

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  05/16/2014
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NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 8, 9, 12, 13, 14, 15 &amp; 16, 2014</p> <p>Facility number: 000385 Provider number: 15E667 AIM number: 100291340</p> <p>Survey team: Marcy Smith, RN-TC Karyn Homan, RN (May 8 &amp; 9, 2014) Dottie Plummer, RN (May 9, 12, 13, 14, 15 &amp; 16, 2014) Patti Allen, SW (May 9, 12, 13, 14, 15 &amp; 16, 2014) Vickie Nearhoof, RN (May 12, 13, 14, 15 &amp; 16, 2014)</p> <p>Census bed type: NF: 37 Total: 37</p> <p>Census payor type: Medicaid: 37 Total: 37</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with the regulations governing the operation of long term care facilities; that this Plan of Correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with federal and state regulations and to correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the opinion that it was in</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000282 SS=D	<p>Quality review completed on May 23, 2014; by Kimberly Perigo, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for 1 of 5 residents who met the criteria for review of psychotherapeutic medication/behavior management therapy. (Resident #35)</p> <p>Findings include:</p> <p>The clinical record of Resident #35 was reviewed on 5/13/14 at 2:00 p.m. Diagnoses included, but were not limited to, obsessive-compulsive disorder, Alzheimer's disease, depressive disorder, senile dementia with delusions and behavioral disturbances, and schizoaffective disorder.</p>	F000282	<p>participation of or that corrective was necessary.</p> <p>F282 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Any resident had the potential to be affected by this deficiency. The urinary analysis was completed and showed negative for any urinary infection. (see attached, exhibit H) 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? There were no other laboratory tests that were noted to be missed for the last four months being due to human error alone. The Director of Nursing will in-service or do staff re-education for the licensed nursing staff, once every two weeks for 2</p>	06/15/2014

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	<p>Resident #35 was admitted to the facility on 3/4/14. His scheduled medications included Risperdal twice a day for his delusional disorder, fluvoxamine maleate for his obsessive-compulsive disorder, and divalproex at bedtime for mood stabilization. On 4/29/14 the resident's physician ordered a urinalysis to be obtained immediately, due to an increase in the resident's behaviors. The results of this urinalysis were not found in the resident's record.</p> <p>During an interview with the Director of Nursing on 5/14/14 at 10:00 a.m., she indicated the urinalysis had not been obtained when ordered. She indicated the physician was notified, and the specimen was obtained on 5/13/14 and sent to the lab.</p> <p>3.1-35(g)(2)</p>		<p>months, followed by once per month times 3 months. The facility will also contact the current laboratory test provider and host a mandatory licensed nursing staff review of correct lab ordering procedures. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Nursing or her designee will in-service or do staff re-education for the licensed nursing staff, once every two weeks for 2 months, followed by once per month times 3 months. The Director of Nursing or her designee will maintain these in-service and/or staff re-education records. Corrective action(s) for Root cause: (systemic changes:) STAT Labs will be monitored and logged by the Director of Nursing or the Assistant Director of Nursing within 72 hours ( consideration given for weekends and holidays) of receiving the orders for STAT labs. Stat labs will have an attached order to notify MD/ARNP of results of those labs as soon as they are available. Residents who have stat labs will also be added to nurses "hot charting" documentation as applicable. ( Usually a 72 hour period). Licensed staff who are found to be out of compliance with these types of physician orders will be re-educated and/or re-inserviced</p>	

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F000362 SS=E	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support		on correct stat labs procedures and the follow ups that are to occur between shifts. The facility will also contact the current laboratory test provider and request a mandatory licensed nursing staff review of correct lab ordering procedures and follow ups on those labs. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? quality assurance program: STAT Labs will be monitored and logged by the Director of Nursing or the Assistant Director of Nursing within 72 hours of receiving the orders for STAT labs. Stat labs will have an attached order to notify MD/ARNP of results of those labs as soon as they are available. Residents who have stat labs will also be added to nurses "hot charting" documentation as applicable. ( Usually the length of a 72 hour period). The facility will also contact the current laboratory test provider and request a mandatory licensed nursing staff review of correct lab ordering procedures and follow ups on those labs. 5) By what date the systemic changes will be completed? 6-15-2014		

