

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155683	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2015
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NAME OF PROVIDER OR SUPPLIER B & B CHRISTIAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3208 N SHERMAN DR INDIANAPOLIS, IN 46218
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 20, 21, 22, 23, and 24, 2015</p> <p>Facility number: 011032 Provider number: 155683 AIM number: 200262860</p> <p>Census bed type: SNF/NF: 4 NF: 23 Total: 27</p> <p>Census payor type: Medicaid: 27 Total: 27</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Please accept this as my credible allegation of compliance.	
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family</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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	<p>member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of out of range blood sugars for 1 of 5 residents reviewed for unnecessary medications. (Resident #1)</p> <p>Findings include:</p> <p>The clinical record for Resident #1 was reviewed on 7/20/15 at 2:00 p.m. The diagnoses for Resident #1 included, but</p>	F 0157	<p>The records for all diabetic residents receiving insulin were reviewed for sliding scale intervention and M.D. notification. Resident # 1's record was immediately reviewed with the doctor and the sliding scale record and order was clarified. All diabetic residents had the potential to be affected by this deficient practice. After chart audits of all other diabetic residents, no others were found</p>	08/21/2015

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	<p>were not limited to, diabetes.</p> <p>The 7/22/15 diabetic care plan for Resident #1 indicated an intervention was to monitor fingerstick blood sugars.</p> <p>The July, 2015 Physician's Orders for Resident #1 indicated sliding scale Novolog (insulin) to be administered for blood sugar readings as follows:</p> <p>201-250 = 4 Units 251-300 = 6 Units 301-350 = 8 Units >351 = Call MD</p> <p>The July, 2015 Fingerstick Record for Resident #1 indicated the following blood sugar readings:</p> <p>7/2/15 @ 4:00 p.m. - 397 7/4/15 @ 4:00 p.m. - 366 7/17/15 @ 4:00 p.m. - 392 7/20/15 @ 4:00 p.m. - 359 7/22/15 @ 4:00 p.m. - 357</p> <p>There was no information in the clinical record to indicate the physician was notified of the 5 blood sugar readings over 351 in the month of July, 2015.</p> <p>An interview was conducted with the Director of Nursing on 7/24/15 at 9:58 a.m. She indicated the facility had no</p>		<p>to be affected. An inservice will be given to all licensed nurses on the proper coordination of the finger stick book and the medication administration record.</p> <p>The sliding scale will no longer be placed on the finger stick sheet. It will only be placed on the medication administration record. This will decrease the potential for mistakes. All out of range blood sugars will be placed in the 24 Hour Book on a monitoring sheet to be checked Monday thru Friday by the D.O.N. and by the charge nurse on weekends. This will be monitored daily for accuracy and physician notification, if warranted. This will ensure that all sliding scales will be followed correctly. This will be a continuous process.</p>	

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F 0329 SS=D Bldg. 00	<p>verification of physician notification of Resident #1's five out of range blood sugar readings in July, 2015.</p> <p>3.1-5(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to administer insulin as ordered and follow up on mental health recommendations for 2 of 6 residents whose medications were reviewed. (Resident #1 and #33)</p>	F 0329	The records for all diabetic residents receiving insulin were reviewed for sliding scale intervention and M.D. notification. Resident # 1's record was immediately reviewed with the doctor and the sliding scale record and order was clarified. All diabetic residents had the	08/21/2015

