

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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F0000	<p>This visit was for the Investigation of Complaints IN00108484, IN00113498, and IN00114756.</p> <p>Complaint IN00108484-Substantiated. Federal/state deficiencies related to the allegations are cited at F325 and F514.</p> <p>Complaint IN00113498-Substantiated. Federal/state deficiency related to the allegation is cited at F325</p> <p>Complaint IN00114756-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F325, and F514.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: August 30-31, 2012 and September 4, 2012</p> <p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Survey team: Janet Adams, RN, TC September 4, 2012 Janelyn Kulik, RN August 30-31, 2012</p>	F0000	<p>Preparation, Submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
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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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	<p>Census bed type: SNF/NF: 109 Total: 109</p> <p>Census payor type: Medicare: 10 Medicaid: 77 Other: 22 Total: 109</p> <p>Sample: 10</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 9, 2012 by Bev Faulkner, RN</p>			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the resident's family of medication changes and weight loss and also failed to notify the resident's Physician of decreased oral</p>	F0157	F157D The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident D has been	09/28/2012			

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	<p>intake and weight loss for 1 of 9 residents reviewed for Physician and family notification in the sample of 10. (Resident #D)</p> <p>Findings include:</p> <p>The closed record for Resident #D was reviewed on 9/4/12 at 9:10 a.m. The resident was admitted to the facility on 7/19/12. The resident's diagnoses included, but were not limited to, anxiety state, hypothyroidism, and essential hypertension (high blood pressure).</p> <p>The 7/12 and 8/12 Physician orders were reviewed. There was an an order written on 7/24/12 for the resident to have a Fentanyl (a narcotic medication given for pain) 12 micrograms/24 hour patch applied to the skin once every 72 hours. There was a Physician order written on 8/9/12 for the resident to receive Neurontin 500 milligrams one tablet three times a day. There was a Physician order written on 8/8/12 for the resident to receive Seroquel (an antipsychotic medication) 25 milligrams one tablet two times a day at 8:00 a.m. and 5:00 p.m.</p> <p>Review of the 7/12 and 8/12 Nurses' Notes indicated there was no documentation indicating the resident's family had been notified of the above</p>		<p>discharged from the facility Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Nursing staff will be reeducated regarding notification of change. DNS/Designee will review nurse's notes 7 days a week during Clinical Start-Up to ensure that notification has been made to physicians and family. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Change of Condition Reports will be completed by the Charge nurse and reviewed daily by DNS/Designee to ensure notification of physician and family has been made. Nursing staff will be reeducated regarding notification of change. DNS/Designee will review nurse's notes 7 days a week during Clinical Start-Up to ensure that notification has been made to physicians and family. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will report findings of audits to monthly</p>		

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	<p>orders for the three new medications.</p> <p>The resident's weight records were reviewed. The following weights were recorded for the resident: 7/20/12 130.4 pounds 7/27/12 113.6 and a reweigh of 130.4 pounds 8/03/12 134 pounds 8/10/12 113 with a reweigh of 121.2</p> <p>The 7/12 and 8/12 Resident Meal Logs were reviewed.</p> <p>The Resident Meal Logs indicated the following consumption percents were recorded: 8/01/12 Breakfast, Lunch, Dinner, and evening snack - all 0% consumed.</p> <p>8/02/12 Breakfast 50% Dinner 0%</p> <p>8/03/12 Breakfast 0% Lunch 25% Evening Snack 0%</p> <p>8/04/12 Breakfast 50 % Lunch 0% Dinner 50% Evening snack 25%</p>		<p>QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented. Addendum: All residents were audited by either DON, ADON and Unit Managers for compliance and all were found compliant. As stated above audit will be reported to the QA committee by DON or Designee monthly for the next 6 months until 100% compliant for 6 months and then quarterly there after.</p>				

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	8/05/12 Breakfast 0% Lunch 25 % Dinner 75% Evening snack 0%			
	8/06/12 Breakfast, Lunch, Dinner, and Evening snack - all 0%			
	8/07/12 Dinner 50% Evening snack 50%			
	8/08/12 Breakfast, Lunch, Dinner, and Evening snack- all 0%			
	8/09/12 Breakfast and Lunch - 0% Dinner 50% Evening snack 0%			
	8/10/12 Breakfast, Lunch, Dinner, and Evening Snack -all 0%			
	8/11/12 Breakfast, Lunch, Dinner, all 0% Evening snack 100%			
	8/12/12 Breakfast and Dinner 0%			

