

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2014
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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 3, 4, 5, 8, 9, 10, 11, & 12, 2014</p> <p>Facility number: 000144 Provider number: 155240 AIM number: 100266760</p> <p>Survey team: Cheryl Mabry, RN-TC Susan Worsham, RN (December 9,10 & 11, 2014) Angela Patterson, RN (December 3, 4, 5, 9, 10, 11, & 12, 2014)</p> <p>Census bed type: SNF/NF: 56 Total: 56</p> <p>Census payor type: Medicare: 7 Medicaid: 36 Other: 13 Total: 56</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December</p>	F000000		
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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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F000242 SS=D	<p>19, 2014; by Kimberly Perigo, RN.</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 that residents were able to choose a bathing preference and what time to get up in the morning according to their preference for 2 of 3 residents who met the criteria for choices review. (Resident #62, Resident #23)</p> <p>Findings include:</p> <p>1). On 12/89/14 at 10:27 a.m., interview with Resident #62 indicated when asked, Do you choose when to get up in the morning? "No, since I have been in this wheelchair they get me up around 6:30 a.m. I would like to sleep until 7:30 a.m. to 8:00 a.m." Have you told staff? "It won't do any good." Does staff ask you if you want to get up? "No, they say get up</p>	F000242	<p>This plan of correction is to serve as Lyons Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Lyon's Health and Living Community is respectfully requesting paper Compliance on all F-Tags. F 242 483.15(b) SELF-DETERMINATION – RIGHT TO MAKE CHOICES Resident #62 and 23 were interviewed regarding bathing</p>	01/11/2015	

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	<p>it's time for breakfast." Do you choose whether you take a shower, tub, or bed bath? "No, there is no tub here. I would like to take a tub bath."</p> <p>Resident #62's clinical record was reviewed on 12/10/14 at 2:34 p.m. Diagnoses included, but were not limited to mild intellectual disabilities and lack of coordination.</p> <p>The current quarterly Minimum Data Set (MDS) assessment dated 10/29/14, indicated a Brief Interview Mental Status score (BIMS) of 13, when 8-15 was cognitively intact and interviewable. The most current annual MDS with Preference for Customary Routine and Activities dated 7/14/14 indicated, "... Resident Interview...choose tub, bath, shower, sponge ... 'While you are in this facility how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?' ...Very important."</p> <p>On 12/11/14 at 11:29 a.m., interview with CNA #3 indicated, when asked steps in getting residents up in the morning "Tell them what you are doing, assist." Do you ever ask residents if they want to get up or stay in bed." "Yes you ask them if they want to get up or stay in bed." How do you know what residents to get up first in the morning? "There is a routine, night shift</p>		<p>choice and what time to get up in the morning and these preferences will be honored. Current residents with a BIMs score of 10 and above will be interviewed regarding preferences on bathing choice and what time to get up in the morning and specific preferences will be noted on the C.N.A. assignment sheet. Residents with a BIM score of less than 10, the family or interested party will be interviewed regarding on preferences on bathing choice and what time to get up in the morning and specific preferences will be noted on C.N.A assignment sheet. C.N.A #3 was educated regarding resident preferences The systemic change includes: · Resident preferences in regards to bathing choice and time to get up in the morning have been added to the nursing admission check list and will be reviewed upon admission. Preferences will also be discussed at the quarterly and as needed care conferences. These preferences will be communicated to the staff via the care plan and the C.N.A. assignment sheet Nursing staff and Social Services will be offered education regarding the systemic change. The DON or designee, will complete a QA tool to audit for completion of the resident interview within 72 hours after admission and notation of specific preferences on the</p>				

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	<p>has a list of who to get up for us. I kind of know who gets up or doesn't on a daily basis." How do you know if their routine has changed? "I would address for myself." Do you have a get up list? "No, we don't have a get up list. We kind of know." What if the resident has changed their mind when you tried to get them up? "I would ask my nurse if anything is going on with the resident." When asked if she wakes Resident #62 up in the morning, CNA #3 indicated "Yes, usually by 7:15 a.m. She has gotten worse. She use to get up by herself." Has Resident #62 ever told you that she didn't want to get up? "Yes, and I told her that I would be back in 10-15 minutes. She pretty well knows what she wants. We [indicating CNA's] generally get up people who need more than one person assist, generally lifts first. Then try to get up the people who are eating in the dining room first. Then begin at the front of the hall and work your way down the hall."</p> <p>On 12/11/14 at 11:17 .am., the DON provided a sheet which she indicated was the CNA assignment sheet for the 100 hall staff. The CNA assignment sheet indicated Resident #62 received showers on Monday, Wednesday, and Saturday on days. There was no indication of whether Resident #62 was offered a tub</p>		<p>C.N.A. Assignment sheet 5 days a week for 30 days, then weekly for 60 days, then monthly for a total 12 months of monitoring The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p>				

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	<p>bath. There were no indication of times to get up on the assignment sheet. There was a column for diet, activity order, side rails, personal equipment, bowel movement, toileting, restorative, C.N.A. restorative, special considerations, and shower schedule.</p> <p>2). On 12/4/14 at 9:29 a.m., interview with Resident #23 indicated when asked could you choose whether to take a shower or tub bath? "No, they don't have a tub here." Would you like a shower or tub bath? "I would like a bath." When asked if staff every asked if he wanted to take a tub bath instead of a shower, Resident #23 indicated, "No."</p> <p>Resident #23's clinical record was reviewed on 12/11/14 at 1:30 p.m., Diagnoses included, but were not limited to cerebrovascular accident and hemiplegia.</p> <p>The current annual Minimum Data Set (MDS) assessment dated 9/22/14, indicated a Brief Interview Mental Status score (BIMS) of 15, which was cognitively intact and interviewable. The most current MDS with Preference for Customary Routine and Activities dated 9/22/14 indicated, "... Resident Interview...choose tub, bath, shower, sponge ... 'While you are in this facility</p>			

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	<p>how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?...Very important."</p> <p>On 12/11/14 at 10:50 a.m., Resident #23 indicated when asked has he every been offered a tub bath? "No." When asked how many times would he prefer a tub bath, Resident #23 indicated, "Every other day or 3 times a week."</p> <p>On 12/11/14 at 11:30 a.m., the Activity Director indicated when asked when are resident preference sheets completed? "On admission and change in conditions I do a full assessment. We do quarterly just to see how things were going or if anything has changed." What questions do you ask on full assessments? "Whether they want a bath or shower, bedtime." Do you ask what time residents want to get up? "That's not on that [full assessment form]." How do you know if the residents have a change in preference? "We [indicating department heads] do caring heart [walking around to see how things are going] weekly." Do you ask residents what time they want to get up? "It's not on assessment but we periodically ask during caring heart." If the resident doesn't come and tell you that they want to sleep late how would staff know? "It would just be in conversation if they tell</p>			

