

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 19, 20, 23, 24, & 25, 2015</p> <p>Facility number: 000144 Provider number: 155240 AIM number: 100266760</p> <p>Census bed type: SNF/NF: 51 Total: 51</p> <p>Census payor type: Medicare: 2 Medicaid: 38 Other: 11 Total: 51</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on December 04, 2015.</p>	F 0000		
F 0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			

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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SS=D Bldg. 00	<p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure a resident</p>	F 0225	This plan of correction is to serve as Lyons Health andLiving	12/21/2015	

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	<p>report of mistreatment was immediately reported to the administrator of the facility as indicated by the facility's abuse policy for 1 of 1 resident interviewed for an allegation of mistreatment (Resident #34) and new employees had received a criminal background check as indicated by facility policy prior to a job offer and/or working with residents for 3 of 5 new hired employee records reviewed. (Licensed Practical Nurse #2, Certified Nursing Assistant (CNA) #3, CNA #4)</p> <p>Findings include:</p> <p>1). On 11/19/2015 at 1:48 p.m., interview with Resident #68 indicated her roommate (Resident #34) was sprayed, by CNA #2, with a cold cleaning solution after voiding (urinating). This was considered as a bed bath. CNA #2 used a wipe tissue, with the cleaning solution sprayed onto the tissue, to complete Resident #34's bed bath.</p> <p>On 11/19/2015 at 1:52 p.m., Resident #34 indicated she did not want CNA #2 to provide any further personal care. Resident #34 indicated, "I told CNA #1 what CNA #2 had done."</p> <p>Resident #68's clinical record was reviewed on 11/25/15 at 11:00 a.m. Diagnoses included, but were not limited</p>		<p>Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to request a desk review/paper compliance for the 2015 annual survey. F225 483.13(c)(1)(ii)-(iii), (c)(2)-(4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #34, 68 have been assessed by a Licensed Nurse, as well as Social Services and monitored to ensure no negative outcomes have occurred, and to date, no negative outcomes have been discovered by the assessment conducted. Psychosocial support has been provided by social services for residents 34 & 68 CNA # 2 no longer employed CNA # 1 and the ADON have received education on reporting allegations of abuse immediately to the administrator. C.N.A #3, C.N.A #4, and LPN#2 have background checks in their files</p>				

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	<p>to: anxiety disorder.</p> <p>The current admission assessment dated 4/12/15, indicated Resident #68 was interviewable and cognitively intact.</p> <p>On 11/24/15 at 2:49 p.m., interview with CNA #1 indicated Resident #34 had complained to her about CNA #2 using periwash spray to do Resident #34's bedbath. CNA #1 indicated, "I told the Assistant Director of Nursing (ADON) immediately. The ADON told me she would take care of it [the allegation of mistreatment]." CNA #1 indicated she thought the matter was taken care of. CNA #1 indicated the facility protocol was to report any abuse to her supervisor or the ADON.</p> <p>On 11/24/15 at 2:58 p.m., interview with ADON indicated she would report any allegations of abuse immediately to the Director of Nursing (DON) and Administrator. The ADON indicated she was not aware of any allegations of mistreatment from Resident #34, in regard to CNA #2, until today.</p> <p>On 11/24/15 at 2:34 p.m., interview with the Administrator (ADM) and the Director of Nursing (DON) indicated they had not been informed of Resident #34's allegation of mistreatment.</p>		<p>and meet employment criteria. The facility has a system in place to ensure strategies are implemented to prevent staff to resident mistreatment, and that staff are aware to report all allegations immediately and directly to the administrator. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents and staff have the potential to be affected Other residents that C.N.A #2 provided care to have been interviewed with no other concerns being reported. A thorough investigation was completed regarding all staff listed in the 2567 by administrative staff, with corporate oversight and appropriate action has been taken on each employee including: further education, progressive discipline, and termination. In servicing will be provided to staff on all shifts on the different types of abuse, and abuse prevention. Staff will also be educated on reporting any allegation directly and immediately to the Administrator. All third party vendors will also be educated on abuse prevention policy and reporting any allegation immediately and directly to the Administrator. A post-test will be given specific to the various types of abuse, and the proper</p>		

