

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155247	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2015
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 9, 10, 11, 12, 13, 16, and 17, 2015</p> <p>Facility number: 000151 Provider number: 155247 AIM number: 100284060</p> <p>Survey Team: Marcy Smith, RN - TC Dottie Plummer, RN Patti Allen, SW Jessica Parsley, RN (2/09, 2/16, 2015)</p> <p>Census bed type: SNF: 31 SNF/NF: 72 Total: 103</p> <p>Census payor type: Medicare: 13 Medicaid: 44 Other: 46 Total: 103</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>This Plan of Correction constitutes the center's Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. The facility respectfully requests a paper compliance/ desk review for review of substantial compliance. Date of Completion for Plan of Correction: 03/19/15.</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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F000241 SS=E	<p>Quality review completed on February 23, 2015; by Kimberly Perigo, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to maintain the confidentiality of payor sources in a staff work area by color coding the charts by payor source and then posting the key to the color coding above the chart racks for the 52 residents residing on the A Hall unit.</p> <p>Findings include:</p> <p>During a random observation of the nurses station on the A Hall unit on 2/11/15 at 12:17 p.m., 2 of 2 chart racks were observed from across the desk area. Posted on the top row of the chart racks were the words, "Medicare, Medicaid, Insurance, VA [Veteran's], Private, and Hospice." Each of the words were</p>	F000241	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No resident was found to have a negative outcome as a result of the alleged deficient practice. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken; Any resident has the potential to be affected by the alleged deficient practice. The payor source key has been removed from the area and is no longer visible. All other units were audited and not found to be affected. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</p>	03/19/2015

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F000278 SS=D	<p>printed on colored tape. Each of the residents names were printed on the charts on corresponding colored tape.</p> <p>During an interview with Medical Records (MR) and Director of Care Delivery (DCD) #8 on 2/12/15 at 5:01 p.m., the MR indicated, "It shows what the payor source is for the residents and the codes are here at the top." DCD #8 indicated the key was placed there to make it easier for the nurses to know which label to place on the charts and reiterated the labeling was consistent with the payor source of the resident. The MR and the DCD #8 indicated the key and the charts with corresponding labels were visible from outside of the desk area and could be seen by staff and visitors.</p> <p>3.1- 3(t)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>		<p>The Medical Records Designee will be in-serviced by 3/19/15 regarding privacy/confidentiality of resident information. The Directors of Care Delivery will check during rounds daily M-F to verify that no confidential information is visible on each unit. The DCDs/DON will immediately correct any negative findings. Rounds will continue until there are four (4) weeks of zero negative findings. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place; Result of rounds/ Findings will be reported to the QA Committee during monthly QA Meetings until there are three (3) months of zero negative findings. The Administrator will be responsible to assign any additional corrective action identified by the Committee.</p>	

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	<p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to accurately reflect the status of 2 residents on the Minimum Data Set (MDS) assessments for a resident receiving hospice services (Resident #159) and a resident with a pressure ulcer (Resident #157).</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #159, completed 2/12/15 at 2:23 p.m., indicated the resident had diagnoses including, but not limited to, cancer of the urinary system. The resident was admitted to the facility on 1/9/15 and</p>	F000278	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; The Assessment for resident #159 was modified on 2/12/15 to include Hospice Services. The Assessment for resident #157 was modified on 2/13/15 to include "at risk for pressure ulcers". (Section M) These residents were not negatively affected by the coding error. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken; Any resident receiving Hospice Services or being "at risk for</p>	03/19/2015