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	<p>me. I don't ask that specific question quarterly. If I learn that on my caring heart I would get that information to the [Name of the Assistant Director of Nursing] and she does the assignment sheet."</p> <p>On 12/11/14 at 10:22 a.m., the Director of Nursing (DON) indicated when asked if there was a tub or spa in the facility, "Yes, on the 300 hall in the shower room." The DON indicated it was a whirlpool. When asked if someone wanted to take a bath can the whirlpool be used? "Yes."</p> <p>On 12/11/14 at 11:15 a.m., interview with the DON indicated when asked how often are the Certified Nursing Assistant [CNA] assignments updated, "It is done daily or when there is a change in condition." When asked if all the residents in the facility took a shower, the DON indicated, "Yes." When asked what if the resident wanted a tub bath could they take one, the DON indicated, "Yes." When asked if all the residents were aware that the facility had a whirlpool, the DON indicated "Yes, we tell them all."</p> <p>On 12/4/14 at 10:00 a.m., the Administrator provided policy "Resident Rights" undated, and indicated that was</p>				

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F000279 SS=D	<p>the policy currently used by the facility. The policy indicated, "Notice of rights and services. 2. You have the right to choose activities, schedules and health care consistent with your interests, assessment, and plans of care;... make choices about aspects of your life ... Care Plans ... The Care Plan team develops the Care Plan under the guidance of your personal physician. Your Care Plan is reviewed quarterly and whenever there is a significant change in your health, wants or needs. ..."</p> <p>3.1-3(u)(3)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services</p>			

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	<p>that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a careplan was developed for a resident who was receiving an antithrombotic medication for 1 of 5 residents reviewed for unnecessary medication use. (Resident #39)</p> <p>Findings include:</p> <p>Resident #39's clinical record was reviewed on 12/09/2014 at 2:20 p.m. Diagnoses included but, were not limited to, congestive heart failure.</p> <p>A physicians order dated 8/15/2014, indicated Plavix 75 mg (antiplatelet medication/antithrombotic) daily for congestive heart failure (CHF).</p> <p>On 12/09/2014 at 2:55 p.m., an interview with the Director of Nursing indicated CHF was not the correct diagnosis for use of Plavix. The DON indicated Resident #39 has had a previous stroke and the diagnosis for use of Plavix should have been cerebrovascular disease.</p> <p>On 12/9/2014 at 3:09 p.m., the Director of Nursing provided the corrected</p>	F000279	<p>F279 483.20(d). 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>Resident #39 has had their care plan updated to include antithrombotic medication</p> <p>All residents on antithrombotic medication have been identified and a care plan is place for this medication.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> A new admission chart review will be completed by nursing administration within 72 hours of the admission. This chart review includes a review of pertinent diagnosis for all antithrombotic medications and appropriate care plans for pertinent medications (including antithrombotic medication) All new medication orders will be reviewed at the morning clinical meeting (Monday through Friday) for antithrombotic agents and appropriate diagnosis and appropriate care plans put into place. <p>Education will be provided for licensed nurses regarding placing an appropriate diagnosis for antithrombotic medications and</p>	01/11/2015

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	<p>physicians orders indicating Plavix 75 mg daily for diagnosis of cerebrovascular disease.</p> <p>On 12/10/2014 at 10:17 a.m., the Director of Nursing provided a copy of Resident #39's careplans. A careplan dated 6/6/2013, indicated "Resident skin fragile and is at risk for skin tears and bruising." No approach related to use of Plavix. A careplan dated 7/2/2013, indicated Problem: "Resident has DX [diagnosis] of CHF [congestive heart failure]." A careplan dated 10/12/2012, indicated a Problem: "...resident picks at skin until it bleeds...no approach related to use of Plavix.</p> <p>The Lippincott's Nursing 2014 Drug Handbook indicated Plavix, "indications & dosages: To reduce thrombotic events in patients with atherosclerosis documented by recent stroke, MI [Myocardial Infarction], or peripheral arterial disease. Adults:75 mg P.O. [by mouth] daily....Effects on Lab test Results May decrease platelet count...Patient Teaching:Advise patient it may take longer than usual to stop bleeding. Tell him to refrain from activities in which trauma and bleeding may occur..."</p> <p>On 12/12/2014 at 11:00 a.m. The</p>		<p>completion of a care plan. In addition, education will be provided to nursing administration regarding the new admission chart review and review of new antithrombotic orders per the systemic change.</p> <p>The Director of Nursing or designee will review all new admissions and new medication orders for residents with antithrombotic medications for inclusion of an appropriate diagnosis and care plan. This audit will be completed 5 days a week for 30 days, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction</p>				

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F000309 SS=D	<p>Director of Nursing (DON) provided the Anticoagulation-Clinical Protocol dated April 2007, and indicated the policy was the one currently used by the facility. The policy indicated, "1. The physician will seek or verify underlying causes of conditions requiring anticoagulation...3. The staff and physician will identify and address potential complications in individuals receiving anticoagulation..."</p> <p>3.1-35(a)</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 ensure documentation was completed between the dialysis center and the facility as the facility policy indicated for 1 of 1 residents reviewed for dialysis. (Resident #68)</p> <p>Findings include: Resident #68's clinical record was reviewed on 12/10/2014 at 11:38 a.m.</p>	F000309	<p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL-BEING Resident #68 has documentation completed between the dialysis center and the facility as per facility policy. All residents receiving dialysis has been identified and has documentation is completed between the dialysis center and the facility, and the pre and post dialysis assessment has been completed as per facility policy.</p>	01/11/2015			

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	<p>Diagnoses included, but were not limited to, polycystic kidney disease and end stage renal disease.</p> <p>A physicians order dated 11/12/2014, indicated "Resident to receive dialysis on Monday, Wednesday and Friday."</p> <p>A physicians order dated 11/12/2014, indicated, "Complete the Pre Dialysis Assessment Observation BEFORE treatment. Monday, Wednesday, Friday."</p> <p>A physicians order dated 11/12/2014, indicated, "Complete the Post Dialysis Assessment Observation AFTER TREATMENT. On Mon, Wed, Fri."</p> <p>A physicians order dated 11/12/2014, indicated, "Dialysis site: for use by dialysis only. Every shift."</p> <p>A physicians order dated 11/12/2014, indicated "Check fistula site (RUE [right upper extremity] or LUE [left upper extremity]), auscultate bruit, palpate thrill. Notify MD if excessive bruising around the site, symptoms of infection/clotting such as warm to touch, red, abnormal swelling, the absence of bruit or thrill, edema above or below the fistula, absence of radial pulse, capillary refill > 3 seconds."</p>		<p>The Systemic Change includes:</p> <ul style="list-style-type: none"> All residents receiving dialysis will be identified on the clinical board. Nursing administration will review the documentation daily (Monday through Friday) for the pre and post dialysis assessment being completed in the medical record. In addition, nursing administration will review for communication received from the dialysis center after each dialysis visit. Education will be provided to licensed nurses regarding completion of the pre and post dialysis assessment as well as receipt of the communication from the dialysis center after each dialysis visit. In addition, the Director of Nursing and Administrator will review the policy for communication post dialysis with the Dialysis Center used by the facility. The Director of Nursing or designee will complete a QA audit for completion of the pre and post dialysis assessment and communication from the dialysis center after each dialysis visit daily (including weekends) for 30 days, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency 				

