

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2016
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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00198643.</p> <p>Complaint IN00198643-Substantiated. Federal/State deficiency related to the allegation was cited at F312.</p> <p>Survey dates: July 6, 7, 8, 11, 12, 13 and 14, 2016</p> <p>Facility number: 000074 Provider number: 155154 AIM number: 100290050</p> <p>Census bed type: SNF: 10 SNF/NF: 92 Total: 102</p> <p>Census payor type: Medicare: 15 Medicaid: 75 Other: 12 Total: 102</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. This facility requests paper compliance for the deficiencies cited.	
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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 0159 SS=D Bldg. 00	<p>Quality review was completed by 21662 on July 20, 2016.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>			

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	<p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to provide a resident access to personal funds when requested for 1 of 1 resident reviewed for personal funds (Resident 94).</p> <p>Finding includes:</p> <p>On 07/06/2016 at 12:10 a.m., a sign posted at the reception desk of the facility indicated, "RESIDENT TRUST FUND OPERATING HOURS" was observed. The sign indicated, "...Monday - Friday 9 am - 4 pm...Saturday and Sunday 10 am - 1 pm. *all changes in operating hours will be announced in advance."</p> <p>During an interview, on 07/06/2016 at 10:40 a.m., a family member of Resident #94 indicated the resident was unable to access any money from her account after</p>	F 0159	<p>1.An envelope with money was placed in the 2ndfloor nurse's cart for off hours banking.</p> <p>2.All residents have the potential to be affectedby this alleged deficient practice.</p> <p>3.Resident Council was informed of the new bankingprocedure on 7/13/16. Nursing staff will be inserviced on 8/2/16. Families willbe notified of this new procedure via letter.</p> <p>4.Business Office Manager/Designee will collectmoney Monday-Friday and replenish finds during this time. Nurse will sign offon log that funds have been received. Any concerns will be discussed in QAmoonthly thereafter times twelve months.</p>	08/13/2016

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	<p>business hours posted by the facility.</p> <p>During an interview, on 07/13/2016 at 10:12 a.m., the Business Office Manager (BOM) indicated there was no one available to retrieve money from the resident accounts after hours. At that time, a representative from the facility corporate office indicated there was a box located in a nurses cart for the residents to access money after hours. She indicated the Executive Director (ED) would have known more about the amount of money in the box for the facility. The BOM indicated she had not been providing money from the business office to the nurses cart for resident use for two months.</p> <p>During an interview, on 07/13/2016 at 1:21 p.m., the ED indicated there should be an envelope of twenty dollars or less in the second floor nurses medicine cart for the residents to utilize after hours. She indicated she was unaware the BOM had not made money available for the residents to use after hours.</p> <p>3.1-6(f)(1)</p>			

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F 0167 SS=C Bldg. 00	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure the signage was posted in a prominent area to indicate where the survey result book was located. This deficient practice had the potential to affect 102 of 102 residents residing in the facility.</p> <p>Finding includes:</p> <p>During the initial facility tour on 7/6/16 at 9:42 a.m., the sign to notify residents and visitors where the survey result book was located was not found.</p> <p>During an interview on 7/6/16 at 11:06 a.m., the Executive Director indicated she did not have a sign indicating where the survey book could be located.</p> <p>3.1-3(b)(1)</p>	F 0167	<p>1.The survey book is located on a table near the facility's main entrance. A sign indicating this location was placed at the first and 2nd floor elevators and at the Dementia Unit nurse's station.</p> <p>2.All residents have the potential to be affected by this alleged deficient practice.</p> <p>3.Resident Council was notified of the location of the survey book on 7/13/16. Staff will be inserviced on the location of the survey book on 8/2/16.</p> <p>4.Executive Director/Designee will audit proper signage five days a week for four weeks and quarterly times twelve months. Concerns and results will be brought to QA monthly times twelve months.</p>	08/13/2016	

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F 0223 SS=D Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on observation, interview and record review, the facility failed to prevent mistreatment of a resident with dementia for 1 of 1 resident reviewed for abuse (Resident #168).</p> <p>Finding includes:</p> <p>On 07/14/2016, the following observations were made:</p> <p>At 9:47 a.m., Resident #168 was sitting in a blue Geri-chair in her room. Home Health CNA #9, who was privately contracted from (Name of the Home Health Company) by the resident's family as a private sitter was sitting in a chair beside her. The resident had a gait belt around her waist and the loose end of the gait belt was wrapped around the right hand of CNA #9. When CNA #9 was asked about the use of the gait belt for the resident, while she was sitting in her chair and why she was holding the end of</p>	F 0223	<p>1. At the time of the event, resident's safety was ensured and Home Health Aide 9 was suspended and escorted out of the facility. Investigation was initiated - skin assessment on the resident was completed and was assessed for any psychosocial concerns/needs. Director of Nursing Services contacted the Home Health Care Clinical Director and notified her of the situation. Resident 168 no longer resides in this facility.</p> <p>2. All residents who require one-one supervision from outside caregivers would have the potential to be affected by the alleged deficient practice. No other residents were affected by this alleged deficient practice.</p> <p>3. Staff to be re-educated on the abuse prohibition, reporting, and investigation policy on 8/2/16. Director of Nursing Services/Designee will meet with outside company representative of families' choice prior to one-one services being provided to discuss expectations, resident specific</p>	08/13/2016
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	<p>the gait belt in her hand she indicated, "You know she gets up out of this chair, you see the gashes on her legs? This is the only way to keep her put."</p> <p>The Director of Nursing Services (DNS) was notified immediately and was asked to come to the resident's room to observe the situation. The DNS observed the resident and immediately removed the gait belt. CNA #9 indicated at that time, the resident "came to her that way." The DNS indicated she had observed RN #5 ambulating with the resident earlier that morning and was using a gait belt. The DNS indicated she did not know why RN #5 did not take off the gait belt when the resident was placed in her chair.</p> <p>During an interview on 7/14/16 at 10:23 a.m., RN #5 indicated she was asked by CNA #9 to give her a break between 8:00 a.m. and 8:30 a.m. She indicated at that time, she observed the gait belt was on the resident's waist as she sat in her chair. RN #5 indicated she transported the resident in her chair into the nurse's station. She indicated the resident became restless and she took the resident on a walk in the hallway and used the gait belt. RN #5 indicated at approximately 9:00 a.m., CNA #9 returned from her break and RN #5 took the resident back to her room, removed the gait belt and</p>		<p>plans of care, and the facility's abuse policy.</p> <p>4. Director of Nursing Services/Designee will complete an Abuse Prohibition and Investigation audit tool weekly for onemonth, monthly for three months, and then quarterly times two. Results will bediscussed in QA monthly times twelve months.</p>	

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F 0242 SS=D Bldg. 00	<p>placed it on the mattress and left the resident in her room in the care of CNA #9.</p> <p>On 7/14/2016 at 1:30 p.m., the resident's medical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavioral disturbance, Lewy body disease very likely, anxiety disorder and pain.</p> <p>3.1-27(a)(1) 3.1-27(a)(4)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure a resident's preference was met and showers were given per her choice for 1 of 3 residents</p>	F 0242	1.Resident 120 received a shower per request.Indicated on resident's, "Preferences for Customary Routine and Activities"assessment, dated	08/13/2016