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	<p>readmitted on 1/17/15.</p> <p>A care plan dated 1/12/15, indicated the resident was receiving hospice services due to the cancer.</p> <p>A physician's progress note dated 1/13/15, indicated the resident was admitted to the facility following hospitalization related to bladder cancer and would continue receiving hospice care.</p> <p>A Nurse Practitioner (NP) progress note dated 1/19/15, indicated the resident was receiving hospice services for pain management related to the cancer.</p> <p>An Admission Minimum Data Set (MDS) assessment completed 1/24/15, assessed the resident as having a Brief Interview for Mental Status (BIMS) of 13 out of 15, indicating the resident had no cognitive deficits. In Section O of the MDS, titled Special Treatments and Programs, the resident was not assessed as receiving hospice services prior to admission to the facility nor was the resident assessed as having hospice services after admission to the facility. The MDS was electronically signed by Registered Nurse (RN) #13 on 1/30/15, "I certify the accompanying information accurately reflects resident assessment</p>		<p>pressure ulcers", have the potential to be affected by the alleged deficient practice. The MDS Coordinator will review the assessments completed in the past 60 days for all residents receiving Hospice Services and all residents identified by Nursing as being at risk for development of pressure sores, to ensure that coding is accurate. Any inaccurate coding found will be modified where allowed. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; MDS Coordinators will be given information daily (M-F) by the DCD's at the Morning Clinical Meeting of all residents receiving Hospice Services and those identified at risk or who actually have pressure areas to assist in accurate coding. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place; The MDS Coordinator will report any inaccurate and/or modified assessments to the QA Committee during monthly QA Meetings. Reporting of findings will continue until three (3) months of zero negative findings. Any additional action needed will be determined by the Administrator ongoing.</p>	

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	<p>information for this resident...."</p> <p>During an interview with the Director of Care Delivery (DCD) #7 on 2/12/15 at 3:00 p.m., DCD #7 indicated the resident was receiving hospice services prior to admission to the facility and had continued with the same hospice service after admission.</p> <p>During an interview with the MDS coordinator on 2/12/15 at 4:36 p.m., the MDS coordinator indicated the MDS was not coded correctly in Section O Special Treatments and Programs and the resident should have been coded as receiving hospice services prior to admission and while a resident of the facility.</p> <p>2. The clinical record of Resident #157 was reviewed on 2/13/15 at 8:31 a.m. Diagnoses for the resident included, but were not limited to, pressure ulcer.</p> <p>A Minimum Data Set assessment, dated 10/15/14, indicated Resident #157 was "at risk" for developing a pressure ulcer.</p> <p>A Minimum Data Set assessment, dated 1/15/15, indicated the resident was "not at risk" for developing a pressure ulcer.</p> <p>Resident #157 was admitted to the facility on 10/8/14. A current care plan,</p>						

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F000282 SS=D	<p>with an original date of 10/9/14, indicated the resident was at risk for alteration in skin integrity related to impaired mobility, terminal diagnoses, and severe hypoxic (deprivation of oxygen) brain injury.</p> <p>A Skin Risk Assessment, dated 10/29/14, indicated the resident was a high risk for developing a pressure ulcer.</p> <p>A Skin Risk Assessment, dated 1/22/15, indicated the resident was a high risk for developing a pressure ulcer.</p> <p>Resident was currently undergoing treatment for an actual pressure ulcer.</p> <p>On 2/13/15 at 2:00 p.m., the Minimum Data Set coordinator indicated the MDS assessment dated 1/15/15, had been coded incorrectly. She indicated Resident #157 should have been coded as being at high risk for developing a pressure ulcer.</p> <p>3.1-31(g) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview,</p>	F000282	I. What corrective action(s) will be accomplished for those residents	03/19/2015