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	<p>Findings include:</p> <p>1. a) The clinical record for Resident #1 was reviewed on 7/20/15 at 2:00 p.m. The diagnoses for Resident #1 included, but were not limited to, diabetes.</p> <p>The 7/22/15 diabetic care plan for Resident #1 indicated an intervention was to administer medications as ordered.</p> <p>The July, 2015 Physician's Orders for Resident #1 indicated sliding scale Novolog (insulin) to be administered for blood sugar readings as follows:</p> <p>201-250 = 4 Units 251-300 = 6 Units 301-350 = 8 Units >351 = Call MD</p> <p>The July, 2015 Fingertstick Record for Resident #1 indicated the following blood sugar readings and administrations of insulin on the following dates and times:</p> <p>7/2/15 @ 4:00 p.m. - 397, 10 Units 7/4/15 @ 4:00 p.m. - 366, 10 Units 7/17/15 @ 4:00 p.m. - 392, 10 Units 7/20/15 @ 4:00 p.m. - 359, 10 Units 7/22/15 @ 4:00 p.m. - 357, 10 Units</p> <p>There was no information in the clinical</p>		<p>potential to be affected by this deficient practice. After chart audits of all other diabetic residents, no others were found to be affected. An inservice will be given to all licensed nurses on the proper coordination of the finger stick book and the medication administration record. This will be monitored monthly by a nurse and the D.O.N. The D.O.N. will ensure that all finger stick records and the medication review record will always be accurate. Residents #'s 1 and 33's recommendations were faxed to the M.D. Orders were received and immediately followed. All mental health and pharmacy recommendations were audited by the charge nurse, D.O.N., and Social Services Director. All residents had the potential to be affected by this deficient practice. After the audits, no others were found to be affected. The facility scheduled a meeting with the pharmacy and the mental health consultants. A plan was put in place where the pharmacy will send their recommendations at the end of the month. These recommendations will be sent specifically to the "attention of the D.O.N." The mental health consultant will give their recommendations directly to the D.O.N. and the Social Services Director to ensure that all recommendations are followed up on in a timely manner. This will</p>		

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	<p>record to indicate an order was received to administer 10 Units of insulin for the above 5 blood sugar readings over 351.</p> <p>An interview was conducted with LPN #1 on 7/23/15 at 11:01 a.m. She reviewed the July, 2015 physician's orders for Resident #1, could not find an order for administration of the 10 Units of insulin, and called the physician at this time.</p> <p>1. b) The clinical record for Resident #1 was reviewed on 7/20/15 at 2:00 p.m. The diagnoses for Resident #1 included, but were not limited to, schizophrenia and delusions.</p> <p>The July, 2015 Physician's Orders for Resident #1 indicated the use of Haloperidol (generic Haldol-antipsychotic medication) daily effective 4/17/15 and Temazepam (hypnotic medication) daily effective 4/29/15.</p> <p>The 6/5/15 mental health consultation note indicated, "Recommendation: Monitor for side effects. Consider discontinue Haldol, in light of stable condition; consider D/D (sic) temazepam in light of avoiding benzos (benzodiazepines) in elderly; staff reports no problems with sleep."</p>		<p>be monitored by the D.O.N. and the Social Services Director on a monthly basis. A Physician Call Order Sheet will be placed in the 24 hour Report Book. This sheet will be used for blood sugar call orders only. Any out of range blood sugars above the sliding scale that require a call to the physician will be placed on this monitoring sheet with the MD notification, time, and date. This will also be documented in the resident's chart. This will be monitored Monday thru Friday by the D.O.N. and on weekends by the charge nurse. This will be an ongoing process.</p>	

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	<p>There was no information in the clinical record to indicate the above recommendation to consider a discontinuation of Haldol or a discontinuation of temazepam was addressed.</p> <p>An interview was conducted with LPN #1 on 7/23/15 at 11:01 a.m. She called Resident #1's physician at this time, indicated there would be no changes to Resident #1's Haldol or Temazepam, and it was her responsibility to act on the recommendations.</p> <p>2. The clinical record for Resident #33 was reviewed on 7/20/15 at 1:30 p.m. The diagnoses for Resident #33 included, but were not limited to, schizophrenia and dementia with agitation.</p> <p>The 7/14/15 mental health consultation note indicated, "Today (name of Resident #33) appears anxious, restless. Staff reports frequent episodes of agitation, aggression and other acting out behaviors towards staff and other residents. Exacerbation last week, (name of mental health staffperson) care coordinator OAS was present....Psych meds: Zyprexa 7.5 in morning and 20 mg evening; Depakote 500 mg twice daily; Remeron 15 mg nightly....Assessment: schizophrenia,</p>			