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	<p>Lunch 25%</p> <p>8/13/12</p> <p>Breakfast 0%</p> <p>Review of the 8/12 Nurses' Notes indicated there was no documentation of the resident's family and/or Physician being notified of the above weight changes or the decrease in the resident's oral meal consumption.</p> <p>The facility policy titled "Clinical Start-Up Guideline" was received from the Director of Nursing on 9/4/12 at 10:35 a.m. The Director of Nursing indicated the policy was current. The policy indicated staff were to assure communication to Physicians, residents, and families was in place on any condition changes.</p> <p>When interviewed on 9/4/12 at 2:40 p.m., the Director of Nursing indicated the resident's family should have been notified of the new medication orders and it should be noted in the Nurses' Notes. The Director of Nursing also indicated the management staff does audit any changes in condition or orders daily and if they note the family was not notified of changes and new orders they should follow-up and ensure the notification is</p>						

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	<p>done.</p> <p>This federal tag relates to Complaint IN00114756.</p> <p>3.1-5(a)(2)</p>			

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to implement interventions for a decrease in oral intake which resulted in weight loss and also failed to initiate interventions after the weight loss was noted for 1 of 3 resident in the sample of 10 reviewed for weight loss. (Resident #D)</p> <p>Finding include:</p> <p>The closed record for Resident #D was reviewed on 9/4/12 at 9:10 a.m. The resident was admitted to the facility on 7/19/12. The resident's diagnoses included, but were not limited to, anxiety state, hypothyroidism, and essential hypertension (high blood pressure). The resident was discharged on 8/13/12.</p> <p>Review of the 8/2/12 Physician Order Statement indicated there was an order for the resident to receive a regular diet with</p>	F0325	<p>F325D The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident D no longer resides at the facility. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Residents with a weight loss will be reviewed at weekly NAR meeting and by RD. All RD recommendations will be reviewed by the NAR members and the DNS/Designee will contact the physician to ensure the recommendations have been implemented The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Residents with a weight loss will be reviewed at weekly NAR meeting and by RD. All RD</p>	09/28/2012			

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	<p>cranberry juice at breakfast and lunch. There were no other nutritional supplements ordered.</p> <p>The residents weight records were reviewed. The following weights were recorded for the resident: 7/20/12 130.4 pounds 7/27/12 113.6 pounds with a re-weigh of 130.4 pounds 8/03/12 134 pounds 8/10/12 113 pounds with a re-weigh of 121.2</p> <p>The 7/12 and 8/12 Resident Meal Logs were reviewed. The Resident Meal Logs indicated the following consumption percents were recorded: 8/01/12 Breakfast, Lunch, Dinner, and evening snack - all 0% consumed.</p> <p>8/02/12 Breakfast 50% Dinner 0%</p> <p>8/03/12 Breakfast 0% Lunch 25% Evening Snack 0%</p> <p>8/04/12</p>		<p>recommendations will be reviewed by the NAR members and the DNS/Designee will contact the physician to ensure the recommendations have been implemented New orders will be reviewed during Clinical Start Up daily through Match Back Procedure These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented. Addendum: All weights were reviewed by Dietician and Dietary Manger for any potential weight loss or increase and appropriate measures were taken for those at risk. Audits will continue for at least 6 months of 100% compliance and quarterly there after if compliance is met.</p>				

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	<p>Breakfast 50 % Lunch 0% Dinner 50% Evening snack 25%</p> <p>8/05/12 Breakfast 0% Lunch 25 % Dinner 75% Evening snack 0%</p> <p>8/06/12 Breakfast, Lunch, Dinner, and Evening snack - all 0%</p> <p>8/07/12 Dinner 50% Evening snack 50%</p> <p>8/08/12 Breakfast, Lunch, Dinner, and Evening snack- all 0%</p> <p>8/09/12 Breakfast and Lunch - 0% Dinner 50% Evening snack 0%</p> <p>8/10/12 Breakfast, Lunch, Dinner, and Evening Snack -all 0%</p> <p>8/11/12 Breakfast, Lunch, Dinner, all 0%</p>						

