

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155448	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2016
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NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 25, 26, 27, 28, 29, &amp; May 2</p> <p>Facility number: 000361 Provider number: 155448 AIM number: 100266340</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 10 Medicaid: 54 Other: 10 Total: 74</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 5/5/16.</p>	F 0000	<p><b>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after June 1, 2016.</b></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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F 0241 SS=E Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents' dignity was maintained during lunch dining services related to dependent residents not assisted with eating in a timely manner. (Resident's #103, #101, #59, #44, #70 and #68)</p> <p>Finding includes:</p> <p>On 4/26/16 in the main dining room, the following was observed during lunch meal service:</p> <p>Table 1 had four dependent residents who needed assistance with eating. Their lunch trays were delivered to the table at 12:30 p.m. Two of the four residents were assisted with eating at the time. The other two residents, Resident #103 and Resident #101, sat at the table with their lunch trays in front of them and</p>	F 0241	<p><b>F241 – Dignity and Respect of Individuality</b></p> <p>It is the practice of this provider to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Residents #103, #101, #59, #44, #70 and #68 – physician and family have been updated regarding each resident's current status. These residents experienced no negative psychosocial reaction or outcome related to this finding. Resident dignity is being maintained during meal service and residents are being served and assisted with eating in a timely manner.</p> <p><b>How other residents having</b></p>	06/01/2016

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	<p>were not assisted with eating until 12:40 p.m.</p> <p>Table 2 had four dependent residents who needed assistance with eating. Their lunch trays were delivered to the table at 12:32 p.m. Two of the four residents were assisted with eating at the time. The other two residents, Resident #44 and Resident #59, sat at the table with their lunch trays in front of them and were not assisted with eating until 12:38 p.m.</p> <p>Table 3 had four dependent residents who needed assistance with eating. Their lunch trays were delivered to the table at 12:36 p.m. Two of the four residents were assisted with eating at the time. The other two residents, Resident #70 and Resident #68, sat at the table with their lunch trays in front of them. Resident #70 was assisted with eating at 12:41 p.m. and Resident #68 was assisted with eating at 12:44 p.m.</p> <p>The record for Resident #103 was reviewed on 4/27/16 at 1:03 p.m. The resident's diagnoses included, but were not limited to, dementia and weakness. The 5 day MDS (Minimum Data Set) assessment dated 4/26/16 indicated the resident was cognitively impaired.</p>		<p><b>thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken:</b></p> <p>Anyresident who requires assist with ADLs such as eating, has the potential to beaffected by this finding and will be identified using the Mealtime Checklist Auditin the main dining room. Completion ofthis Mealtime Checklist Audit will ensure resident dignity is maintained duringmeal service, resident meals are being served timely and residents requiringassistance for eating are assisted in a timely manner after the tray is served. Changes and needed adjustments in the seatingchart in the dining room will be evaluated by the IDT during the daily clinicalmeeting, weekly during the Nutritional At Risk Meeting and during daily mealservice observations. This will ensurethat any resident requiring a need for assistance with eating is seated at anappropriate location to receive the required assistance for meals. An all staff in-service will be conducted onor before 6/1/16. This in-service willinclude review of the facility policy related to resident dignity in the diningroom during meal service and the importance of serving trays and assistingresidents with eating as soon as the meal is served.</p> <p><b>What measures will be put intoplace or what systemic</b></p>	

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	<p>The record for Resident #101 was reviewed on 4/27/16 at 1:03 p.m. The resident's diagnoses included, but were not limited to, dementia. The resident was admitted on 4/22/16.</p> <p>The record for Resident #44 was reviewed on 4/27/16 at 1:03 p.m. The resident's diagnoses included, but were not limited to, dementia. The Quarterly MDS dated 2/4/16, indicated the resident was cognitively impaired and was a one person assist with eating.</p> <p>The record for Resident #59 was reviewed on 4/27/16 at 1:03 p.m. The resident's diagnoses included, but were limited to, Alzheimer's disease and dementia. The Quarterly MDS dated 3/17/16, indicated the resident was cognitively impaired and was a one person assist with eating.</p> <p>The record for Resident #70 was reviewed on 4/27/16 at 1:03 p.m. The resident's diagnoses included, but were limited to, dementia. The Significant Change MDS dated 3/24/16, indicated the resident was cognitively impaired and was a one person assist with eating.</p> <p>The record for Resident #68 was reviewed on 4/27/16 at 1:03 p.m. The resident's diagnoses included, but were</p>		<p><b>changes will be made to ensure that the deficient practice does not recur:</b></p> <p>An allstaff in-service will be conducted on or before 6/1/16. The DNS/designee will be responsible for conducting this in-service. This in-service will include review of the facility policy related to resident dignity in the dining room during meal service and the importance of serving trays and assisting residents with eating in a timely manner after the tray is served. Changes and needed adjustments in the seating chart in the dining room will be evaluated by the IDT during the daily clinical meeting, weekly during the Nutritional At Risk Meeting and during daily meal service observations. This will ensure that any resident requiring a need for assistance with eating is seated at an appropriate location to receive the required assistance for meals.</p> <p><b>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:</b></p> <p>To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit tool titled, "Meal Observation Checklist" daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed.</p>		