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	<p>paranoid type; dementia with agitation; depressive disorder. Continued episodes of agitation and aggression towards staff and other patients. Recommendation: ...Consider increase zyprexa as GDR (gradual dose reduction) may be contributing to continued aggressive behaviors. Monitor for side effects. Also, consider gabapentin as episodes may be associated with varying levels of anxiety."</p> <p>There was no information in the clinical record to indicate the above recommendation to increase Zyprexa or to start Gabapentin was addressed.</p> <p>An interview was conducted with LPN #1 on 7/22/15 at 11:10 a.m. She indicated she did not recall talking to the physician about the Zyprexa or Gabapentin recommendations. LPN #1 called the physician's office at this time.</p> <p>An order, dated 7/22/15, 1:15 p.m., for Resident #33 indicated Gabapentin 300 mg daily for one week, then twice daily.</p> <p>An order, dated 7/22/15, 2:00 p.m., for Resident #33 indicated, "Leave Zyprexa as is. Will see how Gabapentin works."</p> <p>The Consultant's Recommendation policy was provided by the Social Services</p>			

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F 0431 SS=D Bldg. 00	<p>Director on 7/23/15 at 2:29 p.m. It indicated, "All recommendations will be faxed to the Medical Director for approval or disapproval....When there is a "no change per doctor", it will be written on the recommendation. Orders will read "no changes at this time."</p> <p>3.1-48(a)(4)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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</p>			

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	<p>Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired insulin was discarded prior to administration. This had the potential to affect 1 of 6 residents receiving insulin from South Hall Medication Cart. (Resident #26)</p> <p>Findings include:</p> <p>During an observation of the South Hall Medication Cart with LPN #1, on 7/23/15 at 2:50 p.m., a vial of Humalog 100 units/ml (milliliters) for Resident #26 was observed with an open date of 6/21/15.</p> <p>During an interview with LPN #1, on 7/23/15 at 2:55 p.m., LPN #1 indicated she thought insulin expired after 30 days from when it was opened. LPN #1 further indicated she used the Humalog for Resident #26 that morning.</p> <p>A Physician's Order, dated 2/13/15, indicated the following sliding scale for Humalog to administered, as needed: 201-255=2 units, 251-300=4 units,</p>	F 0431	<p>All insulin was checked for expiration dates. All outdated insulin was immediately removed and destroyed. All diabetic residents had the potential to be affected by this deficient practice. After review, no others were found to be affected. The Administrator updated the Insulin Policy. The new policy states that all insulin will be given an open and expiration date. The expiration date is 28 days after it is first opened. It also reminds all nurses to always check the opening and expiration dates before administering insulin. The D.O.N. will give an inservice covering the new insulin policy. A copy of the updated policy was placed on each diabetic resident's medication administration record. All insulin will be dated with an open and expiration date. A calendar is placed on the medication administration record to ensure proper dating. The insulin will be checked daily by the incoming and outgoing nurse to ensure that it has been dated correctly and all expired insulin has been discarded. An insulin daily check sheet will be placed on the medication administration record that will</p>	08/21/2015

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F 0465 SS=D Bldg. 00	<p>301-350=6 units, & 351-400=8 units.</p> <p>A Fingerstick Record indicated Resident #26 had a blood sugar level of 277 and 2 units of Humalog was administered on 7/23/15.</p> <p>The MAR (medication administration record) for Resident #26 indicated Humalog was administered on 7/23/15.</p> <p>A policy titled, "Policy & Insulin" [sic], no date, was received from the Social Services Director, on 7/24/15 at 9:38 a.m. The policy indicated, "...2. [insulin] will be discarded after 28 days."</p> <p>3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure wheelchairs were maintained in proper condition for 3 of 3 residents randomly observed. (Resident #1, #11 & #16)</p> <p>Findings include:</p>	F 0465	<p>require the initials of both nurses verifying that they have completed the insulin check. The D.O.N. will monitor the insulin daily check sheet to ensure that the process of checking the insulin is being done properly. This will be done on a continuous basis.</p> <p>All wheelchairs were checked for those in need of repair. Resident #'s 1, 11, & 16's wheelchairs were repaired or replaced. All other wheelchairs that required repair were fixed. Those that were beyond repair were replaced. All residents in wheelchairs had the</p>	08/21/2015