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	<p>personnel competent to carry out the functions of the dietary service.</p> <p>Based on observation and interview, the facility failed to ensure sufficient staff to serve meals to residents that eat in the dining room. This had the potential to affect 36 of 36 residents who received meals from the kitchen in the main dining room.</p> <p>Findings include:</p> <p>Observation on 5/9/14 at 1:15 P.M., during the second seating of the noon meal there was confusion in the dinning room. Residents from the first seating were requesting to return to their rooms, while residents for the second seating were requesting to be seated for their meal. There was only one staff who was assigned the responsibility of clearing and wiping the tables and no one to assist the residents. This resulted in some residents not being seated or receiving their meal until 1:40 P.M., 25 minutes late. The second seating was scheduled to start at 1:15 P.M. The dietary staff delivered the meal trays to the main dining room on a food cart as schedule.</p> <p>Interview with Dietary Manager on 5/16/14 at 11:30 a.m., indicated they had 20 residents for the first seating and 16 residents in the second seating. The meal</p>	F000362	<p>F362 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Any resident had the potential to be affected by this deficiency. The facility policy has been, to have two certified nursing assistants, the charge nurse and the Qualified Medication Aide attending the dining room for all meals. The facility has changed their policy for meal time attendees to address the corrective action. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident had the potential to be affected by this deficiency. The facility has changed their policy for meal time attendees as the corrective action. The staffing for meal times will include the Restorative Aide and the Dietary Manager; along with two certified nurse aides, the QMA and the charge nurse or ADON. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? systemic changes: The facility has added attendees to the dining room proper for meal times. This added staffing includes the Restorative Aide and the Dietary Manager; along with two certified nurse</p>	06/15/2014

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	time was 12:30 P.M. to 1:15 P.M. (first seating) and 1:15 P.M. to 2:00 P.M. (second seating).  3.1-20(h)		aides, the QMA and the charge nurse or ADON. The Dietary Manager (CDM) will daily sign a log book of all patient meals she has attended and supervised.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? The Dietary Manager (CDM) will daily sign a log book of all patient meals she has attended and supervised. A memorandum to the Director of Nursing and the ADON will be issued regarding their active participation roles during dining times and they will also be responsible to ensure nursing staff attends the dining area at applicable times. Applicable nursing staff will be in-service and/or have staff re-education regarding their attendance in the dining area for meals, by the Director of Nursing and/or her designee, once every two weeks for 2 months, followed by once per month times 4 months. The Dietary Manager (CDM) will in-service and/or complete staff education for dietary staff members who might be called upon to supervise meal times should she be absent. This in-servicing/re-education will take place within the given time frame for this plan of correction and will be given to new members of the dietary team during their orientation period in the kitchen. 5) By what date the systemic	

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and record review, the facility failed to serve food under sanitary conditions during 1 of 2 dining observations. This had the potential to affect 16 of 16 residents who received meals from the kitchen, during the second dining room meal service.</p> <p>Finding include:</p> <p>During dining meal observation on 5/9/14 at 1:17 P.M. CNA #5 was left to clear and scrape dishes used by residents then sanitize tables after the first noon meal seating residents departed; which was immediately before second seating arrived. CNA # 5 cleared and wiped down tables and then proceeded to serve food trays to 10 residents of the second seating of noon meal without sanitizing or washing her hands. CNA #5 continued serving meal trays without washing or sanitized her hands.</p>	F000371	<p>changes will be completed?6-15-2014</p> <p>F 371 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The facility's management was not made aware of an issue with CNA# 5 during meal time until the meal time had concluded. However, once the facility management was notified of this issue after the meal had been served, CNA #5 was given verbal counseling and verbal instructions regarding Infection Control/proper hand washing and sanitizing during meal times. The facility expects that a CNA with a certification provided by the state, has been fully educated on basic CNA skill sets. The facility continues to provide CNA re-education and in-services several times per year, including Infection Control and proper handwashing/disinfecting measures that are to be utilized by CNA's and all other members of the facility staff.2) How other residents having the potential to be affected by the same deficient</p>	06/15/2014			

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	<p>Review of Retail Food Establishment Sanitation Requirements: Title 410 IAC 7-24 (effective November 13, 2004)</p> <p>410 IAC 7-24-129 When to wash hands Sec. 129. (a) Food employees shall clean their hands and exposed portions of their arms as specified under section 128 of this rule immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped and single-service and single-use articles and the following:</p> <p>(6) after handling soiled surfaces, equipment, or utensils.</p> <p>3.1-21(i)(3)</p>		<p>practice will be identified and what corrective actions will be taken?Any resident could have been affected by such a deficient practice.Cna #5 will have re-education including hand washing monitoring ( see attached form, exhibit G), every 2 weeks for 2 months, by the Director of Nursing and/or her licensed designee. Cna #5 will have a 'disciplinary action form' (see attached, exhibit C) and be able to demonstrate immediate improvement and compliancy regarding infection control measures or be subject to suspension and/or termination of her employment; with her state CNA certification reported to the Indiana State CNA Certification Board for continued future non-compliance issues. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Once the facility management was notified of this issue after the meal had been served, CNA #5 was given verbal counseling and verbal instructions regarding Infection Control/proper hand washing and sanitizing during meal times.The facility has added attendees and supervision to the dining room proper for meal times.This added staffing includes the Restorative Aide and the Dietary Manager; along with two certified nurse aides, the QMA and the charge nurse or ADON.The Dietary</p>	