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	<p>Evening snack 100%</p> <p>8/12/12 Breakfast and Dinner 0% Lunch 25%</p> <p>8/13/12 Breakfast 0%</p> <p>The Dietary Notes were reviewed. A Nutrition Assessment was completed by a Registered Dietitian on 8/4/12. The assessment indicated the resident's admission and current weights were 130 pounds and the residents IBW (Ideal Body Weight) range was 117-130 pounds. The assessment indicated the resident had increased nutrient needs. Nutrition interventions in place at this time were for the resident to receive a regular diet, cranberry juice at breakfast and lunch, and to encourage evening snacks. The Nutrition Goals for the resident were for the resident to consume 75% of meals, to tolerate a regular diet, and for her skin to remain intact. There were no further dietary notes or assessments completed by the Registered Dietitian after 8/4/12.</p> <p>The 7/12 and 8/12 Progress Notes were reviewed. NAR (Nutrition at Risk) notes were made on 7/27/12 at 3:17 p.m.,</p>				

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	<p>8/13/12 at 2:00 p.m., and 8/3/12 at 11:38 a.m.</p> <p>The 7/27/12 NAR note indicated the resident's current weight was 130.4 pounds and the resident was consuming 40% of her regular diet and weekly weights were to be monitored x 4 weeks. The 8/3/12 NAR note indicated the resident's current weight stable at 134 pounds and the resident was consuming 25% of her regular diet. The 8/13/12 NAR note indicated the resident's current weight was 121.2 pounds, which was up from 113 pounds and the resident was consuming 20% of her regular diet. The above three NAR notes were made by the Director of Nursing. No interventions were put into place after the resident's weight was noted to decrease between from 134 pounds to 121.1 pounds between 8/3/12 and 8/10/12. The Nurses' progress notes and the NAR notes did not indicate the Registered Dietitian nor the Physician were notified of the weight loss and decreased oral food consumption.</p> <p>An entry made by Nursing on 8/9/12 at 4:15 p.m., indicated the resident consumed bites of her meal and needed assistance from staff to consume 25% of the evening meal. An entry made by Nursing on 8/9/12 at 2:16 p.m., indicated the resident's lunch was served in bed and her appetite was poor. An entry made by</p>						

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	<p>Nursing on 8/8/12 at 2:43 p.m., indicated the resident was served lunch in her room and her appetite was poor.</p> <p>The facility Weight Monitoring Policy was reviewed on 9/4/12 at 10:35 a.m. The policy was received from the Director of Nursing and identified as current. The Policy indicated when a weight change was significant or severe the licensed nurse was to notify the Physician and the resident's family or legal representative. The Policy also indicated the a significant weight loss or trend was identified, an assessment of the resident's nutritional status was to be conducted to identify the cause of the change and nutritional interventions to be implemented.</p> <p>When interviewed on 9/4/12 at 2:40 p.m., the Director of Nursing indicated the resident had a weight loss noted on 8/10/12. The Director of Nursing indicated the resident's weights were reviewed in NAR. The Director of Nursing indicated there were no other interventions noted upon identification of the decreased oral intakes and the weight loss of approximately 12 pounds from 8/3/12 -8/10/12.</p> <p>This federal tag relates to Complaints IN00108484, IN00113498, and IN00114756.</p>			

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	3.1-46(a)(1)			

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F0441 SS=D	<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 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.</p> <p>Based on observation, record review and interview, the facility failed to follow</p>	F0441	F441 D The corrective actions accomplished for those	09/28/2012			

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	<p>standard precautions during the performance of routine testing of blood glucose related to ensuring the glucometer (blood glucose monitoring device) was disinfected after using on 1 of 1 residents (Resident #K) on 1 of 2 units. A total of 49 residents resided on the unit. This had the potential to affect a total of 21 residents on the unit who required blood glucose testing. (The 200 Unit) (LPN #1)</p> <p>Findings include:</p> <p>On 8/31/12 at 11:52 a.m., LPN #1 was observed entering the room of Resident #K. The LPN was observed to put on a pair of gloves, she cleaned the resident's finger with an alcohol wipe, used a lancet to stick the resident's finger and obtained the blood glucose reading. She informed the CNA in the room she would return to help her after she gave the resident his insulin. She returned to the medication cart and set the glucometer on top of the cart. She disposed of the lancet in the sharps container. She removed her gloves and prepared the resident's insulin. She returned to the resident's room, put on gloves and gave the resident his insulin. She then went into the resident's bathroom and washed her hands, re-gloved and assisted the CNA with a</p>		<p>residents found to have been affected by the deficient practice are as follows: LPN#1 was immediately reeducated on cleaning the blood glucose monitoring machine. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Nursing staff was reeducated on cleaning the glucose monitoring machine by 9/28/12. DNS/Designee will audit the nursing staff 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 weeks on different shifts to ensure the blood glucose monitoring machine is cleaned properly. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing staff was reeducated on cleaning the glucose monitoring machine by 9/28/12. DNS/Designee will audit the nursing staff 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 weeks on different shifts to ensure the blood glucose monitoring machine is cleaned properly. These corrective actions will be monitored and a quality assurance program</p>				