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	<p>During the following observations, Resident #11's wheelchair was missing the left arm cushion with the metal bar and a metal screw exposed, while the right arm cushion was missing stuffing and was worn down with threads exposed: 7/20/15 at 12:58 p.m., 7/20/15 at 1:40 p.m., 7/22/15 at 8:43 a.m., & 7/23/15 at 9:17 a.m.</p> <p>During an interview with Resident #11 at 1:40 p.m., on 7/20/15, Resident #11 indicated his left wheelchair arm cushion had been missing for about a week.</p> <p>A Quarterly MDS (minimum data set) assessment indicated Resident #11 had a BIMS (brief interview of mental status) of 9, which was indicative of mild cognitive impairment but interviewable.</p> <p>On 7/23/15 at 9:17 a.m., the Director of Nursing (DoN) indicated she was not aware of Resident #11's missing arm cushion and she further indicated she will just replace the wheelchair since the facility had a few extra wheelchairs available. The DoN indicated the process for maintenance issues was for staff to let Maintenance know about concerns and Maintenance will resolve/repair the</p>		<p>potential to be affected by this deficient practice. All wheelchairs that required repair were immediately fixed. Those that were beyond repair were replaced. The Administrator worked with the Maintenance Supervisor to identify equipment or furniture that was in need of repair. The Administrator created a new Work Order form. The Administrator and Maintenance Supervisor will do a monthly inspection of all furniture and equipment. Any repairs needed will be identified and fixed. All staff have been notified to constantly check for wheelchairs that are in disrepair. They are to notify the Maintenance Supervisor immediately of any wheelchairs that need to be repaired or replaced. If the Maintenance Supervisor is not in the building, they are to record the wheelchair in need of repair in the wheelchair repair order book that will be kept at the nurse's station. All wheelchairs will also be washed on a weekly basis by the night shift. Any wheelchairs found to be in need of repair during cleaning will be reported to the charge nurse. The charge nurse will note any wheelchairs that require repair in the wheelchair repair order book. The Maintenance Supervisor will check this repair book and repair or replace any wheelchairs that have been listed on a daily basis. This will be monitored</p>	

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	<p>concern.</p> <p>During an interview with the Maintenance Director, on 7/23/15 at 2:21 p.m., the Maintenance Director indicated he does not have proactive inspection schedule for wheelchairs.</p> <p>A policy titled, Maintenance Policy, no date, was received from the Maintenance Director, on 7/23/15 at 2:30 p.m. The policy indicated, "...5. Preventative Maintenance Programs shall include the periodic inspection, general maintenance procedures and repair or replacement of at least the following:...b. All Facility equipment c. Resident room and public area furniture and fixtures....10. The department shall maintain all equipment and supplies in a safe and operating condition...."</p> <p>A list of wheelchair replacements, no date, was received from the DoN, on 7/23/15 at 2:55 p.m. The list indicated Resident #11 received a new wheelchair on 7/23/15.</p> <p>The DoN indicated, on 7/24/15 at 9:38 a.m., that all residents on the list of wheelchair replacements needed new wheelchairs because there was an issue/concern with missing/worn wheelchair arms.</p>		<p>monthly by the Administrator and daily by the Maintenance Supervisor. The Administrator will also keep a monthly log of all equipment and furniture requiring repair.</p>	

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F 0502 SS=D Bldg. 00	<p>An observation was made on 7/20/15 at 1:00 p.m., of Resident #1's wheelchair. The right arm's material was torn and had no stuffing.</p> <p>An observation was made on 7/21/15 at 9:52 a.m., of Resident #16's wheelchair. The left arm's material covering was torn with the cushion exposed, and the right arm consisted of a metal bar with no cushion or material covering.</p> <p>An observation was made on 7/23/15 at 9:38 a.m., of Resident #16's wheelchair. The left arm's material covering was torn with the cushion exposed, and the right arm consisted of a metal bar with no cushion or material covering.</p> <p>During an Environmental tour with the Maintenance Director an interview was conducted on 7/23/15 at 1:00 p.m. He indicated he receives verbal notification from the staff when there is a concern with a resident's assistive device.</p> <p>3.1-19(f) 483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review,</p>	F 0502	Residents #'s 1 and 33's charts were audited and missing labs	08/21/2015