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	<p>On 11/24/15 at 2:47 p.m., the Nurse Consultant provided "Abuse prevention" policy and indicated the policy was the one currently used by the facility. The policy indicated, "...Reporting abuse, ...It is the responsibility of our employees, facility consultant, ...to immediately report any incident or suspected incident of neglect or resident abuse ... to the Administrator..."</p> <p>2). On 11/24/15 at 10:24 a.m., review of the following employee files lacked documentation for a criminal background check being obtained prior to hire and working with residents:</p> <p>2a. Certified Nursing Assistant (CNA) #3 was hired on 10/9/15, and the criminal background check was received on 10/13/15. The staffing schedule indicated CNA #3 worked 10/11/15 and 10/12/2015.</p> <p>2b. Certified Nursing Assistant (CNA) #4 was hired on 11/12/15, and the background check was received on 11/24/15. The staffing schedule indicated CNA #4 worked 11/15/15, 11/16/15, 11/17/15, 11/19/15, 11/22/15, and 11/23/2015.</p> <p>2c. Licensed Practical Nurse (LPN) #2</p>		<p>reporting protocol. Staff will be required to achieve a 100% score to demonstrate competency. Employee files will be audited to ensure that a background check has been completed, and reference checks are in place. That information will again be reviewed to ensure the employee is in good standing to continue employment. This is to include CNA #3, 4 and LPN #2. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Abuse prevention education will be provided to employees on all shifts. This education will also include reporting all allegations directly and immediately to the Administrator. In-servicing will begin immediately and will continue quarterly for 12 months. The education will be provided to all newly hired staff during General Orientation before having contact with residents. This will include all types of abuse, how to recognize abuse, how to effectively handle abuse allegations, and reporting any and all allegations directly and immediately to the Administrator. All third party vendors will receive the same education. Human Resources educated on obtaining background checks on all new applicants of interest prior to being hired and working with residents. How the</p>		

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	<p>was hired on 10/16/15, and the background check was received on 10/23/15. The staffing schedule indicated LPN #2 was in orientation on 10/19/15,10/20/15 and 10/23/15.</p> <p>On 11/24/15 at 3:50 p.m., the Administrator provided the schedule for Certified Nursing Assistant and Nurses dated 10/1/15 through 11/28/15.</p> <p>On 11/25/2015 at 10:01 a.m. interview with the Assistant Director of Nursing (ADON) indicated the letter (X) on the schedule meant the staff person worked that day.</p> <p>On 11/24/15 at 2:47 p.m., the Nurse Consultant provided, "Abuse prevention" policy and indicated the policy was the one currently used by the facility. The policy indicated, "...I. BACKGROUND SCREENING INVESTIGATIONS ...This facility will conduct employment background screening checks, reference checks and criminal conviction investigation checks on individuals making application for employment with this facility. ...1. employment background checks, ... criminal conviction checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment.</p>		<p>correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place? The Director of Nursing or designee will complete random audits to verify staff know to report any allegation of mistreatment directly and immediately to the Administrator. Audits will consist of interviewing 5 staff members daily for 30 days, weekly for 60 days, then monthly for 9 months for a total of 12 months. The family and resident QIS interview tool will be broken into 1/3rds and completed on all residents and family members monthly over each quarter to discover any additional concerns ongoing with no stop date. Findings will be addressed, reported and investigated immediately with appropriate actions taken. These interviews will be discussed through the QA committee monthly and will be monitored through the corporate nurse monthly for 3 months and re-evaluated after that. Human Resources will complete a QA tool to audit pre-employment screenings prior to General Orientation to verify background checks have been obtained and in employee file weekly for a total of 12 months of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months</p>		