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	<p>No charting for post dialysis treatment on 11/17/2014 and 12/8/2014, as the physicians' order indicated.</p> <p>On 12/10/2014 at 11:30 p.m., an interview with Director of Nursing indicated the nurses are required to chart before and after a resident goes to dialysis.</p> <p>On 12/10/2014 at 3:05 p.m., an interview with Director of Nursing indicated the only 2 dialysis forms the facility still had for Resident #68 since admission on 11/11/2014, were dated 12/5/2014 and 12/8/2014. The Dialysis Communication form dated 12/8/2014, indicated no nurse signature from the dialysis nurse and no information provided from the dialysis center.</p> <p>On 12/4/2014 at 8:27 a.m., the Administrator provided the SNF Outpatient Dialysis Services Agreement dated 4/20/2007, and indicated the policy was the one currently used by the facility. The policy indicated, "...D. To provide to the Nursing Facility information on all aspects of the management of the residents care related to the provision of dialysis services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding/hemorrhage,</p>		<p>and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p> <p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL-BEING Resident #68 has documentation completed between the dialysis center and the facility as per facility policy. All residents receiving dialysis has been identified and has documentation is completed between the dialysis center and the facility, and the pre and post dialysis assessment has been completed as per facility policy. The Systemic Change includes: · All residents receiving dialysis will be identified on the clinical board. Nursing administration will review the documentation daily (Monday through Friday) for the pre and post dialysis assessment being completed in the medical record. In addition, nursing administration will review for communication received from the dialysis center after each dialysis visit. Education will be provided to licensed nurses regarding completion of the pre and post</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014
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	infection/bacteria, and care of dialysis access site and disinfection of dialysis access site." 3.1-37(a)		dialysis assessment as well as receipt of the communication from the dialysis center after each dialysis visit. In addition, the Director of Nursing and Administrator will review the policy for communication post dialysis with the Dialysis Center used by the facility. The Director of Nursing or designee will complete a QA audit for completion of the pre and post dialysis assessment and communication from the dialysis center after each dialysis visit daily (including weekends) for 30 days, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction. F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL-BEING Resident #68 has documentation completed between the dialysis center and the facility as per facility		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2014
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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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			<p>policy.</p> <p>All residents receiving dialysis has been identified and has documentation is completed between the dialysis center and the facility, and the pre and post dialysis assessment has been completed as per facility policy.</p> <p>The Systemic Change includes:</p> <ul style="list-style-type: none"> All residents receiving dialysis will be identified on the clinical board. Nursing administration will review the documentation daily (Monday through Friday) for the pre and post dialysis assessment being completed in the medical record. In addition, nursing administration will review for communication received from the dialysis center after each dialysis visit. <p>Education will be provided to licensed nurses regarding completion of the pre and post dialysis assessment as well as receipt of the communication from the dialysis center after each dialysis visit.</p> <p>In addition, the Director of Nursing and Administrator will review the policy for communication post dialysis with the Dialysis Center used by the facility.</p> <p>The Director of Nursing or designee will complete a QA audit for completion of the pre and post dialysis assessment and communication from the dialysis center after each dialysis visit daily (including weekends) for 30 days, then weekly for a duration of 12</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014
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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical		months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.		

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	<p>condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to ensure an accurate assessment and implementation of care to prevent a resident from losing weight for 1 of 5 residents reviewed for nutritional status. (Resident #8)</p> <p>Findings include:</p> <p>Resident #8's clinical record was reviewed on 12/11/2014, at 4:07 p.m. Diagnoses included but, were not limited to, edema, hypopotassemia, hyperlipidemia, Alzheimer's disease and hypertension.</p> <p>Resident #8's weights: On 6/6/2014 = 130 pounds On 8/22/2014 = 123 pounds On 10/28/2014 = 123 pounds On 11/25/2014 = 119 pounds On 11/24/2014, Resident #8's BMI (Body Mass index) was 21.8, which indicated a 9 percent weight loss in the past 6 months.</p> <p>A current careplan (non-dated) indicated at risk for altered nutrition r/t (related to) requires mechanically altered diet, weight loss r/t inadequate energy intake.</p> <p>Interventions included, monthly weights,</p>	F000325	<p>F325 483.25(i) MAINTAIN NURTRITION STAUUS UNLESS UNAVOIDABLE</p> <p>Resident #8 has had a reassessment completed for nutritional status by the Registered Dietician and the plan of care has been updated to include prevention from losing weight.</p> <p>Residents with significant weight loss have been identified and will be audited for a review by the Registered Dietician and the plan of care will be updated to include prevention of weight loss.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> · The weight management report (electronic record of weights) will be reviewed weekly at the interdisciplinary at risk meeting and any resident with a significant weight loss will be identified. Any resident with significant weight loss will be reviewed at the weekly interdisciplinary at risk meeting by nursing and dietary. This will be documented in the electronic medical record and the weight loss care plan will be reviewed and updated. All residents with a significant weight loss will then be referred to the Registered Dietician for assessment. · The Registered Dietician will 	01/11/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014
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	<p>mechanically altered diet and a bedtime snack.</p> <p>A Nutritional Assessment dated 10/23/2014, indicated res (resident) weight down slightly in 90 days, remains on high end of IBWR (ideal body weight range)...Eats in room per choice. Has HS (at bedtime) snack. Recommend to liberalize diet to Regular Mechanical soft.</p> <p>On 11/20/2014, a speech therapy assessment by Speech Therapist #1 indicated, Resident #8 had a recent weight loss, "patient has lost 8.1 lbs (pounds) since June 2014. Patient with no noticeable difficulties with intakes, consumes meals in her room and receives house (mighty) shakes daily. St [speech therapy] to rec'd [request] dietician to evaluate for possible addition of supplements."</p> <p>Current record review lacked documentation the resident had been evaluated by the RD (Registered Dietitian as requested from ST (Speech Therapy).</p> <p>On 12/12/2014 at 11:30 a.m. an interview with a Unit Manager indicated she did not know why the speech therapy department charted Resident #8 was on mighty (house) shakes there is no</p>		<p>meet with the Director of Nursing with each visit for a review of which residents have a significant weight loss and the Director of Nursing will then review the Registered Dietician's assessment on the following business day for follow up to her recommendations. The plan of care will be updated with this review.</p> <p>The Speech Therapist, or designee and the Director of Nursing will meet weekly regarding any resident with a new significant weight loss to discuss the effectiveness of the current interventions.</p> <p>Education will be provided to nursing administration, dietary manager, Registered Dietician and Speech Therapist, or designee regarding the systemic change.</p> <p>The Director of Nursing will complete a QA audit tool to review that all residents with significant weight loss have had a weekly interdisciplinary review, Registered Dietician assessment and review. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>		