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F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, record review, and	F000412	Manager (CDM) will daily sign a log book of all patient meals she has attended and supervised. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? The Dietary Manager (CDM) will daily sign a log book of all patient meals she has attended and supervised. The Director of Nursing will maintain the re-education/in-servicing documentation for the nursing staff.A memorandum to the Director of Nursing and the ADON will be issued regarding their active participation roles during dining times and they will also be responsible to ensure nursing staff attends the dining area and act accordingly at applicable times. 5) By what date the systemic changes will be completed?6-15-2014	06/15/2014

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	<p>interview, the facility failed to ensure a resident needing dental work arrived at scheduled appointments, for 1 of 5 residents who met the criteria for review of dental services. (Resident #32)</p> <p>Findings include:</p> <p>The clinical record of Resident #32 was reviewed on 5/13/14 at 9:00 a.m. Diagnoses included, but were not limited to, dementia and schizophrenia.</p> <p>During an interview with Resident #32 on 5/12/14 at 10:45 a.m., he indicated he had no upper teeth and his lower teeth hurt. An observation, at that time, indicated the resident did not have any teeth in the upper part of his mouth. The resident indicated he had not seen a dentist.</p> <p>On 5/13/14 at 12:00 p.m., the Social Service Director indicated Resident #32 had been seen by the facility dentist, who sent him to an outside dental office to have some work done, which could not be performed in the facility.</p> <p>In an interview with the dental assistant/office manager at the outside dental office on 5/14/14 at 9:45 a.m., she indicated Resident #32 was missing his upper teeth. She indicated his lower teeth</p>		<p>will be accomplished for those residents found to have been affected by the deficient practice? Resident #32 was seen by the in house facility dentist. The ancillary dental appointment for resident #32 that was scheduled on 12-10-2013 was cancelled due to unforeseeable winter weather conditions, as the facility has confirmed at this time, with the transportation provider. This resident was then seen by the ancillary dentist on 1-28-2014 and the dental issues were taken care of at that time. Resident was then scheduled for continued ancillary dental services on 4-11-2014 due to that date being the only time the ancillary dentist could see the resident as the appointment was not deemed to be an emergency. The ancillary dentist cancelled the resident appointment for 4-11-14. The ancillary dentist purportedly rescheduled the resident's appointment for 4-28-2014. The dental office alleges that this appointment was missed. This ancillary dentist submits their appointment form, marked Physician Sheet (see attached, exhibit D) for all scheduled appointments. The 4-28-2014 appointment (physician sheet) was not delivered to this facility and the dental office is unable to provide proof that this appointment had been made; nor with what nurse from this facility that this appointment was</p>	

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	<p>needed fillings for cavities. She indicated he had an appointment on 12/10/13, which the facility cancelled at the last minute. At a rescheduled appointment on 1/28/14, the resident's cavities were filled.</p> <p>Resident #32 was scheduled for a cleaning appointment on 4/11/14, which the dental office had to cancel. The facility was notified of the cancellation approximately 2 weeks prior to 4/11/14, according to the dental assistant/office manager. She indicated the facility brought the resident to the office on 4/11/14 anyway.</p> <p>The cancelled 4/11/14 appointment was rescheduled for 4/28/14. The dental assistant/office manager indicated Resident #32 was a "no show" for that appointment. She indicated the facility had just called back "this week" to reschedule the 4/28/14 missed appointment. She indicated the next available appointment was not until 8/8/14, but the dentist could see the resident prior to this if he was having problems.</p> <p>During an interview with the Social Service Director on 5/14/14 at 10:05 a.m., she indicated the transportation service the facility always used was not</p>		<p>scheduled. Many times, ancillary medical services are attempted to be scheduled by offices who call the facility, identify themselves only by name and ask to speak to the resident directly. Should the resident themselves speak with these offices, the facility is not made aware. The facility attempted to make a dental follow up appointment for resident #32 on 5-14-2014 and was informed that the ancillary dentist could not see the resident until 8-8-2014. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident has the potential to be affected by such a deficiency. The current ancillary dentist office continues to cancel and reschedule appointments frequently. (see attached, exhibit E-3 pages) The facility has identified three other ancillary dentist's that are willing to see Medicaid only residents and accept Medicaid only payments for their services. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility will honor appointments through this ancillary dental service for this resident. The facility will utilize other ancillary dental services for future resident needs. Appointments will be confirmed by the charge nurse</p>		