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	<p>reviewed for choices (Resident #120).</p> <p>Findings include:</p> <p>During an interview on 7/8/16 at 11:13 a.m., Resident #120 indicated she got her showers on Tuesdays or Thursdays in the afternoon one time a week, but she would like to have her shower twice a week.</p> <p>During an interview on 7/14/16 at 9:48 a.m., LPN #2 indicated the second floor shower schedule listed the days residents were to receive showers. After the showers were completed, they were documented on shower sheets. The sheets were given to the nurse to sign and put into "a tray at the nurse's station." The sheets were later removed from the tray and given to medical records.</p> <p>During a review of the second floor shower schedule, the schedule list indicated Resident #120 was to receive a shower on Tuesdays and Thursdays during the afternoon.</p> <p>Shower sheets for the months of June and July 2016, indicated Resident #120 received a shower on 6/10/16, 6/21/16, and 7/5/16. Two other shower sheets were provided with no date indicating when the showers were given.</p>		<p>5/3/16, resident request one shower per week. Resident was re-interviewed on 7/26/16 and care plan and resident profile was updated to reflect current preferences for bathing. Staff education was provided onresident's new bathing preferences.</p> <p>2.All residents have the potential to be affected by this alleged deficient practice. Director of Nursing Services/Designee will re-interview all interviewable residents regarding bathing preferences. Residents' care plans and profiles will be updated accordingly.</p> <p>3.Nursing staff will be inserviced on residents rights to make choices and the importance of providing showers per their preferences. Charge nurses will be responsible for collecting shower sheets for all residents due to being bathed on that particular day. Shower sheets will be returned in weekly to the Director of Nursing Services/Designee to ensure that showers are being given per resident's preference. The "Preference for Customary Routine and Activity" assessment will be completed quarterly and care plans and profiles will be updated accordingly.</p> <p>4. Director of Nursing Services/Designee will complete an Accommodation of Needs audit tool weekly for one month, monthly for three months, and then quarterly for two months.</p>				

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F 0248 SS=D Bldg. 00	<p>During an interview on 7/14/16 at 9:45 a.m., LPN #2 indicated she was unable to locate additional shower sheets for Resident #120.</p> <p>During an interview on 7/14/16 at 4:30 p.m., the Director of Nursing Services indicated she was unable to locate a policy related to providing showers.</p> <p>3.1-3(1)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure activities were followed according to a resident's Care Plan and failed to ensure individual activity program needs were met for 1 of 2 residents reviewed for activities (Resident #96).</p> <p>Finding includes:</p> <p>On the following dates and times the</p>	F 0248	<p>Results will be discussed in QA monthly times twelve months.</p> <p>1.Resident 96 no longer resides in the facility.Care plans, activity assessments, and participation logs could not be updated.</p> <p>2.All residents have the potential to be affected by this alleged deficient practice. An audit of all resident participation logs, activity assessments (based onresident and family interview of activity preferences), and care plans will be completed by the Activity Director.</p> <p>3.Activity Consultant will</p>	08/13/2016

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	<p>following observations were made:</p> <p>On 7/7/16 at 11:23 a.m., Resident #96 was lying in bed facing his TV. The TV was playing a National Geographic channel. The volume on his TV was very low and his roommate's TV was very loud, so the resident's TV could not be heard. His eyes were closed.</p> <p>On 7/8/16 at 9:26 a.m., the resident was lying in bed facing his TV. The TV show playing was National Geographic channel and the volume was very low and his roommate's TV was loud. Resident #96's TV was barely audible.</p> <p>On 7/11/16 at 2:31 p.m., the resident was lying in bed facing his TV with the National Geographic channel playing. The volume of the TV was low and his roommate's TV was louder than the resident's TV, so the resident's TV was difficult to hear. The resident's eyes were closed.</p> <p>On 7/12/16 at 8:25 a.m., the resident was lying in bed facing the TV. The TV was playing the National Geographic channel. The volume of the resident's TV was low and his roommate's TV was louder making it difficult to hear the resident's TV.</p> <p>On 7/12/16 at 8:50 a.m., LPN #2 and</p>		<p>inservice Activity Department on the policies regarding completion of participation logs, conducting 1:1 visits, following care plans, and utilizing the activity assessments to create resident-centered activities.</p> <p>4. Activity Director/Designee will audit all participation logs five times a week for four weeks, then weekly thereafter. Results will be discussed in QA monthly times twelve months.</p>	

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	<p>CNA #4 had transferred the resident to his broda chair and he agreed to go to the resident lounge and watch TV. LPN #2 transported him to the lounge. A housekeeper had just mopped the lounge floor, so LPN #2 sat Resident #96 in the hallway in front of the half wall partition in front of the resident lounge. She indicated to him as soon as the floor was dry, she would take him inside the lounge to watch TV.</p> <p>On 7/12/16 at 9:00 a.m., a resident was brought out of the dining room and pushed into the resident lounge and placed in front of the TV. The TV was playing.</p> <p>On 7/12/16 at 9:09 a.m., a second resident was brought out of the dining room and pushed into the resident lounge and placed in front of the TV.</p> <p>On 7/12/16 at 9:10 a.m., a third resident was brought out of the dining room and pushed into the resident lounge and placed in front of the TV. An unidentified CNA who had taken the third resident into the resident lounge indicated to Resident #96 sitting in the hallway, in front of the resident lounge "Hello (Name of resident)" and she walked away from him going back into the dining room.</p>			

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	<p>On 7/12/16 at 9:11 a.m., LPN #2 and the MDS (Minimum Data Set) Coordinator pushed Resident #96 into the TV lounge at that time.</p> <p>On 7/12/16 at 3:05 p.m., the resident was lying in bed facing his TV with the National Geographic channel playing and the volume was very low. His roommate's TV was louder, making it harder to hear the resident's TV. He had his eyes closed.</p> <p>On 7/13/16 at 8:12 a.m., the resident was sitting in his broda chair in the resident lounge up close to the TV on the wall. He was facing the TV. The TV was turned off. No staff member was present in the lounge. The resident was the only resident in the lounge.</p> <p>On 7/13/16 at 8:33 a.m., the resident continued to sit in his broda chair in the resident lounge facing the TV with the TV turned off. No staff member was present in the lounge. The resident was the only resident in the lounge.</p> <p>On 7/13/16 at 9:05 a.m., the resident was sitting in the resident lounge in his broda chair facing the TV and Fox News was playing. No staff member was present in the lounge.</p>			

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	<p>Resident #96's record was reviewed on 7/13/16 at 2:43 p.m. Diagnoses included, but were not limited to, adult failure to thrive, secondary Parkinsonism, vascular dementia with behavior disturbance, and altered mental status.</p> <p>The significant change MDS assessment dated 6/4/16, indicated the resident's BIMS (Brief Interview Mental Status) was 6, which indicated his mental status was severely impaired. His Preferences for Customary Routine and Activities indicated the activities that were very important to him was to have books, newspapers and magazines to read, listen to music he liked, to keep up with the news and somewhat important to do his favorite activities.</p> <p>He had a Care Plan dated 5/16/16 with a revised date 6/29/16, which addressed the problem he was unable to participate in scheduled programming as he previously did. He required individualized activity programming. Approaches included, but were not limited to, "...6/4/16--Invite [name of resident] and assist him to come to bingo and musical entertainment--will require one to one support in bingo...5/23/16--Offer one to one sessions two to three times a week...."</p>			

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	<p>The June and July 2016, activity participation documentation and one to one sessions were reviewed and the following was indicated:</p> <p>The June 2016, activity participation calendar indicated bingo was offered every Tuesday between 2-3 p.m., every Thursday between 2-3:15 p.m. and every Sunday at 3:00 p.m. Gospel Music Sing a Long was every Monday between 9:30-10:15 a.m., Classical music was an activity on June 1, 2016 between 3:30-4:15 p.m., Music and Rhythm was every Thursday between 9:45-10:15 a.m.</p> <p>The resident attended one activity the month of June 2016, on June 3, 2016, which was Gentle Stretch. There was no documentation found to indicate the resident was asked to activities and he refused.</p> <p>The July 2016, activity participation calendar indicated bingo was offered on the last three Mondays of the month at 2:00 p.m., the first and third Wednesday of the month at 2:00 p.m., the second and last Thursday of the month at 2:00 p.m. and every Sunday at 3:00 p.m. There was a music activity four of the five Thursdays out of the month at 2:00 p.m.</p> <p>He attended three activities the month of</p>			