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	<p>physicians order. At that time, she indicated she doesn't know why the dietician has not seen the resident.</p> <p>On 12/12/2014 at 12:00 p.m., an interview with the Speech Therapist #1 indicated, the Registered Dietician had resigned on November 1, 2014, and she doesn't know whether the corporate dietician has addressed the weight loss. The Speech therapist indicated at a facility meeting in November the weight loss was brought to management and the Director of Nursing was to enter orders for the residents who needed supplements. After reviewing the Dietician's nutritional assessment dated 10/23/2014, with the speech therapist, the assessment indicated HS stood for at bedtime snack and not house shakes. The Speech Therapist #1 indicated she thought it meant Resident #8 was receiving house shakes.</p> <p>On 12/12/2014 at 12:30 p.m., an interview with the Director of Nursing indicated Resident #8 had not been ordered a supplement and had not been receiving a house shake. She indicated every resident in the facility receives a bedtime snack.</p> <p>3.1-46(a)(1)</p>		<p>Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p>				

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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure each residents drug regimen was not used in excessive dose, without adequate monitoring, or without adequate indication for its use for 1 of 5 resident reviewed for unnecessary medication use. (Resident #36)</p> <p>Findings include:</p>	F000329	<p>F329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Resident #36 has had a dose reduction in the diazepam and will be gradually weaned off of the medication. Other resident's drug regimen has been identified and the drug</p>	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014	
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443			
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	<p>Resident #36's clinical record was reviewed on 12/9/14 at 2:01 p.m. Diagnosis included, but were not limited to: episodic mood disorder and depressive disorder.</p> <p>The current Minimum Data Set (MDS) assessment dated 11/24/14, indicated a Brief Interview Mental Status score (BIMS) of 3, which was not cognitively intact nor interviewable.</p> <p>A care plan dated 11/12/13 indicated, "Mood State, PROBLEM: The resident has a medical condition that requires the use of antidepressant[s], ...GOAL: The resident will use the lowest possible dose of antidepressant[s] while maintaining the highest practical level of psychosocial well-being. ...Activities...encourage to attend activities the resident enjoys, .. monitor side effects every shift, ..."</p> <p>Physician's order dated 10/21/14, indicated Resident #36 received diazepam 10 mg (milligram) every morning for mood disorder and diazepam 5 mg hs (hour of sleep).</p> <p>Lippincott's Nursing Drug Guide dated 2014, indicated "Diazepam ...Anxiety, ... Acute alcohol withdrawal, ...Muscle</p>		<p>regimen has been reviewed for excessive dose, monitoring for side effects, behavior monitoring and adequate indication. The pharmacist will review all like medications for any other possible doses that are in excess according to geriatric dosage recommendations. Any concerns were addressed.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> The facility has converted to an electronic medication administration record. This format provides an electronic format for monitoring of side effects and targeted behaviors for which diazepam and other like medications that require behavior/side effect monitoring are ordered on an every shift basis. This documentation is then reviewed daily at the clinical meeting (Monday through Friday) for compliance. All new admissions and drug regimen orders will be reviewed at the daily clinical meeting (Monday through Friday) by nursing administration for excessive dose and adequate indication as well as the side effect monitoring and targeted behavior monitoring in the electronic record. <p>Education will be provided to licensed nurses regarding the conversion to the electronic medication administration record that will include monitoring of side effects and targeted behaviors as</p>				

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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443			
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	<p>spasm, ...Status epilepticus, severe recurrent seizure, ...INDICATIONS & DOSAGES: For elderly or debilitated patients, give 2-2.5 mg PO [by mouth] daily-bid [twice a day]..."</p> <p>There were no active diagnosis indicated for the use of diazepam in the clinical records.</p> <p>On 12/11/14 at 11:40 a.m., interview with the DON indicated when asked to explain why Resident #36 was receiving Diazepam, "He was getting it for a while back. He tends to pick at his face. They should have put the diagnosis on his face sheet or his order." Observed the DON to look on physician's order for diazepam and she indicated the diagnosis was mood disorder. When asked if mood disorder was an indicated diagnosis for diazepam, the DON indicated, "No."</p> <p>There were no behavioral tracking sheet provided for Resident #36 picking of face.</p> <p>On 12/11/14 at 9:00 a.m., the DON provided policy "Behavioral management program" dated October 2013, and indicated that was the policy currently used by the facility. The policy indicated, "... Unnecessary drugs: Each resident has the right to be free from unnecessary</p>		<p>well as excessive dosing and adequate indication for psychoactive medications.</p> <p>In addition, nursing administration will be offered education regarding the systemic change.</p> <p>The Director of Nursing or designee will complete a QA audit tool for residents receiving a psychoactive medication for excessive dose, monitoring for side effects, behavior monitoring and adequate indication daily (including weekends) for 30 days, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p>				

