

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS	STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037
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F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey</p> <p>This visit included the Investigation of IN00163025 and IN00163594.</p> <p>Complaint IN00163025-Substantiated. Federal/State deficiencies related to the allegations are cited at F-425.</p> <p>Complaint IN00163594-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 2, 3, 4, 5, 6, 9, 10 and 11, 2015</p> <p>Facility number: 012644 Provider number: 155793 AIM number: 201046710</p> <p>Survey team: Michelle Hosteter, RN-TC Sandie Nolder, RN Gloria Bond, RN</p> <p>Census bed type: SNF: 44 SNF/NF: 51 Residential : 29 Total : 124</p>	F 0000	<p>February 27, 2015</p> <p>Kim Rhoades, Director</p> <p>Long-Term Care Division</p> <p>Indiana State Department of Health</p> <p>2 North Meridian Street</p> <p>Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on February 11, 2015. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace of Fishers credible allegation of compliance. We allege compliance on March 13, 2015. We are requesting a desk review for this plan of correction.</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 payor type: Medicare: 37 Medicaid: 26 Other: 32 Total: 95</p> <p>Sample: 10 Residential sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 AIC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on February 18, 2015.</p>		<p>If you have any further questions, please do not hesitate to contact me at 317-813-4444.</p> <p>Sincerely,</p> <p>Melissa Hampton H.F.A Administrator</p> <p>Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility.</p>	

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F 0157 SS=D Bldg. 00	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		The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on February 11, 2015. Please accept this plan of correction as Hamilton Trace of Fishers credible allegation of compliance by March 13, 2015. This statement of deficiencies and plan of correction will be reviewed at the March Quality Assurance/Assessment Committee meeting.	

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	<p>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 interview and record review, the facility failed to notify a Physician regarding a resident's weight changes for 1 of 1 residents being reviewed for change in condition. (Resident #107)</p> <p>Findings include:</p> <p>Resident #107's record was reviewed on 2/6/15 at 10:49 a.m. Diagnoses included, but were not limited to, anemia, dysphagia, pancytopenia (medical condition where there is a reduction in the number of red and white blood cells and platelets), Alzheimer's disease, congestive heart failure, vitamin deficiency, diabetes mellitus type II, and renal failure.</p> <p>Resident #107's Medication</p>	F 0157	<p>F157 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The physician of Resident 107 was notified of the weight change on 1/15/15. II. The facility will identify other residents that may potentially be affected by the deficient practice. Resident's with daily weights have the potential to be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Daily weights outside of the parameters will be notified to the resident's attending physician and documented in the resident's medical record. Licensed nurses will be re-educated on physician notification policy including notification of the daily weights</p>	03/13/2015

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	<p>Administration History documents dated August 2014 thru January 16, 2015 included, but were not limited to the following orders:</p> <p>7/30/14--"Obtain and record daily weight upon rising before breakfast. Notify MD if weight gain is > [greater than] 2 lbs [pounds] daily or > 5 lbs in a week." (Discontinued 9/19/14)</p> <p>9/19/14--"Obtain and record daily weight upon rising before breakfast. Notify MD if weight gain is > 2 lbs daily or > 5 lbs in a week." (Discontinued 1/6/15)</p> <p>1/06/15--"Obtain and record daily weight upon rising before breakfast. Look back at past 7 days of weights and notify MD if weight gain is > 2 lbs daily or > 5 lbs in a week." (Discontinued 1/16/15)</p> <p>The resident's weights taken from the Medication Administration History dated August 2014 thru January 16, 2015, that were above the ordered amount to be called to the Physician were as follows:</p> <p>8/13/14--Previous Weight was 156.2 Current Weight was 161.8 Difference was 5.6 lbs Physician was not notified of weight gain over 2 lbs in one day.</p> <p>8/20/14--Previous Weight was 158.0 Current Weight was 161.6 Difference was 3.6 lbs. Physician was not notified of weight gain over 2 lbs in one day.</p>		<p>and daily weight parameters. Licensed nurses will be re-educated on documentation in the resident's EMAR/Medical record system of physician notification of daily weights outside the parameters. Nurse Managers have been re-educated on monitoring the daily weights during clinical report. IV. The facility will monitor the corrective action by implementing the following measures. DON or Designee will audit random sample of residents with daily weights weekly x 4 weeks, monthly x 1 month, then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p>				

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	<p>9/3/14--Previous Weight was 158.8 Current Weight was 161.2 Difference was 2.4 lbs. Physician was not notified of weight gain over 2 lbs in one day.</p> <p>9/24/14--Previous Weight was 153.8 Current Weight was 151.6 Difference was 2.2 lbs. Physician was not notified of weight gain over 2 lbs in one day.</p> <p>10/6/14--Previous Weight was 155.0 Current Weight was 147.9 Difference was 7.1 lbs. Physician was not notified of weight gain over 2 lbs in one day.</p> <p>The difference in the above weights were not totaled by the facility staff.</p> <p>During an interview on 2/10/15 at 9:30 a.m., the DON indicated the nurses had not notified the Physician with the weight change on the days the resident had gained more than 2 lbs. She indicated that more than a 2 lb weight change in a day for a resident with a diagnosis of congestive heart failure was considered a change of condition and the Physician should have been notified.</p> <p>A current policy titled "Change in a Resident's Condition or Status" dated October 2010, provided by the DON on 2/9/15 at 9:30 a.m., indicated "...Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the</p>			

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F 0242 SS=D Bldg. 00	<p>resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been...d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly... h. Instructions to notify the physician of changes in the resident's condition... 2. A 'significant change' of condition is a decline or improvement in the resident's status that:</p> <p>a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self-limiting')... c. Requires interdisciplinary review and/or revision to the care plan... 4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status...."</p> <p>3.1-5(a)(2)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose</p>			

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	<p>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.</p> <p>Based on interview and record review, the facility failed to ensure preferences for showers were honored for 1 of 1 residents reviewed for choices. (Resident #90)</p> <p>Findings include:</p> <p>During an interview on 2/3/15 at 2:35 p.m., the resident indicated he was supposed to receive showers on Mondays, Wednesdays and Fridays, but he did not always get them three days a week as he requested them.</p> <p>During an interview on 2/10/15 at 2:23 p.m., Resident #90 indicated on 2/6/15 and 2/9/15 he received a bed bath because the CNA's told him they were giving him a bed bath instead of a shower. He indicated he had refused his shower once because it was too cold, but he did not refuse his showers on 2/6/15 or 2/9/15.</p> <p>Resident #90's record was reviewed on 2/10/15 at 9:56 a.m. Diagnoses included, but were not limited to, muscle</p>	F 0242	<p>F242 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #90 showers were correct on the c.n.a. assignment sheet. Resident #90 showers are offered Monday, Wednesday, and Friday. Resident #90 shower refusals will be addressed in the medical record as the resident refusals occur. C. N.A. #1 has been re-educated on providing showers per the resident's preferences. II. The facility will identify other residents that may potentially be affected by the deficient practice. Resident's residing in the facility have the potential to be affected. The facility has completed an audit of current residents to determine their choice of shower/ bath and preferred bathing times. C. N. A. assignment sheets were updated to reflect the preferences of bath/shower and preferred bathing times. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Nursing personnel were re-educated on the</p>	03/13/2015			

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	<p>weakness, gait abnormality, paralysis agitans (Parkinson's), upper joint contracture, hemiplegia (paralysis on half the body) affected nondominant side.</p> <p>The resident's Medication Administration History dated February 2015, included, but were not limited to the following orders: 9/14/14--Shower twice weekly on Mondays and Thursdays.</p> <p>The residents significant change MDS (Minimum Data Set) assessment dated 9/1/14, indicated the resident felt it was very important to choose between a tub bath, shower, bed bath, and sponge bath.</p> <p>An untitled document dated 1/16/15, provided by the Director of Nursing (DON) on 2/10/15 at 4:30 p.m., indicated the resident's preferred type of bathing was a shower, the time of bathing was morning and the day of the week was Monday, Wednesday and Friday. At that time the DON indicated that document was Resident #90's preference sheet.</p> <p>An undated "CNA Daily Assignments" document provided by the DON on 2/10/15 at 4:30 p.m., indicated the resident's shower days were Mondays, Wednesdays and Fridays on the 6 a.m. to 2 p.m., shift and his bathing preference</p>		<p>importance of following choice of a bath/shower, preferred bathing times and following the C.N.A. assignment sheets. Nursing personnel were re-educated on documenting refusals or if a resident requests a change in shower/bath type in the medical record. Nursing managers/designee will be re-educated on updating the Plan of Care for resident refusals of bath/showers. IV. The facility will monitor the corrective action by implementing the following measures. The DON or designee will audit shower/bathing preferences 3 times a week for 4 weeks, weekly times 4 weeks, monthly times 1 month then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p>				