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	in operation during April, 2014, and she had to find another transportation service to use. She did not indicate why Resident #32 missed his dental appointments on 12/10/13 and 4/28/14.  3.1-24(b)		who will request this ancillary dental service to complete the "Physician Sheet" and fax these sheets to the facility. The form is maintained in the resident's medical record, forwarded to the Director of Nursing and to the Social Service Department. An appointment copy is also given to the Dietary Manager. The appointment is also written on the nurses station calendar for the date. Social Service will contact and set up transportation for each appointment. ( with copies of transportation and times given to the Director of Nursing and other applicable parties in house) All resident appointments will be logged, all transportation will be logged. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Social Service will monitor all scheduled resident appointments. Social Service will contact and set up transportation for each appointment. ( with copies of transportation and times given to the Director of Nursing and other applicable parties in house)*These appointments will be discussed/verified/logged and monitored in morning meetings with the Director of Nursing. (See attached sheet marked Lynhurst Healthcare appointments. Exhibit F)*Same from to be used to schedule and discuss with Director of Nursing in morning		

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing</p>		meetings. Social Services will maintain these records for 12 months. 5) By what date the systemic changes will be completed? 6-15-2014	

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	<p>dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe storage of medications requiring refrigeration, failed to ensure insulin vials were discarded 28 days after date opened, and failed to ensure medications were labeled and stored according to manufacturers' recommendations in 2 of 2 medication carts and 1 of 1 medication refrigerator reviewed for medication storage. (Medication Refrigerator, Medication Cart #1, and Medication Cart #2)</p> <p>Findings include:</p> <p>1. On 5/15/15 at 4:15 p.m., the refrigerator in the medication room was observed with a temperature of 38 degrees Fahrenheit (F). During a review on 5/15/14 at 4:15 p.m., the temperature logs for the refrigerator in the medication room indicated temperatures in a range of 32 degrees to 52 degrees (F). Temperatures were recorded on a form titled, "Quintet Blood Glucose Monitoring System Daily Quality Control Record." On 4/4, 4/9 and 4/10/14, a temperature of 48 was recorded in the "Medication Room" column. On 4/11/14 a temperature of 50 was recorded. On 4/12 and 4/13/14 a temperature of 48 was recorded. No</p>	F000431	<p>F431 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Corrective actions will include night nursing staff in-services and/or direct nursing staff re-education regarding refrigerator temperature maintenance, medication cart maintenance and medication storage procedures.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident had the potential to be affected by such a deficiency. Corrective actions will include night nursing staff in-services and/or direct nursing staff re-education regarding refrigerator temperature maintenance, medication cart maintenance and medication storage procedures. The night charge nurse (RN) that was employed with this facility during survey, is no longer employed at the facility. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The facility has contracted with the pharmacy company to have a licensed nurse check medications and carts, once per month.Night nurses will be re-educated on the facility's "Night Shift Duty Log", that includes but is not limited to,</p>	06/15/2014

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	<p>record of a temperature was found for 4/14/14. On 4/15/14 a temperature of 50 was recorded. On 4/16/14 "fridge off" was documented in the column. On 4/17/14 a temperature of 40 was recorded. No documentation was found for a temperature for 4/18 or 4/19/14. On 4/20/14 a temperature of 32 was recorded, and a temperature of 52 was recorded on 4/21/14. A temperature of 32 was recorded for 4/26, 4/27, a date recorded as "4/31", 5/7, and 5/14/14.</p> <p>During an interview with licensed practical nurse (LPN) #3 on 5/15/14 at 4:15 p.m., LPN #3 indicated the column marked "Medication Room" was used to record the temperatures in the refrigerator in the medication room. LPN #3 indicated the temperatures were recorded by the night shift nurse when the refrigerators were checked. LPN #3 indicated a work order was filled out if the temperatures were found to be too high or too low. During the interview, LPN #3 called the Maintenance Director and requested a copy of the work orders for the medication room refrigerator.</p> <p>During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:30 a.m., the DoN indicated no work orders were completed in April 2014 for the refrigerator located in the medication</p>		<p>monitoring for outdated and mis-labeled medications, cleaning the medication carts and refrigerator maintenance. (see attached, marked exhibit B--3 pages)This in-servicing/re-education will take place once a week for 4 weeks and continue once per month for 5 months for the night shift licensed nurses. The Director of Nursing or her licensed designee will also check the carts and log that these checks have been accomplished for the medication carts (2) and the treatment cart (1) and both the medication room refrigerator and the pantry refrigerator, once per week. These corrective actions shall have no specific end date. Scheduled cart maintenance accomplished by night shift personnel that is not being completed will also be logged and followed up using the facility's Action Forms. (see attached, exhibit C) 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Night nurses will be re-educated on the facility's "Night Shift Duty Log", that includes but is not limited to, monitoring for outdated and mis-labeled medications, cleaning the medication carts and refrigerator maintenance. (see attached, marked exhibit B--3 pages)This in-servicing/re-education will take place once a week for 4 weeks</p>	