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	<p>July 2016, on July 11, 2016, which was Hand massage, exercise and coffee and Trivia. There was no documentation found to indicate the resident was asked to activities and he refused.</p> <p>A "One-to-One Participation Record" dated 6/22/16, indicated the visit was for 15 minutes and the activity offered was talking and reading to the resident and he was given a hand massage.</p> <p>On 7/14/16 at 2:48 p.m., the Activity Director indicated Resident #96 was in some sensory groups, but a lot of times he refused to go to the activities when the activity staff asked him. She indicated she had failed to document these refusals. She indicated because he stayed in his room he was supposed to receive one on one sessions two to three times a week. She indicated Friday 6/3/16 was the only activity participation documented for June 2016. She indicated he had one, one to one session for June 2016. She indicated July 11, 2016, was the only activity participation documented for July 2016. She indicated he only had one, one on one visit in June 2016 and no one on one sessions in July 2016.</p> <p>3.1-33(a) 3.1-33(b)</p>			

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to invite a resident to care plan meetings for 1 of 3 residents reviewed for participation in care planning (Resident #30).</p> <p>Finding includes:</p> <p>During a resident interview on 7/7/16 at 3:20 p.m., Resident #30 indicated she was not kept informed regarding her care.</p>	F 0280	<p>1.Resident 30 was invited to a care plan meeting on 7/13/16 and declined the invitation. Conversation was documented in the clinical record.</p> <p>2.All residents have the potential to be affected by this alleged deficient practice. Social Services Director/Designee will audit all residents to care plan invitations have been offered and documented.</p> <p>3.Social Services Consultant will inservice Social Services</p>	08/13/2016

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	<p>Resident #30's record was reviewed on 7/12/16 at 2:25 p.m. Diagnoses included, but were not limited to unspecified dementia without behavioral disturbance, major depressive disorder and anxiety disorder.</p> <p>The resident's facesheet had a note indicating "ATTENTION RESIDENT REQUEST NIECE TO BE NOTIFIED IN EVENT OF EMERGENCY-NOT FOR ROUTINE CALLS INCLUDING FALLS W/OUT [without] INJURY, ROUTINE ORDER CHANGES/ETC."</p> <p>The annual MDS (Minimum Data Set) assessment dated 4/28/16, indicated the resident's BIMS (Brief Interview Mental Status) was 10, which indicated her mental status was moderately impaired.</p> <p>During an interview on 7/13/16 at 3:16 p.m., the Social Service Director indicated the legal representative did not want to be notified about anything unless it was an emergency, so she was not invited to the care plan meetings. She indicated the resident had not been invited to a care plan meeting within the last year.</p> <p>A current policy titled "IDT [Interdisciplinary Team] Care Plan</p>		<p>Department on the policies regarding resident and family care plan invitations.</p> <p>4.Social Services Director/Designee will audit care plan invitations and documentation five times a week for four weeks, then weekly thereafter. Results will be discussed in QA monthly times twelve months.</p>		

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F 0309 SS=D Bldg. 00	<p>Review" dated 1/2010 with a revised date 4/2014, provided by the Director of Nursing Services on 7/14/16 at 3:25 p.m., indicated "... Procedure:.. Resident, resident's families or others as designated by resident will be invited to care plan review. Preferably the care plan with family or others as designated by resident should be conducted face to face; however phone conference, video conference or written communication is acceptable...."</p> <p>3.1-35(c)(2)(C)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to collaborate resident care between the hospice company and the facility for 1 of 1 resident reviewed for hospice (Resident #96).</p> <p>Finding includes:</p>	F 0309	<p>1.No adverse reactions noted for resident #96 related to alleged deficient practice. Resident no longer resides at facility. 2.All other residents receiving hospice services have the potential to be affected by this alleged deficient practice. 3.Hospice provider will provide weekly schedules for hospice</p>	08/13/2016

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	<p>Resident #96's record was reviewed on 7/13/16 at 2:43 p.m., Diagnoses included, but were not limited to, adult failure to thrive, secondary Parkinsonism, vascular dementia with behavior disturbance, and altered mental status.</p> <p>The resident had a Care Plan dated 6/3/16 revised on 6/17/16, which addressed the problem he required hospice related to alcohol induced dementia. The resident's hospice Care Plan did not indicate what care the facility was responsible to provide for the resident or what care the hospice company was responsible to provide for the resident.</p> <p>During an interview on 7/13/16 at 2:55 p.m., with LPN #2 in attendance NA #1 indicated he did not communicate with the Hospice CNA about the resident's care after they finished caring for the resident. LPN #2 indicated each resident on hospice had his or her own hospice binder and when the Hospice CNA came in to care for the residents, the Hospice CNA got the resident's binder they were caring for that day out of the cabinet. She indicated the Hospice CNA documented the care the hospice CNA provided to the resident in his or her specific binder and reported off to the resident's specific nurse prior to leaving. LPN #2 indicated if the resident's CNA</p>		<p>caregivers. Schedule will be placed in the hospice communication binder, located at the nurse's station, for staff to view. Education will be provided to the nursing staff on 8/2/16, as to where they can obtain the communication binder for the details of the services the hospice provider has completed for that resident during that visit. An audit will be completed by the Director of Nursing Services/Designee of all other residents receiving hospice services. Care plans will reflect ADL care to be provided by hospice staff.</p> <p>4. Director of Nursing Services/Designee will complete a Hospice Quality Assurance audit tool once a week for one month, monthly times three months, and then quarterly times two. Results will be reviewed in QA monthly times twelve months.</p>	

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F 0312 SS=D Bldg. 00	<p>needed to know something about the care provided by the Hospice CNA, the resident's nurse would inform the CNA. She indicated there was no information available for the resident's CNA to know what kind of care the Hospice CNA was going to provide to the resident when they came in the facility.</p> <p>During an interview on 7/13/16 at 3:06 p.m., LPN #2 indicated she had called the hospice company and the person she spoke to at the hospice company indicated the hospice CNA's schedules vary from day to day, so she was not able to give LPN #2 specific days when the Hospice CNA's would be at the facility to visit each specific resident on Hospice.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and</p>	F 0312	1.Resident D was shaved and groomed by staff. Resident C was	08/13/2016

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	<p>record review, the facility failed to ensure residents were provided ADL (Activities of Daily Living) care for 2 of 3 residents reviewed for ADL's (Residents D and C).</p> <p>Findings include:</p> <p>1. On 7/7/16 at 10:10 a.m., Resident D was observed with facial hair on his upper lip, across his face and under his chin approximately 1/4 inches long.</p> <p>On the following dates and times Resident D was observed with facial hair on his upper lip, across his face and under his chin approximately 1/8 inches long.</p> <p>7/11/16 at 2:13 p.m. 7/12/16 at 8:59 a.m. 7/13/16 at 8:20 a.m. 7/14/16 at 11:47 a.m.</p> <p>A document titled "Resident Profile", which is the resident's plan of care for the CNA's to know what care to provide for the resident did not indicate any specific information regarding shaving the resident.</p> <p>LPN #2 provided three shower sheets for the months of June and July 2016. The resident had documented showers on 6/23/16, 7/11/16 and an undated shower sheet. The 6/23/16 and the undated</p>		<p>provided assistance with oral care. Caregivers were educated on Resident D and C's need for assistance with ADL care. Residents' care plans and profiles updated per these residents' needs.</p> <p>2. All residents needing assistance with ADL care have the potential to be affected by this alleged deficient practice. Director of Nursing Services/Designee will interview all interviewable residents regarding receiving assistance with ADL care. Residents' care plans and profiles will be updated accordingly.</p> <p>3. Nursing staff will be inserviced on AM and HS care including but not limited to shaving, grooming, and/or oral care. Charge nurses will be responsible for collecting shower sheets for all residents due to be bathed on that particular day. Shower sheets will be turned in weekly to the Director of Nursing Services/Designee to ensure that oral care and shaving are being completed as indicated.</p> <p>4. Director of Nursing Services/Designee will complete an Accommodation of Needs audit tool weekly for one month, monthly for three months, and then quarterly times two. Results will be discussed in QA monthly times twelve months.</p>		