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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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F000371 SS=F	<p>drug consumption which is defined as: Excessive dose, ...Excessive duration, ineffective monitoring, no indication for use, ..."</p> <p>There was no documentation for monitoring side effects for diazepam. There was documented excessive dose provided to Resident #36 when maximum recommended dose for Geriatric was 5 mg daily.</p> <p>3.1-48(a)(1) 3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and</p>	F000371		01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014
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	<p>record review, the facility failed to ensure staff used proper handwashing in the kitchen, failed to ensure food was discarded from 1 of 1 dry storage room when the expiration date had passed, nutritional refrigerator maintained proper temperature, and infection control practices were followed as indicated by facility policy and 410 IAC Retail Food Establishment Sanitation Requirements Manual. This deficient practice had the potential to affect 56 out of 56 residents who were served from the kitchen. (Cook #1, Dietary Aide #1)</p> <p>Findings include:</p> <p>On 12/3/2014 at 10:20 a.m. during initial tour the following were observed:</p> <p>A container of honey opened on 5/11/2014, no expiration date available. A container of corn syrup opened on 6/7/2014, with no expiration date available. An opened bag of cocoa which had been rolled down to close it, had an open date of 6/3/2014, no expiration date available. Bag of tortilla chip with an open date of 5/1/2014, no expiration date available.</p> <p>On 12/3/2014 at 10:30 a.m., an interview with the DM (Dietary Manager) indicated items without an expiration date they</p>		<p>F371 483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY</p> <p>Cook #1 and Dietary Aide #1 have received education regarding proper hand-washing and _____, and have completed a hand-washing competency check off. Cook #1 has been provided education regarding covering a cough and proper use of a thermometer for holding temperatures. The identified foods were discarded from the dry storage room during the survey process. The nutritional refrigerator is being maintained at the proper temperature, and has a temperature log to document the appropriate temperature recording. Infection control practices are being followed as indicated by facility policy and 410 IAC Retail Food Establishment Sanitation Requirement.</p> <p>All items in dry storage have been audited for dating if the item is opened and discarded if not dated. Any item opened with a date of longer than 30 days and without expiration date was discarded. Hand washing competencies will be completed for dietary staff. All refrigerators containing food items were audited for proper temperature log. Dietary staff has been re-educated o covering their</p>		

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	<p>dispose of within 30 days after opening. When asked about the cocoa, honey, tortilla chips, and corn syrup. The dietary manager indicated they would need to be disposed of since there was no expiration date on the containers and the items had been opened longer than 30 days.</p> <p>On 12/4/14 at 11:50 a.m., observed Cook #1; while taking the temperature of food on the holding table; to cough several times without covering her mouth nor handwashing. When brought to her attention Cook #1 was observed to handwash. The DM indicated, "I will deal with that, I will deal with that right now." Cook #1 was observed to take the temperature of food on the steam table and not waiting for the 15 seconds holding temperature once the thermometer had stopped. When asked how long should the temperature hold once stopped. Cook #1 indicated, " I don't know."</p> <p>On 12/4/14 at 12:00 p.m., observed Dietary Aide #1 (DA) in the kitchen touching clothing and face before taking the temperature of milk and yogurt. No handwashing was observed. When asked when should she handwash, DA #1 indicated, "Before and after I touch anything." Was that done? "I need to go wash my hands." Observed DA #1 walk</p>		<p>mouths when coughing and hand washing.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> · New dietary employees will be educated on the hand washing/infection control policy and procedure during orientation process and will complete a hand washing skills validation upon hire and at least annually · New dietary employees will be educated on food temperature protocols during the orientation process and will complete a skills validation upon hire and at least annually · New protocol put into place on nutritional refrigerator log monitoring that includes the appropriate temperatures, and who to contact if the temperatures are out of range · Food products will be audited for expiration twice weekly by the Dietary Manager, or designee. This auditing will be ongoing. <p>Education will be provided to dietary staff regarding systemic changes.</p> <p>Dietary Manager or designee will monitor kitchen/food prep area for hand washing per facility policy and infection control practices daily</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>over to the sink and handwash for 20 seconds.</p> <p>On 12/12/14 at 10:50 a.m., observation of the nutritional refrigerator with 100 hall Unit Manager indicated a temperature of 42.5 degrees Fahrenheit. When asked who maintains the nutritional refrigerator the 100 hall Unit Manager indicated "Dietary."</p> <p>On 12/12/14 at 11:10 a.m., the Dietary Manager provided documentation dated September, October and December of 2014. She indicated those were the Nutritional refrigerator temperature logs. She indicated she was not able to provide the temperature log for November. The temperature logs indicated during those 3 months documented temperatures above the recommended facility and 410 IAC 7-24 manual temperature of 41 degrees Fahrenheit.</p> <p>The December 2014 log indicated "...TEMPERATURE CHART-STORAGE AREAS ... PROPER TEMPERATURE: as reported on thermometer in unit, ... Refrigerator: 32 degrees Fahrenheit-41 degrees Fahrenheit, ..."</p> <p>On 12/12/14 at 10:55 a.m., interview with the Dietary Manager (DM) indicated</p>		<p>(including weekends) for 30 days, then weekly for a duration of 12 months of education. Any concerns will be addressed.</p> <p>In addition, Dietary Manger or designee will also monitor for proper use of a thermometer for holding temperatures, discarding items from dry storage, and completion of nutritional refrigerator temperature logs 3 times weekly for 30 days, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 2 months and then quarterly thereafter once compliance is at 100%. Frequency and duration will be increased as needed, if compliance is below 100%.</p> <p>Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014	
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443			
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	<p>the temperature in the nutritional refrigerator should have been 41 degrees or below." When asked what steps should be taken when the temperature is not within range, the DM indicated, "The nursing staff should have notified maintenance because they chart the temperatures."</p> <p>On 12/12 at 12:00 p.m., interview with Maintenance Supervisor indicated when asked if staff had informed him of temperature irregularity with the Nutritional refrigerator, "No."</p> <p>On 12/12/14 at 12:05 p.m., interview with the Administrator indicated nursing staff was suppose to notify maintenance when temperatures were not correct. The Administrator indicated there was no policy available on steps to take when the temperatures are out of range in the refrigerator.</p> <p>On 12/11/14 at 9:00 a.m., the Dietary Manager provided policy "Environmental Sanitation/Infection Control" dated 2012, and indicated that was the policy currently used by the facility. The policy indicated...2. Hands are properly washed before and /or after the following activities ...: After touching bare human body parts,...after touching clothing."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443		