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F 0226 SS=D Bldg. 00	<p>...Reporting abuse VII. REPORTING ABUSE TO: ...It is the responsibility of our employees, facility consultants, ...etc., to immediately report any incident or suspected incident of neglect or resident abuse, ... to the Administrator or Designee if the Administrator is unavailable."</p> <p>3.1-28(b)(1) 3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure implementation of their abuse policy and procedure by immediately reporting to the administrator of the facility a resident's allegation of mistreatment as indicated by the facility's abuse policy for 1 of 1 resident reviewed for an allegation of mistreatment (Resident #34) and new employees had received a criminal</p>	F 0226	<p>and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/21/2015. The Administrator at Lyons Health and Living Community is responsible in ensuring compliance in this Plan of Correction.</p> <p>This plan of correction is to serve as Lyons Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does</p>	12/21/2015	

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	<p>background check prior to a job offer and/or working with residents for 3 of 5 new hired employee records reviewed. (Licensed Practical Nurse #2, Certified Nursing Assistant (CNA) #3, CNA #4)</p> <p>Findings include:</p> <p>1). On 11/19/2015 at 1:48 p.m., interview with Resident #68 indicated her roommate (Resident #34) was sprayed, by CNA #2, with a cold cleaning solution after voiding (urinating). This was considered as a bed bath. CNA #2 used a wipe tissue, with the cleaning solution sprayed onto the tissue, to complete Resident #34's bed bath.</p> <p>On 11/19/2015 at 1:52 p.m., Resident #34 indicated she did not want CNA #2 to provide any further personal care. Resident #34 indicated, "I told CNA #1 what CNA #2 had done."</p> <p>Resident #68's clinical record was reviewed on 11/25/15 at 11:00 a.m. Diagnoses included, but were not limited to: anxiety disorder.</p> <p>The current admission assessment dated 4/12/15, indicated Resident #68 was interviewable and cognitively intact.</p> <p>On 11/24/15 at 2:49 p.m., interview with</p>		<p>this submission constitute an agreement or admission of the survey allegations. We would like to request a desk review/paper compliance forthe 2015 annual survey. F226 483.13(c) DEVELOPMENT/IMPLEMENT ABUSE/NEGLECT,ETCPOLICIE S What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? Resident #34, 68 have been assessed by a Licensed Nurse, as well as Social Services and monitored to ensure no negative outcomes have occurred, and to date, no negative outcomes have been discovered by the assessment conducted. Psychosocial support has been provided by social services for residents 34 & 68 CNA # 2 no longer employed. CNA # 1 and the ADON have received education on reportingallegations of abuse immediately to the administrator. C.N.A #3, C.N.A #4, and LPN#2 have background checks intheir files and meet employment criteria. The facility has a system in place to ensure strategies are implemented to prevent staff to resident mistreatment, and that staff are aware to report all allegations immediately and directly to the administrator. How other residentshaving the potential to be affected by the same deficient practice will be identified and what corrective</p>				

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	<p>facility consultant, ...to immediately report any incident or suspected incident of neglect or resident abuse ... to the Administrator..."</p> <p>2). On 11/24/15 at 10:24 a.m., review of the following employee files lacked documentation for a criminal background check being obtained prior to hire and working with residents:</p> <p>2a. Certified Nursing Assistant (CNA) #3 was hired on 10/9/15, and the criminal background check was received on 10/13/15. The staffing schedule indicated CNA #3 worked 10/11/15 and 10/12/2015.</p> <p>2b. Certified Nursing Assistant (CNA) #4 was hired on 11/12/15, and the background check was received on 11/24/15. The staffing schedule indicated CNA #4 worked 11/15/15, 11/16/15,11/17/15, 11/19/15,11/22/15, and 11/23/2015.</p> <p>2c. Licensed Practical Nurse (LPN) #2 was hired on 10/16/15, and the background check was received on 10/23/15. The staffing schedule indicated LPN #2 was in orientation on 10/19/15,10/20/15 and 10/23/15.</p> <p>On 11/24/15 at 3:50 p.m., the</p>		<p>or what systemic changes will be made to ensure that thedeficient practice does not recur? Abuse prevention education will be provided to employees on all shifts. This education will also include reporting all allegations directly and immediately to the Administrator. In-servicing will begin immediately and will continue quarterly for 12 months. The education will be provided to all newly hired staff during General Orientation before having contact with residents. This will include all types of abuse, how to recognize abuse, how to effectively handle abuse allegations, and reporting any and all allegations directly and immediately to the Administrator. All third party vendors will receive the same education. Human Resources educated on obtaining background checks on all new applicants of interest prior to being hired and working with residents. How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place? The Director of Nursing or designee will complete random audits to verify staff know to report any allegation of mistreatment directly and immediately to the Administrator. Audits will consist of interviewing 5 staff members daily for 30 days,</p>				

