

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2015
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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 22, 23, 26, 27, 28, and 29, 2015</p> <p>Facility number: 011387 Provider number: 155762 AIM number: 200853180</p> <p>Survey team: Barbara Gray, RN-TC Leslie Parrett, RN Diana Sidell, RN Angel Tomlinson, RN</p> <p>Census bed type: SNF: 22 SNF/NF: 42 Residential:22 Total: 86</p> <p>Census payor type: Medicare: 33 Medicaid: 22 Other: 9 Total: 64</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on January 29, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000242 SS=D	<p>Quality review completed on February 3, 2015 by Cheryl Fielden, RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure one resident had a choice of when to bathe (Resident #84), and failed to ensure one resident had a choice of his method of bathing, and shaving (Resident #47), for 2 of 6 residents interviewed in the sample of 21 who met the criteria for choices.</p> <p>Findings included:</p> <p>1. During an interview, on 1/22/15 at 10:47 a.m., Resident #84 indicated he had tried to say no to a bed bath twice, a few weeks ago, and didn't want his clothes changed, and the CNAs made</p>	F000242	<p>F 242 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #47 has been discharged. Resident #84 was interviewed and his choice of when to bathe is being honored. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents and/or family members will be interviewed to ensure their choice of when to bathe and method of bathing and shaving is being honored. In addition, will ensure that appropriate bathing and shaving equipment is being utilized. Measures put in place and systemic changes</p>	02/28/2015

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	<p>him take a bath and change his clothes.</p> <p>Resident #84's record was reviewed on 1/23/2015 at 2:12 p.m. The record indicated Resident #84 was admitted with diagnoses that included, but were not limited to, hypothyroidism, glaucoma, history of right hip and right humerus (bone in upper arm) fracture, atrial fibrillation, constipation, diastolic heart failure, high blood pressure, type 2 diabetes, end stage kidney disease, stroke, anemia, back surgery, and depression.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 8/9/14, indicated Resident #84 was independent in cognitive skills for daily decision making, required extensive assistance of two staff for shaving and mouth care, and was total assist of two staff for bathing.</p> <p>A quarterly MDS assessment, dated 11/1/14, indicated Resident #84 was moderately impaired, decisions poor, cues or supervision required in cognitive skills for daily decision making, required extensive assist of one for shaving and mouth care, and was totally dependent of one staff for bathing.</p> <p>A care plan, with a last review date of 1/23/15, indicated: "I have problems</p>		<p>made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing staff on the following: 1). Bill of Residents Rights 2). Guidelines for Bathing Preference 3). Personal Preference Form 4). Caretracker documentation of ADL completion and refusal 5), Appropriate bathing and shaving equipment How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance on 5 residents : 1). Residents will be interviewed to ensure their choice of when to bathe and method of bathing and shaving is being honored. 2). Residents will be observed to during bathing to ensure appropriate bathing equipment is being utilized 3). Residents will be observed during shaving to ensure he / she is satisfied with the equipment being used The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p>	

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	<p>providing my own care r/t (related to) chronic debility, ESRD (end stage renal disease), anemia, dm (diabetes mellitus), CHF (congestive heart failure), A-fib (atrial fibrillation, a heart condition), glaucoma, and depression...I require assist with transfers using a mechanical lift. I am currently non-ambulatory. I rely on a wheelchair and staff assist for my locomotive needs. Encourage me to participate with choosing my own clothing. Lie the clothing beside me and encourage/allow me to dress as much of myself as I am able. Assist me as needed to complete the task...Provide set up assist for my grooming and hygiene needs. Encourage/allow me to participate at my highest possible level while providing me with cues and supervision. Assist me as needed to complete each task. I would like to be showered at least two times a week and bathed on all other days. Give me a prepared cloth and encourage me to wash all the easy to reach places. Assist me to clean the more difficult to reach areas. I want to participate in my daily care as much as possible, continuing to wash my face and hands, feed myself, and assist with washing my upper torso and dressing...."</p> <p>During an interview, on 1/27/2015 at 10:05 a.m., CNA #6 indicated Resident #84 doesn't take showers on first shift,</p>			

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	<p>they wash him on first shift.</p> <p>During an interview, on 1/28/2015 at 2:13 p.m., Resident #84 was observed in bed, and said he had gone out for an appointment today. He indicated he cannot take a shower at this point, he gets a bed bath every day, that is what he wants right now, and if he is able to become more mobile, he can take a shower but right now he can't.</p> <p>2. On 1/22/15 at 11:43 a.m., an interview with Resident# 47 indicated "I have not received a shower since I have been here. The CNA brought a pan of water in and dumped it on my head to wash my hair, because I had an appointment at the wound center this morning, that's the only time I've had my hair washed and the CNA's have never washed my left leg below my knee or my foot since I have been here. The CNA tried to shave me this morning before I went to the wound center but their razors won't cut it and it hurt, so I told them to forget it."</p> <p>Observation on 1/22/15 at 11:45 a.m., of Resident# 47 indicated the Resident's face was not shaved, had approximately 1/2 inch stubble of beard on his face. His hair appeared clean, finger nails were clean but long and left foot appeared to have crusty, dry peeling skin between his toes, toenails were long, ragged and dirty.</p>			