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	<p>shower sheet indicated the resident had been shaved. The 7/11/16, shower sheet indicated the resident was given a complete bed bath and he was not shaved and this day was his shower day.</p> <p>During an interview on 7/12/16 at 3:10 p.m., a family member of the resident indicated the resident did not get shaved like he should. She indicated he frequently went without being shaved. She indicated a while back the staff was letting him grow "whiskers" and she had to say something to them to get them to shave him. She indicated she believed his shower days were on Tuesdays and Thursdays in the evening and she did not know if that was the only days he got shaved or not, but that was what it seemed like.</p> <p>During an interview on 7/14/16 at 11:53 a.m., LPN #2 indicated the male residents got shaved twice a week on their shower days and this resident's shower days were on Mondays and Thursdays. She indicated the CNA's document when they shave the residents on the shower sheets and there was no other place where the CNA's documented when the residents were shaved.</p> <p>2. During an interview, on 7/8/16 at 8:50 a.m., Resident C indicated she did not receive oral care and when she asked</p>			

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	<p>staff to help her use her electric toothbrush they told her "later, later, later."</p> <p>Resident C's record was reviewed on 7/13/16 at 9:45 a.m. Diagnoses included, but were not limited to, depression, aphasia, gingivitis, hemiplegia, lymphedema, dysphasia, and facial weakness.</p> <p>The resident had a Care Plan, which addressed the problem of a self care deficit related to decreased mobility, debility related to a history of a stroke with right side hemiplegia, aphasia, decreased safety awareness, chronic lymphedema, and obesity. Approaches included, but were not limited to, "...extensive assist with ADL's (activities of daily living)...assist with oral care twice daily-requires set up assist...."</p> <p>During an interview, on 7/13/16 at 10:22 a.m., Resident C indicated she did not get her teeth brushed that morning and had not had her teeth brushed in a long time.</p> <p>During an interview, on 7/14/16 at 10:05 a.m., LPN #2 indicated Resident C needed to be set up completely including placing the tooth paste on her brush. She indicated she would assist her at that time.</p>			

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F 0314 SS=D Bldg. 00	<p>During an observation, on 7/14/16 at 10:17 a.m., Resident C requested LPN #2 rinse her toothbrush in the sink first, since it had been so long since she used it. LPN #2 rinsed the electric toothbrush in the sink, placed toothpaste on the brush, and placed it in the resident's left hand.</p> <p>The facility's current skills validation checklist for CNA's providing a.m. and p.m. care, dated 4/2012, indicated "...7. Assist resident with oral hygiene, including denture care if applicable. 8. Shave resident, as needed...."</p> <p>This Federal tag relates to Complaint IN00198643.</p> <p>3.1-38(a)(3)(C) 3.1-38(b)(3)(D)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a</p>			

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	<p>resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to follow their policy and procedure regarding wound care to prevent the possibility of a wound infection for 1 of 1 resident observed for a pressure ulcer dressing change (Resident #157).</p> <p>Finding includes:</p> <p>Resident #157's record was reviewed on 7/11/16 at 3:01 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the pancreas, pressure ulcer of coccyx Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle was not exposed. Slough (yellow, tan, gray, green or brown) may be present but, did not obscure the depth of tissue loss. May include undermining and tunneling.), pressure ulcer of the left and right heels unstageable (Full thickness tissue loss in, which the base of the ulcer was covered by slough and /or eschar (tan, brown or black) in the ulcer bed. Note: Until enough slough or eschar was removed to</p>	F 0314	<p>1. One-one education was provided to LPN 3. No adverse reactions noted during alleged deficient practice. Wound care services are provided weekly.</p> <p>2. All residents with pressure injuries and that have physician treatment orders have the potential to be affected by the alleged deficient practice. Director of Nursing Services/Wound Care Nurse will observe dressing changes on all residents with pressure injuries. No other residents were found to have been affected.</p> <p>3. Director of Nursing Services/Wound Care Nurse will inservice licensed nursing staff on the proper procedure for dressing changes on 8/2/16. Licensed nursing staff will complete a dressing changes skills validation check off by 8/2/16.</p> <p>4. Director of Nursing/Designee will complete a Skin Management Program audit tool weekly for one month, monthly for three months, and then quarterly times two. Results will be discussed in QA monthly times twelve months.</p>	08/13/2016

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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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	<p>expose the base of the ulcer, the true depth and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels served as the body's natural (biological) cover and should not be removed.) and anxiety disorder.</p> <p>A "[Name of Company] Pressure Wound Skin Evaluation Report" dated 7/6/16 at 8:00 a.m., indicated the coccyx pressure ulcer was an existing area, which was present on admission. The wound was originally noted on 6/10/16. The wound was a Stage III. The most severe tissue type was Granulation (Pink-red moist tissue that filled an open wound when it began to heal). The wound measured 1.4 x 1.4 x > (greater than) 0.1 cm (centimeter). The wound color was 100% granulation. The current treatment was Xeroform and Optifoam.</p> <p>A "[Name of Company] Pressure Wound Skin Evaluation Report" dated 7/6/16 at 8:02 a.m., indicated the resident had a right heel pressure ulcer, which was an existing area present on admission. The wound was originally noted on 6/10/16. The wound was unstageable. The most severe type of tissue was necrotic/eschar (Thick, leathery necrotic or divitalized tissue, frequently black or brown in color). The wound measured 4.5 x 3.5 x</p>			

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	<p>0.3 cm. The wound color was 100% necrotic. The wound drainage was black. The current treatment was Santyl (a debriding medication, which removed dead tissue).</p> <p>A "[Name of the Company] Pressure Wound Skin Evaluation Report" dated 7/6/16 at 8:04 a.m., indicated the left heel pressure ulcer, which was an existing area present on admission. The wound was originally noted on 6/10/16. The most severe tissue type was Necrotic/eschar. The wound measured 3.3 x 5.0 x 0.3 cm. The wound color was 80% slough and 20% necrotic. The wound drainage was scant serosanguineous. The current treatment was Santyl and Vaseline gauze.</p> <p>On 7/12/16 at 1:26 p.m., LPN #3 was observed changing Resident #157's wound dressings. LPN #3 washed her hands and donned clean gloves. She prepared her dressing supplies. She used a pair of scissors and cut the left foot dressing off the resident, then she removed the dressing down to the yellow gauze. She placed the resident's left heel back onto the comforter with the wound covered with a thin piece of yellow gauze. She cut the right foot dressing off the resident's right foot with the same scissors, then removed the dressing down</p>			