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	<p>was a shower. At that time the DON indicated the "CNA Daily Assignments" sheets were used as a communication tool for the CNA's to care for the residents.</p> <p>On 02/10/2015 at 4:30 p.m., shower sheets were provided by the DON for all the resident's showers from 1/16/15 to 2/10/15. All the shower sheets were present for Monday, Wednesday and Friday showers except for 1/26/15 and 2/4/15. The shower sheets for 2/6/15 and 2/9/15 indicated the resident received a bed bath instead of a shower. There was no documentation on either sheet to indicate he had refused his shower and a bed bath was given.</p> <p>Resident #90's record lacked a Care Plan, which addressed the problem he refused personal care or hygiene or showers. The resident's progress notes from 1/16/15 to 2/10/15 were reviewed and no documentation was found to indicated he refused personal hygiene or showers or requested a bed bath over a shower during this time period.</p> <p>During an interview on 2/10/15 1:30 p.m., CNA #1 indicated she received Resident #90's preferences for his bathing from her CNA assignment sheet. She indicated he was scheduled to receive his showers on Monday, Wednesday and</p>			

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	<p>Friday. She indicated there had been a couple of occasions in which he had refused his showers, but she could not remember any here recently. She indicated if the resident refused a shower she let the nurse know he refused, she filled out her shower sheet and documented in the computer the resident refused his shower.</p> <p>During an interview on 2/10/15 at 2:10 p.m., the DON indicated she had talked to CNA #1 and she had indicated that if the computer indicated a partial or bed bath was given Resident #90 had refused his shower. The DON indicated he had gotten one of those types of baths because the CNA's could not document refusals in the computer. The DON indicated she was still looking for the shower documentation for 1/26/15 and 2/4/15. She indicated she did not find any refusals documented on the 2/6/15 or 2/9/15 shower sheets. The DON indicated she had not found documentation in the progress notes from the nurses where the CNA's had informed them the resident had refused his shower on these dates. She indicated his MAR was not updated to reflect he was to receive his showers three times a week, but they were updated now.</p> <p>During an interview on 2/11/15 4:05</p>			

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F 0309 SS=D Bldg. 00	<p>p.m., the DON indicated she found the 1/26/15 shower sheet on her desk, but she was unable to find the 2/4/15 shower sheet and she was unable to provide further documentation the resident received his shower for that date.</p> <p>3.1-3(u)(1)</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.</p> <p>2. On 02/09/2015 at 3:06 p.m., the record review for Resident #10 was completed. Diagnoses included, but were not limited to, chronic kidney disease Stage IV and pneumonia(diagnosed 12/11/14), congestive heart failure, depression, high blood pressure and diabetes.</p> <p>The nursing progress notes indicated on 12/11/14, the resident returned to facility</p>	F 0309	<p>F309 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #10 is receiving a pre and post dialysis observation on the day of dialysis. The physician of Resident 107 was notified of the weight change on 1/15/15. II. The facility will identify other residents that may potentially be affected by the deficient practice.</p>	03/13/2015			

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	<p>with diagnosis of ARF (Acute Renal Failure) and had come back with a perma cath (a device that provides direct access to the venous system) in the right upper chest. The nurses were to monitor for symptoms of infection or clotting such as; warm to touch, red abnormal swelling, edema (extra swelling in body tissue) , sudden onset of unrelieved shortness of breath.</p> <p>The nursing progress note dated 12/17/14, indicated the resident's dialysis schedule would change for the next two weeks due to the holidays. She would be going to dialysis on Sunday and Tuesday.</p> <p>A physician's order dated 12/11/14, indicated, "...Complete pre dialysis assessment observation before treatment and post dialysis assessment after treatment...dialysis Monday, Wednesday and Fridays..."</p> <p>The dialysis care plan dated 12/30/14 indicated,"...Observe resident for discomfort side effects of the disease and treatment (ie: cramping, fatigue, headaches, itching, anemia, body image changes, etc.), observe permacath site daily for signs and/or symptoms of infection and/or bleeding..."</p> <p>During the time frame 12/12/14 through</p>		<p>Resident's residing in the facility that receive dialysis have the potential to be affected. No other residents residing in the facility currently receive dialysis services.</p> <p>Resident's with daily weights have the potential to be affected.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Resident's on dialysis will have a pre dialysis and post dialysis observation completed on the day of dialysis. Licensed nurses will be re-educated on completing the pre and post dialysis observation on the day of dialysis. Daily weights outside of the parameters will be notified to the resident's attending physician and documented in the resident's medical record. Licensed nurses will be re-educated on physician notification policy including notification of the daily weights and daily weight parameters. Licensed nurses will be re-educated on documentation in the resident's EMAR/Medical record system of physician notification of daily weights outside the parameters. Nurse Managers were re-educated on monitoring of daily weights during clinical report. IV. The facility will monitor the corrective action by implementing the following measures. DON or Designee will audit random sample of dialysis residents for</p>	

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F 0314 SS=D Bldg. 00	<p>2/4/15, there was no pre dialysis assessment for 2/4/15.</p> <p>During the time frame 12/12/14 through 2/4/15, there were no post dialysis assessments for: 12/17/15, 12/19/15, 1/2/15, 1/14/15 and 2/6/15.</p> <p>On 2/11/2015 at 3:15 p.m., the Director Of Nursing indicated the resident should have a pre and post dialysis assessment done each time she goes to dialysis and the dialysis site should be assessed each time as well.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to put weight loss interventions in place to</p>	F 0314	<p>documentation of pre and post dialysis observation weekly x 4 weeks, monthly x 1 month, then quarterly thereafter for a total of 12 months. DON or Designee will audit random sample of residents with daily weights weekly x 4 weeks, monthly x 1 month, then quarterly thereafter for a total of 12 months. Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p> <p>F314 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient</p>	03/13/2015	

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	<p>assist in pressure ulcer prevention for 1 of 4 residents reviewed for pressure ulcers. (Resident #107)</p> <p>Findings include:</p> <p>Resident #107's record was reviewed on 2/6/15 at 10:49 a.m. Diagnoses included, but were not limited to, anemia, dysphagia (difficulty swallowing), pancytopenia (medical condition where there is a reduction in the number of red and white blood cells and platelets), Alzheimers disease, vitamin deficiency, diabetes mellitus type II, and renal failure.</p> <p>A "Change of Condition" document dated 12/2/14 at 11:57 p.m., indicated the resident had an open area to his coccyx that started on 12/2/14 at 10:00 p.m. The area was measured as 0.75 cm (centimeters) x 0.5 cm.</p> <p>A "Change of Condition" document dated 12/27/14 at 6:47 a.m., indicated the resident had an open area to the left buttock that started on 12/27/14 at 6:00 a.m. The open area was measured as 0.8 cm x 0.8 cm x 0.1 cm.</p> <p>A "Pressure Ulcer Evaluation" document dated 12/31/14 at 2:28 p.m., indicated the resident had a Stage II pressure ulcer that</p>				<p>practice. Resident #107 open area to coccyx identified on 12/2/14 was identified as excoriation related to incontinence not pressure and resolved on 1/6/15. Resident # 107 open area to left buttock identified on 12/27/14 resolved on 1/6/15. Resident #107 Stage 1 – bilateral buttocks identified on 2/4/15 resolved on 2/13/15. Resident #107 had nutritional supplement put in place on 1/21/15 II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents residing in the facility with pressure ulcers have the potential to be affected. Residents with pressure ulcers and weight loss were reviewed by the IDT (interdisciplinary team), physician/Nurse practitioner, and Registered Dietitian and weight loss interventions were initiated based on the residents need for weight loss interventions. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Residents with pressure ulcers and weight loss will reviewed by the IDT (interdisciplinary team), physician/Nurse practitioner, and Registered Dietitian and weight loss interventions added based on the residents need for weight loss intervention. Nurse Managers received re-education</p>		

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	<p>developed in the facility to the left buttock. The date of onset was 12/27/14. The measurements were 0.3 cm x 0.5 cm x <0.1 cm. The wound bed was red.</p> <p>A "Change of Condition" document dated 2/4/15 at 9:27 p.m., indicated the resident had a Stage I pressure area that developed in the facility to the bilateral buttocks, which started on 2/4/15 at 8:25 p.m. No measurements were provided.</p> <p>On 2/09/15 at 10:30 a.m., the resident was observed to have a reddened area on each side of his bilateral inner buttocks by the coccyx. He did not have a dressing on at that time. At that time RN #12 indicated he was only to receive Vasolex cream (used on pressure ulcers to promote healing and relieve pain) to his buttocks and coccyx area and no dressing.</p> <p>The resident's weights taken from the computer under the "Vitals" tab from the last 180 days were as follows: 08/02/14--175 09/01/14--173 09/19/14--170 09/22/14--172 10/01/14--174 11/03/14--175 12/04/14--169 12/29/14--138</p>		<p>on weight loss interventions.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures. DON or Designee will audit random sample of residents with pressure ulcers and weight loss for weight loss interventions weekly x 4 weeks, monthly x 1 month, and quarterly thereafter up to 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance.</p> <p>V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p>		