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	<p>Review of Resident# 47's record on 1/26/15 at 8:30 a.m., indicated diagnoses included but were not limited to hypertension, spinal stenosis, paraplegic and right above the knee amputation. Resident# 47 was admitted to the facility on 12/5/14.</p> <p>Review MDS assessment dated 12/12/14 indicated a Brief Interview for Mental Status- moderately impaired, decisions poor, cues or supervision required in cognitive skills for daily decision making. Interview for daily preferences- How important is it to you to choose between a tub bath, shower, bed bath or sponge bath: very important. Activities of Daily Living: Personal hygiene- how resident maintains personal hygiene, including combing hair, brushing teeth, shaving... extensive assistance of two persons physical assist. Bathing- total dependence of two person physical assist.</p> <p>Review on 1/26/15 at 8:45 a.m., of shower documentation sheet dated 12/5/14 through 1/26/15 indicated Resident# 47 had 5 complete bed baths in 7 weeks. Monday, 12/15/14, on first shift Wednesday, 12/17/14, on second shift Sunday, 12/21/14, on third shift Sunday, 1/4/15, on first shift Tuesday, 1/20/15 on first shift</p>			

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	<p>No documentation on shower sheet until 12/8/14 to indicate Resident# 47 had received a bath.</p> <p>On 1/26/15 at 8:50 a.m., review of a document provided by LPN #5 indicated "CNA New Admission Checklist dated 12/9/15... What day would you like your showers?- Wednesday (Make sure you tell them they will get a partial bath on the days they do not get a shower). What time of day do you prefer your showers and partial bathes?- day shift</p> <p>On 1/26/15 at 9:00 a.m., an interview with LPN #5 indicated "we don't give him showers because he is a paraplegic and slides out of the shower chair. We don't have a strap on the shower chair to keep him from slipping out of it, but he does get a complete bed bath."</p> <p>On 1/27/15 at 10:30 a.m., observation of Resident# 47 indicated the Resident's face was not shaved had approximately 1 inch stubble of beard on his face. His hair appeared greasy, dirty, finger nails were clean and long. Resident's left foot appeared crusty, dry peeling skin between his toes with his toenails long, dirty and ragged.</p> <p>An interview on 1/27/15 at 2:07 p.m., with CNA# 3 indicated "Resident# 47</p>			

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F000246 SS=D	<p>refuses to be shaved, he said the razors the facility has pulls and hurts him that's why he refuses."</p> <p>On 1/28/15 at 3:30 p.m., interview with CNA# 4 indicated "Resident# 47 wouldn't let me shave him, I tried to talk him into it but he said it would take at least 5 razors if they would even cut it and it pulls and hurts so bad that it's not worth it."</p> <p>On 1/28/15 at 4:15 p.m., interview with the Campus Clinical Support Nurse indicated they don't have a policy for activities of daily living.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review the facility failed to provide a shower chair with a safety strap for a paraplegic residents showering needs and failed to provide hair care, nail</p>	F000246	F 246 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #47 has been discharged. Identification of other residents having the	02/28/2015

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	<p>care and shaving needs for 1 of 3 residents in a sample of 5 who met the criteria for activities of daily living. (Resident# 47)</p> <p>Findings include:</p> <p>On 1/22/15 at 11:43 a.m., an interview with Resident# 47 indicated "I have not received a shower since I have been here...I had an appointment at the wound center this morning, That's the only time I've had my hair washed and the CNA's have never washed my left leg below my knee or my foot since I have been here. The CNA tried to shave me this morning before I went to the wound center but their razors won't cut it and it hurt, so I told them to forget it."</p> <p>Observation on 1/22/15 at 11:45 a.m., of Resident# 47 indicated the Resident's face was not shaved had approximately 1/2 inch stubble of beard on his face. His hair appeared clean, finger nails were clean but long and left foot appeared to have crusty, dry peeling skin between his toes, toenails were long, ragged and dirty.</p> <p>Review of Resident# 47's record on 1/26/15 at 8:30 a.m., indicated diagnoses included but were not limited to hypertension, spinal stenosis, paraplegic and right above the knee amputation.</p>		<p>potential to be affected by the same alleged deficient practice and corrective actions taken: All residents requiring safety equipment for bathing will be observed to ensure it is in place. All residents will be interviewed and / or observed to ensure their hair care, nail care and shaving needs are being met. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing staff on the following: 1). Appropriate bathing and shaving equipment 2). Personal preference related to: Hair care, nail care, shaving 3). Guidelines for Bathing Preference 4). Personal Preference Form How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance on 5 residents: 1). All residents requiring safety equipment for bathing will be observed to ensure it is in place. 2). Residents will be interviewed and / or observed to ensure their hair care, nail care and shaving needs are being met. The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus</p>				

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	<p>Resident # 47 was admitted to the facility on 12/5/14.</p> <p>Review of Minimum Data Set assessment dated 12/12/14 indicated a Brief Interview for Mental Status- moderately impaired, decisions poor, cues or supervision required in cognitive skills for daily decision making. Interview for daily preferences- How important is it to you to choose between a tub bath, shower, bed bath or sponge bath: very important. Activities of Daily Living: Personal hygiene- how resident maintains personal hygiene, including combing hair, brushing teeth, shaving... extensive assistance of two persons physical assist. Bathing- total dependence of two person physical assist.</p> <p>Review on 1/26/15 at 8:45 a.m., of shower documentation sheet dated 12/5/14 through 1/26/15 indicated Resident# 47 had 5 complete bed baths in 7 weeks. Monday, 12/15/14, on first shift Wednesday, 12/17/14, on second shift Sunday, 12/21/14, on third shift Sunday, 1/4/15, on first shift Tuesday, 1/20/15 on first shift No documentation on shower sheet until 12/8/14 to indicate Resident# 47 had received a bath since admission on 12/5/14.</p>		Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.				