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	<p>to the yellow gauze. She placed the right heel back down onto the comforter on the bed. She performed hand hygiene and donned clean gloves. She cleansed around the left heel wound in a circular motion on the outside of the wound going farther to the inside of the wound each time she cleansed around the outside of the wound with a Normal Saline soaked 4 x 4 gauze. She repeated this step three more times with a new Normal Saline soaked 4 x 4 gauze each time. She did not clean in the middle of the wound. She sat the left heel back on the comforter on the bed after cleansing it. She cleansed the right heel with Normal Saline soaked 4 x 4 's from the box. She cleansed the wound on the outside in a circular motion going farther to the inside of the wound each time she cleansed around the outside of the wound. She repeated this step three times, but did not clean the inside of the wound, then she sat the right heel back onto the comforter on the bed. The left foot wound had a foul odor.</p> <p>LPN #3 folded a 4 x 4 piece of Vaseline gauze into a thick square, then placed a dime size area of Santyl in the middle of the folded gauze and placed it over the open area on the resident's left heel. She placed an ABD (abdominal) pad on top and under the left foot, then wrapped the</p>			

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	<p>foot with kerlix gauze. She folded a 4 x 4 Vaseline gauze into a thick square and placed two ABD pads under the Vaseline gauze. She placed a dime size area of Santyl in the middle of the gauze and placed the 4 x 4 gauze and the top ABD pad under the right heel over the wound and the other one on top of his foot and wrapped his foot with the kerlix gauze. LPN #3 wrapped both feet starting at the toes to the ankles with an ace wrap.</p> <p>On 7/12/16 at 1:54 p.m., LPN #3 was observed changing the coccyx wound dressing. She gathered her supplies and prepared them. She washed her hands and donned clean gloves. She poured Normal Saline on 4 x 4 gauzes and cleansed the coccyx wound by wiping on each side of the resident's coccyx wound on the outside of the wound in a diagonal line from the top of the buttock area towards the opposite shoulder with a new 4 x 4 gauze. LPN #3 took a 4 x 4 gauze and dabbed the inside of the coccyx wound. She used the pair of scissors, which she had cut the dirty dressings off the resident's feet and she cut a thin piece of Vaseline gauze the size of the wound on the coccyx. She placed the Vaseline gauze over the coccyx wound. She placed an Alleyvn foam dressing over the wound.</p>			

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	<p>During an interview on 7/12/16 at 2:13 p.m., LPN #3 indicated she should have changed her gloves in between cleansing the coccyx wound and applying the new dressing She indicated she did not clean her scissors after cutting the bilateral feet dressings off and cutting the Vaseline gauze for the coccyx wound. She indicated she should have cleansed the wounds from the inside of the wound to the outside of the wound. She indicated she should not have placed the resident's heels back on the comforter on the bed after she cleansed them, she indicated she should have placed them on a clean surface.</p> <p>During an interview on 7/13/16 at 1:30 p.m., the Director of Nursing Services indicated she expected the nurses to apply Santyl to a wound with a sterile applicator in small amounts.</p> <p>A current policy titled "Dressing Change" dated 1/2010 with a revised date of 9/2012, provided by the Director of Nursing Services at 4:09 p.m., indicated "Procedure Steps:..7. Remove old dressing from residents and put directly in trash receptacle, 8. Remove gloves and discard, 9 . Perform hand hygiene, 10. Put on gloves... 12. Wound care requirements: a) Cleanse away debris or drainage from the wound b) Cleanse from</p>			

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F 0315 SS=D Bldg. 00	<p>center of wound outward. c) Cleanse in one direction...."</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure an anchored catheter drainage bag and tubing were positioned in a manner to prevent the possibility of an infection for a resident with a history of a UTI (Urinary Tract Infection) for 1 of 1 resident reviewed for urinary tract infections (Resident #96).</p> <p>Finding includes:</p> <p>On 7/7/16 at 8:44 a.m., LPN #2 and CNA #4 was observed transferring Resident</p>	F 0315	<p>1.No adverse reactions noted for Resident 96 related to this alleged deficient practice. LPN 2 and CNA 4 were provided with one-one education regarding foley catheter care including the importance of foley catheter drainage bag and tubing positioning.</p> <p>2.All other residents with indwelling catheters have the potential to be affected by this alleged deficient practice. Director of Nursing Services/Designee observed transfers of all residents with indwelling catheters on 7/26/16 and no other residents were</p>	08/13/2016

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	<p>#96 from his bed into his broda chair. The resident's catheter drainage bag and part of the catheter tubing connected to the catheter drainage bag was lying on the floor beside the broda chair during the transfer. CNA #4 was observed using her foot and scooted the resident's catheter drainage bag from beside his broda chair to in front of his broda chair. After she scooted it, LPN #2 picked the catheter drainage bag up and hung it underneath his broda chair. The catheter drainage tubing had yellow urine with sediment in it.</p> <p>Resident #96's record was reviewed on 7/13/16 at 2:43 p.m. Diagnoses included, but were not limited to, UTI (urinary tract infection), retention of urine, obstructive and reflux uropathy and enlarged prostate without lower urinary tract symptoms.</p> <p>The resident had a Care Plan dated 5/17/16 revised 6/3/16, which addressed the problem he required an indwelling urinary catheter related to a diagnosis of urinary retention and obstructive uropathy. Interventions included, but were not limited to, "5/17/16--Do not allow tubing or any part of the drainage system to touch the floor... Position bag below level of bladder...."</p> <p>A History and Physical from (Name of</p>		<p>found to be affected by this alleged deficient practice.</p> <p>3. Director of Nursing Services/Designee will conduct daily rounds of residents with indwelling catheters to ensure foleycatheter drainage bags and tubing are positioned properly.</p> <p>4. Director of Nursing Services/Designee will complete a Catheter Assessment audit tool weekly for one month, monthly for three months, and then quarterly times two. Results will be discussed in QA monthly times twelve months.</p>	

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F 0323 SS=D Bldg. 00	<p>Hospital) dated 5/10/16, indicated the resident was admitted to the hospital secondary to UTI.</p> <p>During an interview on 7/12/16 at 8:53 a.m., LPN #2 indicated the catheter drainage bag should not have been on the floor during the transfer. She indicated she did not observe CNA #4 scoot the catheter drainage bag with her foot on the floor after the transfer.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a safe transfer method was provided to prevent a potential accident hazard (Resident #96) and failed to ensure potential hazardous items were not within reach of a dementia resident (Resident #87) for 2 of 5 residents being reviewed for Accident hazards and Supervision.</p>	F 0323	<p>1.No adverse reactions were noted for Residents 96 or 87 due to the alleged deficient practice. LPN 2 and CNA 4 were provided one education on proper transfers and gait belt use. All staff's personal items were removed from the Cottage nurse's station.</p> <p>2.All residents requiring assistance with transfers and/or all residents residing on the Cottage</p>	08/13/2016
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	<p>Findings include:</p> <p>1. On 7/12/16 at 8:44 a.m., LPN #2 and CNA #4 were observed transferring Resident #96 from his bed to his broda chair. LPN #2 was on his left side and CNA #4 was on his right side. Both of them placed one arm under each one of the resident's arms. At the same time LPN #2 grabbed the back of the resident's pants and they lifted the resident. When LPN #2 pulled on the back of Resident #96's pants his ankles and lower portion of his legs were observed when his pant legs were raised with the back of his pants. After the resident was placed in the broda chair LPN #2 pulled his pant legs down to cover the lower portion of his legs, which were exposed.</p> <p>Resident #96's record was reviewed on 7/13/16 at 2:43 p.m. Diagnoses included, but were not limited to, adult failure to thrive, secondary Parkinsonism, vascular dementia with behavior disturbance, rhabdomyolsis (a serious syndrome due to direct or indirect muscle injury and releases muscle fiber contents into the blood) and altered mental status.</p> <p>During an interview on 7/12/16 on 8:53 a.m., LPN #2 indicated she should have had her gait belt to complete the transfer.</p>		<p>have the potential to beaffected by the alleged deficient practice. Director of Nursing Servicesobserved transfers for all residents requiring assistance of gait belt fortansfers on 7/26/16 and no other residents were found to be affected by thisalleged deficient practice.</p> <p>3.Nursing staff will be inserviced on propertransfers and use of gaitbelts on 8/2/16. Licensed nursing staff and CNAs willcomplete a skills validation check off for gait belt transfers with theDirector of Nursing Services or Rehabilitation Services Manager. All Cottagestaff will be inserviced on keeping potential hazardous items, includingpersonal items, out of reach of residents at all times.</p> <p>4.Director of Nursing Services/Designee willcomplete a gait belt transfer skills validation check off with CNAs three timesa week for four weeks, then weekly times one month, then monthly times threemonths, then quarterly times two. Results will be discussed in QA monthly timestwelve months.</p>	