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	<p>On 12/11/14 at 10:32 a.m., the Dietary Manager provided policy "HAND WASHING" undated, and indicated that was the one currently used by the facility. The policy indicated, ...Sec. 128.[a] for at least twenty [20] seconds in water ... 129 When to wash hands ...1. After touching bare human body parts other than clean hands and clean, exposed portions of arms, ... 4. After coughing, sneezing, or using handkerchief or disposable tissue, ... 11. After engaging in other activities that contaminate the hands. ..."</p> <p>Review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24" dated November 13, 2004 on 12/14/14 at 1:00 p.m., indicated ..."Hand cleaning and drying procedure ... (a) Food employees shall, except as specified in section 343 (c) of this rule, clean their hands and exposed portions of their arms with a cleaning compound at a hand washing sink that is equipped as specified by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water ... When to wash hands (a) Food employees shall clean their hands and exposed portions of their arms as specified ... immediately before engaging in food preparation. ... and the following... (6) After handling soiled</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014	
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443			
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F000428 SS=D	<p>surfaces, equipment, or utensils ... after engaging in other activities that contaminate the hands."</p> <p>410 IAC 7-24-187 Potentially hazardous food; hot and cold holding 2) At a temperature specified in the following: (A) At forty-one (41) degrees Fahrenheit or less. (B) At forty-five (45) degrees Fahrenheit or between forty-five (45) degrees Fahrenheit and forty-one (41) degrees Fahrenheit in existing refrigeration equipment that is not capable of maintaining the food at forty-one (41) degrees Fahrenheit or less if: (i) the equipment is in place and in use in the retail food establishment; and (ii) by April 29, 2010, the equipment is upgraded or replaced to maintain food at a temperature of forty-one (41) degrees Fahrenheit or less. (b) For purposes of this section, a violation of subsection (a) is a critical item."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2014
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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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	<p>reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure that the pharmacist reported any irregularities to the attending physician and Director of Nursing when a resident prescribed an anticonvulsant drug did not have adequate indication for its use and was given in excessive dosage for 1 of 5 residents reviewed for unnecessary medication use. (Resident #36)</p> <p>Findings include:</p> <p>Resident #36's clinical record was reviewed on 12/9/14 at 2:01 p.m. Diagnosis included, but were not limited to: episodic mood disorder, and depressive disorder.</p> <p>The current Minimum Data Set (MDS) assessment dated 11/24/14, indicated a Brief Interview Mental Status score (BIMS) of 3, which was not cognitively intact nor interviewable.</p> <p>Physician's order dated 10/21/14, indicated Resident #36 received</p>	F000428	<p>F428.60 (c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>Resident #36 has had a dose reduction of the diazepam. The diagnosis has been reviewed by the pharmacist and physician for adequate indication.</p> <p>Resident #36 experienced no negative adverse reactions or negative outcome from diazepam dosing</p> <p>The pharmacist consultant will complete a review of all residents receiving diazepam and like medications in regards to adequate indication for its use and any excessive doses and any concerns were addressed.</p> <p>The Systemic Change includes:</p> <ul style="list-style-type: none"> The pharmacy consultant will review all residents' records monthly for like medications in relation to adequate indication for its use and any excessive doses. This review is supplied to the Director of Nursing and appropriate physicians monthly for any actions needed. <p>Education will be provided to Nursing administration and the pharmacy consultant regarding the systemic change.</p>	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014	
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>diazepam 10 mg (milligram) every morning for mood disorder and diazepam 5 mg hs (hour of sleep).</p> <p>Lippincott's Nursing Drug Guide dated 2014, indicated "...Anxiety, ... Acute alcohol withdrawal, ...Muscle spasm, ...Status epilepticus, severe recurrent seizure, ...INDICATIONS & DOSAGES: For elderly or debilitated patients, give 2-2.5 mg PO [by mouth] daily-bid [twice a day]..."</p> <p>There were no active diagnosis indicated for the use of Diazepam in the clinical records.</p> <p>On 12/11/14 at 11:40 a.m., interview with the DON indicated when asked to explain why Resident #36 was receiving Diazepam, "He was getting it for a while back. He tends to pick at his face. They should have put the diagnosis on his face sheet or his order." Observed the DON to look on physicians order for Diazepam and she indicated the diagnosis was mood disorder. When asked if mood disorder was an indicated diagnosis for Diazepam, the DON indicated, "No."</p> <p>There were no behavioral tracking sheet provided for Resident #36 picking of face.</p>		<p>The Director of Nursing or Designee will complete a quality assurance tool to audit that all residents receiving diazepam and like medications have been reviewed by the pharmacy consultant and action taken as appropriate per the pharmacist's recommendations. This review will be completed monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 2 months and then quarterly thereafter once compliance is at 100%. Frequency and duration will be increased as needed, if compliance is below 100%. Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014	
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 12/11/14 at 9:00 a.m., the DON provided policy "Behavioral management program" dated October 2013, and indicated that was the one currently used by the facility. The policy indicated, "... Unnecessary drugs: Each resident has the right to be free from unnecessary drug consumption which is defined as: Excessive dose, ...Excessive duration, ineffective monitoring, no indication for use, ..."</p> <p>There was no documentation for monitoring side effects for diazepam. There was documented excessive dose provided to Resident #36 when maximum recommended dose for Geriatric was 5 mg daily.</p> <p>During July-December 2014, Pharmacist reviewed medications monthly.</p> <p>On 12/4/14 at 10.00 a.m., the Administrator provided policy "Resident Rights"undated, and indicated that was the policy currently used by the facility. The policy indicated, "... Pharmacy Services, Our Community's pharmacy services will consult with your physician regarding your medications. A licensed pharmacist will review your prescription records each month. ..."</p> <p>3.1-25(i)</p>						