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	<p>On 1/26/15 at 9:00 a.m., an interview with LPN #5 indicated "we don't give him showers because he is a paraplegic and slides out of the shower chair. We don't have a strap on the shower chair to keep him from slipping out of it, but he does get a complete bed bath."</p> <p>On 1/27/15 at 10:30 a.m., observation of Resident# 47 indicated the Resident's face was not shaved had approximately 1 inch stubble of beard on his face. His hair appeared greasy, dirty, finger nails were clean and long. Resident's left foot appeared crusty, dry peeling skin between his toes with his toenails long, dirty and ragged.</p> <p>An interview on 1/27/15 at 2:07 p.m., with CNA# 3 indicated "Resident# 47 refuses to be shaved, he said the razors the facility has pulls and hurts him that's why he refuses."</p> <p>On 1/28/15 at 3:30 p.m., interview with CNA# 4 indicated "Resident# 47 wouldn't let me shave him, I tried to talk him into it but he said it would take at least 5 razors if they would even cut it and it pulls and hurts so bad that it's not worth it."</p> <p>On 1/28/15 at 4:15 p.m., interview with the Campus Clinical Support Nurse</p>						

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F000312 SS=D	<p>indicated they don't have a policy for activities of daily living.</p> <p>3.1-3(v)(1)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 3 residents who required assistant with activities of daily living (ADL) were provided daily oral care (Resident #84), nail care, hair care and showers (Resident #47), and nail care and showers (Resident #50) for 3 of 5 residents who met the criteria for ADL care. (Residents #84, #47, and #50)</p> <p>Findings include:</p> <p>1. Resident #84's record was reviewed on 1/23/2015 at 2:12 p.m. The record indicated Resident #84 was admitted with diagnoses that included, but were not limited to, hypothyroidism, glaucoma, history of right hip and right humerus (bone in upper arm) fracture, atrial fibrillation, constipation, diastolic heart</p>	F000312	<p>F 312 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #47 has been discharged. Resident #84 teeth are free of debris and is being assisted with oral care. Resident #50 fingernails have been cleaned and trimmed. Resident #50 is receiving showers per his preference. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents oral cavity will be observed to ensure teeth are free of debris and residents will be interviewed to ensure oral care is being provided / assisted with. All residents will be interviewed and / or observed to ensure their hair care, nail care and shower needs are being met.</p> <p>Measures put in place and systemic changes made to</p>	02/28/2015

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	<p>failure, high blood pressure, type 2 diabetes, end stage kidney disease, stroke, anemia, back surgery, and depression.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 8/9/14, indicated Resident #84 was independent in cognitive skills for daily decision making, required extensive assistance of two staff for shaving and mouth care, and was total assist of two staff for bathing.</p> <p>A quarterly MDS assessment, dated 11/1/14, indicated Resident #84 was moderately impaired, decisions poor, cues or supervision required in cognitive skills for daily decision making, required extensive assist of one for shaving and mouth care, and was totally dependent of one staff for bathing.</p> <p>A care plan, with a last review date of 1/23/15, indicated: "I have problems providing my own care r/t (related to) chronic debility, ESRD (end stage renal disease), anemia, dm (diabetes mellitus), CHF (congestive heart failure), A-fib (atrial fibrillation, a heart condition), glaucoma, and depression...I require assist with transfers using a mechanical lift. I am currently non-ambulatory. I rely on a wheelchair and staff assist for my locomotive needs...Assist me as</p>		<p>ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing staff on the following: 1). Personal preference related to: Hair care and showers 2). Guidelines for Bathing Preference 3). Personal Preference Form 4). Nail Care 5). Guideline for oral care</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance on 5 residents: 1). Resident's oral cavity will be observed to ensure teeth are free of debris 2). Residents will be interviewed to ensure oral care is being provided / assisted with 3). Residents will be interviewed and / or observed to ensure their hair care, nail care and shower needs are being met. The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2015	
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	<p>needed to complete the task...Provide set up assist for my grooming and hygiene needs. Encourage/allow me to participate at my highest possible level while providing me with cues and supervision. Assist me as needed to complete each task...I want to participate in my daily care as much as possible, continuing to wash my face and hands, feed myself, and assist with washing my upper torso and dressing...."</p> <p>During an observation on 1/22/2015 at 11:02 a.m., Resident #84 was observed in bed with debris in his teeth. He is right handed and his right hand is "permanently frozen", he said staff gets out the equipment to brush his teeth then leaves him, and he has great difficulty, about once every 10 days or so is all they have offered to get out his toothbrush, toothpaste and basin so he can attempt to brush his teeth.</p> <p>During an interview, on 1/27/2015 at 10:05 a.m., CNA #6 indicated Resident #84 lets them know when he wants his teeth brushed.</p> <p>During an interview, on 1/28/2015 at 2:20 p.m., Occupational Therapist #7 indicated Resident #84 cannot grip with his hands so he has to have help.</p> <p>2. On 1/22/15 at 11:43 a.m., an interview</p>						

