the doors opposite from the kitchen were observed with a brownish film on the windows and scattered cobwebs between the glass and the screens. The door tracks were observed to have a build up of a black and brown substance. 6.) The trash can in the dining room was observed to have black stains one fourth of the way up from the floor.		to be power washed form the outside. - The trash can in the dining room has been replaced -The facility is shopping for new dining room and hall chairs. However, the chairs in question were cleaned while the survey members were in the facility. -The dining room blinds have been cleaned and the facility is shopping for new window treatments. -The glass lights in the dining room have been cleaned.The areas of concern in/around room #11 will be repaired/replaced as needed. -The rugs in questioned were cleaned while the survey members were in the facility.(The debris was possibly from wheelchairs coming in and out from the outside patio). 3) What measures will be put into place or what systemic changes will be made? The above ares of concern have been added to a 'weekly walking rounds form' that the Maint. Director and/or his designee will accomplish as stated. A copy of the completed rounds form will be discussed in morning meeting, weekly and as needed. These forms will be signed in the meeting to demonstrate that this correction has been accomplished. The members of the environmental team will be in serviced on walking rounds and what will be inspected. The members of the environmental team will be in serviced/re-trained on their	

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	7.) Twelve of the dining room chairs were observed with scattered, stained spots from cup size to saucer sizes. The chair occupied by Resident #19 was observed to have several brown substances in the middle of the chair. During the initial tour observation on 6/14/15 from 4:10 p.m. to 4:40 p.m., the following was observed: 8.) In the dining room the blinds on the sliding glass doors were observed to have black stained substance on the lower one inch of all of the blinds. 9.) In the hallway approaching the Director of Nursing's office four chairs had dark stains on all of the seats. A brown substance covered the baseboards in this same hallway. 10). Dust buildup on the glass globes of light fixtures was observed in the dining room. 11.) In Resident #11's room, the bathroom door was observed to stick when opening, the plaster on the wall was peeling by the plug in receptacle in the bathroom, and the entrance door to this room had chipped wood on the lower area of the door.		responsibilities for environmental cleanliness and disinfection of equipment. Night shift staff is responsible for some continuation of equipment cleaning and/or disinfecting and they will be in serviced on their duties pertaining to these also. This in servicing and re-training for the environmental team will take place once per month and will have no end date. The facility is shopping for new dining room and hall chairs. The facility is shopping for new window treatments. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Environmental issues as noted will be repaired. Quality Assurance: The aforementioned ares of concern have been added to a 'weekly walking rounds form' that the Maint. Director and/or his designee will accomplish as stated. (Please see exhibit D) A copy of the completed rounds form will be discussed in morning meeting, weekly and as needed. These forms will be signed in the meeting to demonstrate that this correction has been accomplished. The members of the environmental team will be in serviced on walking rounds and what will be inspected. (exhibit D) The members of the environmental team will be in serviced/re-trained on their responsibilities for environmental cleanliness and disinfection of	

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 06/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNHURST HEALTHCARE	5225 W MORRIS ST INDIANAPOLIS, IN 46241

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	12.) Two of two rugs in front of the sliding glass doors in the dining room had debris on them. 3.1-19(f)		equipment. Night shift staff is responsible for some continuation of equipment cleaning and/or disinfecting and they will be in serviced on their duties pertaining to these also. (Please see exhibit example E) This in servicing and re-training for the environmental team will take place once per month and will have no end date. The Maint. Director and/or his designee will be responsible for these corrective actions and will maintain documents concerning this Quality Assurance. 5) By what date the systemic changes will be completed. 7-18-15	