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	<p>Administrator provided the schedule for Certified Nursing Assistant and Nurses dated 10/1/15 through 11/28/15.</p> <p>On 11/25/2015 at 10:01 a.m. interview with the Assistant Director of Nursing (ADON) indicated the letter (X) on the schedule meant the staff person worked that day.</p> <p>On 11/24/15 at 2:47 p.m., the Nurse Consultant provided, "Abuse prevention" policy and indicated the policy was the one currently used by the facility. The policy indicated, "...I. BACKGROUND SCREENING INVESTIGATIONS ...This facility will conduct employment background screening checks, reference checks and criminal conviction investigation checks on individuals making application for employment with this facility. ...1. employment background checks, ... criminal conviction checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment. ...Reporting abuse VII. REPORTING ABUSE TO: ...It is the responsibility of our employees, facility consultants, ...etc., to immediately report any incident or suspected incident of neglect or resident abuse, ... to the Administrator or Designee if the Administrator is</p>		<p>weekly for 60 days, then monthly for 9 months for a total of 12 months. The family and resident QIS interview tool will be broken into 1/3rds and completed on all residents and family members monthly over each quarter to discover any additional concerns on-going with no stop date. Findings will be addressed, reported and investigated immediately with appropriate actions taken. These interviews will be discussed through the QA committee monthly and will be monitored through the corporate nurse monthly for 3 months and re-evaluated after that. Human Resources will complete a QA tool to audit pre-employment screenings prior to General Orientation to verify background checks have been obtained and in employee file weekly for a total of 12 months of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/21/2015. The Administrator at Lyons Health and Living Community is responsible in ensuring compliance in this Plan of Correction.</p>		

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F 0319 SS=D Bldg. 00	<p>unavailable."</p> <p>3.1-28(a)</p> <p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents with the potential for disruptive behaviors were provided services to promote psychosocial well-being for 1 of 1 randomly observed resident. (Resident #55.)</p> <p>Findings include:</p> <p>On 11/20/15 at 11:20 a.m., Resident #51 indicated he has a problem getting back to sleep after Resident #55 screams out in the middle of the night. At this same time Resident #43 confirmed Resident #55 yells out around 1:00 a.m. or 2:00 a.m., almost every night.</p> <p>Observations of Resident #55 included</p>	F 0319	<p>This plan of correction is to serve as Lyons Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to request a desk review/paper compliance for the 2015 annual survey. F319 483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIALDIFFI CULTIES What Correctiveaction(s) will be accomplished for those</p>	12/21/2015	

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	<p>the following:</p> <p>On 11/19/15 at 1:08 p.m., the resident's wife and daughter were present in the room. The resident smiled and rested in his wheelchair.</p> <p>On 11/20/15 at 11:32 a.m., the resident shouted, "Hey!"</p> <p>On 11/23/15 at 10:56 a.m., the resident shouted, "Hey! Hey! Hey!" CNA (Certified Nursing Assistant) #1 was observed to walk into the resident's room and ask him what was the matter. The CNA indicated the resident said he did not need anything and she would go back and sit with him after she passed out water to the other residents. She further indicated he is calmer when someone is with him.</p> <p>On 11/23/15 at 10:58 a.m., the resident shouted, "Help! Somebody?" A nurse was observed to walk into the resident's room and asked him what was wrong.</p> <p>On 11/24/15 at 10:20 a.m., the resident was lying in bed and shouted, "Help! I need to get out of here!" The social worker was observed to walk into the resident's room and ask him what he needed. The resident yelled, "I want to get out of here!"</p>		<p>residents found to have been affected by the deficient practice? Staff was provided with in servicing during the survey on interventions that have been effective in calming resident #55. Updates have been made to care plans and nurse aide assignment sheets to provide staff with interventions in dealing with the disruptive behavior. Resident 55 has received psychosocial support and reevaluated by Social Services and a licensed nurse, as well as Medical Staff at a behavioral health facility. Resident #55, #51, and #43 have been interviewed by Social Services and assessed by a licensed nurse to ensure no negative outcomes have occurred, and to date, no negative outcomes have been discovered by the assessment conducted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents who have disruptive behaviors have the potential to be affected and other residents within hearing distance have the potential to be affected by disruptive behaviors. Resident #55 has received proper medical attention by a behavior specialist. An audit of all residents with disruptive behaviors has been completed and care plans updated to ensure no other</p>		