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	<p>with Resident# 47 indicated "I have not received a shower since I have been here...I had an appointment at the wound center this morning, That's the only time I've had my hair washed."</p> <p>Observation on 1/22/15 at 11:45 a.m., of Resident# 47 indicated the Resident's face was not shaved had approximately 1/2 inch stubble of beard on his face. His hair appeared clean, finger nails were clean but long and left foot appeared to have crusty, dry peeling skin between his toes, toenails were long, ragged and dirty.</p> <p>Review of Resident# 47's record on 1/26/15 at 8:30 a.m., indicated diagnoses included but were not limited to hypertension, spinal stenosis, paraplegic and right above the knee amputation. Resident # 47 was admitted to the facility on 12/5/14.</p> <p>Review MDS assessment dated 12/12/14 indicated a Brief Interview for Mental Status- moderately impaired, decisions poor, cues or supervision required in cognitive skills for daily decision making. Interview for daily preferences- How important is it to you to choose between a tub bath, shower, bed bath or sponge bath: very important. Activities of Daily Living: Personal hygiene- how resident maintains personal hygiene,</p>			

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	<p>including combing hair, brushing teeth, shaving... extensive assistance of two persons physical assist. Bathing- total dependence of two person physical assist.</p> <p>Review on 1/26/15 at 8:45 a.m., of shower documentation sheet dated 12/5/14 through 1/26/15 indicated Resident# 47 had 5 complete bed baths in 7 weeks. Monday, 12/15/14, on first shift Wednesday, 12/17/14, on second shift Sunday, 12/21/14, on third shift Sunday, 1/4/15, on first shift Tuesday, 1/20/15 on first shift No documentation on shower sheet until 12/8/14 to indicate Resident# 47 had received a bath since he was admitted on 12/5/14.</p> <p>On 1/27/15 at 10:30 a.m., observation of Resident# 47 indicated the Resident's face was not shaved had approximately 1 inch stubble of beard on his face. His hair appeared greasy, dirty, finger nails were clean and long. Resident's left foot appeared crusty, dry peeling skin between his toes with his toenails long, dirty and ragged.</p> <p>An interview on 1/27/15 at 2:07 p.m., with CNA# 3 indicated "Resident# 47 refuses to be shaved, he said the razors the facility has pulls and hurts him that's why he refuses."</p>			

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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374
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	<p>On 1/28/15 at 3:30 p.m., interview with CNA# 4 indicated "Resident# 47 wouldn't let me shave him, I tried to talk him into it but he said it would take at least 5 razors if they would even cut it and it pulls and hurts so bad that it's not worth it."</p> <p>3. On 1/22/15 at 11:00 a.m., Resident #50 was observed with jagged fingernails and a dark substance underneath his nails.</p> <p>On 1/26/15 at 10:44 a.m., Resident #50 was observed seated in his recliner in his bedroom with his feet elevated. His fingernails were jagged with a dark substance underneath his nails. He was unsure if staff had ever cleaned his fingernails but recalled staff had trimmed his fingernails before. He stated his fingernails needed "trimmed and cleaned."</p> <p>Resident #50's record was reviewed on 1/27/15 at 8:45 a.m. His diagnoses included but were not limited to, dementia malaise and fatigue, and debility.</p> <p>Resident #50's Admission MDS assessment dated 10/29/14, indicated he was moderately impaired in his cognitive daily decision making skills. He required</p>			

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	<p>extensive assistance of 1 person for dressing and personal hygiene. He was totally dependent on 1 person for bathing.</p> <p>A Care Plan for Resident #50 indicated the following: "I have problems providing my own care r/t (related to) dementia, and weakness... Provide set up assist for my grooming and hygiene needs. Encourage/allow me to participate at my highest possible level while providing me with cues and supervision. Assist me as needed to complete each task. I would like to be showered at least two times a week and bathed on all other days. Give me a prepared cloth and encourage me to wash all the easy to reach places. Assist me to cleanse the more difficult to reach areas... My goal is to improve or maintain my current level of self care. Please review my interventions by 1/29/15 to determine if any changes are needed."</p> <p>A review of Resident #50's Resident Bathing Type Chart indicated from 11/16/14 until 1/27/15, he had received 1 shower and 3 bed baths.</p> <p>On 1/27/15 at 10:24 a.m., Resident #50 was observed seated in his recliner in his bedroom with his feet elevated. His fingernails were jagged with a dark substance underneath his nails. He stated</p>			