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	<p>01/05/15--134 01/12/15--134 01/13/15--137 01/14/15--137 01/19/15--131 01/21/15--134 01/28/15--134 02/01/15--135</p> <p>A "Nutritional Assessment Comprehensive" dated 1/18/15 at 7:56 p.m., indicated the assessment was for a readmission. The assessment indicated he weighed 137 pounds. He had lost 5% or more in the last month or 10% or more in the last 6 months and he was not on a prescribed weight loss regimen. His average food intake at meals was 50-100%. Additional Observations indicated the resident had about a 21% weight loss over 164 days.</p> <p>On 2/9/15 at 10:30 a.m., RN #12 indicated the resident was receiving cream to his buttocks and coccyx area now and no dressing, but the area continued to be reddened.</p> <p>During an interview on 2/9/15 at 1:18 p.m., the CNC (clinical nurse consultant) indicated the resident's monthly weights were not documented accurately and she believed that a previous Unit Manager (UM) that worked at the facility was</p>			

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	<p>putting the wrong weights in the computer for this resident. She indicated the previous Unit Manager was documenting monthly and weekly weights in the computer that were not the same weights as the daily weights the nurses caring for the resident were documenting in the Electronic Medication Administration Record.</p> <p>During an interview on 2/10/15 at 9:30 a.m., the DON indicated the resident did not get any nutritional supplements started until 1/21/15, because the UM of the unit the resident resided on did not accurately document his weight each week and month. She indicated the monthly and weekly weights the UM documented in the computer did not match up to the daily weights that were being documented in the computer by the floor nurses and she did not realize he had a significant weight loss until December. She indicated when she noticed the weight inaccuracies the IDT(Interdisciplinary Team) started him on supplements. She indicated they implemented interventions as soon as they caught the significant weight loss and the resident was starting to gain weight then. She indicated the supplements were started on 1/21/15, not in December when the inaccuracies were discovered.</p>			

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F 0323 SS=D Bldg. 00	<p>3.1-40(a)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident was not left unsupervised while eating in his room for 1 of 4 residents reviewed for accidents. (Resident #107)</p> <p>Findings include:</p> <p>Resident #107's record was reviewed on 2/6/15 at 10:49 a.m. Diagnoses included, but were not limited to, anemia, dysphagia (difficulty swallowing), pancytopenia (medical condition where there is a reduction in the number of red and white blood cells and platelets), Alzheimer's disease, vitamin deficiency, diabetes mellitus type II, and renal failure.</p>	F 0323	<p>F323 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #107 has been on Speech Therapy caseload since. Speech therapy determined resident should be upright at 90 degrees when eating and has been determined to require no supervision at meal time, only encouragement. Speech Therapy #11 re-educated on removing meal tray from room when resident has stated he is finished eating. II. The facility will identify other residents that may potentially be affected by the deficient practice. Resident's that reside in the facility that require supervision at meal times have the potential to</p>	03/13/2015	

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	<p>On 2/5/15 at 5:24 p.m., Resident #107 was observed receiving baked chicken, baked beans, coleslaw, dinner roll, pudding parfait and an 8 oz glass of nectar thickened juice for his dinner meal. An unidentified CNA assisted the resident with his chicken and cut the chicken into large pieces. He was eating with his left hand in the main assist area dining room. He was observed to chew a piece of chicken multiple times before he swallowed it. He had a pocket of food on the right side of his cheek and placed more food in his mouth and chewed that food multiple times before he swallowed. The resident was observed taking a piece of chicken out of his mouth and he placed it on his plate, while he continued to chew the food he had in his mouth. He was observed taking a large piece of chicken out of his mouth and placed it on his plate, then the large lump in the right cheek area was gone. The resident ate 75% of his meal, while 15% of that 75% was his baked chicken. He drank 4 oz of the NTL (Nectar Thickened Liquid) juice. No staff was present assisting him to finish his meal after he had finished eating.</p> <p>On 2/6/15 at 1:25 p.m., the resident was observed laying in bed with his lunch tray in front of him eating corn with a fork out</p>		<p>be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Nursing personnel will be re-educated on meal time supervision. Resident's plan of care and aide assignment sheet will be updated for resident's requiring supervision at meal time. Speech therapist were re-educated on removing meal tray from room when residents state they are done eating. IV. The facility will monitor the corrective action by implementing the following measures. DON or designee will audit random sample of residents requiring supervision at meal time weekly x 4 weeks, monthly x 1 month, and quarterly thereafter up to 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015.</p>	

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	<p>of a bowl 1/2 full of corn, a 1/2 a hamburger on a bun and he had eaten his salad and his dessert. He had a full glass of NTL water sitting on his lunch tray and he had taken a drink of the water.</p> <p>On 2/6/15 at 1:32 p.m., CNA #6 was observed picking up the resident's tray.</p> <p>The resident's Medication Administration History dated February 2015, included, but was not limited to, the following order: 2/4/15--2 gram Na (Sodium) diet with NTL.</p> <p>The resident's significant change MDS (Minimum Data Set) assessment dated 1/27/15, indicated he required extensive assist with one person physical assist with eating.</p> <p>A Therapy Screen note dated 1/20/15 at 11:52 a.m., indicated the screen date was 1/20/15, and the facility referral was because the resident had increased dehydration/malnutrition. The ST (Speech Therapy) services warranted at that time was to monitor safe oral intake with LRD (Laryngopharyngeal Reflux Disease) (the backup of gastric content into the larynx and pharynx). Swallowing function was poor. There was a recent weight loss or diet change. The</p>			

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	<p>evaluation recommendation was for Speech therapy.</p> <p>A Speech Therapy (ST) progress note dated 1/22/15 at 12:57 p.m., indicated "recommended diet at this time is regular diet with NECTAR THICK LIQUID. Medication consumed via NTL consistency. Pt [patient] to upright 90 degrees for all meals or in dining room with supervision. compensatory safe swallow strategies Include: small sips, small bites, complete oral hygiene prior to meals, be sure dentures are in place prior to oral intake, upright following meal for 20-30 minutes."</p> <p>A ST progress progress note dated 2/9/15 at 2:55 p.m., indicated "Pt to be upright 90 degrees for all oral intake with supervision to encourage hydration/nutrition and increased PO [by mouth] intake...."</p> <p>The resident had a Care Plan dated 1/22/15, that addressed the problem he had dysphagia and a potential for complications related to nectar thick liquids. The approaches included, but were not limited to, "...1/22/15--Monitor and record intake, Observe resident for difficulty swallowing, coughing, watering eyes during meals, and/or aspiration...."</p>			

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	<p>The resident had a Care Plan dated 2/4/15, that addressed the problem he was experiencing weight loss related to dysphagia and inconsistent po (oral) intake. The approaches included, but were not limited to, "2/5/15--Encourage res to feed himself as much of meal as res can and offer assistance with remainder of meal..."</p> <p>During an interview on 2/09/15 at 1:18 p.m., the Registered Dietitian indicated the resident was not to eat alone in his room due to he had dysphagia and required supervision during meals.</p> <p>During an interview on 2/11/15 12:15 p.m., Speech Therapist (ST) #11 indicated on 2/6/15, she was with Resident #107 until 1:00 p.m., supervising him with his meal, then she left his meal tray in his room. After she left the resident's room she went to inform the nurse he was finished eating and was complaining of groin pain and she did not re-enter the resident's room. She indicated she had been doing vital stimulation to strengthen his throat muscles and he had been downgraded to NTL. She indicated he got fatigued easily while eating because he ate three to four bites when she was with him, then he did not want anymore to eat.</p>			

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F 0325 SS=G Bldg. 00	<p>3.1-45(a)(2)</p> <p>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 condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to recognize a severe weight loss and implement prevention interventions in a timely manner to prevent a resident from experiencing a 30.6% severe weight loss for 1 of 4 residents reviewed for nutrition (Resident #107) and failed to provide weight loss interventions to 1 of 4 residents reviewed for nutrition. (Resident B). These deficiencies impacted 2 of 4 residents reviewed for nutrition and weight loss.</p> <p>Findings include:</p>	F 0325	<p>F325 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #107 meal ticket and plan of care reviewed and new order received for Marinol on 2/24/15. Resident #107 family contacted regarding enteral feeding options and declined feeding tube on 2/24/15. Resident #B meal ticket and plan of care reviewed and nutritional interventions remain. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents residing in the facility</p>	03/13/2015	

