

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/20/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN46311
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F0000	<p>This visit was for the Investigation of Complaints IN00097871 and IN00098323.</p> <p>Complaint IN00097871-Substantiated. Federal/state deficiencies related to the allegations are cited at F246, F323, and F325.</p> <p>Complaint IN00098323-Substantiated. Federal/state deficiencies related to the allegation are cited at F311.</p> <p>Survey dates: October 19 &amp; 20, 2011</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey team: Lara Richards, R.N., T.C. Heather Tuttle, R.N. Kathleen "Kitty" Vargas, R.N. (10/20/11)</p> <p>Census bed type: SNF/NF: 136 Total: 136</p> <p>Census payor type: Medicare: 33 Medicaid: 76</p>	F0000		

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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F0246 SS=D	<p>Other: 27 Total: 136</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/21/11 by Suzanne Williams, RN</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review and interview, the facility failed to ensure reasonable accommodation of the residents' needs were met related to the lack of positioning a bedside table and drinking fluids within the resident's reach, for 1 of 1 resident observed with fluids outside of their reach in the sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B was observed in bed on 10/19/11 at 11:15 a.m. There was a can of soda on the resident's overbed table. The table was positioned at the foot of the resident's bed. The overbed table was not within the resident's reach.</p>	F0246	<p>F 246</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident B has liquid within reach. A cup holder has been attached to the resident's side rail for easy access.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>A full facility audit was conducted to ensure availability of fluids for residents at bedside. Additional interventions were put in place when deemed necessary.</p>	11/04/2011	

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	<p>The resident was observed in bed on 10/20/11 at 9:10 a.m. There were 2 mattresses stacked together on the floor next to the resident's bed. The resident's water was on a bedside table that was 3 feet from the end of the resident's bed. The resident was not able to reach the water glass.</p> <p>The resident was again observed in bed on 10/20/11 at 11:35 a.m. The resident's water glass remained on the bedside table. The water was not within the resident's reach.</p> <p>The 200 Unit Manager was interviewed on 10/20/11 at 11:50 a.m. She indicated that when mattresses were placed next to a resident's bed, as a fall device, staff were to place fluids on the overbed table and position the table near the head of the bed, within the resident's reach.</p> <p>Resident #B was observed on 10/20/11 at 11:55 a.m. in bed. There were 2 mattresses stacked next to the resident's bed. The resident's water was on a table, 3 feet from the foot of the resident's bed. Interview with the 200 Unit Manager at that time, indicated the resident's overbed table with his water was not positioned near the head of the bed where the resident could reach it. She indicated the overbed table was at the foot of the bed.</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Nursing staff will be educated on the importance of consistent placement of liquids within resident's reach at bedside.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>Unit nurses to verify fluid available at each resident's bedside at least once per shift. Nurse management to conduct random rounds 5 times per week for four weeks and then randomly thereafter to ensure compliance.</p> <p>Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance.</p> <p>Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>The record for Resident #B was reviewed on 10/20/11 at 10:15 a.m. The resident had diagnoses that included, but were not limited to, colon cancer and hypertension. Review of the Admission MDS (Minimum Data Set) assessment completed on 10/10/11, indicated the resident required extensive assistance with eating and drinking.</p> <p>Interview with CNA #3 on 10/20/11 at 12:35 p.m., indicated the resident was able to take liquids with set up help. She indicated he could feed himself with some assistance.</p> <p>Interview with the 200 Unit Manager on 10/20/11 at 11:50 a.m., indicated the resident's wife had requested that fluids be positioned so that the resident could reach them. The 200 Unit Manager indicated there needed to be documentation on the nurse aide assignment sheet to inform the staff of the positioning of the overbed table.</p> <p>The form titled "CNA (Certified Nurse Aide) Assignment Sheet" was reviewed on 10/20/11 at 3:00 p.m. There was no information related to the proper positioning of the overbed table and fluids documented on the assignment sheet for Resident #B.</p>				

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F0311 SS=G	<p>Interview with the 200 Unit Manager on 10/20/11 at 3:30 p.m., indicated the CNA assignment sheet did not contain information related to the positioning of the overbed table within the resident's reach. She also indicated the resident's table with fluids should have been within his reach.</p> <p>This Federal tag relates to Complaint IN00097871.</p> <p>3.1-3(v)(1)</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, record review and interview, the facility failed to ensure a restorative ambulation program was implemented for 1 of 1 resident discharged from physical therapy in the sample of 6. The failure to implement the ambulation program for the resident resulted in a decline in the distance he was able to ambulate. (Resident #C)</p> <p>Findings include:</p> <p>On 10/19/11 at 11:20 a.m., Resident #C was observed in his room seated in a wheelchair. There was no rolling walker</p>	F0311	<p>F 311</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident C has been re-evaluated and is currently on therapy case load</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Full facility audit was conducted to ensure orders for restorative</p>	11/04/2011