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	<p>his fingernails needed "cleaned and clipped."</p> <p>On 1/28/15 at 9:22 a.m., Resident #50 was observed seated in his wheelchair in his bedroom. His fingernails were jagged with a dark substance underneath his nails. He recalled a girl had washed him off in the bathroom earlier that morning but it had "been a week or more" since he had a shower. He stated "that would be nice" if someone could trim and clean his fingernails.</p> <p>On 1/28/15 at 9:34 a.m., CNA #12 indicated she worked day shift and cared for Resident #50 often, but had never given him a shower. She believed he was showered on evening shift. The CNA's were responsible for cleaning and trimming resident's fingernails on the residents shower days unless the resident was a diabetic. The nurses cared for the diabetic resident's fingernails. After she reviewed Resident #50's profile in the Kiosk at that time, Resident #50 did not have a set shower schedule, so it was his preference when he wanted one.</p> <p>On 1/28/15 at 9:44 a.m., CNA #12 observed Resident #50's fingernails and stated "they need some attention, yes they need cleaned and trimmed."</p>			

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F000323 SS=G	<p>During an interview, on 1/28/15 at 4:15 p.m., the Campus Clinical support nurse indicated they didn't have an ADL policy and procedure.</p> <p>3.1-38(a)(3)(A)(B)(C)(D)(E)</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 identify the root cause of falls in order to develop individualized careplan and interventions for 2 of 4 residents who met the criteria for accidents, this resulted in a fracture T2 & T5 for Resident #157 (Resident #157 and Resident #50).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #157 on 1/27/15 at 1:17 p.m., indicated the resident's diagnoses included, but were not limited to, abnormal gait, abdominal pain, anxiety, Alzheimer disease, C-diff, renal failure, osteoarthritis and muscular atrophy and history of falls.</p> <p>The local hospital history and physical</p>	F000323	<p>F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #157 has been discharged. Resident #50 has a care plan in place with appropriate fall prevention interventions. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Review of all falls for the past 14 days to ensure the root cause of the fall has been identified and a care plan has been developed with appropriate interventions. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1. Fall</p>	02/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2015	
NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374			
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	<p>for Resident #157 dated 12/3/14, indicated the resident lived alone and was found by a family member laying on the floor face down. The resident was very confused and was not able to give any additional information. Cat Scan (CT) of her head did not show any acute abnormality. The hip X-rays showed no fracture bilaterally.</p> <p>Resident #157 was admitted to the facility on 12/6/14 from the local hospital.</p> <p>The Nursing admission assessment for Resident #157 dated 12/6/14, indicated the resident was one assist for transfers and ambulation and used a walker and wheelchair.</p> <p>The fall risk assessment for Resident #157 dated 12/6/14, indicated the resident had a mobility impairment, past history of falls and medical condition/diagnosis that may contribute to falls.</p> <p>The safety careplan for Resident #157 dated 12/6/14, indicated the interventions were; provide assistance for transfers and ambulation, ensure glasses clean and in place, observe for side effects of medications, toilet the resident per toileting schedule and ensure the call</p>		<p>Management Program 2. Circumstance and Reassessment Form (root cause, intervention update) How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Review of falls to ensure the root cause of the fall has been identified and a care plan has been developed with appropriate interventions. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374			
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	<p>light was in reach.</p> <p>The careplan for Resident #157 indicated she was at risk for falls. The interventions included but were not limited to, (12/10/14) please ensure I have nonskid footwear in place for transfers and ambulation, (12/14/14) I have a floor sensor pad on my floor, (12/22/14) Please ensure my bed is in the lowest position, (12/23/14) please ensure cushion pad is placed beside my bed, the sensor can be removed, (12/26/14) 30 minute visuals for 72 hours, (12/28/14) 30 minute visuals to continue through 12/29/14 and while up in wheelchair place in the TV room by nurse station.</p> <p>The Medication Record Administration (MAR) dated 12/12/14, indicated the resident had a bed and chair alarm due to decrease safety awareness.</p> <p>The Fall circumstance, assessment and intervention record for Resident #157 dated 12/10/14 at 10:00 p.m., indicated the resident had an witnessed fall in her room with no injury. The root cause was the resident was up with staff "footing slipped" and was lowered to the ground. The prevention update was nonskid footwear. The nursing note for Resident #157 dated 12/10/14 at 10:30 p.m., indicated the resident had to be lowered</p>						

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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374			
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	<p>to the floor by staff. The resident lost "footing" with staff.</p> <p>Interview with the Campus Clinical Support Nurse on 1/28/15 at 10:45 a.m., indicated the nurse who was assisting Resident #157 on 12/10/14 when she was lowered to the ground should have ensured the resident had on appropriate footwear.</p> <p>The Fall circumstance, assessment and intervention record for Resident #157 dated 12/14/14 at 6:35 p.m., indicated the resident had an unwitnessed fall in her room. The root cause of the fall was the resident was non compliant with calling for assistance and had been unplugging alarms. The documentation indicated there was no injury, no pain and no treatment required.</p> <p>The local emergency room orders and report for Resident #157 dated 12/14/14, indicated the resident fell at the facility hit her head and complained of pain in her tailbone and headache. The resident had a CT scan of her spine and there were no fractures.</p> <p>The Fall circumstance, assessment and intervention record for Resident #157 dated 12/22/14 at 5:00 p.m., indicated the resident had an unwitnessed fall in her</p>						