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	<p>1. Resident #107's record was reviewed on 2/6/15 at 10:49 a.m. Diagnoses included, but were not limited to, anemia, dysphagia (difficulty swallowing), pancytopenia (medical condition where there is a reduction in the number of red and white blood cells and platelets), Alzheimer's disease, vitamin deficiency, diabetes mellitus type II, and renal failure.</p> <p>On 2/5/15 at 12:25 p.m., Resident #107 received meatloaf, green beans and potatoes, mashed potatoes and brown gravy, bread and butter and he had 2 chocolate covered strawberries on a plate in front of him with a glass of nectar thickened juice for lunch. He was eating with his left hand in the main assist area dining room with his fingers, then he picked up his fork and used it for a minute. His meatloaf was not cut up into pieces at that time, so he tore pieces of meatloaf off the slice of meatloaf with his fingers. He picked up his fork and attempted to cut a piece of the meatloaf off the slice, but when he could not do that, he went back to picking the meatloaf up with his fingers. He was observed cutting the slice of meatloaf into pieces with only his left hand. He was observed having trouble getting food onto his fork at times. He would lean forward in his wheelchair for awhile, then he would</p>		<p>with significant weight loss have the potential to be affected. Current resident weights were evaluated to ensure that any significant losses were identified/ recognized and the physician was notified. An interdisciplinary (IDT) review was conducted for all residents with significant weight loss including the development of a nutritional care plan with individualized interventions. These residents will continue to be reviewed by the interdisciplinary team and Registered Dietitian to ensure interventions are effective and nutritional goals have been met.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Nursing and dietary staff will be re-educated on providing meal ticket items during meal service. Any residents who experience a 5% or more weight loss in 30 days or 10% or more weight loss in 180 days/6 months will be reviewed by the interdisciplinary team and Registered Dietitian for current nutritional status and implementation of individualized interventions. CarDon Weight Management Policy in-service will be provided by the Clinical Specialist to the interdisciplinary team members. IV. The facility will monitor the corrective action by implementing the following</p>				

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	<p>lean back against the back of the wheelchair and try to eat his lunch. At that time when he was leaning forward in his wheelchair was the time he had the most trouble getting the food onto his fork. He closed his eyes and had facial grimacing with furrowed brows when he swallowed bites of food or his NTL juice. He ate 75% of his meal and drank 4 ounces of his juice and pushed himself away from the table. No staff was present to assist the resident finishing his meal after he had finished eating.</p> <p>A lunch meal ticket dated 2/5/15, indicated the following food items were circled: 2 ounces (oz) meatloaf-LS (Low Sodium) with 1 oz NTL brown gravy-LS, 4 oz green beans and potatoes-LS, 4 oz steamed broccoli-LS, 1 slice bread and 1 iced sugar cookie. The resident's lunch meal lacked the steamed broccoli and the iced cookie.</p> <p>On 2/5/15 at 5:24 p.m., Resident #107 was observed receiving baked chicken, baked beans, coleslaw, dinner roll, pudding parfait and an 8 oz glass of nectar thickened juice for his dinner meal. An unidentified CNA assisted the resident with his chicken and cut the chicken into large pieces. He was eating with his left hand in the main assist area dining room. He was observed to chew a</p>		<p>measures. Director of Dining Services will audit random meal tickets weekly x 4, monthly x 1 months, and quarterly thereafter up to 12 months. DON or Designee will audit random sample of residents with significant weight loss weekly x 4 weeks, monthly x 1 month, and quarterly thereafter up to 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p>		

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	<p>piece of chicken multiple times before he swallowed it. He had a lump of food on the right side of his cheek and placed more food in his mouth and chewed that food multiple times before he swallowed. The resident was observed taking a piece of chicken out of his mouth and he placed it on his plate, while he continued to chew the food he had in his mouth. He was observed taking a large piece of chicken out of his mouth and placed it on his plate, then the large lump in the right cheek area was gone. The resident ate 75% of his meal, while only 15% of that 75% he ate was his baked chicken. He drank 4 oz of the NTL juice. No staff was present to assist him to finish his meal after he had finished eating.</p> <p>A dinner meal ticket dated 2/5/15, indicated the following food items were circled: 8 oz NTL Pureed vegetable soup, 2 oz each piece baked chicken-LS, 1 piece corn on the cob-LS, #10 scoop creamy coleslaw-LS, dinner roll and #8 scoop pudding parfait. The resident's dinner meal lacked the pureed vegetable soup and the corn on the cob.</p> <p>On 2/6/15 at 8:03 a.m., Resident #107 was observed eating a breakfast meal with a banana cut into slices, a small bowl of oatmeal and scrambled eggs with</p>			

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	<p>an 8 oz glass of NTL water and NTL cup of coffee to drink. He was observed eating the banana with his fingers. He ate 50% of his breakfast and drank 4 oz of his water and 2 oz of his coffee. His toast did not have butter or jelly on it and he only took one bite of the dry toast. No staff was present to assist him to finish his meal after he had finished eating.</p> <p>On 2/6/15 at 1:25 p.m., the resident was observed laying in bed with his lunch tray in front of him eating corn with a fork out of a 1/2 filled bowl of corn,. He ate a 1/2 a hamburger on a bun and he had ate his salad and his dessert. He had a full glass of NTL water sitting on his lunch tray and he took a drink of the water.</p> <p>On 2/6/15 at 1:32 p.m., CNA #6 was observed picking up the resident's tray.</p> <p>The resident's Medication Administration History dated February 2015, included, but were not limited to, the following orders: 1/18/15--Offer bedtime snack 1/21/15--Magic cups (a supplement) twice daily between meals at 10:30 a.m. and 2:30 p.m. 2/4/15--2 gram Na (Sodium) diet with NTL.</p> <p>The resident's weights taken from the</p>			

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	<p>computer under the "Vitals" tab from the last 180 days were as follows:</p> <p>08/02/14--175 09/01/14--173 09/19/14--170 09/22/14--172 10/01/14--174 11/03/14--175 12/04/14--169 12/29/14--138 01/05/15--134 01/12/15--134 01/13/15--137 01/14/15--137 01/19/15--131 01/21/15--134 01/28/15--134 02/01/15--135</p> <p>The resident's weights taken from the Medication Administration History documentation dated August 2014 thru January 16, 2015, for the last 180 days included, but were not limited to the following:</p> <p>08/02/14--175 09/01/14--159 09/19/14--not documented 10/01/14--148 11/03/14--149 12/04/14--146 12/29/14--not documented 01/05/15--not documented 01/12/15--134</p>			

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01/13/15--134 01/14/15--137	<p>The resident's annual MDS (Minimum Data Set) assessment dated 9/12/14, indicated he required supervision with setup of his meal tray during mealtime. He did not have any swallowing disorders, his weight was 173 and he had not had any weight loss. The CAA (Care Area Assessment) summary for Nutritional Status dated 9/17/14, for the annual MDS assessment dated 9/12/14, indicated "Resident receiving a regular diet with adequate intakes. BMI [Body Mass Index] is slightly in overweight category. Registered Dietitian reviews as needed. Will continue to monitor."</p> <p>The resident's significant change MDS assessment dated 1/27/15, indicated he required extensive assist with one person physical assist with eating. He did not have any swallowing disorders, his weight was 134, and he was on a therapeutic diet. The CAA summary for Nutritional Status dated 2/9/15, for the significant change MDS assessment dated 1/27/15, indicated "resident remains at risk for altered nutritional and weight status related to need for therapeutic diet prescribed due to hx [history] of CHF [congestive heart failure]. resident with significant weight</p>			

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	<p>loss at this time. Interventions per IDT [Interdisciplinary Team] and RD [Registered Dietitian] recommendations."</p> <p>An "IDT Clinically At Risk Review" note dated 1/7/15 at 4:18 p.m., indicated the note was a weekly review and Resident #107 was an ongoing risk for skin and wound issues and weight loss. The root cause indicated the resident's weight loss was possibly related to flu like symptoms, anemia and diagnosis of Wry neck (a painfully twisted and tilted neck). The current status indicated he had a 3.7 pound weight loss in the last week. He had been on antibiotic therapy for flu like symptoms and wry neck. He was to be seen by the Gastrointestinal Physician related to visible blood in his stool and a low hemoglobin. The interventions the IDT had in place were obtain weight as ordered, complete labs as ordered by the Physician, administer the resident's medications, treatments and diet as ordered.</p> <p>An "IDT Clinically at Risk Review" note dated 2/4/15 at 4:23 p.m., indicated the note was an initial review and Resident #107 was a new risk for weight loss. The root cause indicated he had experienced weight loss related to dysphagia and poor food intake. The resident's current status indicated his weight had increased 0.8</p>			