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	<p>in the resident's room.</p> <p>The record for Resident #C was reviewed on 10/19/11 at 12:40 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, osteomyelitis, rheumatoid arthritis, and ulcers of lower limbs.</p> <p>The resident was readmitted to the facility on 7/18/11 with orders for physical and occupational therapy evaluations. The resident received physical therapy from 7/19-9/16/11. The physical therapy discharge summary dated 9/22/11, indicated the resident's physical therapy was discontinued on 9/16/11 due to the resident reaching his maximum potential. The discharge summary indicated the resident had made significant progress in the past week and the resident was able to ambulate 10-15 steps with a rolling walker with maximum assist of 1 or moderate assist of 2. The discharge recommendations indicated the resident was to have a functional maintenance program/restorative aide for active range of motion and ambulation.</p> <p>The physical therapy functional maintenance program dated 9/20/11, indicated the resident's current status was able to walk up to 10 steps with maximum assist with rolling walker. The</p>		<p>nursing services were received and will be implemented if still applicable.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>A restorative program has been developed and services initiated. Residents will be added to the program as deemed appropriate per program guidelines.</p> <p>Nursing administration shall receive all orders related to restorative services per skilled therapy team to ensure timely follow up.</p> <p>The restorative nurse, nursing administration and the therapy team has received education related to implementation and development of the restorative program.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The restorative nurse will reconcile restorative orders with therapy manager on a weekly basis to ensure ongoing compliance with timely implementation.</p> <p>A PI tool related to restorative services will be completed on a weekly basis ongoing with results</p>		

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	<p>goal was to continue current level of functioning and prevent decline.</p> <p>Interview with the resident on 10/20/11 at 1:45 p.m., indicated nobody had walked with him since therapy was discontinued in September.</p> <p>Interview with CNA #1 on 10/20/11 at 1:55 p.m., indicated that he had not walked the resident since he had been employed at the facility.</p> <p>Interview with the Staff Development Coordinator, who used to oversee the Restorative Nursing Program, on 10/20/11 at 1:15 p.m., indicated the facility currently did not have a formal restorative nursing program. She indicated the aides were to complete range of motion with care and assist residents with ambulation when they could. There was no documentation to ensure range of motion and ambulation was being completed. The Staff Development Coordinator further indicated that she was not aware if the resident had ambulated since being discharged from therapy in September.</p> <p>An entry in the Physician Progress Notes dated 9/26/11, indicated the resident was complaining that he wanted better therapy so he could walk.</p>		<p>being forwarded to the PI committee for further review</p> <p>Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>A letter was faxed to the facility from the Wound Clinic on 10/13/11. The letter indicated the physician from the Wound Clinic would like the resident to be re-evaluated for physical and occupational therapy.</p> <p>A plan of care dated 10/18/11, indicated the resident continued to make repetitive statements about therapy. One of the approaches indicated the resident would be re-evaluated by therapy.</p> <p>A physician's order dated 10/19/11, indicated the resident was to be evaluated by therapy.</p> <p>The physical therapy evaluation form dated 10/19/11, indicated the resident would be seen in therapy five times a week for 4 weeks for gait training, therapeutic exercise, therapeutic activities, wheelchair management, and neuromuscular re-education. The resident was referred to therapy by nursing for ambulation and general conditioning. The justification for skilled services was to improve strength, ambulation, and balance. The baseline evaluation indicated the resident was able to ambulate approximately 5 steps with a rolling walker and maximum assistance.</p> <p>Interview with Physical Therapist #1 on</p>						

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F0323 SS=D	<p>10/20/11 at 1:40 p.m., indicated when the resident was evaluated on 10/19/11 that he was able to walk approximately 4-5 steps with the rolling walker and maximum assistance. Continued interview at the time, indicated the resident did have a decline in the distance he was able to walk since last being seen in September.</p> <p>This federal tag relates to complaint IN00098323.</p> <p>3.1-38(a)(2)(B)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident was free from accidents related to a fall and sustaining a wrist sprain for 1 of 3 residents reviewed for falls in the sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>On 10/20/11, at 9:10 a.m., Resident #D was observed in bed. The resident's right arm was wrapped in an ace wrap with her hand and fingers exposed. The resident's</p>	F0323	F 323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident D no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Full facility audit of C.N.A. assignment sheets was completed to ensure preventative/assistive devices are current for all involved residents. No other issues were identified through this audit. Room rounds conducted to ensure	11/04/2011