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	<p>A current policy titled "Transfer to Chair/Wheelchair-Two Person" dated 4/2012, provided by the Director of Nursing Services on 7/13/16 at 4:09 p.m., indicated "Procedure Steps: Note: Resident must be able to stand or partially stand with assistance. If unable to stand or partially stand a mechanical lift should be used...6. Assist resident to sit on side of bed with feet flat on floor. (Make sure resident is wearing non-skid footwear.) 7. Place gait belt around resident's waist. 8. Each staff should stand on side of resident. 9. Staff should reach around resident's back and grasp gait belt with one hand Staff hands should be close Staff's other hand should grasp gait belt midway between resident's side and front...12. Each staff should use the gait belt to assist the resident from sit to stand...16. Remove body alignment...."</p> <p>A current policy titled "Gait Belt-Application" dated 2/2010 with a review date 4/2012, provided by the Director of Nursing Services on 7/13/16 at 4:09 p.m., indicated "Procedure Steps:...4. Assist resident to a sitting position. 5. Place the belt over the resident's clothing and around the waist. 6. Do not put belt on bare skin. 7. Tighten the buckle until it is snug. Leave enough room to insert two</p>			
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	<p>fingers comfortably into the belt... 9. Secure belt through buckle. 10. Place the buckle off-center in the front or back of the resident...."</p> <p>2. On 07/11/2016 at 2:02 p.m., Resident # 87 was in her wheelchair in the center of the nurses station. LPN #6 and LPN #7 walked up to the station and obtained items from the medication cart during that time. One banana was sitting on the counter within reach of the resident. One partially full bottle of orange soda and three purses were sitting on a cardboard box on the floor under the counter within reach of the resident.</p> <p>At 2:06 p.m., LPN #7 removed the resident from the nurses station and transported her to the dining room.</p> <p>On 07/12/2016 at 8:50 a.m., the resident was attempting to wheel herself into the nurses station. One staff member's purse was present on the cardboard box on the floor.</p> <p>During an interview on 07/12/2016 at 3:12 p.m., LPN #6 indicated the resident often came into the nurses station. She indicated the nursing staff was not to keep their purses in the nursing station and she did not know who the purses belonged to.</p>			

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	<p>On 07/13/2016 at 9:57 a.m., one lunch bag and one zippered bag were sitting on the floor of the nurses station. One styrofoam cup with brown liquid was on the floor by the bags. During an interview at that time, LPN #6 and LPN #7 indicated they did not know who the bags or drink belonged to.</p> <p>On 07/13/2016 at 9:56 a.m., LPN #7 indicated the resident wandered on the unit in her wheelchair.</p> <p>During an interview on 07/13/2016 at 11:56 a.m., the Executive Director indicated there were lockers for personal belongings downstairs for staff use and the staff were encouraged to use them, but they "had a habit" of leaving their personal belongings up on the unit.</p> <p>During an interview on 07/14/2016 at 3:00 p.m., the Director of Nursing Services indicated the facility lacked a policy regarding the storage of staff personal items on the unit.</p> <p>On 07/13/2016 at 3:52 p.m., the medical record for Resident #87 was reviewed. Diagnoses included, but were not limited to, dementia, anxiety disorder, major depressive disorder, insomnia, and hypertension.</p>			

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F 0371 SS=F Bldg. 00	<p>Physician orders dated July 2016, included, but were not limited to, pureed diet.</p> <p>A current care plan dated July 2016, indicated, "Problem: Resident resides on a secured memory care center related to DX [diagnosis] of dementia...Approaches:...Keep environment free from hazards as much as possible...."</p> <p>A current care plan dated July 2016, indicated, "Problem: Resident has impaired daily decision making with memory impairments R/T [related to] DX of dementia...."</p> <p>The quarterly MDS (minimum data set) dated 07/10/16, indicated the resident had a behavior of wandering 1-3 days a week.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p>			

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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food items were labeled and stored under sanitary conditions and failed to maintain a clean and sanitary kitchen. This deficient practice had the potential to affect 99 of 102 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>During a kitchen tour on 07/06/2016 at 9:20 a.m., with the Kitchen Manager (KM) in attendance the following observations were made:</p> <p>1. The surface of the kitchen floor was damp and slick. Scattered areas of fluid were pooled around the base of and around the three compartment sink, which was in use.</p> <p>During an interview at that time, the KM indicated the floor was often damp when it was humid.</p> <p>2. Sitting directly on the kitchen floor adjacent to the three compartment sink the following was observed:</p> <p>a. 2 boxes of frozen broccoli florets.</p>	F 0371	<p>1.The surface of the kitchen floor was cleaned. Food from the delivery boxes were stored away in their proper locations. All food items that were found open have been properly labeled and dated.The dessert bowls were inverted and stored appropriately. The beverage pitchers were discarded. The surface sanitizing solution bucket was discarded and replaced with the appropriate 200 ppm concentration. The floor beneath the hand sanitizing sink, stove, and oven was cleaned and wiped down. The 3 dry storage bins were cleaned and containers have been purchased for the scoops. A secure lid was purchased for the plastic container and was labeled and dated. Employee drinks was discarded. The can of oven cleaner and citrus cleaning spray whereremoved and put in the chemical storage area. The white cloths were taken to laundry.</p> <p>2.All residents who receive food from the kitchen have the potential to be affected by this alleged deficient practice.</p> <p>3.Dietary Manager will inservice Dietary Department on policies regarding proper food storage, labeling and dating,cleaning and sanitizing stationary equipment,</p>	08/13/2016

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	<p>b. 2 - 40 pound boxes of frozen meatballs.</p> <p>c. 4 large containers of ice cream.</p> <p>d. 4 - 40 pound boxes of frozen ground beef.</p> <p>e. 1 box of frozen biscuit dough</p> <p>f. 1 box of frozen brussel sprouts.</p> <p>g. 2 boxes of frozen garlic bread.</p> <p>During an interview at that time, the KM indicated the food truck had arrived about 40 minutes ago.</p> <p>3. In the walk in freezer the following were observed:</p> <p>a. 1 box of frozen beef fritters containing 20 fritters was open and undated.</p> <p>b. 1 box of frozen veggie burgers containing 3 bags was open and undated.</p> <p>c. 1 large package of sausage patties was open and undated.</p> <p>d. 1 box of frozen fish sticks containing 20 fish sticks was open and undated.</p> <p>e. 1 frozen, partially full collapsed water bottle.</p> <p>f. 1 - 5 pound frozen sausage roll was undated.</p> <p>g. 1 box of ground beef patties, containing 10 patties was open and undated.</p> <p>h. 1 box containing 3 bags of lasagna was open and undated.</p> <p>i. 1 bag of frozen breaded chicken breasts were undated.</p> <p>j. 1 box of frozen green beans, 1/4 full</p>		<p>sanitation of the kitchen, andinfection control policies.</p> <p>4. Dietary Manager/Designee will audit food storage, and labeling and dating five times a week for eight weeks, monthly times three months, and quarterly thereafter. Dietary Manager/Designee will audit kitchen sanitation weekly five times a week for eight weeks, monthly times three months, and quarterly thereafter. Results will be reviewed in QA monthly times twelve months.</p>	