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	<p>pounds the last 4 days. The interventions the IDT had in place was weekly weights, MVI with minerals, a regular diet with NTL, fortified cereal with breakfast, a magic cup twice a day between meals, a 2 gram Na diet and a snack at bedtime.</p> <p>A "Nutritional Assessment Comprehensive" dated 9/22/14 at 8:39 a.m., indicated the assessment was for a readmission. He was on a 2 gm Na diet. He ate in the area dining room and weight 173 lbs. His UBW (usual body weight) was 170-180 lbs and his IBW (ideal body weight) was 128-156. His body mass index (BMI) was 27.9. He had not lost 5% or more in a month or >10% in 6 months. He consumed an average of 50-75% of his food at meals. His total calories, total protein required to meet his estimated needs were 60-80 grams of protein /day. His weight status was BMI <18.5 or >24.9. His oral/nutritional intake of food met 25-75% of his estimated needs. The RD Summary indicated he was on a regular 2 gm Na diet order. He remained at risk for altered nutritional/weight status related to being on a regular 2 gram Na diet. The interventions indicated no new recommendations at that time.</p> <p>A "Nutritional Assessment Short Form" dated 11/12/14 at 1:05 p.m., indicated the</p>				

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	<p>resident did not have any swallowing disorders. He weighed 175 pounds. His BMI was 28 and he was on a therapeutic diet. His diet order was 2 gram Na and he received routine snacks. He consumed an average of 76-100% of his meals. The summary indicated "resident continues to receive therapeutic diet with adequate intakes. BMI is slightly in the overweight category...."</p> <p>A "Nutritional Assessment Comprehensive" dated 1/18/15 at 7:56 p.m. indicated the assessment was for a readmission. The diet order was 2 gm NA. The resident ate his meals in the area dining room and he weighed 137 pounds. His IBW should be 133-163. His BMI was 21.4. He had lost 5% or more in the last month or 10% or more in the last 6 months and he was not on a prescribed weight loss regimen. His average food intake at meals was 50-100%. His total protein required to meet his estimated needs was 62-80 grams of protein/day. His weight status was BMI 18.5 to 24.9. He had a less than 7.5% weight change in 90 days and a less than 10% weight change in 6 months. His oral/nutritional intake met 76-100% of his estimated needs and met 26-75% of his estimated needs. The RD Summary indicated The Interventions were he was to follow a 2 gram Na diet</p>			

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	<p>order, MVI with iron and the weekly weights monitored. The note indicated because of his history of weight loss the RD suggested fortified cereal with breakfast, magic cup twice daily between meals. Additional Observations indicated the resident had about a 21% weight loss over 164 days.</p> <p>A Therapy Screen note dated 1/20/15 at 11:52 a.m., indicated the screen date was 1/20/15 and the facility referral was because the resident had increased dehydration/malnutrition. The ST (Speech Therapy) services warranted at that time was to monitor safe oral intake with LRD (Laryngopharyngeal Reflux Disease) (the backup of gastric content into the larynx and pharynx). His swallowing function was poor. There was a recent weight loss or diet change. The evaluation recommendation was for Speech therapy.</p> <p>A Speech Therapy (ST) progress note dated 1/22/15 at 12:57 p.m., indicated "recommended diet at this time is regular diet with NECTAR THICK LIQUID. Medication consumed via NTL consistency. Pt [patient] to upright 90 degrees for all meals or in dining room with supervision. compensatory safe swallow strategies Include: small sips, small bites, complete oral hygiene prior</p>						

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	<p>to meals, be sure dentures are in place prior to oral intake, upright following meal for 20-30 minutes."</p> <p>A Physician progress note dated 2/8/15 at 10:02 a.m., indicated "HPI [History, Physical, Information] Weight loss Pt [patient] triggered for weight loss evaluation... 02/01/2015 10:33 AM Weight 135.2 lbs [pounds]... 01/28/2015 10:49 AM Weight 134.4 lbs... 01/21/2015 5:04 PM Weight 134.0 lbs... 01/19/2015 2:21 PM Weight 130.8 lbs... Acceptable Range: 5 percent change in weight in 30 days. 01/14/2015 11:19 AM Weight 137.0 lbs... 01/14/2015 9:48 AM Weight 137 lbs... 01/13/2015 11:19 AM Weight 136.6 lbs... 01/12/2015 11:19 AM Weight 134.2 lbs... 01/05/2015 4:18 PM Weight 134.4 lbs...12/29/2015 11:21 AM Weight 138.0 lbs... Assessment: 1. Weight loss. Plan: Weight loss <10%, Continue nursing and dietary interventions, Will not intervene with appetite stimulation meds until 10% weight loss...."</p> <p>The resident's record was reviewed from 8/1/14 to 2/11/15, and the record lacked documentation that the Physician was notified of a severe weight loss of 30.6% in 180 days.</p>						

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	<p>A RD progress note dated 2/9/15 at 12:59 p.m., indicated "Resident with weight loss and stage 1 PU [pressure ulcer]. current weight of 135 lb [pounds] reflects a BMI WNL [within normal limits] at 21.7. Weights past few weeks have ranged around 134 +/-2-5 lb. Diet remains regular 2 g Na with intakes averaged at ~ [about] 50%...Nutrition interventions in place include MVI w [with]/minerals, fortified cereal with breakfast, Magic Cup BID [twice daily] b/w [between] meals...weights monitored...."</p> <p>A ST progress progress note dated 2/9/15 at 2:55 p.m., indicated "Pt to be upright 90 degrees for all oral intake with supervision to encourage hydration/nutrition and increased PO [by mouth] intake...."</p> <p>The resident had a Care Plan dated 1/19/15, that addressed the problem he was at risk for weight loss related to anemia, poor food intakes and he removed his dentures and sat them on the table. The approaches included, but were not limited to, "1/21/15--Fortified cereal with breakfast, Magic cup BID [twice daily] between meals...supplements as needed."</p> <p>The resident had a Care Plan dated</p>			

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	<p>1/22/15, that addressed the problem he had dysphagia and a potential for complications related to nectar thick liquids. The approaches included, but were not limited to, "...1/22/15--Monitor and record intake, Observe resident for difficulty swallowing, coughing, watering eyes during meals, and/or aspiration..."</p> <p>The resident had a Care Plan dated 2/4/15, that addressed the problem he was experiencing weight loss related to dysphagia and inconsistent po intake. The approaches included, but were not limited to, "2/5/15--Encourage res to feed himself as much of meal as res can and offer assistance with remainder of meal. 2/4/15--diet as ordered, fortified cereal with breakfast, HS snack, Magic cup BID between meals..."</p> <p>The resident's meal intakes were reviewed from 8/1/14 to 1/31/15 and he averaged these intakes for the following meals: Breakfast-51-75% Lunch-51-75% Dinner-51-75%</p> <p>The resident's supplement intakes were reviewed for the following times and months and he averaged these intakes: 1/22/15 thru 1/31/15 10:30 a.m.-0-50%</p>			

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	<p>2:30 p.m.-25-50%</p> <p>2/1/15 thru 2/6/15 10:30 a.m.-50-100% (2/3/15-resident was unavailable) 2:30 p.m.-0-50%</p> <p>During an interview on 2/09/15 at 1:18 p.m., the RD, Director of Dining Services (DDS), Dietary Manager (DM), Director of Nursing (DON) and Clinical Nurse Consultant (CNC) were present. The RD indicated she was going to look at his fluids and at his diuretic use in regards to his weight loss. She indicated he had not had MedPass or house shakes as far as she knew as a supplement since he had the severe weight loss. She indicated if residents with weight losses had meal intakes above 50% they did not routinely get Medpass, boost or house shake as a supplement. She indicated the resident was not to eat alone in his room due to he had dysphagia and required supervision during meals.</p> <p>The Director of Dietary Services (DDS) indicated at that time if food items were circled on a meal ticket, the resident had chosen those food items as his meal preferences for that particular meal. She indicated if the resident was unable to fill the meal ticket out himself and did not have family to assist him, the CNA's</p>			