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	<p>On 11/24/15 at 12:03 p.m., the resident's wife visited at bedside and the resident was very calm.</p> <p>On 11/25/15 at 9:43 a.m., the resident yelled, "Hey!" LPN #1 indicated the resident sometimes yells out of nowhere and it scares her when he yells.</p> <p>On 11/24/15 at 11:36 a.m., Resident #55's clinical record was reviewed. Diagnosis included, but were not limited to: dementia without behavioral disturbance, generalized anxiety disorder, visual hallucinations, and Parkinson's disease.</p> <p>A review of Resident #55's current care plans indicated the following:</p> <p>A care plan titled, "The Resident has Dx [diagnosis] of anxiety that requires the use of anxiolytic medication(s) AEB [As Evidence By] vocal outburst," with a start date of 10/19/15, included the following interventions: "If resident [sic] awake and yelling out bring resident to nurses station to be observed ... If resident is yelling out assess for hunger, thirst or needs to go to restroom ... Encourage resident to appropriately express feelings and concerns ... Medication as ordered ... Monitor resident ... Psych [psychiatric]"</p>		<p>disruptive behavior is occurring interfering with the activities of daily living for all residents at Lyons as needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff will be provided education on Behavioral Management Policy. Nursing staff educated on reporting and documenting of disruptive behaviors that may interfere with other residents daily activities. C.N.A assignment sheets and care plans will be updated on effective interventions on residents who have disruptive behaviors. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or designee will review nursing progress notes to verify that Behavioral Events are opened. IDT will review Behavioral Events daily and will update care plans as needed. All new/worsening behaviors will be reviewed a second time in weekly IDT and will include interventions that are effective in calming resident. C.N.A assignment sheets and care plans will be audited using a QA tool weekly in the weekly IDT to verify that residents with new/worsening behaviors have been updated</p>				

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	<p>eval [evaluation] as indicated ...</p> <p>Encourage the resident's family and friends to routinely visit the resident socially to help alleviate the targeted symptoms, New or worsening behaviors will be monitored and new interventions will be considered in order to promote the highest level of quality of life for this resident ... Nursing to monitor resident every shift ..."</p> <p>A care plan titled, "Resident has physical behavioral symptoms toward others ..." with a start date of 11/16/15, included the following interventions: "Administer medications ... Assess whether the behavior endangers the resident and/or others ... Avoid over-stimulation ... Convey an attitude of acceptance toward the resident ... Document behaviors as noted ... Maintain a calm environment and approach to the resident ... Offer one step verbal directions for tasks ... When the resident becomes physically abusive, keep distance between resident and others ... When resident becomes physically abusive, move to a quiet, calm environment ... When the resident becomes physically abusive, STOP and try task later. Do not force to do task."</p> <p>A review Resident #55's November 2015, orders indicated the following:</p>		<p>with new interventions. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 12/21/2015. The Administrator at Lyons Health and Living Community is responsible in ensuring compliance in this Plan of Correction.</p>				

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	<p>On 11/12/15 the resident was prescribed Xanax (antianxiety medication) 0.5 mg (milligrams) once a day at 8:00 p.m.</p> <p>Resident #55's Post-Behavior IDT (Interdisciplinary Team) Form, dated 11/11/15, indicated, "Resident yelled an [sic] swatted at therapist arm while trying to provide treatment..."</p> <p>Resident #55's IDT Form, dated 11/13/15, indicated, "Resident with recent increase in Xanax due in crease [sic] anxiety related to yelling out. Resident has dx [diagnosis] of dementia, parkinson [sic]. Resident does not recall to use call light for assistance. Resident has vocal out burst [sic] through the day an [sic] evening..."</p> <p>Resident #55's Post-Behavior IDT form, dated 11/16/15, indicated, "... verbally and physically combative..."</p> <p>The IDT forms for Resident #55's behaviors did not indicated investigation for what seems to calm the resident during theses times.</p> <p>On 11/24/15 at 11:15 a.m., the Social Service Director indicated Resident #55 has Parkinson's disease and does not know how to use his call light, which is why he often yells out. She indicated staff</p>				