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	<p>room.</p> <p>On 5/16/14 at 1:35 p.m., the administrator provided a policy titled "Cleaning and Maintaining Refrigerators, Medicine Room/Pantry" dated 2/24/14, and indicated the policy was currently used by the facility. The section titled "Refrigerator and Freezer Temperature Monitoring" included "...Procedure: ...Temperatures are documented by staff daily. Refrigerators need to be maintained at temperatures between 34 and 46 degrees F [Fahrenheit] (or 2 to 8 degrees C [Celsius]);...Whenever the temperatures are out of range (either minimum/maximum history or current) or nearing out of range, the staff member will make a temperature adjustment and document that information on the problem log or in the notes area of the temperature log, and notify the supervisor as applicable. Refrigerator or freezer maintenance, operational problems and repairs, will be noted in the Maintenance Repair Log...."</p> <p>2. a. During a review of the Medication Cart #2 on 5/15/14 at 4:15 p.m., a vial of insulin aspart (NovoLog) insulin, with an opened date of 4/10/14, was found in the drawer. Licensed Practical Nurse (LPN) #11 indicated the vial was opened in excess of 28 days and should be replaced.</p>		<p>and continue once per month for 5 months for the night shift licensed nurses. The corrective action will be monitored weekly by the DON and/or her licensed designee by use of a log book. Pharmacy review records of the medication carts will also be maintained by the DON, with follow up as applicable on issues identified by this pharmacy review. Quality Assurance: The Director of Nursing or her licensed designee will also check the carts and log that these checks have been accomplished for the medication carts (2) and the treatment cart (1) and both the medication room refrigerator and the pantry refrigerator, once per week. These corrective actions shall have no specific end date. Night nurses will be in-serviced and/or re-educated on the facility's "Night Shift Duty Log", that includes but is not limited to, monitoring for outdated and mis-labeled medications, cleaning the medication carts and refrigerator maintenance. (see attached, exhibit B) This in-servicing/re-education for night shift licensed personnel will take place once a week for 4 weeks and continue once per month for 5 months. The DON will maintain these records for the facility and for future state survey review. 5) By what date the systemic changes will be completed? 6-15-2014</p>				

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	<p>LPN #11 indicated the vial belonged to Resident #8, and Resident #8 had a current physician's order for NovoLog.</p> <p>2. b. During a review of the Treatment Cart #1 on 5/15/14 at 4:15 p.m., two vials of insulin lispro (Humalog), with opened dates of 4/14/14, were found in the drawer. Registered nurse (RN) #12 indicated the vials were opened in excess of 28 days and should be replaced. RN #12 indicated the vials belonged to Resident #28 and Resident #31, and both residents had current physician's orders for Humalog.</p> <p>The "Nursing 2014 Drug Handbook" 34th edition, copyright 2014, indicated, "Store drug between 36 [degrees] F and 46 [degrees] F...Opened vials of NovoLog are stable at room temperature for 28 days...."</p> <p>"Patient Information Humalog" (revised November 14, 2013) was retrieved on 5/20/14 from the Humalog website. The "Patient Information" indicated, "Store all unopened (unused) Humalog in the original carton in a refrigerator at 36 [degrees] F to 46 [degrees] F...After starting use (open) vials: Keep in the refrigerator or at room temperature below 86 [degrees] for up to 28 days...Throw away an opened vial after 28 days of use,</p>			

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F000441 SS=D	<p>even if there is insulin left in the vial...."</p> <p>3. During a review of Medication Cart #1 and Medication Cart #2 on 5/15/14 at 4:15 p.m., 27 unidentified pills were found laying loose in the drawers. The pills were various colors and sizes and were covered with dust and debris. Medication Cart #1 had 11 unidentified pills. Medication Cart #2 had 16 unidentified pills. LPN #11 and RN #12 indicated the pills could not be identified, should not have been loose in the drawers, and disposed of the pills into the containers attached to the medication carts.</p> <p>3.1-25(j) 3.1-25(m)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>						

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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility dispensed pills into the hand of the staff member, failed to ensure gloves were worn while administering eye drops (Resident #14) and failed to use good handwashing during medication preparation and administration for 3 of 9 residents observed during medication administration. (Resident #3, Resident #5 and Resident #14)</p>	F000441	F441 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Corrective actions will include in-servicing/re-education on QMA #4.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident had the potential to be affected by such deficiency. Corrective actions will include in-servicing/re-education on QMA	06/15/2014