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	<p>would assist him in circling his food item preferences for his meals. The DDS indicated the resident should have gotten the food items that were circled on his meal ticket. She indicated he would have gotten the main meal for breakfast if he did not have any food items circled on his meal ticket or Dietary Aide #10 would have asked him what he wanted before she started serving his meal.</p> <p>The DM indicated at that time Resident #107 received fortified cereal and a banana with breakfast and a magic cup between meals as interventions to prevent him from losing weight and to try to maintain his weight.</p> <p>The CNC indicated at that time the resident's monthly weights were not documented accurately and she believed that a previous Unit Manager (UM) that worked at the facility was putting the wrong weights in the computer for this resident. She indicated the previous Unit Manager was documenting monthly and weekly weights in the computer that were not the same weights as the daily weights the nurses caring for the resident were documenting in the Electronic Medication Administration Record.</p> <p>During an interview on 2/10/15 at 8:40 a.m., the Administrator indicated she had</p>			

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	<p>not seen corn on the cob served at the facility and she was surprised to see it listed as a food item selection on Resident #107's dinner meal ticket.</p> <p>During an interview on 2/10/15 at 9:30 a.m., the DON indicated the resident did not get any supplements started until 1/21/15, because the UM of the unit the resident resided on did not accurately document his weight each week and month. She indicated the monthly and weekly weights the UM documented in the computer did not match up to the daily weights that were being documented in the computer by the floor nurses and she did not realize he had a significant weight loss until December. She indicated when she noticed the weight inaccuracies the IDT started him on supplements. She indicated they implemented interventions as soon as they caught the significant weight loss and the resident was starting to gain weight then. She indicated the supplements were started on 1/21/15, not in December when the inaccuracies were discovered.</p> <p>During an interview on 2/11/15 at 12:15 p.m., Speech Therapist (ST) #11 indicated the resident was on Speech Therapy for silent aspirating thin liquids (ingesting fluids into the lungs without</p>			

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	<p>coughing to protect the lungs). She indicated he got fatigued easily while eating and he did not have much of an appetite because he ate three to four bites when she was with him, then he did not want anymore to eat. She indicated on 2/6/15, she was with him until 1:00 p.m. supervising his meal, then she had left his meal tray in his room. After leaving his room she went to inform the nurse that he was done eating and he was complaining of groin pain and she did not re-enter his room. She indicated she talked with the DM on 2/10/15, regarding the resident's decreased appetite and if he was on an appetite stimulant. She indicated the DM indicated she did not think he was on an appetite stimulant, but she was going to inquire about getting one for him.</p> <p>2. Resident B's record was reviewed on 2/5/15 at 4:06 p.m. Diagnoses included, but were not limited to, dysphagia, parkinsonism, and esophageal reflux.</p> <p>On 2/05/15 at 12:19 p.m., the resident was observed receiving meatloaf, broccoli, mashed potatoes and gravy, bread and butter, peaches, a sugar cookie and an 8 oz glass of prune juice. He was in a family member's room eating with her.</p> <p>A lunch meal ticket dated 2/5/15,</p>			

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	<p>indicated the following food items were circled: 2 ounces (oz) meatloaf with 1 oz brown gravy, #10 scoop mashed potatoes and 1 oz gravy, 4 oz steamed broccoli, 1 serving fruit of the day and 1 iced sugar cookie. The resident had a diamond symbol next to #8 scoop fortified pudding and 8 fluid oz whole milk.</p> <p>On 2/05/15 12:57 p.m., the resident ate 75% of his meal and his family member's fruit and cookie. He drank his prune juice. His meal tray lacked the fortified pudding and whole milk when he received it and he did not receive either one by the time he had left his family member's room to go back to his room after lunch at that time.</p> <p>On 2/05/15 5:59 p.m., Resident B was observed receiving a dinner tray in a family members room with baked BBQ chicken, coleslaw, baked beans, parfait pudding, an 8 oz glass of water and an 8 oz glass of milk. The resident did not drink any of his milk. He ate 50% of his meal. He ate his family member's apricots and he did not eat his own dessert. He drank 6 oz of his water.</p> <p>A dinner meal ticket dated 2/5/15, indicated the following food items were circled: #10 scoop baked beans, #10 scoop creamy coleslaw, #8 pudding</p>			

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	<p>parfait and thigh was written above the 2 oz each piece BBQ chicken. The resident had a diamond symbol next to 8 fluid oz whole milk. At that time, the resident indicated he did not usually get milk on his tray for meals except for at breakfast and he only used it for his cereal. He indicated he had not been getting milk with his meals until this meal. He indicated he did not drink milk.</p> <p>On 2/06/15 8:05 a.m., the resident received an 8 oz glass of milk and a 4 oz glass of milk, a bowl of oatmeal, a banana and a bowl of corn flakes. He received a cup of coffee to drink. He ate 75% of his breakfast. At that time, Resident B's family member indicated he was never a big breakfast eater and all he ate for breakfast was a bowl of hot cereal and a bowl of cold cereal. She indicated that was why that was all he ate at the facility because he did not eat a traditional breakfast of eggs and breakfast meat when he was at home.</p> <p>The resident's Physicians Orders dated February 2015, included, but were not limited to the following orders: 7/21/14--Whole milk three times a day with meals. 8/31/14--Fortified cereal with breakfast daily. 10/5/13--Regular diet.</p>						

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	<p>1/9/15--Offer resident bedtime snack. 1/17/15--MedPass (a supplement) 120 ml by mouth three times a day at 8:30 a.m., 11:30 a.m. and 4:30 p.m. (Discontinued 2/10/15)</p> <p>The resident had a Care Plan dated 1/7/15, which addressed the problem he was experiencing weight loss related to decreased appetite and poor food intake. The approaches included, but were not limited to, "2/5/14-Fortified pudding at lunch. 1/16/14--Med pass 120 ml TID [three times daily]. 1/7/15--Cont [continue] fortified cereal with breakfast, cont whole milk TID with meals, diet as ordered...."</p> <p>The resident's meal intakes were reviewed from 9/1/14 to 2/10/15 and he averaged these intakes for the following meals: Breakfast--76-100% Lunch--50-100% Dinner--50-100%</p> <p>The resident's weights taken from the computer under the "Vitals" tab from the last 180 days were as follows: 08/05/14--146 09/03/14--146 09/08/14--146 10/04/14--141 10/28/14--135</p>			

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	<p>11/03/14--133 11/10/14--135 11/17/14--136 11/24/14--137 12/01/14--140 01/05/15--131 01/14/15--134 01/19/15--134 01/26/15--133 02/04/15--135</p> <p>A "Nutritional Assessment Comprehensive" note for an annual review dated 8/25/14 at 8:37 a.m., indicated his weight was 146. His BMI was 19.8. His BMI was lower for his age at 19. The resident remains at risk for altered nutritional/weight status related to regular diet order, history of weight loss (not significant) lower BMI for his age at 19.</p> <p>A RD progress note dated 11/3/14 at 12:51 p.m., indicated "current weight of 134 lb [pound] reflects a 4.5% decline x ~ [about] 1 month from weight of 141 lb and 12.5% x 176 days from weight 152 lb. BMI is lower for age of 18.7. Intakes on regular diet are averaged at 50-100%...."</p> <p>An "IDT Clinically At Risk Review" note dated on 11/5/14 at 2:17 p.m., indicated the resident was a new risk for skin and</p>			

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	<p>wound issues. The root cause was he had a weight loss related to decreased appetite. His current status was he had an 8.8% weight loss during the last 2 months.</p> <p>A "Nutritional Assessment Short Form" note dated 11/24/14 at 7:55 p.m., indicated he weighed 137 pounds. His BMI was 18.6. He had not lost 5% or more in the last month or 10% or more in the last 6 months. He consumed an average of 51-100% of his meals. The summary indicated "... however had weight loss in October 2014...."</p> <p>An "IDT Clinically At Risk Review" noted dated on 1/7/15 at 1:44 p.m., indicated the resident was a new risk for weight loss. The root cause was poor appetite and food intake. The current status was the resident had an 8 lb weight loss within the last 30 days.</p> <p>A RD progress note dated 1/12/15 at 3:17 p.m., indicated "resident's current weight of 131 lb [pound] reflects a 6.2% decline x 35 days and 12.1% x 160 days. BMI is low at 17.1. Diet is regular with fluctuating PO [by mouth] intakes ~ [about]50-75%...."</p> <p>An "IDT Clinically At Risk Review" noted dated on 1/21/15 at 12:59 p.m.,</p>			