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NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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F000431 SS=D	<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</p>			

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
--------------------------------------------------------------------	------------------------------------------------------------------------------------

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	<p>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 that expired medications were disposed of as the facility policy indicated for 1 of 1 medication rooms and 1 of 6 medication carts reviewed for medication storage. (Resident #14, Resident #56, and Resident #81)</p> <p>Findings include:</p> <p>1. On 12/11/2014 at 11:35 a.m., observation with LPN (Licensed Practical Nurse) #2 of the medication refrigerator in the medication storage room observed Resident #81's IV (intravenous) antibiotic Vancomycin 1.5 gm/250 ml (milliliter) NS (normal saline) was received from the pharmacy on 11/19/2014, and expired on 12/03/2014. One of one doses expired.</p> <p>Resident #81's Vancomycin 1.5 GM/250 ml NS IV antibiotic received from the pharmacy on 11/18/2014, and expired on 12/02/2014. Three of five doses were expired.</p> <p>Vancomycin 1.5 gm/250 NS sent from pharmacy on 11/18/2014, expired on 12/02/2014 found Unrefrigerated in Resident #81's bin. The pharmacy label on bag indicated refrigerate.</p>	F000431	<p>F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORAGE DRUGS & BIOLOGICALS</p> <p>The expired medications for Resident #14, #56 and #81 were destroyed during the survey process.</p> <p>All medication storage areas were audited during the survey process for any expired medications, proper storage of medications and discontinued medications and no other concerns were noted.</p> <p>LPN #1 and LPN #2 received re-education on expired medications, medication administration documentation, and proper storage of medications.</p> <p>The Systemic change includes:</p> <ul style="list-style-type: none"> A "Cart Captain Program" will be initiated, in which a designated Nursing Administrative person reviews all medication carts and medication storage areas for expired medications and proper storage of medications. <p>Education will be provided to licensed nurses regarding the Cart Captain Program and proper medication storage, and timely</p>	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014	
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Two Vancomycin 1 gm/100 ml found in Resident #80's bin one bag with expiration of 12/08/2014, sent from pharmacy on 11/24/2014, and the other bag expired on 12/10/2014 bag was sent from the pharmacy on 11/26/2014.</p> <p>2. Resident #14's Gentamycin 120/mg/100 ml NS IV antibiotic was received from the pharmacy on 12/06/2014 and expired 12/10/2014, 4 of 8 doses were expired.</p> <p>None of the IV antibiotics were labeled as expired or discontinued.</p> <p>On 12/11/2014 at 11:45 a.m., an interview with LPN #2 indicated the medications were expired and were removed by LPN #2.</p> <p>3. An observation of the 300 hall (odd room number) medication cart indicated Resident #56's NovoLog (fast acting insulin) flexpen had been dispensed and opened on 11/10/2014 and expired on 12/8/2014. At that time, an interview with LPN #2 indicated the NovoLog was expired.</p> <p>On 12/12/14 at 9:27 a.m., the Administrator provided the Drug Storage policy undated, and indicated the policy</p>		<p>destruction of expired medication.</p> <p>The Unit Manager or designee will complete a QA Audit tool to monitor medication storage areas for proper storage of medications, as well as timely disposal of expired medications 5 days a week for 30 days, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Compliance date: 1/11/2015. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/12/2014	
NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=D	<p>was the policy currently being used by the facility. The policy indicated, "...All expired, damaged and/or contaminated medications are removed from resident care areas and stored separately from medications available for administration....9. Discontinued and expired medications should be removed from medications carts, refrigerators and cupboards promptly...discontinued drug container shall be marked to indicate that the drug has been discontinued...Refrigerator Storage: 4. Discontinued and expired medications should be removed from medication refrigerators promptly. Return drugs or destroy them according to pharmacy and facility policies....7. Insulin...need to be dated when opened. All vials should be discarded within 28 days of the open date...."</p> <p>3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease</p>						

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--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
--------------------------------------------------------------------	------------------------------------------------------------------------------------

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	<p>and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing during patient care in that a Certified Nursing Assistant was observed not to handwash 20 seconds after emptying a residents urinal as indicated by the facility policy for 1</p>	F000441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS C.N.A. #1 has been provided education and completed a competency check for hand washing. Hand washing skills validation will be completed for nursing staff Resident #23 was assessed and has had no negative outcome related to this	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443
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	<p>randomly observed resident during stage 2. (Resident #23) (CNA #1)</p> <p>Findings include:</p> <p>On 12/4/14 at 9:48 a.m., observed CNA #1 to enter Resident #23's room to answer call light. No handwashing was observed. She put on gloves and emptied Resident #23's urinal. She entered the bathroom and handwashed for 7 seconds and exited the room. When asked when should you hand wash, CNA #1 indicated, "Before, or after any type of patient care, leaving room, before resident meals, and assisting with people eating, wash in between. Anytime you touch your face, hair or clothes, you need to wash your hands." When asked if that was done, CNA #1 indicated, "No, we have no hot water." When asked how long you should handwash, CNA #1 indicated, "At least 20 seconds." When asked was that done, CNA #1 indicated, "No, the water was too cold."</p> <p>On 12/11/14 at 9:00 a.m., the Dietary Manager provided policy "Environmental Sanitation/Infection Control" dated 2012, and indicated that was the policy currently used by the facility. The policy indicated...2. Hands are properly washed before and /or after the following activities ...: After touching bare human</p>		<p>alleged deficiency The Systemic Change includes: · New nursing employees will be educated on hand washing policy and a skills validation will be completed upon hire and at least annually Nursing staff will be provided education on the hand washing policy Director of Nursing or designee will be doing audits to monitor 3 nursing staff members for proper hand washing techniques on varying shifts and hallways 5 days a week for 4 weeks, then weekly for 60 days, then every other week for a duration of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p>	

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F000465 SS=D	<p>body parts,...after touching clothing."</p> <p>On 12/11/14 at 10:32 a.m., the Dietary Manager provided policy "HAND WASHING" undated, and indicated that was the one currently used by the facility. The policy indicated, ...Sec. 128.[a] for at least twenty [20] seconds in water ... 129 When to wash hands ...1. After touching bare human body parts other than clean hands and clean, exposed portions of arms, ... 4. After coughing, sneezing, or using handkerchief or disposable tissue, ... 11. After engaging in other activities that contaminate the hands. ..."</p> <p>3.1-18(I)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure residents had a clean environment in that overhead lighting in resident halls indicated dead bugs as well as dirty vents. This was observed on resident halls 100, 200 and 300 for 3 of 3 halls observed.</p>	F000465	<p>F465 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMF ORTABLE ENVIRON</p> <p>The overhead lighting and vents were cleaned on resident halls 100, 200 and 300 during the survey</p>	01/11/2015			

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	<p>Findings include:</p> <p>Observation on 12/8/14 at 10:00 a.m., on resident hallway 100, a dead bug was noted in the fifth light from the front of the hall.</p> <p>Observation on 12/8/14 at 10:15 a.m., on resident hallway 200, in 1 out of 14 lights were noted to have dead bugs in them. The ceiling air vents were observed with a build up of dust.</p> <p>Observation on 12/8/14 at 10:30 a.m., on resident hallway 300, in 1 of 2 lights on the front of the 300 hall had dead bugs in them. The last two lights on the 300 hall had dead bugs in it, as well as 2 of 7 lights on the back part of 300 hall.</p> <p>Re-observation of these areas on 12/10/14 at 3:00 p.m., indicated no changes since the time of initial observations.</p> <p>Interview with Maintenance Supervisor on 12/10/14 at 3:45 p.m., indicated he would take a vacuum and clean the vents and would remove all dead bugs from light fixtures.</p> <p>3.1-19(f)</p>		<p>process.</p> <p>All overhead lighting fixtures and vents have been audited and cleaned</p> <p>The Systemic Changes includes:</p> <ul style="list-style-type: none"> The Maintenance Director, or designee will follow a routine monthly cleaning schedule and document date and location that cleaning occurred <p>Education will be provided to the Maintenance Director and housekeeping staff on cleaning requirements of lighting fixtures and vents.</p> <p>The Maintenance Director, or designee will complete a QA audit for clean lighting fixtures and vents weekly for 30 days, then monthly for a duration of 12 months of monitoring. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring</p>		