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	<p>Hoyer transfer. She removed her gloves and washed her hands. At 12:00 p.m., the LPN put a monitoring strip into the glucometer that had been left on the medication cart and started to leave the medication cart. She was asked if she was going to do another blood sugar reading and she indicated, yes. When asked if she had cleaned the glucometer she indicated no and returned to the cart and cleaned the glucometer. She then indicated she used 70% alcohol to clean the glucometer. At 12:02 p.m., when questioned as to the policy to clean the glucometer she indicated she was not sure of the policy but thought alcohol was part of the policy. The policy was requested at this time.</p> <p>On 8/31/12 at 12:10 p.m., the Blood Glucose Cleaning/Control Testing for Individual Resident Monitors was provided by LPN #1. The policy indicated,"Individual blood glucose monitors will be issued to resident requiring testing and will be cleaned and control tested per policy. For purposes of this procedure it is assumed the monitor is used for a single resident." Policy interpretation and implementation: The monitors will be cleaned at least weekly. Use 70% alcohol.</p> <p>On 8/31/12 at 12:14 p.m. the Director of</p>		<p>implemented to ensure the deficient practice will not recur per the following: DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented. Adendum: Audits will continue monthly for 6 months and quarterly if 100% compliance is met for 6 months.</p>	

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	<p>Nursing provided a policy for Blood Glucose Monitor Decontamination, the original date of the policy was 6/2012. The purpose of the policy: "To implement a safe and effective process for decontaminating blood glucose monitors. A wipe that is an EPA registered as tuberculocidal, effective against HIV, HBV, and a broad spectrum of bacteria will be utilized to clean the monitor. It is 0.525% sodium hypochlorite which is equivalent to a 1:10 bleach dilution solution, and meets recommendation for use on equipment for Clostridium difficile rooms. If a product wipe is not available, a 1:10 bleach solution may be substituted. Policy: The blood glucose monitor will be cleaned and disinfected with wipes following use on each resident when monitors are shared by multiple residents and at times designated on Blood Glucose Monitor Cleaning/Control Testing for Individual Resident Monitors Policy. Gloves will be worn. Procedure: I. The nurse will obtain the blood glucose monitor along with the wipes and place the monitor on a clean surface. II. After performing the glucose testing, the nurse wearing gloves, will use a dispatch wipe to clean all external parts of the monitor. III. A second wipe will be used to disinfect the blood glucose monitor. IV. The disinfected monitor will be placed on another clean surface.</p>			

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	<p>V. Gloves will be removed and hand hygiene performed."</p> <p>At this time, the Director of Nursing handed LPN #1 a container of disinfectant wipes to put on her medication cart. She indicated all of the carts were to have the wipes and she was making sure all of the carts had the wipes at this time.</p> <p>Interview with LPN #1 on 8/31/12 at 12:20 p.m., indicated she had been in-serviced on the the cleaning of the glucometers, but she did not remember having been told anything about the disinfectant wipes. She also indicated she had not seen the wipes on the medication cart before today.</p> <p>Interview with the Director of Nursing on 8/31/12 at 3:20 p.m., indicated staff had been in-serviced on the disinfecting of the glucometers, but LPN #1 had not attended. The Director of Nursing indicated she was in the process of in-servicing all of the staff at the present time.</p> <p>3.1-18(b)(1)</p>						

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F0514 SS=B	<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 record review and interview, the facility failed to ensure clinical records were accurate and completed related to incomplete food consumption records and not signing out ordered tube feedings and flushes on the Treatment Records for 3 of 9 residents reviewed for clinical record documentation in the sample of 10. (Residents #B, #C, and #D)</p> <p>Findings include:</p> <p>1. The closed record for Resident #D was reviewed on 9/4/12 at 9:10 a.m. The resident was admitted to the facility on 7/19/12. The resident's diagnoses included, but were not limited to, anxiety state, hypothyroidism, and essential hypertension (high blood pressure).</p>	F0514	<p>F514B The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident D is no longer a resident at the facility. Resident C is no longer a resident at the facility. Resident B had his meal consumption record reviewed. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Nursing staff educated on recording meal consumption, tube feedings and recording flushes by 9/28/12. Charge nurses will run meal consumption reports at end of shift to ensure consumptions have been reported.</p>	09/28/2012			