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	<p>indicated the resident was an ongoing risk for weight loss. The root cause was poor appetite and food intake. The current status was he had a 0.4% weight loss during this week.</p> <p>A nursing progress note dated 2/5/15 at 2:30 p.m., indicated "Noticed at end of afternoon meal pass, fortified pudding was not on meal tray but in refrigerator. Offered fortified pudding and whole milk as afternoon snack. Resident refused both. Staff encouraged res [resident] to eat pudding and drink milk. continued to refused [sic] but allowed staff to leave in room at bedside in case res changes his mind."</p> <p>A nursing progress note dated 2/5/15 at 4:12 p.m., indicated "Resident consumed 50% of fortified pudding but continued to refuse the whole milk. Asked writer to get rid of it."</p> <p>During an interview on 2/9/15 at 1:18 p.m., the Director of Dining Services indicated if the resident had a diamond symbol next to a food item on his meal ticket that symbolized the resident was to receive that food item at that meal.</p> <p>During an Interview on 2/09/2015 2:08 p.m., the Dietary Manager indicated she noticed when the kitchen was being</p>			

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	<p>cleaned up that there was a fortified pudding left in the refrigerator and that Resident B did not get his fortified pudding and his whole milk at lunch, so she took it down to his room. She indicated she tried to give the fortified pudding and whole milk to him, but he did not want either one. She indicated she left the pudding and milk in the resident's room on his bedside table and told the nurses that she left them for him.</p> <p>During an interview on 2/09/15 2:12 p.m., the Clinical Nurse Consultant indicated on 2/5/14, there was documentation that the resident was offered his whole milk and fortified pudding after the staff realized he did not receive it with his lunch tray and it was documented at 2:30 p.m.</p> <p>During an interview on 2/11/15 4:52 p.m., the DON indicated she was unable to locate any albumin, pre-albumin or total protein laboratory tests for either of these residents in the last year since Feb 2014.</p> <p>A current policy titled "Nutrition & Hydration At Risk Program" undated, provided by the DON on 2/9/15 at 10:35 a.m., indicated "Residents at nutrition and/or hydration risk will be identified through the interdisciplinary process.</p>			

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	<p>Residents who are found to be at risk are placed on a Nutritional/Hydration Risk Program. Residents are reviewed through the Interdisciplinary Nutrition at Risk (NAR) meeting bi-monthly...Residents who develop conditions/needs as listed below may be placed in the nutrition/hydration at risk monitoring program: Residents with weight loss of 5% in one month and 10% in 6 months which was not desired or expected...The RD is responsive for recommending nutritional interventions... If there is a significant weight loss, the licensed nurse will add the resident to the bi-weekly weight list and the nutrition at risk program...."</p> <p>A current policy titled "Nutritional and Weight Monitoring" undated, provided by the DON on 2/9/15 at 10:35 a.m., indicated "...Weights are collected and reviewed monthly (or bi-monthly if on NAR [Nutrition at Risk]; or weekly for 4 weeks if the resident is a new admission) and recorded on the resident's weight record. Significant weight loss is defined as: 5% in 1 month, 7.5% in 3 months, 10% in 6 months... Once the weight loss is verified, nursing will notify the RD/CDM [Registered Dietitian/Certified Dietary Manager] in writing. The licensed nurse will also notify the resident's physician and the resident's</p>			

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	<p>responsible party of the significant weight loss. The RD/CDM is responsible for reviewing each resident with unplanned weight loss, recommending the appropriate intervention and documenting in the resident's clinical record...."</p> <p>3/1-46(a)(1)</p>			

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F 0328 SS=D Bldg. 00	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper equipment care for enteral feeding equipment was provided for 1 of 1 residents reviewed for enteral feedings. (Resident #69)</p> <p>Findings include:</p> <p>Resident #69's record was reviewed on 2/10/15 at 1:24 p.m. Diagnoses included, but were not limited to, attention to gastrostomy and dysphagia (trouble swallowing).</p>	F 0328	<p>F328 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Syringe for resident #69 was changed on 2/9/15. II. The facility will identify other residents that may potentially be affected by the deficient practice. All residents that receive enteral feeding have been identified. Residents receiving enteral feeding will have their syringe changed once every 24 hours. III. The facility will put into place the following systematic changes to ensure that the deficient practice does</p>	03/13/2015

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	<p>The resident's Medication Administration History dated February 2015, included, but were not limited to, the following orders:</p> <p>4/24/14--Tube feeding: Glucerna 1.2 continuous at 55 ml (milliliters)/hour.</p> <p>On 2/3/15 at 1:33 p.m., the resident had Glucerna 1.2 tube feeding infusing by a feeding pump at 55 ml/hour. She had a 60 ml syringe hanging in a plastic package dated 2/2/15, next to a bottle of tube feeding on the feeding pump pole.</p> <p>On 2/9/15 at 10:24 a.m., the resident had Glucerna 1.2 tube feeding infusing by a feeding pump at 55 ml/hour. She had a 60 ml syringe hanging in a plastic package dated 2/6/15, next to the bottle of tube feeding on the feeding pump pole.</p> <p>During an interview on 2/9/15 at 10:24 a.m., LPN #2 indicated the 60 ml syringe was dated 2/6/15, and it should have been changed out with a new syringe every 24 hours by the midnight shift nurse.</p> <p>A skills validation titled "Licensed Nurse Administration of Medications via Feeding tubes Clinical Skills Validation" undated, provided by the Director of Nursing on 2/10/15 at 10:31 a.m., indicated "Medications Via Feeding Tubes... 30. Check syringe and tubing</p>		<p>not recur. The syringe change will be recorded on the MAR daily. Licensed nurses will be re-educated regarding changing enteral feeding syringes per facility policy. IV. The facility will monitor the corrective action by implementing the following measures. The Unit Manager or designee will review syringe change completion as documented on the MAR and by viewing enteral feeding syringes 3 times a week for 4 weeks, weekly for 4 weeks, monthly for 4 months. Any identified concerns from the audits will be addressed immediately. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p>	

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F 0332 SS=D Bldg. 00	<p>for dates (no more than 24 hours)...."</p> <p>3.1-47(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rates of 5% or greater. During the medication pass observation, 4 errors were made in an total of 27 opportunities, for an error rate of 14.8%. This deficiency impacted 3 of 6 residents observed receiving medications during the medication pass task. (Resident C, #210 and D).</p>	F 0332	<p>F332 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. No residents were adversely affected. LPN #3, LPN #4, and RN #5 received 1:1 education regarding correct procedure for medication administration with medication administration observation to determine compliance. II. The facility will identify other</p>	03/13/2015

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	<p>Finding include:</p> <p>1. During a medication pass observation on 2/4/2015 at 4:29 p.m., LPN #3 was observed, administering the antihypertensive medication, carvedilol 3.125 mg (milligrams) by mouth without food, to Resident C. The resident was complaining of feeling dizzy and a little disoriented at the time.</p> <p>The resident's record was reviewed on 2/4/2015 at 5:18 p.m. Diagnoses included, but were not limited to hypertension and muscle weakness. Resident C's current February 2015, physician medication orders included, but were not limited to : "...carvedilol tablet; 3.125 mg; amt[amount]; 1 tab; oral. Special Instructions: Give with meals...."</p> <p>During an interview with LPN #3 on 2/4/2015 at 5:30 p.m., she indicated Resident C had just gotten his dinner and was eating in his room. She indicated she is not allowed to give medications to the residents in the dining room and she had not thought about giving the resident food with his medication.</p> <p>2. During a medication pass observation on 2/5/2015 at 9:10 a.m., LPN #4 was observed, administering one biotin</p>		<p>residents that may potentially be affected by the deficient practice. All Residents receiving medications have the potential to be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Licensed nursing staff have been re-educated on appropriate medication administration techniques. IV. The facility will monitor the corrective action by implementing the following measures. Staff Development Coordinator or designee will audit by observation of medication administration rotating shifts 3 times per week for 4 weeks, then weekly for one month, then monthly for a total of 12 months. Any identified concerns from the audits will be addressed immediately. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p>				

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	<p>(vitamin B) 5 mg capsule, to Resident #210.</p> <p>The resident's record was reviewed on 2/5/2015 at 9:25 a.m. Diagnoses included, but were not limited to nutritional deficiency and vitamin B deficiency. Resident #210's current February 2015, physician medication orders included, but were not limited to : "...biotin tablet; 5 mg; amt: 2 caps; oral...." once a day.</p> <p>During an interview with LPN #4 on 2/5/2015 at 11:30 a.m., she indicated she thought the resident was just ordered 1. In addition she could not remember how many capsules she had given the resident.</p> <p>3. During a medication pass observation on 2/5/2015 at 4:27 p.m., RN #5 was observed, administering the antidiabetic medication glipizide 5 mg extended release crushed and put in applesauce, to Resident D. In addition the resident did not receive any eye drops during the medication pass observation.</p> <p>The resident's record was reviewed on 2/5/2015 at 4:45 p.m. Diagnoses included, but were not limited to dementia, diabetes and glaucoma. Resident D's current February 2015, physician medication orders included, but</p>						