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	<p>room. There were no injuries. The root cause of the fall was the resident was up without assistance related to dementia. The prevention update was bed in low position and monitor for triggers for rising.</p> <p>Interview with the Campus Clinical Support Nurse on 1/28/15 at 1:30 p.m., indicated the bed in the low position was not an appropriate intervention after the fall on 12/22/14 because the bed should have already been in the lowest position. The Campus Clinical Support Nurse indicated she was unsure why this intervention would have been put in place.</p> <p>The Fall circumstance, assessment and intervention record for Resident #157 dated 12/23/14 at 8:00 p.m., indicated the resident had an unwitnessed fall in her room. There was no injuries. The root cause of the fall was the resident was up without assistance related to dementia. The prevention update was to remove the floor sensor and place a floor mat by the bed.</p> <p>The Fall circumstance, assessment and intervention record for Resident #157 dated 12/26/14 at 9:30 a.m., indicated the resident had an unwitnessed fall in her room. The resident was sent to the</p>				

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	<p>emergency room due to increased drowsiness and complaints of pain of her head of pain rated an 8 on the 1-10 pain scale. The root cause of the fall was the resident was up without assistance due to noncompliance and dementia. The prevention update was to send the resident to the emergency room for treatment and 30 minute visuals for 72 hours.</p> <p>The local hospital note for Resident #157 dated 12/26/14, indicated the resident fell at the Extended Care Facility (ECF). The resident was very noncompliant per ECF staff. The resident was found on the floor complaining of neck and back pain. The CT scan of the residents spine showed a new T2 and T5 compression fracture.</p> <p>The Fall circumstance, assessment and intervention record for Resident #157 dated 12/28/14 at 8:10 p.m., indicated the resident had an unwitnessed fall in her room. The resident hit her head and was complaining of pain rated as 9 on the 1-10 pain scale. The root cause of the fall was resident continues to be up without assistance related to non compliant and dementia. The resident was sent to the emergency room. The prevention update was keep in the TV room by the nursing station.</p>			

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	<p>The local emergency room department discharge orders for Resident #157 dated 12/28/14, indicated "up with help only".</p> <p>The nursing note for Resident #157 dated 12/30/14 at 11:00 a.m., indicated the fire department transported the resident to the local hospital emergency room for mental status change.</p> <p>The local hospital note for Resident #157 dated 12/30/14, indicated the resident expired shortly after being admitted.</p> <p>Interview with the Campus Clinical Support Nurse on 1/28/15 at 1:30 p.m., indicated there was no documented assessment for Resident #157 on 12/30/14. The Campus Clinical Support Nurse indicated she was unable to find a thorough investigation into the root cause of this fall. The Campus Clinical Support Nurse indicated the facility did not have a careplan meeting with Resident #157's family to discuss possible solutions to prevent the resident's falls.</p> <p>2. On 1/26/15 at 10:44 a.m., Resident #50 was observed seated in his recliner in his bedroom with his feet elevated. He stated "I'm not even supposed to walk to the bathroom with nobody with me."</p> <p>Resident #50's record was reviewed on</p>			

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NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374			
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	<p>1/27/15 at 8:45 a.m. His diagnoses documented on his January 2015 physician recapitulation orders included but were not limited to, dementia, malaise and fatigue, debility, and a history of falls.</p> <p>Resident #50's Admission Minimum Data Set (MDS) assessment dated 10/29/14, indicated he was moderately impaired in his cognitive daily decision making skills. He required extensive assistance of 2 plus persons for bed mobility. He required extensive assistance of 1 person for transfers, walking in his room, and toileting. His mobility devices included a walker and wheelchair. He had not experienced any falls within 6 month prior to his admission to the facility and had not fallen at the facility since his admission. He was occasionally incontinent.</p> <p>A Care Plan for Resident #50 indicated the following: "I am at risk for falls r/t (related to) dementia, HOH (hard of hearing), anemia, urinary frequency. Place my bed at an appropriate level for my body height to facilitate safe transfers. Lock the brakes. Keep my call light and frequently used items with easy reach to prevent me from overstretching. Ensure my environment is appropriately lit for the time of day and my pathways</p>						

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	<p>are free of clutter. 12/18/14: Place a PSA (Personal Safety Alarm) on my bed/chair.</p> <p>1/9/15: Please encourage and remind me to use my call light to call for assistance when I need to get up or transfer.</p> <p>1/13/15: Please have therapy to screen me for any needs. My goal is to have no falls or at least no injuries from falls. Please review my interventions by 1/29/15 to determine if any changes are needed."</p> <p>A Nurse's Note for Resident #50 dated 12/18/14 at 5:00 p.m., indicated the following: "Res (Resident) was found on floor of his bedroom at 1625 (4:25 p.m.) between his bed et recliner. Res stated that he stood up et fell backwards et hit his head pretty hard. Res also c/o (complained of) mid back pain. Res was left on the floor until 911 personnel arrived. This res also c/o pain to the EMT's." His neurological assessment was within normal limits. His vital signs were obtained. He was transported to a local hospital at 4:35 p.m.</p> <p>A Fall Circumstance, Assessment and Intervention form for Resident #50 indicated the following: Resident #50 had an unwitnessed fall in his room on 12/18/14 at 4:25 p.m. He had hit his head and was sent to the local emergency room for evaluation. He had no</p>			