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	<p>wheelchair was located in the corner of the room with a black cushion. There was no dycem (an adhesive piece of material to prevent residents from sliding) observed on top or under the cushion.</p> <p>On 10/20/11 at 11:00 a.m., CNA #2 was observed in the resident's room. At that time, the CNA was asked to remove the resident's bed linen. The resident was wearing a pair of black knitted slipper socks. There was no sole observed on the bottom of the slippers, nor was there any adhesive type of material to prevent the resident from sliding. The resident's wheelchair was located in the corner of the room with a black cushion. There was no dycem observed on top or under the cushion.</p> <p>On 10/20/11 at 1:20 p.m., the resident was observed up in her wheelchair. On 10/20/11 at 1:40 p.m., the resident's son had placed the resident back in her bed. At that time, the resident's wheelchair was observed in the corner of the room. There was no dycem in the resident's chair, either under or on top of the cushion.</p>		<p>preventative/assistive devices were in place and functional as outlined on the C.N.A. assignment sheet. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All care staff will be re-educated on utilizing the C.N.A. assignment sheets to visually verify that all preventative/assistive devices are in place. In addition to the Unit Managers verifying compliance via direct observation, nursing administration will also validate the placement of preventative/assistive devices as stated on the C.N.A. assignment sheets through random room rounds three times weekly on various shifts. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. PI tool related to the assurance that preventative/assistive devices are in place as ordered will be completed by nursing administration on 10 residents weekly for a month; monthly for a quarter; and then quarterly thereafter to ensure ongoing compliance. Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction</p>		

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	<p>Interview with the resident's son at the time, indicated he was aware of the dycem, however, he indicated "that thing has not been in the chair for awhile."</p> <p>Interview with LPN #1 at the time, further indicated the resident's son often puts his mother back to bed and gets her up.</p> <p>Interview with the West Unit Manager on 10/20/11 at 1:50 p.m., indicated the dycem was placed in the resident's chair on 10/9/11 by herself. She further indicated she had not checked to see if it was in the chair since then.</p> <p>The record for Resident #D was reviewed on 10/20/11 at 9:15 a.m. The resident's diagnoses included, but were not limited to, fracture of the left humerus, history of falls, dementia, and compression fracture of T-12. The resident was admitted to the facility from the hospital on 8/5/11 after falling at home and sustaining a fracture.</p> <p>Review of the Care Plan Conference Summary dated 9/21/11, indicated "We will put an alarm to the wheelchair and bed since resident has been seen walking in her room."</p>		developed and implemented as deemed necessary.		

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	<p>Review of the Post Fall Evaluation dated 10/8/11, indicated the resident was found on the floor in her room by a CNA. The post fall interventions were to place a dycem in her wheelchair.</p> <p>Review of Physician Orders dated 10/10/11, indicated dycem to wheelchair.</p> <p>Nursing Progress Notes dated 10/19/11 at 2:45 a.m., indicated the resident was up at the nurse's station in her wheelchair. She stood up from the wheelchair and fell onto her right side. The resident immediately complained of pain to her right wrist. The physician was notified and the resident was sent to the emergency room.</p> <p>Review of the Post Fall Evaluation dated 10/19/11, indicated the resident was wearing slippers.</p> <p>Interview with LPN #2 on 10/20/11, at 1:42 p.m., indicated she was the midnight nurse taking care of the resident. The LPN indicated the resident was restless most of the night so staff decided to get her up. The staff had taken the resident to</p>				

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	<p>the bathroom and given her a snack and then placed her in front of the nurse's station. The LPN indicated the resident was wearing slipper socks. She further indicated they were the same pair that she always wears.</p> <p>Review of the Emergency Room discharge instructions dated 10/19/11, indicated the resident had sustained a right wrist sprain and was to wear the post mold cast and follow up with the Orthopedic Physician.</p> <p>Review of the right wrist x-ray dated 10/19/11, indicated the resident had osteoporosis with minimal arthritis.</p> <p>Review of the current care plan dated 8/17/11, indicated the resident was at risk for falls related to recent fall and left humerus fracture. The nursing approaches were to ensure the resident was wearing proper fitting footwear.</p> <p>Review of the 9/21/11 plan of care, indicated the resident had a fracture of the left humerus related to fall at home. The nursing approaches added on 10/8/11</p>				