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F 0425 SS=D Bldg. 00	<p>were not limited to glipizide 5 mg extended release tablet twice a day, and the antiglaucoma eye medication Combigan 0.2-0.5% 1 drop to each eye.</p> <p>"Nursing 2014 Drug Handbook" indicates: "glipizide...Administration P.O.[orally]...don't split or crush extended-release tablets."</p> <p>During an interview with RN #5 on 2/5/2015 at 5:11 p.m., she indicated she was new, and nervous. She understood Resident D received her medications crushed so she did not think about it and crushed it.</p> <p>3.1-48(c)(1)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>			

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	<p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to provide a medication as ordered for 3 residents reviewed for medication availability. (Resident B, C and D)</p> <p>Findings include:</p> <p>1. On 2/4/2015 at 5 p.m., LPN #3 was observed unable to give Resident B his antipsychotic medication, olanzapine 5 mg(milligrams), because it was unavailable.</p> <p>Resident B's record was reviewed on 2/5/2015 at 8:45 a.m. Diagnoses included, but were not limited to, weakness, chronic pain, constipation and nonorganic psychosis. The resident's February 2015 medication administration history indicated he was receiving, but was not limited, to the following medications: "Zyprexa (olanzapine [generic name]) 2.5 mg; 1 tab; oral Once A Day...Start/End Date 1/21/2015 - Open Ended" and "Zyprexa (olanzapine) 5 mg; 1 tab; oral Once An Evening...Start/End Date 1/21/2015 - Open Ended"</p> <p>The resident's progress notes dated</p>	F 0425	<p>F425 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. No residents were adversely affected. LPN #3, LPN #4, and RN #5 received 1:1 education regarding correct procedure for medication administration with medication administration observation to determine compliance. Pharmacy provided medication per order for resident B and D.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice. All Residents receiving medications have the potential to be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Licensed nurses re-educated on medication administration, accessing the pharmacy EDK, and proper protocol for re-ordering medication from the pharmacy. Nurse managers educated on monitoring Medication Administration Report during clinical report. IV. The facility will monitor the corrective action by</p>	03/13/2015

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	<p>2/4/2015 at 5:35 p.m., indicated the resident received Zyprexa 2.5 mg due to, "zyprexa 5 mg being unavailable."</p> <p>2. Resident C's record was reviewed on 2/4/2015 at 5:18 p.m. Diagnoses included, but were not limited to hypertension, muscle weakness and athrosclerosis (hardening of the arteries). The resident's January 2015 medication administration history indicated the resident was receiving, but was not limited to, the following medications: "aspirin tablet, delayed release; 81 mg; oral Once A Day Every Other Day...Start/End Date 12/31/2014 - Open Ended"</p> <p>The resident's Medication Administration History dated 01/01/2015 - 01/31/2015 indicated on 01/04/2015 at 8:30 a.m., the aspirin tablet was not administered and under reasons / comments, " Drug/Item unavailable...LPN #7"</p> <p>The facility's document titled, "Skilled Care of Indiana Standard EDK [Emergency Drug Kit]" with an expiration date of 4/30/2015 was reviewed on 2/11/2015 at 3 p.m. The document contained a list of the available medications with name, strength and quantity as well as the expiration date. The list of medications available</p>		<p>implementing the following measures. Nurse Managers will monitor the Medication Administration Report in clinical report. Staff Development Coordinator or designee will audit by observation of medication administration rotating shifts 3 times per week for 4 weeks, then weekly for one month, then monthly for a total of 12 months. Any identified concerns from the audits will be addressed immediately. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p>				

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	<p>included, but was not limited, to "Aspirin 81 mg Chewable Tab" and it indicated that the quantity was 4 and the expiration was 3/31/2016.</p> <p>3. Resident D's record was reviewed on 2/5/2015 at 4:45 p.m. Diagnoses included, but were not limited to dementia, diabetes and senile psychosis. The resident's medication administration history dated January 2015, indicated the resident was receiving, but was not limited to, the following medications: anti- psychotic Zyprexa 2.5 mg tablet once a day scheduled in the morning and Zyprexa 5 mg tablet once a day scheduled in the evening.</p> <p>The resident's Medication Administration History dated 01/01/2015 - 01/31/2015 indicated on 01/11/2015 at 9:00 a.m., and on 01/14/2015 at 8:57 a.m., the Zyprexa 2.5 mg was not administered and under reasons / comments, for 1/11/2015 "Drug / Item unavailable...LPN #8" and for 1/14/2015 "Drug / Item unavailable...LPN #9."</p> <p>During an interview on 2/11/2015 at 4:10 p.m., the DON (Director of Nursing) indicated the medications are on a cycle filled basis. The reason medications may not be available sometimes is because medications get dropped and have to be</p>				

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F 0441 SS=D Bldg. 00	<p>discarded and sometimes pharmacy sends a note indicated that refill order is too soon.</p> <p>During an interview on 2/11/2015 at 4:45 p.m., the DON indicated she had contacted some of the nurses to clarify the medication unavailability problems but they were either unavailable or did not remember what had happened.</p> <p>At exit on 2/11/2015 at 6 p.m., no other information was provided by the facility.</p> <p>This Federal Tag relates to Complaint IN00163025.</p> <p>3.1-25(a) 3.1-25(g)(2)</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 and infection.</p> <p>(a) Infection Control Program</p>				

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	<p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review the facility failed to ensure a bathroom was clean and free from the possibility of spreading infection for 1 of 1 bathrooms observed where a resident had a diagnosis of C-diff. (Resident #135 and #107)</p> <p>Findings include:</p> <p>On 02/03/2015 at 10:43 a.m., Resident</p>	F 0441	<p>F441 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #107 and #135 toilet was cleaned. Housekeeping associates were re-educated regarding the proper procedure for cleaning toilets for residents who have c-diff. II. The facility will identify other residents that may potentially be affected by the deficient</p>	03/13/2015

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	<p>#135 and Resident #107's toilet was observed with a brown colored substance smeared down the front of the outside of the toilet bowl.</p> <p>On 02/04/2015 at 11:05 a.m., the residents's toilet bowl continued to have a brown colored substance smeared down the front of the toilet bowl.</p> <p>During an interview on 02/09/2015 at 11:43 a.m., CNA #11 indicated Resident #135 was on contact precautions due to C-diff (clostridium difficile-- a bacterium that can cause diarrhea and inflammation of the colon) but the resident was changed on his side of the room and Resident #107 who resides on the other side of the room partition used a bedside commode.</p> <p>On 02/09/2015 at 12:10 p.m., Resident #135 and Resident #107's bathroom was observed with a dried smear of a brown colored substance smeared on the outside area of the toilet bowl that faced the wall. The ED(Executive Director) was in attendance at this time and she indicated she would go to housekeeping immediately.</p> <p>On 02/09/2015 at 12:49 p.m., the record of the facility's policy titled, "Clostridium Difficile (C-Diff) Policy" dated</p>		<p>practice. Residents with roommates and have c-diff could be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Housekeeping associates were re-educated regarding the proper procedure for cleaning bathrooms/toilets for residents who have c-diff. Housekeeping associates will continue to receive education on the proper procedure for cleaning bathrooms/toilets for resident who have c-diff during initial orientation and as needed. IV. The facility will monitor the corrective action by implementing the following measures. Director of Environmental Services or designee will audit by observation bathrooms of residents with c-diff cleaning 3 times per week for 4 weeks, weekly for 4 weeks, then monthly x 1 month, then quarterly thereafter up to 12 months. Any identified concerns from the audits will be addressed immediately. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Completion date is March 13, 2015</p>				

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R 0000 Bldg. 00	<p>10/10/2014 was reviewed. The policy indicated, "...A resident with an active case of C-Diff that has been confirmed must be placed in contact isolation because C-Diff is transmitted by direct and indirect contact. This means that the patient and the environment can cause others to contract the same infection..."</p> <p>3.1-18(a)</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>February 27, 2015</p> <p>Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p>	

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			<p>Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on February 11, 2015. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace of Fishers credible allegation of compliance. We allege compliance on March 13, 2015. We are requesting a desk review for this plan of correction.</p> <p>If you have any further questions, please do not hesitate to contact me at 317-813-4444.</p> <p>Sincerely,</p> <p>Melissa Hampton H.F.A Administrator</p>	

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			<p>Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on February 11, 2015. Please accept this plan of correction as Hamilton Trace of Fishers credible allegation of compliance by March 13, 2015.</p> <p>This statement of deficiencies and plan of correction will be reviewed at the March Quality Assurance/Assessment Committee meeting.</p>		