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	<p>was open and undated.</p> <p>k. 3 bags of frozen chicken breasts were undated.</p> <p>l. 1 - half case of frozen mixed vegetables were open and undated.</p> <p>m. 1 bag of frozen corn was open and undated.</p> <p>n. 1 - half box of frozen cauliflower was open and undated.</p> <p>o. 8 bags of frozen peas/carrots were undated.</p> <p>p. 1 -half of a case of frozen biscuit dough was open and undated.</p> <p>q. 1 - 5 pound plastic container of frozen, cooked pulled pork was undated.</p> <p>r. 1 box of frozen chicken leg quarters contained 2 of 8 bags was undated.</p> <p>s. 1 - 5 pound tube of frozen ground pork was undated.</p> <p>t. 2 bags of breaded chicken patties were undated.</p> <p>u. 2 bags of frozen onion rings were undated.</p> <p>v. 1 bag of frozen, breaded chicken thighs were undated.</p> <p>w. 1 -10 pound container of strawberry ice cream was open and undated.</p> <p>x. 1 -10 pound container of rainbow sherbet was open and undated.</p> <p>4. Sitting on a shelf over a prep table at the rear of the kitchen were the following:</p> <p>a. 1 container of Spanish paprika was</p>			

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	<p>open and undated.</p> <p>b. 1 container of ground cinnamon was open and undated.</p> <p>c. 1 container of ground basil was open and undated.</p> <p>d. 1 container of ground mustard was open and undated.</p> <p>e. 1 container of ground rosemary was open and undated.</p> <p>f. 1 container of ground thyme was open and undated.</p> <p>g. 1 container of baking powder was open and undated.</p> <p>h. 1 container of dill weed was open and undated.</p> <p>i. 1 container of parsley was open and undated.</p> <p>j. 2 containers of taco seasoning were open and undated</p> <p>5. In the walk-in cooler the following were observed:</p> <p>a. 1 clear, square container contained diced tomatoes lacked a label or date.</p> <p>b. 1/2 of a plastic wrapped boneless ham lacked a label or date.</p> <p>c. 1/2 bag of salad was wrapped in plastic and lacked a label or date.</p> <p>d. 1 large white bucket contained 1/4 of 13 dozen peeled, hard boiled eggs lacked an open date.</p> <p>6. Numerous small, clear dessert bowls were stored in a heavy, gray plastic bin</p>			

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	<p>and were not inverted. Scattered dark, dry debris was sitting in the bottom of the bin.</p> <p>During an interview at that time, the KM indicated the bowls should be inverted to prevent debris from falling into the bowls and that was an "issue" he had been dealing with.</p> <p>7. 10 beverage pitchers were stored on a four tier metal rack behind a prep table. The beverage pitchers had dry, beige and white food debris splattered on the surfaces.</p> <p>During an interview at that time, the KM indicated he had no place to store the beverage pitchers.</p> <p>8. The surface sanitizing solution bucket contained dark blue liquid with brown and black debris floating in the water with a gray cloth with dark black stains in the solution. The KM tested the solution strength and the test strip indicated the ppm (parts per million) were 400+. The KM indicated the solution strength should be 200 ppm.</p> <p>9. Brown and black debris and a dry, gray cloth with black debris were on the floor beneath the hand sanitizing sink.</p> <p>10. 3 large, white, dry storage bins located in center of the kitchen contained</p>			

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	<p>sugar, bread crumbs and pureed bread mix. All three bins contained scoops that rested on the dry ingredients.</p> <p>During an interview at that time, the KM indicated the scoops should be hanging free and not stored in the bins.</p> <p>11. Food particles and dry, gray and black debris was on the floor behind the stoves and ovens.</p> <p>12. 1 large, plastic container with an unsecured lid, 3/4 full of cereal lacked a label or date.</p> <p>13. 1 - 32 ounce beverage cup with a straw was located on the lowest tier of a prep table.</p> <p>During an interview at that time, the KM indicated he allowed employee drinks in the kitchen if they had a lid and were on the lower shelf.</p> <p>14. 1 -50 pound bag of dry food thickener was located on the lower tier of a prep table and lacked a open date.</p> <p>15. 1 large, 1/4 full bottle of salad oil lacked an open date.</p> <p>16. In the dry storage room the following were observed:</p> <p>a. 1/2 package of open, wrapped, dry gravy mix lacked an open date.</p>			

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	<p>b. 1 - 10 pound can of sliced apples was dented and lacked a date.</p> <p>c. 1 - 5 pound box of muffin mix was open and lacked a date.</p> <p>d. 1 gallon of corn syrup lacked a date.</p> <p>e. 4 - 5 pound boxes of muffin mix lacked a date.</p> <p>f. 6 packages of dry ranch dressing mix lacked a date.</p> <p>g. 1 bag of raisin bran cereal lacked a date.</p> <p>h. 3 bags of corn flakes cereal lacked a date.</p> <p>i. 2 boxes of floss sugar were opened and lacked a date.</p> <p>j. 1 bag of rice crispies lacked a date.</p> <p>k. 5 bags of toasted oats lacked a date.</p> <p>l. 2 chicken flavored gravy mixes lacked a date.</p> <p>m. 1 box of brown gravy mix open and lacked date.</p> <p>n. 1/2 bag of powdered sugar was open and lacked a date</p> <p>o 1 box of 8 fudge rounds open and lacked date.</p> <p>p. 2 - 6 pound cans of pizza sauce lacked a date. One can was dented.</p> <p>q. 4 -3 pound cans of ham shanks lacked a date.</p> <p>r. 5 - 7 pound cans of cranberry sauce lacked a date. One can was dented,</p> <p>s. 1 - 6 pound can of shredded sauerkraut was dented and sitting on the floor.</p> <p>t. 8 - 6 pound cans of red kidney beans</p>			

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	<p>lacked a date</p> <p>u. 4 - 6 pound cans of stewed tomatoes lacked a date.</p> <p>v. 4 - 6 pound cans of chili con carne lacked a date.</p> <p>w. 1 - 6 pound can of three bean salad lacked a date.</p> <p>x. 3 -1 pound boxes of cornstarch lacked a date.</p> <p>y. 6 - 2 pound bags of powdered sugar lacked a date.</p> <p>z. 3 boxes of fudge rounds lacked a date.</p> <p>aa. 2 boxes of oatmeal cream pies lacked a date.</p> <p>bb. 24 graham cracker crusts were open, not contained and lacked a date.</p> <p>cc. 5 bags of penne lacked a date.</p> <p>dd. 2 bags of macaroni lacked a date.</p> <p>ee. 2 boxes of mashed potatoes were open and without a date.</p> <p>ff. 3 cans of cream of celery soup lacked a date.</p> <p>gg. 23 cans of tomato soup lacked a date.</p> <p>hh. 11 cans of vegetable soup lacked a date.</p> <p>ii. 9 cans of cream of mushroom soup lacked a date.</p> <p>jj. Storage room floor had scattered food debris and paper debris,</p> <p>16. 1 can of oven cleaner with a white cloth stained with gray debris was sitting on food prep table beside the food</p>			