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	<p>Findings include:</p> <p>1.) During an observation of medication administration on 5/14/14 at 4:15 p.m., qualified medication assistant (QMA) #4 was observed while preparing medications for Resident #14. QMA #4 pulled the medication cards from the drawer, selected which medications were scheduled for administration, and then pushed the pills from the bubble packs into her hand. QMA #4 then placed the pills into a medication cup. QMA #4 went to the room of Resident #14, identified the resident, and then proceeded to the sink and washed her hands. QMA #4 then administered the pills to Resident #14 followed by a drink of water. When Resident #14 finished the water, QMA #4 informed the resident that he was scheduled to receive eye drops as well as the pills, and proceeded to hand a tissue to the resident. QMA #4 removed the lid on a bottle of eye drops, and then proceeded to administer one drop into each eye of Resident #14. QMA #4 did not wear gloves while administering the eye drops.</p> <p>2.) During observation of medication administration on 5/14/14 at 4:30 p.m., QMA #4 was observed while preparing medications for Resident # 3. QMA #4 pulled the medication cards from the</p>		<p>#4On the day that this issue was brought to the attention of this facility's management staff, the re-education of QMA #4 began. (As of 6-4-2014, QMA #4 has completed 3 in-servicing/re-education opportunities.)-please see attached marked exhibit A 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? QMA admitted to her error(s) and stated that she was extremely nervous during the survey when the survey team member observed her passing medications. QMA will be in-serviced and/or re-educated weekly times 6 weeks by the DON/ADON and/or their licensed designees and the facility will have QMA #4's medication pass observation accomplished by the facility's pharmacy representative.The facility will also in-service and/or utilize re-education techniques for all LPN, RN staffing who pass medication, twice per year.Any staff member known to have issues with the medication pass will have an observed med pass . 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? QMA will be in-serviced and/or re-educated weekly times 6 weeks by the DON/ADON and/or</p>	
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	<p>drawer, selected which medications were scheduled for administration, and then pushed the pills from the bubble packs into her hand. QMA #4 then placed the pills into a medication cup. QMA #4 went to the room of Resident #3, identified the resident, and then proceeded to the sink and washed her hands. QMA #4 then administered the pills to Resident #3 followed by a drink of water.</p> <p>3.) During observation of medication administration on 5/14/14 at 4:15 p.m., QMA #4 was observed while preparing medications for Resident #5. QMA #4 pulled the medication cards from the drawer, selected which medications were scheduled for administration, and then pushed the pills from the bubble packs into her hand. QMA #4 then placed the pills into a medication cup. QMA #4 went to the room of Resident #5, identified the resident, and then proceeded to the sink and washed her hands. QMA #4 then administered the pills to Resident #5 followed by a drink of water.</p> <p>On 5/15/14 at 2:00 p.m., the administrator provided a policy titled "Guidelines Policy for Medication Administration - May 2005 adjunct to pharmacy manual (Updated: September</p>		<p>their licensed designees and the facility will have QMA #4's medication pass observation accomplished by the facility's pharmacy representative. The corrective actions will be monitored, documented per the DON/ADON and/or their licensed designee on the facility form marked In-service Program Report. (see attached exhibit A). Quality Assurance: The facility will also in-service and/or utilize re-education techniques for all LPN, RN staffing who pass medication, twice per year. Any staff member known to have issues with the medication pass will have an observed med pass.</p> <p>5) By what date the systemic changes will be completed? 6-15-2014</p>	

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F000465 SS=E	<p>2012)." The administrator indicated the policy was currently used by the facility. In the section titled "5.2 Step by Step Procedures...Procedure 1: Wash hands...Procedure 6: Prepare the correct dosage of medication without touching medication, if possible...Procedure 21: Wash hands..."</p> <p>During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:30 a.m., the DoN indicated QMA #4 should have pushed the pills directly into the medication cup and not into her hand, should have utilized handwashing techniques, and should have worn gloves when administering the eye drops.</p> <p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE 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 maintain floors and entrances in good repair in the resident rooms, affecting residents residing in those rooms. The nursing unit hallways</p>	F000465	F465 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Any resident had the potential to be affected by such a	06/15/2014			