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	<p>were to place a dycem in the wheelchair.</p> <p>Review of the Initial Minimum Data Set (MDS) Assessment dated 9/19/11, indicated the resident needed extensive assistance with transfers and ambulation. The resident had a history of falls in the last month including the last two to six months. The resident also had a fracture in the last six months.</p> <p>Review of the CNA Assignment Sheet, indicated the resident was to have a dycem in her wheelchair.</p> <p>Interview with the Nurse Consultant on 10/20/11 at 3:35 p.m., indicated it was the CNAs' responsibility to make sure the resident had all of the safety equipment in place including the dycem.</p> <p>This Federal tag relates to Complaint IN00097871.</p> <p>3.1-45(a)(2)</p>				

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F0325 SS=D	<p>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 observation, record review, and interviews, the facility failed to ensure each resident maintained adequate nutrition related to supplements, weekly weights, and Nutrition At Risk (NAR) meetings for 2 of 3 residents reviewed for nutrition in the sample of 6. (Residents #F &amp; #G)</p> <p>Findings include:</p> <p>1. On 10/20/11 at 12:00 p.m., Resident #F was observed eating lunch in the West Unit Dining Room. The resident was served a baked potato, mixed vegetables, ground chicken, and a fruit bowl. The resident did not receive super soup (a high calorie supplement) on her tray.</p> <p>The record for Resident #F was reviewed on 10/19/11 at 1:00 p.m. The resident's diagnoses included, but were not limited to, chronic pain, anemia, and depressive disorder.</p>	F0325	<p>F 325 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident F super soup was discontinued due to poor preference of nutritional intervention. Resident is now on 2 cal and has better intake. The resident's current weight is 99 lbs. indicating a weight gain of 4 lbs placing her at her usual body weight. Resident discontinued from NAR meetings on 10-27-11 due to being at her baseline weight. Weekly weights were obtained for the 13, 21 and 27. Resident continues on monthly weights per facility protocol. Resident G is currently in the hospital and will be re-evaluated upon readmission.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Full facility audit was completed to ensure residents who require nutritional supplements are being provided as ordered. Orders were clarified when deemed necessary as a</p>	11/04/2011

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	<p>Review of the 10/11 Physician's Order Summary, indicated the resident was to receive super soup at lunch and dinner.</p> <p>Review of the monthly weight log, indicated the resident weighed 115 pounds on August 7, 2011. The resident weighed 96 pounds on September 6, 2011 and 93 pounds on September 13, 2011.</p> <p>Review of the NAR meeting minutes dated 9/16/11, indicated the resident weighed 93 pounds and the August weight was probably inaccurate. The plan was to continue the NAR meetings related to the weight variations.</p> <p>Review of the NAR meeting minutes dated 9/23/11, indicated the resident weighed 95 pounds. The plan was to continue with the NAR meetings.</p> <p>Review of Dietary Progress Notes, indicated there were no more NAR meeting notes after 9/23/11 for the resident. Review of the October 6, 2011 weight indicated the resident weighed 96 pounds.</p> <p>Review of the current plan of care dated 5/11/11 and updated on 9/1/11, indicated the resident had inadequate intake related to calorie intake not meeting needs to prevent weight loss. The nursing</p>		<p>result of the audit. Full facility audit was completed to ensure residents who require weekly weights are being completed per facility protocol. NAR meetings are now occurring weekly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Dietary staff re-educated on the importance of ensuring tray accuracy. Facility has secured consistent staff members to obtain both weekly and monthly weights. This "weight team" has been educated on facility protocol for obtaining weights and reporting results. IDT re-educated on the importance of conducting consistent NAR meetings on a weekly basis as outlined in facility protocol. Dietician and/or designee will be responsible for ongoing compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. PI tool has been developed related to tray accuracy for required supplements. Dietician and/or designee to audit 3 meals per week at different meal times to ensure compliance. Dietician and/or designee will utilize the weight history tracking form to ensure weekly weights are obtained per facility protocol. Any discrepancies will be addressed as indicated. Administrator and/or designee to validate</p>		