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	<p>Review of the 8/12 Resident Meal Logs indicated the resident's food consumption amounts were not recorded for the following dates and meals: 8/2/12 -Lunch meal 8/7/12- Breakfast and Lunch meals.</p> <p>When interviewed on 9/4/12 at 12:15 p.m., the Director of Nursing indicated the staff were to document the percentage of each meal intake on the Meal Consumption Logs.</p>		<p>DNS/Designee will review the meal consumption daily during Clinical Start Up DNS/Designee will audit tube feeders to ensure feedings and flushes 5 times a week for 4 weeks, 3 times for 4 weeks, and then weekly for 4 weeks. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing staff was reeducated on cleaning the glucose monitoring machine by 9/28/12. DNS/Designee will audit the nursing staff 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 weeks on different shifts to ensure the blood glucose monitoring machine is cleaned properly. These corrective actions will be monitored and a quality assurance program implemented to ensure the plan written and interventions implemented.deficient practice will not recur per the following: DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action. Adendum: All residents with flushes had charts audited for compliance and were found in compliance for past 60 days.Audits will be reported monthly to the QA committee until</p>		

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	<p>2. The record for Resident #C was reviewed on 8/31/12 at 2:50 p.m. His diagnoses included, but were not limited to, Parkinson's Disease, hypertension, and depression. The resident was admitted to the facility on 5/10/12 and discharged on 5/12/12.</p> <p>The May 2012 Physician Order Statement indicated the resident was to receive Jevity 1.5 (tube feeding nutrient) 120 CC (cubic centimeters) every 6 hours bolus feed via peg tube (tube inserted into stomach in order to administer tube feeding) and 200 CC of water flush every 6 hours via peg tube.</p> <p>Review of the May 2012 Medication Administration Record indicated the tube feeding and the 200 cc water flush had not been signed out as completed on 5/12/12 at 12:00 p.m.</p> <p>The Oral Medication Administration Procedure was provided by the Director of Nursing on 9/4/12 at 10:35 a.m.. The purpose was to administer oral medications in an organized and safe manner. The procedure included, but was not limited to, return to the medication cart and document medication administration</p>		100% compliant for 6 months and then will be reviewed quarterly thereafter.				

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	<p>with initials in appropriate spaces on the MAR (Medication Administration Record).</p> <p>When interviewed on 9/4/12 at 9:20 a.m., the Director of Nursing indicated the tube feedings and flushes should have been signed out on the Medication Administration Record.</p> <p>3. The record for Resident #B was reviewed on 8/31/12 at 1:40 p.m. Her diagnoses included, but were not limited to, pain, dementia, anxiety, chronic obstructive pulmonary disease, irritable bowel syndrome and depression.</p> <p>Review of the Resident #C's Meal Log for June 2012, indicated no intake had been documented for the following dates and meals: 6/8/12-lunch, 6/9/12-evening snack, 6/17/12-dinner, 6/20/12-dinner and evening snack, 6/21/12-dinner and evening snack, and 6/30/12-breakfast and lunch.</p> <p>Review of the Meal Log for July 2012, indicated no intake had been documented for the following dates and meals: 7/3, 7/4, 7/6, 7/7, and 7/8/12-all meals and evening snack, 7/9/12-breakfast and lunch, 7/11/12-lunch, 7/17/12-dinner and evening snack, 7/21/12-dinner and evening snack, 7/25/12-dinner, and</p>			

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	<p>7/29/12-lunch and dinner.</p> <p>Review of the Meal Log for August 2012, indicated no intake had been documented for the following dates and meals: 8/1/12-lunch, dinner, and evening snack, 8/2/12-evening snack, 8/5/12-evening snack, 8/8/12-lunch, 8/14/12-breakfast, dinner, and evening snack, 8/17/12-lunch, 8/22/12-lunch, 8/24/12-lunch, 8/25/12-lunch, and 8/27/12-lunch.</p> <p>Review of the Meal Log for September 2012, indicated no intake had been documented for the following dates and meals: 9/2/12-breakfast.</p> <p>When interviewed on 9/4/12 at 12:15 p.m., the Director of Nursing indicated the staff were to document the percentage of each meal intake on the Meal Consumption Logs.</p> <p>This federal tag relates to Complaints IN00108484 and IN00114756.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				