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	<p>and nursing stations, had pitted, cracked, and soiled floor tiles. This had the potential to affect 37 residents residing in the facility. (resident rooms # 3,6, 8, 9, 14,15,17&amp; 18 )</p> <p>Findings include:</p> <p>An environmental tour was done on 5/15/14 at 1:00 p.m., with the facility Maintenance Manger with the following observations:</p> <ol style="list-style-type: none"> <li>1. The floors in the hallways throughout the nursing unit and the floors in resident rooms : 3,6,8,9,14,15,17,&amp; 18 had a build-up of dirt, dust, and debris in the corners and along the baseboards. It appeared as if the floors had been waxed without being properly cleaned.</li> <li>2. Resident room number 6 had eight cracked floor tiles located in the entrance.</li> <li>3. Located in front of the janitors closet, there was 18 floor tiles that were pitted, cracked, and had pieces missing.</li> <li>4. Shower room C had missing and loose anti-skid floor coating in a 12" x 12" area in front of the toilet.</li> <li>5. In front of the Staff restroom there was 8 floor tiles that were cracked, soiled, and</li> </ol>		<p>deficiency.All mentioned ares of concern will be repaired and/or have parts ordered by the correction date listed below in question #5.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?Any resident had the potential to be affected by such a deficiency.All mentioned ares of concern will be repaired and/or have parts ordered by the correction date listed below in question #5.Replacement floor tiles were ordered and the contractor has partially filled that order.Tiles are being replaced.Areas of concern in shower room C have been replaced.The area of concern on the main entrance doors: a contractor has been called to set up this repair.The fan of concern in the main dining area will be replaced. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance will be responsible to maintain tiles and floor areas. The maintenance employee who is responsible for floors will keep a log book of floors that have been stripped and waxed. This person will also be responsible to notify the maintenance manager of any future trouble spots concerning floor tiles and these areas of concern will be added to</p>	

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	<p>had missing pieces. The floor tiles appeared to have been waxed over without being properly cleaned.</p> <p>6. The Soiled utility room had 18 floor tiles that were cracked, pitted and had pieces missing.</p> <p>7. There was 31 cracked and pitted floor tiles in front of the nurse's station. It appeared as if the floor tiles had been waxed over before being properly cleaned.</p> <p>8. There was 1/4" x 2' gap in between the main entrance doors located near the floor.</p> <p>9. A the service entry there were 3, 1/2" x 1" , gaps across a 2' area in between the doors.</p> <p>10. The tracks on the patio doors, located in the dining room and leading to the courtyard, had a heavy accumulation of dirt, grease, debris, and dust.</p> <p>11. One of two ceiling fans located in the dining room made a rather loud and disturbing clanking sound throughout both seating's of the meal.</p>		<p>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place?The maintenance employee who is responsible for floors will keep a log book of floors that have been stripped and waxed. This person will also be respoonsible to notify the maintenance manager of any future trouble spots concerning floor tiles and these areas of concern will be added to aforementioned log book.Quality Assurance:The maintenance manager will be responsible to check the floor log book once per week.The maintenance manager will sign the log book as proof that s/he has thus been notified.Areas of concern in shower room C have been replaced.The area of concern on the main entrance doors: a contractor has been called to set up this repair.The fan of concern in the main dining area will be replaced.Administrative rounds are completed once per week. The maintenance manager will accompany the Administrator on these rounds and a log book will be signed by both parties to document these rounds have been completed. (Should the Administrator be unavailable, these rounds will be completed by the maintenance manager and the log book signed.) 5) By what date the systemic changes will be completed?June 15th 2014</p>	

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F000514 SS=D	<p>Interview with Maintenance Manger after environmental tour on 5/15/14 at 1:00 p.m. indicated that he had seen the above listed observations.</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure amounts of sliding scale insulin given to a resident were clearly documented and readily accessible for review as needed, for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #3)</p>	F000514	F514 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The facility has determined that 6 out of 7 resident's sliding scale insulin (listed by state surveyors) were actually given. The facility respectfully here offers an employee schedule (see attached) that shows the corresponding shifts and nurses	06/15/2014

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	<p>Findings include:</p> <p>The clinical record of Resident #3 was reviewed on 5/14/14 at 1:00 p.m. Diagnoses for the resident included, but were not limited to, insulin dependent diabetes mellitus, organic brain syndrome, and renal insufficiency.</p> <p>A physician's order, dated 5/8/14, indicated Resident #3 was to have his blood sugar checked at 6:00 a.m. and 4:00 p.m. daily. He was to receive Novolin R insulin, based on the results of his blood sugar check, according to the following sliding scale:</p> <p>Blood sugar (BS) of 111-150 = 2 units of insulin            BS of 151-200 = 4 units            BS of 200-250 = 6 units            BS of 251-300 = 8 units            BS of 301-350 = 10 units            BS of 351-400 = 12 units            BS of 401-450 = 14 units            BS of 451-500 = 16 units            call md (medical doctor) if over 501</p> <p>The Medication Administration Record for Resident #3 for May, 2014, indicated he received his sliding scale insulin, but the record did not indicate how much insulin was given on the following days:</p>		<p>for the dates implied by the state survey team members; this also corresponds with the sheet intitled "Site of Administration" to show that a sliding scale insulin coverage was given but remains without an exact time. In printing off the electronic records, the facility is unable to determine the time of insulin administration, due to a glitch in the pharmacy's system. (please see attached documentation "Site of Administration"/6 pages.)Without the aforementioned information made readily available the facility is not able to definatively prove their determinations. ( IE: "If it is not documented, [and additionally; documented properly] it was not done")The facility has contacted our pharmacy/electronic medication administration technical support service and their web support engineers will be working on this issue.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?Any resident had the potential to be affected by such a deficiency.The facility has contacted our pharmacy/electronic medication administration technical support service and their web support engineers will be working on this issue. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does</p>	