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F 0465 SS=E Bldg. 00	<p>goes in after he yells to see if he needs to go to the bathroom or if he's hungry, or staff will take him down to the nurse's station in the middle of the night after he yells. The social worker further indicated the resident's wife hasn't visited as often as usual, and could be why he is yelling out.</p> <p>On 11/25/15 at 10:49 a.m., the Director of Nursing indicated she thinks Resident #55 is a loud person and hard of hearing.</p> <p>On 11/25/15 at 12:27 p.m., RN #5 indicated the facility is going to have an outside social service come into the facility to start weekly visits with Resident #55. At this time, she provided the facility's policy, "Behavior management program," dated October 2013, and indicated it was the policy currently being used by the facility. The policy indicated, "... behaviors have the potential to create a negative effect on the resident, other residents, visitors and the staff..."</p> <p>3.1-43(a)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional,</p>			

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	<p>sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure staff repaired damaged handrails which were loose, contained splinters, two small nails protruding and were free from dirt and lint as indicated by facility policy for 3 of 3 hallways randomly observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 11/24/2015 at 2:00 p.m., during a facility tour, an observation of facility handrails indicated the following: <ol style="list-style-type: none"> a. A splinter in the hallway handrail outside of resident rooms 101, 103, 105, 201, 311, 313, outside the oxygen storage room across the hall from room 209, and in the hallway below the therapy window. b. A small nail protruding from the handrail outside of room 204 which contained a sharp edge. c. In the corner of the 200 hall on the right side, a splinter, a small nail protruding and the handrail was loose and able to be moved. d. Handrails were observed to be covered with lint and dirty with a visible black substance that covered the 	F 0465	<p>This plan of correction is to serve as Lyons Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to request a desk review/paper compliance for the 2015 annual survey.</p> <p>F465 483.70(h) SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents listed in the 2567 have been assessed by a licensed nurse and no negative outcomes have been discovered by the assessments conducted.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All residents have the</p>	12/21/2015			

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	<p>surveyor's hand after inspection.</p> <p>During an interview on 11/24/2015 at 2:00 p.m., the Director of Nursing (DON) did not deny the handrails needed to be cleaned and repaired.</p> <p>On 11/25/2015 at 2:03 p.m., the Administrator provided the policy "Maintenance Services" dated 2003, and indicated the policy was the one currently being used by the facility. The policy indicated, "Maintenance services are established to keep the interior and exterior building environment safe, comfortable, and attractive for the residents, visitors, and staff ... A year round preventative maintenance program is established to preserve the building as a company asset ... It may include repetitive servicing such as cleaning ... or repairs or overhauling of critical equipment or devices. ..."</p> <p>3.1-19</p>		<p>potential to be affected whose handrails outside of their rooms that need repaired.</p> <p>All handrails in the facility have been inspected by a 3rd party vendor. All areas found to have sharp areas have been sanded, gaps filled in, and all nails have been nailed in to no longer protrude. Handrails have also been painted.</p> <p>All handrail, including those outside of resident rooms listed on the 2567 have been cleaned and repaired and no longer have any sharp edges.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>The Maintenance Director has been educated on routine assessment of all handrails within the facility, and measures to be taken to repair all sharp edges.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Administrator or designee will</p>		

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			<p>use a QA audit tool to perform routine auditing of all handrails within the facility 5 days a week for 30 days, then weekly for 60 days, then every other week for a total of 12 months of monitoring.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Compliance date: 12/21/2015.</p> <p>The Administrator at Lyons Health and Living Community is responsible in ensuring compliance in this Plan of Correction.</p>	