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	<p>processor.</p> <p>17. 1 bottle of citrus cleaning spray and a white cloth were sitting on top of a food service cart.</p> <p>A current policy titled, "Food Storage" dated 02/02 and revised 07/13 provided by the KM indicated, "...4. Containers with tight fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be accurately labeled and dated. 5. Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods. 6. Chemicals must be clearly labeled, kept in original containers when possible, and kept in an area away from food. 7. Scoops must be provided for flour, sugar, cereals, dried vegetables and spices. Scoops are not stored in the food containers, but may be kept covered in a protected area near the containers..12. Food is stored a minimum of 6" above the floor and 18" below the sprinkler heads on clean racks or other clean surfaces, and is protected from splash, overhead pipes, or other contamination. 13. Perishable food such as meat, poultry, fish, dairy products, fruits, vegetables and frozen products much be refrigerated immediately to retain</p>			

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	<p>nutritive value and quality...14. Leftover prepared foods are to be stored in covered containers or wrapped securely. the food must be labeled with the name of the product, the date it was prepared and marked to indicate the date by which shall be consumed or discarded...15. Refrigerated, ready to eat, potentially hazardous food purchased from approved vendors, shall be clearly with the date the original container is opened and the date by which the food shall be consumed or discarded...Label these items when opened and use or dispose of within 30 days of opening to ensure quality...18...b. All foods should be covered, labeled and dated. 19...d. Foods should be covered, labeled and dated. e. All food items should be stored upon delivery and careful rotation procedures should be followed."</p> <p>A current policy titled, "Cleaning and Sanitizing Stationary Equipment" dated 12/02 and revised 07/15, provided by the Executive Director (ED) on 7/7/16 at 10:56 a.m., indicated, "...1. Equipment manufacturers will usually provide cleaning instructions. Refer to equipment manual for specific instructions...."</p> <p>An undated Manufacturers Recommendation, provided by the KM on 07/11/2016, at 12:24 p.m., titled</p>			

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	<p>"Sani-Tabs Quaternary Sanitizer Tablets" indicated, "...A fresh sanitizing solution must be prepared at least daily or more often if the solution becomes diluted or soiled. Sani-tabs sanitizing solutions of 200 ppm concentration may be safely used on food processing equipment and utensils and on other food contact articles...."</p> <p>A current policy titled, "Sanitation of Kitchen" dated 02/02 and revised 07/15, provided by the ED on 7/7/16 at 10:56 a.m., indicated, "...The dietary staff will maintain the sanitation of the dietary department through compliance with a written, comprehensive cleaning schedule...."</p> <p>A current policy titled "Infection Control" dated 02/02 and revised 07/15, provided by the Executive Director on 7/14/16 at 4:01 p.m., indicated, "...2...g. Personal items should not be stored on food preparation equipment or in food storage areas...3...b...Poisonous and toxic materials including cleaning agents are stored (and secured) outside the storage area for food and paper products...."</p> <p>3.1-21(i)(3)</p>			

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F 0431 SS=E Bldg. 00	<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 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 date medication when opened, store medications as recommended, utilize</p>	F 0431	1.Residents 166, 21, 130, 62, 17, 162, 6, 156,109, 136, and 82's medications have been labeled and dated appropriately, discarded properly if expired,	08/13/2016	

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	<p>direction change labels, and failed to discard expired medication in 5 of 6 medication carts and 1 of 3 medication storage rooms reviewed for medication storage (Residents #166, #21, #130, #62, #17, #162, #6, #156, #109, #136, #82).</p> <p>Findings include:</p> <p>During medication storage review on 7/13/16 at 2:37 p.m., the second floor was observed to have the following:</p> <ol style="list-style-type: none"> 1. The medication cart for rooms 200-212B was found to have a Proair HFA (an Albuterol medication) inhaler opened and not dated for Resident #166. 2. The medication cart for rooms 213-223B was found to have: <ol style="list-style-type: none"> a. A bottle of Travatan (a glaucoma medication) 0.004% eye drops for Resident #21 opened and not dated. b. Two bottles of Lisinopril (a blood pressure medication), a bottle of Mary's Magic Mouthwash (a medication used for mouth sores), a bottle of Zinc Sulfate (a mineral medication), a bottle of Omperazole (stomach medication), and a bottle of Amlodipine (a blood pressure medication) with an expiration date of 7/11/16, for Resident #130. All of the medications were in blue bottles and labeled to be stored in the refrigerator. 		<p>stored in an appropriate place, and havedirection change labels placed if indicated by the Director of Nursing Services/Designee. No adverse effects have been noted due to this alleged deficient practice.</p> <ol style="list-style-type: none"> 2. All residents who receive medications have thepotential to be affected by this alleged deficient practice. 3. An audit will be completed by the Director of Nursing Services/Designee of medication carts and/or medication storage rooms, to identify any other residents affected by this alleged deficient practice. Director of Nursing Services/Designee will complete a weekly audit of all medication carts and/or medication storage rooms. Licensed nursing staff will be inserviced on correct medication storage, dating, labeling, and discarding on 8/2/16. 4. Director of Nursing Services/Designee will complete a medication storage review audit tool weekly for one month, monthly for three months, and then quarterly times two. Results will be reviewed monthly during QA times twelve months. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2016
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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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	<p>3. The medication cart for rooms 224-237 was found to have a bottle of Travatan 0.004% eye drops for Resident #62 and Resident #17 both with an opened date of 6/6/16.</p> <p>During medication storage review on 7/14/16 at 4:05 p.m., the first floor was observed to have the following:</p> <p>1. The medication cart for rooms 100-110 was found to have:</p> <p>a. A vial of Levemir (insulin) for Resident #162 opened and not dated.</p> <p>b. A vial of Novolog (insulin) for Resident #6 dated as opened on 6/14/16.</p> <p>c. A vial of Novolog for Resident #156 opened and not dated.</p> <p>2. The medication cart for rooms 111-117 was found to have:</p> <p>a. A vial of Humulin N (insulin) for Resident #109 dated as opened on 6/13/16.</p> <p>b. A vial of Humulin R (insulin) for Resident #136 dated as opened on 6/9/16 and a vial of Lantus (insulin) dated as opened on 6/13/16.</p> <p>3. The medication storage room in the Auguste's Cottage unit, had a vial of Aplisol (a tuberculin testing solution)</p>			

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	<p>with an opened dated of 4/30/16.</p> <p>During an observation on 7/14/16 at 9:37 a.m., LPN #10 was observed preparing insulin for Resident #82. The nurse drew up 16 units of Humalog and 32 units of Levemir. During this observation, the medication bottle provided from the pharmacy contained the following directions "Humalog inject 14 units subcutaneously at breakfast" and "Levemir inject 25 units subcutaneously every morning and night."</p> <p>A reconciliation of the current physician orders dated 7/13/16, indicated "Humalog inject 16 units subcutaneously at breakfast" and "Levemir inject 32 units subcutaneously every morning and night." The medication bottle lacked a "change" of order label to alert the nurse.</p> <p>During an interview on 7/13/16 at 2:45 p.m., LPN #2 indicated inhalers, eye drops, and insulins should be dated when opened, discarded when expired, and blue bottles with a "refrigerate" sticker should be stored in the refrigerator.</p> <p>During an interview on 7/14/16 at 2:15 p.m., LPN #10 indicated Resident #82's insulin bottle should have had a "direction change" label placed when his</p>			

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	<p>orders changed.</p> <p>During an interview on 7/14/16 at 4:30 p.m., the DNS (Director of Nursing Services) indicated the facility followed the pharmacy recommendations for storage and expiration of medications.</p> <p>The current pharmacy policy, titled "Medications Requiring Special Storage" dated 11/19/15, received from the DNS on 7/14/16 at 4:00 p.m., indicated "Date opened stickers should be placed on all medications listed here with date of first opening...Travatan eye drops expires 28 days after opening...Lantus expires 28 days after opening...Novolog expires 28 days after opening...."</p> <p>3.1-25(o)</p>			