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	<p>the facility failed to ensure lab draws were performed as ordered and performed timely for 2 of 5 residents reviewed for labs. (Resident #1 and #6)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #6 was reviewed on 7/21/15/15 at 2:15 p.m. The diagnoses for Resident #6 included, but were not limited to, bipolar, dementia with psychosis, insomnia, and seizures.</p> <p>The July 2015 Physician's Orders indicated an order for a phenobarbital level (lab to ensure phenobarbital [anti-seizure medication] was at a therapeutic level) every 6 months (no date) and an order for Primidone 50 mg (milligrams) to be given daily, which was initiated on 4/16/13.</p> <p>A Physician Progress Note, dated 6/13/14, indicated the note, "...2/15/14- [name of pharmacy] requests monitoring phenobarbital levels nows [sic] and q 6 mo [every 6 months] due to pt [patient] on Primidone, & med [medication] is metabolized into phenobarbital...." The Progress Note indicated this recommendation became an order on 3/24/14.</p> <p>A phenobarbital lab draw, dated 9/17/14,</p>		<p>were obtained. All other resident's charts were audited for missing labs. No others were found. All residents had the potential to be affected by this deficient practice. After all charts were audited, no other missing labs were found. The D.O.N. scheduled an inservice with one of the lab consultants. The lab consultant came to the facility and updated all nurses over the proper input of labs into the computer. The inservice covered how to identify expiring labs, the proper input of new labs, and how to check for quarterly and bi-annual labs. A follow up inservice will be given at a later date by the lab consultant to reiterate the procedures covered in the first inservice. A new audit sheet was created by the D.O.N. to audit labs and ensure that lab draws are being performed as ordered. The D.O.N. and charge nurse will monitor this audit sheet weekly for two months, then bi-weekly for two months, and then monthly on a continuous basis. This will be used in conjunction with the expiring lab reports that is printed out of the computer on a monthly basis. This new audit sheet will be placed in each resident's chart.</p>	

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	<p>was located in the chart. No other phenobarbital labs were located in the clinical record.</p> <p>During an interview with the Director of Nursing (DON), on 7/22/15 at 3:05 p.m., the DON indicated the lab was not done as ordered and the phenobarbital lab will be ordered that day.</p> <p>2. The clinical record for Resident #33 was reviewed on 7/20/15 at 1:30 p.m. The diagnoses for Resident #33 included, but were not limited to, schizophrenia and dementia with agitation.</p> <p>The 7/14/15 mental health consultation note indicated, "Today (name of Resident #33) appears anxious, restless. Staff reports frequent episodes of agitation, aggression and other acting out behaviors towards staff and other residents. Exacerbation last week, (name of mental health staffperson) care coordinator OAS was present....Psych meds: Zyprexa 7.5 in morning and 20 mg evening; Depakote 500 mg twice daily; Remeron 15 mg nightly....Assessment: schizophrenia, paranoid type; dementia with agitation; depressive disorder. Continued episodes of agitation and aggression towards staff and other patients. Recommendation: Obtain depakote level, and CBC (complete blood count) with diff (differential)..."</p>			

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	<p>The 7/16/15 lab results for Resident #33 indicated, "Test Name(s) CBC, VALP (valproic acid/depakote) Unable to obtain -1st attempt. Unable to obtain specimen-1st attempt. The phlebotomist was unable to obtain an adequate sample for testing. A second phlebotomist will be sent. Thank you. Lab will redraw (date): 7/16/15"</p> <p>There was no further information in the clinical record to indicate the lab came back for a second attempt or that the facility contacted the lab to address them not coming back.</p> <p>An interview was conducted with LPN #1 on 7/22/15 at 11:10 a.m. She indicated the lab could not get the specimen, so she called the lab on this day (7/22/15), and they were going to come out on this day (7/22/15) and do the labs. She indicated she didn't know why they didn't come back on 7/16/15.</p> <p>The Laboratory and Radiological Services policy was provided by the Social Services Director on 7/23/15 at 2:29 p.m. It indicated, "Services provided must be both accurate and timely. Timely means that laboratory tests are completed and results are provided to the facility (or resident's</p>			

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	physician) within timeframes normal for appropriate intervention." 3.1-49(a)				