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F 0431 SS=D Bldg. 00	<p>limited to, Alzheimer's disease and Parkinson's disease. The Quarterly MDS dated 4/5/16, indicated the resident was cognitively impaired and was dependant on someone else for eating.</p> <p>Interview with the Dietary Manger on 4/26/16 at 1:40 p.m., indicated Resident #103 needed assistance with eating due to low food intakes.</p> <p>Interview with the Dietary Manager on 4/26/16 at 1:40 p.m., indicated Resident #101 needed cueing with eating.</p> <p>Interview with the Dietary Manager on 4/26/16 at 1:40 p.m., indicated her goal was to have two residents that needed assistance with eating and two residents that just needed cueing at each table.</p> <p>3.1-3(t)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug</p>		<p>Findings will besubmitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic changes will be completed:</b> ComplianceDate: 6/1/16.</p>		

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	<p>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 dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an expired insulin vial was not in use and another vial of insulin was labeled with an open date for 2 of 4 medication carts observed. (North First Floor and North Third Floor Medication Carts)</p> <p>Findings include:</p> <p>1. During the First Floor North</p>	F 0431	<p><b>F431 – Drug Records, Label/Store Drugs &amp; Biologicals</b></p> <p>It is the practice of this provider that all drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been</b></p>	06/01/2016

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	<p>Medication Cart observation on 5/2/16 at 9:45 a.m., the following was observed:</p> <p>Resident #74 had two open vials of Novolog (insulin), one had an open date of 3/1/16 and the other vial with an open date of 3/23/16.</p> <p>Interview with the Director of Nursing (DON) on 5/2/16 at 9:45 a.m. indicated Novolog, once opened, expired in 28 days, the nurse should have used a new vial of insulin.</p> <p>2. During the Third Floor North Medication Cart observation on 5/2/16 at 9:30 a.m., the following was observed:</p> <p>Resident #61's open Levemir (insulin), was not labeled with an open date. The insulin was delivered from the pharmacy on 3/15/16.</p> <p>Interview with the DON on 5/2/16 at 9:47 a.m., indicated Levemir, once opened is usable for 42 days and the nurse should have labeled the vial with an open date.</p> <p>The policy titled "Pharmacy-Medication Requiring Special Storage" provided by the DON on 5/2/16 at 10:15 a.m. and deemed as current, indicated "...Levemir ...expires 42 days after opening</p>		<p><b>affected by the deficient practice:</b></p> <p>Resident#74– The opened vials of NovologRegular Insulin identified during the survey was discarded. A new vial was obtained and properlylabeled. Physician and family wereupdated regarding this resident's status.</p> <p>Resident#61 – The opened vial of Lememir Insulin identified during the survey wasdiscarded. A new vial was obtained andproperly labeled. Physician and familywere updated regarding this resident's status.</p> <p><b>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken:</b></p> <p>Allresidents who receive insulin have the potential to be affected by thisfinding. The DNS/designee will completean inspection of all medication rooms, medication room refrigerators andmedication carts to ensure that any opened multi-dose vials of medications haveappropriate date opened stickers in place and are within the drug expirationdate per manufacturer's recommendations. Any expired medications will be destroyed and/or discardedimmediately. In addition, the DNS/designeewill be responsible for facility wide weekly medication</p>		

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	<p>...Novolog ...expires 28 days after opening ...."</p> <p>3.1-25(j)(k)</p>		<p>cart/room/refrigerator inspections. This will ensure that all medications are within the drug expiration date per manufacturer's recommendations. A mandatory nursing in-service will be conducted by the DNS/designee on or before 6/1/16. This in-service will include review of the facility policy related to use of multi-dose vial medications such as insulin. Nursing staff will be re-educated regarding applying a date opened sticker on all multi-dose vials of medications and the importance of checking expiration dates prior to administration of any medication.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The DNS/designee will be responsible for facility wide weekly medication cart/room/refrigerator inspections. A mandatory nursing in-service will be conducted by the DNS/designee on or before 6/1/16. This in-service will include review of the facility policy related to use of multi-dose vial medications such as insulin. Nursing staff will be re-educated regarding applying a date opened sticker on all multi-dose vials of medications and the importance of checking expiration dates prior to administration of any</p>	