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F000514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure the clinical records and the medication administration records were accurate as the facility policy indicated for 4 of 21 residents whose charts were reviewed. (Resident #21, Resident #35, Resident #43 and Resident #79)</p> <p>Findings include:</p> <p>1. Resident #79's clinical record was reviewed on 12/10/2014 at 10:55 a.m. Diagnoses included but, were not limited to: lung cancer, pressure ulcer, chronic obstructive pulmonary disorder.</p>	F000514	<p>compliance in this Plan of Correction</p> <p>F514 483.75(l)(1) RES RECORDS – COMPLETE/ACCURATE/ACCESSIBLE</p> <p>Weekly skin assessments are being completed on resident #79. Resident #79 has appropriate wound treatment per physician orders. Documentation is complete and accurate in the medical record.</p> <p>All residents with skin conditions have been identified and documentation will be reviewed for accuracy and complete documentation in the medical record for the last 30 days. All concerns will be addressed.</p>	01/11/2015			

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	<p>A skin assessment on admission dated 10/23/2014 at 11:43 p.m., indicated a pressure ulcer to the coccyx measuring 1.0 X 1.0 <0.1 cm (centimeters) and a pressure ulcer to the right buttock measuring 0.7 X 0.6 < 0.1 cm.</p> <p>Review of 72 hour observation dated 10/24/2014, signed by LPN #6 indicated skin was clean/dry/intact.</p> <p>Review of 72 hour post admission-readmission assessment dated 10/27/2014 at 11:05 p.m., indicated Resident #79's skin was clean/dry/intact, dry and warm. Signed by LPN #4.</p> <p>Review of the Pressure Ulcer Evaluation dated 10/28/2014 at 8:48 p.m., indicated, " Wound to coccyx measures 0.9 X 0.6<0.1 [cm]. Wound to right buttock measures 0.8 X 0.8 <0.1 [cm]. Both wounds staged at Stage 2 pressure."</p> <p>Review of the Pressure Ulcer Evaluation dated 11/4/2014, at 6:13 p.m., signed by the Wound Care Nurse, indicated, "a stage 2 pressure ulcer to the coccyx measuring 1.0 X 0.7 < 0.1 cm."</p> <p>Review of the Weekly skin Inspection Tool dated 11/5/2014, at 2:22 a.m. and signed by LPN #5 indicated a nurses note indicated Resident #79's skin was: "WDI</p>		<p>LPN #3, 4, 5, 6 have been given education regarding accurate documentation of skin conditions, timely signing off on medication administration, side effect monitoring, pain assessment, and documentation of IV flushes.</p> <p>Resident #43 had no negative side effects for the lack of monitoring for side effects of the anxiolytic and is being monitored now. Any concerns will be addressed.</p> <p>Resident #21 had no negative side effects from the lack of documentation of pain and fluid documentation and was assessed and found to be well hydrated.</p> <p>Resident #35 Midline catheter was assessed to be patent and without problems and had no negative outcome from the lack of flush documentation.</p> <p>Resident physicians and responsible parties were notified of the documentation omissions.</p> <p>Medication compliance report was audited on current residents for past 2 week time period. Any omissions were addressed.</p> <p>All residents with skin conditions have been identified and documentation reviewed for accuracy for the last 2 weeks. Any</p>				

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	<p>[Warm Dry and Intact] DRG [dressing] CDI [clean, dry,and intact] to coccyx. Steri Strip over left eye. Scattered bruises to ABD [abdomen]."</p> <p>On 12/10/2014 at 12:00 p.m., an interview with the Wound Care Nurse indicated the charting on Resident #79 that indicated his skin was intact was inaccurately documented.</p> <p>On 12/11/2014 at 10:18 a.m., the Administrator provided the Charting and Documentation policy dated April 2008, and indicated it was the policy currently used by the facility. The policy indicated, "1. All observations, medication, administered, services performed, etc., must be documented in the resident's clinical records."</p> <p>2. On 12/11/2014 at 9:43 a.m., an observation of Resident #43's medication administration record (MAR) during review of medication administration with RN #3 indicated LPN #3 had not signed off the 6:00 a.m. scheduled levothyroxine 125 mcg and the 5:00 a.m., scheduled alprazolam 0.25 mg.</p> <p>Observation of Resident #43's MAR indicated LPN #3 had not signed off the resident had been monitored for side effects of the anti-anxiety medication.</p>		<p>concerns were addressed.</p> <p>The Systemic Changes include:</p> <ul style="list-style-type: none"> Medication compliance report and resident progress notes will be reviewed in the clinical meeting Monday – Friday for omissions and accuracy. Any concerns will be addressed with the involved nursing staff member. Licensed nurses and QMAs will complete a medication compliance report at the end of each shift for any missed documentation. This will be completed between the on-coming nurse/QMA with the off-going nurse/QMA to review any concerns with omission of medication administration documentation. <p>Education will be provided to licensed nurses and QMAs regarding accurate and complete documentation in the medical record for skin conditions, medication administration, medication side effect and pain monitoring</p> <p>The Director of Nursing or designee will complete a QA audit tool monitoring documentation of medication administration. In</p>				

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	<p>LPN #3 had also failed to document on Resident #21's MAR's that the resident's pain had been assessed on the shift, and the 90 ml (milliliters) of fluid was given with medication pass.</p> <p>Resident #35's MAR's indicated LPN #3 had not documented the Midline catheter, Multi-lumen central catheter, PICC line flush-normal saline 5 ml followed by 2 ml of Heparin every shift for each lumen.</p> <p>On 12/11/2014 at 10:00 a.m., an interview with the Director of Nursing indicated LPN #3 was returning to the facility to sign the resident's medication records that had not been signed off.</p> <p>On 12/11/2014 at 10:18 a.m., the Administrator provided the Medication Administration General Policies & Procedures undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "6. The nurse or designee administering the medication is to initial the resident's MAR in the space provided under the date for that drug and time of administration. The nurse is responsible for verifying the initials with a full signature and title in the space provided at the bottom of the resident's MAR...9. If a dose of regularly scheduled</p>		<p>addition, the QA auditing tool will include monitoring of pain and medication side effect monitoring in the MAR. This auditing will include a review of progress notes on all residents with skin conditions for accuracy. This auditing will be completed daily (including weekends) for 30 days, weekly for 5 months, and then monthly for an additional 6 months for a total of 12 months of monitoring.</p> <p>The results of these reviews will be discussed in the monthly facility Quality Assurance Committee meeting for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%</p> <p>Compliance date: 1/11/15. The Administrator at Lyons Health and Living is responsible in ensuring compliance in this Plan of Correction.</p>				

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	<p>medication is withheld, refused or spit out, the nurse or approved designee is to initial and circle the initials in the residents MAR, or electronically document...An explanatory note is then to be entered on the reverse side of the record in the space provided for PRN documentation..."</p> <p>3.1-50(a)(2)</p>				