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	<p>May 8 at 4:00 p.m., BS was 178. Should have received 4 units.</p> <p>May 10 at 4:00 p.m. BS was 194. Should have received 4 units.</p> <p>May 11 at 4:00 p.m. BS was 301. Should have received 10 units.</p> <p>May 12 at 6:00 a.m. BS was 117. Should have received 2 units.</p> <p>May 12 at 4:00 p.m. BS was 203. Should have received 6 units.</p> <p>May 13 at 4:00 p.m. BS was 194. Should have received 4 units.</p> <p>May 14 at 6:00 a.m. BS was 127. Should have received 2 units.</p> <p>Administered medications are documented in the computer when given. On the above dates, the nurses had documented that the sliding scale insulin was administered, but did not indicate how much insulin was given. During an interview with Licensed Practical Nurse #1 on 5/16/14 at 11:10 a.m., she indicated, after reviewing the computer medication administration record for May, 2014, if a physician called and wanted to know how much sliding scale insulin Resident #3 had receive for the blood sugars listed above, she would only be able to tell the physician what the sliding scale orders were and that the resident had received his sliding scale insulin, but the actual amount given was not documented.</p>		<p>not recur?Systemic change:The facility as of 6-5-2014 has developed a form (written) for the documentation of sliding scale insulin coverage. (see attached "Diabetic Flow Sheet")This additional documentation is to be completed whenever a resident requires sliding scale insulin coverage and it denotes date, time, sliding scale dose given, blood glucose level and the nurse's signature. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place?The Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON) will be responsible to educate the licensed staff on the proper use of this sliding scale insulin documentation.Licensed staff will be in-service and/or re-educated on this new proceedure now and once per week for 4 weeks.Newly hired licensed staff will be educated on this proceedure during their orientation period and thereafter as applicable.The facility has also requested a licensed pharmacy representative to hold an electronic record 'education day'/or days, for our licensed staff.The use of the electronic system will be discussed and re-taught and documented as applicable. 5) By what date the systemic changes will be completed?6-15-2014</p>	

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F009999	<p>During an interview with the Executive Director and Director of Nursing on 5/16/14 at 2:00 p.m., they indicated the way the sliding scale insulin was documented on the May, 2014 Medication Administration Record was very confusing. They indicated they think it had something to do with the way the order was put into the computer.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			
	<p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the</p>	F009999	<p>1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All new employees, beginning 5-16-2014 must have a completed physical examination prior to starting employment with this facility. 2) How other residents having the</p>	06/15/2014

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	<p>Mantoux method (5TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(3) The facility shall maintain a health record of each employee that includes:</p> <p>(A) a report of the preemployment physical examination; and</p> <p>(B) reports of all employment-related health examinations.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure newly hired employees had a physical examination prior to starting work for 3 of 6 employees hired within the last 120 days. (Certified Nursing Assistants #7, #8, and #9)</p> <p>Findings include:</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident had the potential to be affected by such a deficiency. Previously employees were required to have a completed physical within one month of employ. This practice was ceased and all new employees must have a completed physical prior to employment. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All new employees, beginning 5-16-2014 must have a completed physical examination prior to starting employment with this facility. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? The Medical Records Department will not allow paperwork orientation for any new employee candidate, without a completed physical. Medical Records will maintain employee physical files. 5) By what date the systemic changes will be completed?6-15-2014</p>				

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	<p>During a review of employee records on 5/14/14 at 3:00 p.m., pre-employment physical examinations were not found for Certified Nursing Assistants (CNA) #7, #8, and #9. CNA #7 was hired on 3/11/14. CNA #8 was hired on 5/1/14. CNA #9 was hired on 3/27/14.</p> <p>In an interview on 5/15/14 at 1:00 p.m., medical records staff #10 indicated CNAs #7, #8 and #9 had provided care to residents. She indicated, at that time, she thought the Executive Director had told her newly hired employees had 30 days after their hire date to get their physical examination.</p>				