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F 0465 SS=B Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain an environment that was safe, clean and in a state of good repair, related to brown discolorations in the sinks, a hole in the floor and gouged walls. (100 and 300 Units)</p> <p>Findings include: During the Environmental Tour on 4/28/16 from 10:45 a.m. through 11:00 a.m. with the Maintenance Supervisor, the Housekeeping/Laundry Supervisor</p>	F 0465	<p>medication.</p> <p><b>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:</b> To ensure ongoing compliance with this corrective action, the DNS/SSD/designee will be responsible for completion of the CQI Audit Tool, "Medication Storage Review" daily for 3 weeks, weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic changes will be completed:</b> Compliance Date: 6/1/16.</p> <p><b>F465 -Safe/Functional/Sanitary/Comfortable Environment</b> It is the practice of this provider to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Rm#122 -the entryway door</p>	06/01/2016	

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	<p>and the Executive Director, the following was observed:</p> <p>1. 100 Unit:</p> <p>a. In Room # 122, the entryway door frame had chipped paint, the baseboard near the bathroom had a hole in the wall and the cable faceplate was detached from the wall. There were two residents who resided in this room.</p> <p>b. In Room #124, the bathroom sink drain and faucet handles had a brown discoloration. There were four residents who shared this bathroom.</p> <p>c. In Room #125, the bathroom door frame had chipped paint. There were two residents who shared this bathroom.</p> <p>2. 300 Unit:</p> <p>a. In Room #301, there was a hole in the floor near the air/heating unit. There were two residents who resided in this room.</p> <p>b. In Room #302, the bathroom wall above the baseboard was gouged. There were four residents who shared this bathroom.</p> <p>c. In Room 324, the bathroom sink drain had a brown discoloration. There were four residents who shared this bathroom.</p> <p>Interview with the Maintenance Supervisor at the end of the tour, agreed the above was in need of repair or to be cleaned.</p>		<p>frame has been repainted, the hole in the wall in the baseboard near the bathroom has been repaired and the cable faceplate has been re-attached to the wall.</p> <p>Rm#124 –the brown discoloration in the bathroom sink drain and faucet handles has been removed.</p> <p>Rm#125 –the bathroom door frame has been repainted.</p> <p>Rm#301 –the hole in the floor near the air/heating unit has been repaired.</p> <p>Rm#302 –the bathroom wall above the baseboard has been repaired.</p> <p>Rm#324 –the brown discoloration in the bathroom sink drain has been removed</p> <p><b>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:</b></p> <p>All residents have the potential to be affected by this finding. All resident rooms, bathrooms and bathing areas have been observed for the items listed above and all repairs were made where needed. In addition, the facility will conduct Environmental Inspections daily through the Customer Care Program. These Environmental Inspections will include inspections/observations of resident rooms and bathrooms such as walls, baseboards, and</p>				

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	3.1-19(f)		<p>bathroom sinks and fixtures in need of repair. Any environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Request issues to ensure all necessary repairs and corrections have been completed. A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 6/1/16. This in-service will include review of the facility policy related to notification to the Maintenance Department and Housekeeping Department for housekeeping issues, repairs or maintenance needs and the importance of maintaining a safe/functional/sanitary/comfortable environment.</p> <p><b>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 6/1/16. This in-service will include review of the facility policy related to notification to the Maintenance Department for repairs or</p>	

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			<p>maintenance needs and the importance of maintaining a safe/functional/sanitary/comfortable environment. Environmental Inspections will be conducted daily through the Customer Care Program. These Environmental Inspections will include inspections/observations of resident rooms and bathrooms such as walls, baseboards, and bathroom sinks and fixtures in need of repair. Any environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Request issues to ensure all necessary repairs and corrections have been completed.</p> <p><b>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:</b></p> <p>To ensure ongoing compliance with this corrective action and to ensure the environment is safe/functional/sanitary and comfortable, the ED/DNS/designee will be responsible for directing the Environmental Inspections Audit daily for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155448	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2016
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356		
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			submitted to the CQI Committee for review and followup. <b>By what date the systemic changes will be completed:</b> ComplianceDate: 6/1/16.		