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	<p>complaint of pain. His activity at the time of the fall was transferring himself. A personal inspection indicated he had toileting needs. A prevention update indicated a bed and chair alarm and he was sent to the local emergency room. The IDT (Interdisciplinary Team) Review identified the root cause of the fall to be a bed alarm.</p> <p>An appropriate root cause was not identified for Resident #50's fall on 12/18/14.</p> <p>A physician's order for Resident #50 dated 1/8/15, indicated the following: "Add bed and chair alarm d/t safety awareness."</p> <p>A Nurse's Note for Resident #50 dated 1/9/15 at 3:25 p.m., indicated "Resident was found on floor in bathroom of room." His vital signs were obtained and he would continue to be observed.</p> <p>A Fall Circumstance, Assessment and Intervention form for Resident #50 indicated the following: Resident #50 was found on the floor in his bathroom on 1/9/15 at 3:25 p.m. He had no injuries. He had no complaint of pain or non-verbal signs of pain. His activity at the time of the fall was ambulating. An environmental inspection indicated he</p>			

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	<p>had become dizzy and lost his balance attempting to toilet himself and did not call for assistance or use his walker. A prevention update indicated a walker, call bell, and bed and/or chair alarm. The IDT Review identified the root cause of the fall as he was found sitting on the floor in his bathroom and stated he became dizzy and lost his balance. Other IDT Review comments indicated he would be encouraged and reminded to use his call light for assistance and to use his walker with assistance from staff.</p> <p>The Fall Circumstance, Assessment and Intervention form or the Nurse's Note for Resident #50 dated 1/9/15, did not indicate his PSA was alarming when he was found on the floor of his bathroom. The prevention update on the Fall Circumstance, Assessment and Intervention listed interventions that were documented previously as already being in place. An appropriate root cause was not identified for Resident #50's fall on 1/9/15.</p> <p>A Nurse's Note for Resident #50 dated 1/13/15 at 9:50 a.m., indicated a CNA was walking by Resident #50's room and observed him attempting to transfer from his wheelchair. The CNA assisted him to the floor as he lost his balance. He had no injuries noted and denied any pain.</p>			

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	<p>His vital signs were obtained. He was assisted back to his wheelchair and his alarm was in place. His call light was within reach.</p> <p>A Fall Circumstance, Assessment and Intervention form for Resident #50 indicated the following: Resident #50 was assisted to the floor in his room on 1/13/15 at 9:50 a.m. He had no injuries. He had no complaint of pain. His activity at the time of fall was transferring himself. The Care Plan section indicated toilet every 2 hours, call bell, and bed and chair alarm. The IDT Review identified the root cause of the fall as Resident #50 was attempting to transfer from his wheelchair to his chair. He was observed by a CNA and was assisted to the floor and his alarm was sounding. He would be screened and picked up for therapy.</p> <p>The Fall Circumstance, Assessment and Intervention form for Resident #50 being lowered to the floor on 1/13/15, while attempting to transfer from his wheelchair to his chair did not provide any new immediate appropriate interventions to prevent falls.</p> <p>On 1/27/15 at 9:57 a.m., Resident #50 was observed ambulating in the therapy room with the use of a rollator (walker</p>			

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	<p>with wheels) and therapy staff holding on to a gait belt fastened around the residents waist. Resident #50 ambulated with a slow gait and he was slightly bent over at his trunk.</p> <p>On 1/27/15 at 10:24 a.m., Resident #50 was observed seated in his recliner in his bedroom with his feet elevated. His bedside table was placed in between his recliner and bed and his call light was tied around his bed rail out of reach. After being informed, LPN #11 provided Resident #50 with his call light.</p> <p>On 1/28/15 at 2:03 p.m., the Campus Clinical Support Nurse indicated the bed alarm documented as the root cause on the IDT Review section of the Fall Circumstance, Assessment and Intervention form for Resident #50's fall on 12/18/14, was an intervention not the root cause. The Nurse's Note for Resident #50 dated 12/18/14, "said he stood up and fell backwards. I would say that is the root cause. He was responding to his toileting needs." The documentation didn't say where he was getting up from, it just said he was transferring himself. The Prevention Update section on the Fall Circumstance, Assessment and Intervention forms was where new interventions were supposed to be documented.. At that time, after</p>			

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	<p>reviewing the Fall Circumstance, Assessment and Intervention form for Resident #50's fall on 1/13/15, it looked to her the IDT decided to have therapy screen him and not do the toileting every 2 hours. The call bell and bed and chair alarm were already in place.</p> <p>On 1/28/15 at 3:46 p.m., the Campus Clinical Support Nurse indicated she could not provide any documentation Resident #50's PSA was sounding when he was found on the floor of his bathroom on 1/9/15.</p> <p>The Falls Management Program Guidelines provided by the Campus Clinical Support Nurse on 1/28/15 at 10:45 a.m., indicated the facility strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. The care plan interventions should be implemented that address the resident's risk factors. Should the resident experience a fall the attending nurse shall complete the "Fall Circumstance and Reassessment Form". The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce the risk of a repeated episode, and review by the Interdisciplinary Team</p>			