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	<p>approaches were to provide supplements as ordered.</p> <p>Interview with the Registered Dietitian (RD) on 10/19/11 at 2:00 p.m., indicated the facility had not obtained any weekly weights for the last week of September, 2011, therefore a weekly NAR meeting was not held for the resident. The RD further indicated at the time, the last NAR meeting held was on 10/13/11 and she did not have any notes for the resident. The RD indicated NAR meets every week and residents who were on NAR should have their weights obtained weekly.</p> <p>2. The record for Resident #G was reviewed on 10/20/11 at 9:30 a.m. The resident had diagnoses that included, but were not limited to, chronic kidney disease, hypothyroidism and depression.</p> <p>The form titled "Weight History" was reviewed. The form indicated the resident's weights were:</p> <p>9/7/11 weight 147 pounds 9/13/11 weight 146.5 pounds 9/20/11 weight 136.5 pounds 10/6/11 weight 119.5 pounds</p> <p>The NAR (Nutrition at Risk) notes were reviewed. The NAR notes dated 9/23/11 indicated, "Current weight 136.5. Resident refused a reweight. Previous</p>		<p>weekly NAR meetings through review of meeting minutes/log to ensure ongoing compliance.</p> <p>Audit findings to be reported to the Performance Improvement Committee monthly for 3 months and then quarterly to ensure ongoing compliance. Audit results and system components will be reviewed by the PI Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>week's weight was 146.5 pounds. This is a sig (significant) weight loss. Weight change may be in part r/t (related to) dialysis as well as BLE (bilateral lower extremity) edema fluid retention.</p> <p>Recommendation: previously was going to DC (discontinue) from NAR, however weight obtained during weekly weights was 10# (pounds) significantly less. Will continue to monitor."</p> <p>The next NAR notes were dated 10/13/11 and indicated, "Current weight 125.5# with reweight of 119#. This has sig weight changes of a loss of -27.5# /30 days. Sig weight loss unplanned undesirable. Some weight loss may be in part r/t improvement in BLE as well as decreased oral intakes. Current diet orders: Regular diet po (by mouth) intakes poor as resident continues to be picky, recent changes with enteral orders: to increase from 4 x/day Nepro bolus to 1 can 5 x/day (5 am, 9 am, 4 pm, 9 pm, 11 pm) providing resident with 2125 kcal (kilocalories) ... TF (tube feeding) was increased r/t sig weight loss ...</p> <p>Recommend: Continue with current nutritional interventions. Will continue to monitor weight status TF tolerance."</p> <p>Interview with the Registered Dietitian on 10/20/11 at 11:00 a.m., indicated the resident was reviewed for NAR (Nutrition</p>				

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	<p>at Risk) on 9/23/11 and again on 10/13/11. She indicated the resident was not reviewed on 9/30/11 and on 10/7/11. She also indicated the resident had a significant weight loss identified on 9/20/11 and did not have another weight obtained at the facility until 10/6/11.</p> <p>Continued interview with the Registered Dietitian on 10/20/11 at 2:25 p.m., indicated when a resident had a significant weight loss they were to be reviewed during the Nutrition at Risk meetings weekly. She also indicated residents on the NAR were to be weighed by the facility weekly and those weights were to monitored during the weekly NAR meetings. She indicated Resident #G did not have weekly weights completed by the facility and was not reviewed weekly in the NAR meeting after a significant weight loss was noted.</p> <p>The Resident Progress Notes, written by the Registered Dietitian and dated 10/12/11, were reviewed. The notes indicated, "Rec (recommend) change TF to a bolus of 240 ml (milliliters) (1 can) of Nepro to be given 5 x / day at 5 a.m., 9 a.m., 4 p.m., 9 p.m. and 11 p.m. will provide 2125 kcal . . . r/t significant weight changes; Current weight 119.5# (reweight obtained to ensure accuracy). This is a significant loss of 18.7% / 30</p>				

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	<p>day. Some is likely r/t decrease of edema to BLE (bilateral lower extremities)."</p> <p>The physician's orders were reviewed. The form titled "Physician's Orders for Enteral Nutrition" and dated 10/12/11, indicated Nepro 240 ml was to be administered 5 x per day per gastric tube at 5 a.m., 9 a.m., 4 p.m., 9 p.m. and 11 p.m.</p> <p>Review of the October 2011 Medication Administration Record (MAR), indicated the 240 ml of Nepro was not documented as administered at 11 p.m. on 10/13/11, 10/14/11 and 10/17/11.</p> <p>Interview with the 200 Unit Manager on 10/20/11 at 11:45 a.m., indicated the Nepro was not administered to the resident as ordered by the physician on 10/13/11, 10/14/11 and 10/17/11.</p> <p>This Federal tag relates to Complaint IN00097871.</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p>				