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F000325 SS=D	<p>(IDT) to evaluate thoroughness of the investigation and appropriateness of the interventions. The nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours.</p> <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 provide a nutritional health shake with each meal as prescribed by the physician for a resident with malnutrition for 1 of 3 residents who met the criteria for nutrition of 3 residents reviewed for significant weight loss (Resident #46).</p> <p>Finding include:</p> <p>Review of the record of Resident #46 on 1/26/15 at 11:28 a.m., indicated the resident's diagnoses included, but were not limited to, hypotention, dyspnea,</p>	F000325	<p>F 325</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #46 is receiving nutritional supplements as ordered.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS</p>	02/28/2015			

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	<p>glaucoma, renal failure, malnutrition, depression and diverticulitis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #46 dated 10/28/14, indicated the resident's Brief Intervention for mental status (BIMS) was 12 indicating modified independence for decisions of daily decision making and eating- supervision set up only.</p> <p>The nutritional diagnosis/assessment for Resident #46 dated 10/7/14, indicated the resident did not meet estimated nutritional needs, inadequate oral food/beverage intake and increased nutrition needs related to demand for healing. The nutritional interventions were add fortified foods with meals three times a day(chocolate shakes). The nutritional diagnosis/assessment was signed by the Registered Dietician.</p> <p>The weight report for Resident #46 indicated the following: 9/30/14 weight was 84 pounds, 10/28/14 weight was 96 pounds, 11/24/14 weight was 96 pounds, 12/29/14 weight was 86 pounds and 1/26/15 weight was 89 pounds.</p> <p>The physician order for Resident #46 dated 10/8/14, indicated the resident was ordered fortified foods with meals three times a day (likes chocolate shakes).</p>		<p>or designee will review all residents with ordered nutritional supplements to ensure the order has been communicated to the dietary department, the order is listed on the tray card (if ordered with meals) and the resident is receiving the supplement.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following guidelines: 1. Nutritional Recommendations 2. Medication Orders</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents with ordered nutritional supplements has been communicated to the dietary department, the order is listed on the tray card (if ordered with meals) and the resident is receiving the supplement.</p>				

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	<p>The nutritional progress note for Resident #46 dated 11/2/14 indicated the resident's weight had decreased over past two months by 8%. The resident did have edema in November, but usual body weight was 90 pounds and weight is now below the resident's usual body weight. The resident's intake were 62% at meals. Nursing staff indicated the resident usually would take supplements but at times would take half or refuse.</p> <p>The physician recapitulation (recap) for Resident #46 dated 1/1/15 to 1/31/15 indicated the resident was ordered a regular fortified diet with meals three times a day (likes chocolate shakes). Fortified shakes with meals three times a day.</p> <p>The Clinical at risk monitoring sheet for Resident #46 dated 12/11/14, indicated the resident weights were as follows: 11/17/14 98 pounds, 11/24/14 96 pounds, 12/1/14 93 pounds and 12/8/14 95 pounds.</p> <p>During observation on 1/26/15 at 12:51 p.m., Resident# 46 had sweet potatoes ham, broccoli, coffee and coke. The resident did not have a health shake. LPN#1 indicated dietary was suppose to serve the health shake to Resident #46</p>		The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	<p>and did not. Interview with the Dietary Manager indicated the health shake should have been on the resident's tray card and it was not.</p> <p>Interview with LPN #2 on 1/26/15 at 1:45 p.m., indicated the nurse signed off the health shake for residents but dietary was the one that provides them. LPN #2 indicated she would normally ask the nursing staff to determine if a resident received a nutritional supplement with their meal.</p> <p>Interview with Resident #46 on 1/26/15 at 1:51 p.m., indicated sometimes she got a health shake with her meals, but not always. When queried if she got a health shake with all three meals the resident indicated no she did not. Resident #46 was unaware that she was suppose to have one with each meal and would like to have a health shake with her meals . Resident #46 indicated chocolate shakes were her favorite flavor and did not receive a shake with her meal at lunch.</p> <p>Interview with Dietary Manager on 1/26/15 at 2:00 p.m., was unsure why Resident #46 diet change was not on her tray card. The Dietary Manager indicated the facility had a double check system if dietary does not send out a nutritional supplement, then the nursing staff was</p>						

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	<p>suppose to check the diet card and if they see something missing from the resident's tray get it from dietary.</p> <p>Interview with the Dietary Manager on 1/26/15 at 2:12 p.m., indicated dietary did not receive the change in Resident #46 diet for the fortified shakes in Oct 2014.</p> <p>Interview with the Campus Clinical Support Nurse on 1/26/15 at 2:40 p.m., indicated the Nurse that received the physician order for a diet change was responsible to fill out a dietary communication form and send it to dietary for the changes.</p> <p>The guidelines for weight tracking policy provided by the Clinical Campus Support Nurse on 1/28/15 at 10:45 a.m., indicated the purpose was to ensure resident weight is monitored for weight gain and or loss to prevent complications arising from compromised nutritional/hydration. The facility dietician or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted.</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p>			