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	<p>the facility failed to ensure plans of care were followed for a resident on a fluid restriction (Resident #107), a resident with significant weight loss (Resident #53), and a resident who had physician orders to be weighed daily. (Resident #8)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #107 was reviewed on 2/16/15 at 12:16 p.m. Diagnoses for the resident included, but were not limited to, end stage kidney disease and high blood pressure.</p> <p>An admission Minimum Data Set assessment indicated Resident #107 was independent in her ability to make decisions.</p> <p>Resident #107 received hemodialysis every Monday, Wednesday, and Friday. Hemodialysis is a process where a machine removes waste material, fluids and salt from the body when the kidneys are no longer able to adequately perform this function.</p> <p>A care plan, dated 11/21/14, and current through 3/11/15, indicated the resident was at risk for alteration in hydration related to fluid restriction. The care plan indicated the resident selected her own fluids. Interventions included, "Maintain</p>		<p>found to have been affected by the alleged deficient practice; 1. Resident #107's fluid restriction worksheet was placed in the front of the MAR on 2/17/15. The Resident was not adversely affected by the absence of the worksheet. 2. Resident #53's physician was notified of weight loss by the R.D. The Resident was not negatively affected as his choice was followed. 3. Resident #8 was re-started on daily weights on 2/16/15. Resident received weekly weights beginning 2/1/15 and weight has been stable with gradual increase. The resident was not negatively affected by the alleged deficient practice. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken;</p> <p>1. Any resident with fluid restriction has the potential be affected by the alleged deficient practice. All residents with fluid restrictions have been reviewed by the DCDs and Dietitian to verify that the worksheets are current, that worksheets are in front of the MARs and that care plans are current. 2. Any resident with a weight loss has the potential to be affected by the alleged deficient practice. The R.D. will review the medical records of any resident with a significant weight change in the past 60 days to verify documentation of physician</p>				

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	<p>fluid restriction as ordered."</p> <p>A care plan for the resident, dated 11/21/14 and current through 3/11/15, indicated her nutritional status was at risk. Interventions included, "Fluid restrictions as ordered."</p> <p>Resident #107 had a physician's order, dated 11/28/14, which indicated she was to restrict her fluids to 2000 milliliters (mls) per day. A Fluid Restriction Worksheet, dated 12/10/14, indicated the resident could receive 1260 mls per day from the dietary department and 246 mls per shift (total of approximately 740 mls) from the nursing staff.</p> <p>On 2/16/15, at 10:50 a.m., DCD (Director of Care Delivery) #8 indicated the Fluid Restriction Worksheet was supposed to be kept in the Medication Administration Record (MAR) book so the nursing staff would know how much fluid the resident could take in during each shift. An observation at that time did not indicate the worksheet was in the Medication Administration book. DCD #8 indicated, "It's not there."</p> <p>On 2/16/15 at 3:45 p.m., Licensed Practical Nurse #6 indicated she did not know how much fluid Resident #107 could receive on her shift. She indicated,</p>		<p>notification. Any resident found to have no physician notification documentation will have their physician notified at that time. 3. Any resident with an order for daily weights has the potential to be affected by the alleged deficient practice. The DCDs will audit, by 3/19/15, all residents who currently have daily weight orders to verify they are recorded on the MAR. Any resident found to be affected will be corrected immediately. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; 1. Licensed nurses will be in-serviced by 3/19/15, regarding location of Fluid Restriction Worksheets in the MAR and proper documentation of on the MAR for fluid restrictions each shift. 2. The Dietitian will by in-serviced by 3/19/15 on physician notification of weight changes. 3. The DCD's will review the monthly order recaps to ensure orders continue to be carried forward. Ongoing. The DCDs will give a written report of daily weights to the R.D. and the D.O.N. to review changes, need for intervention and verification of MD notification of significant changes based n the MDs "call order". IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance</p>		

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	<p>"I just try not to give her too much." She indicated the amount of fluid the resident could receive was not told to her during the shift report.</p> <p>On 1/21/15, a physician's order indicated Resident #107 was to reduce her fluids to 1500 mls per day. A Hemodialysis Communication Form of that date indicated, "Needs to follow fluid restriction better!!"</p> <p>A Fluid Restriction Worksheet, updated with the new fluid restriction orders from 1/21/15, of 1500 mls per day, which would indicate how much fluid dietary and nursing staff could give the resident, was not found in the resident's record.</p> <p>On 2/16/15 at 3:00 p.m., DCD #8 indicated she was not able to find an updated Fluid Restriction Worksheet for Resident #107.</p> <p>On 2/17/15 at 12:20 p.m., the Registered Dietician indicated an updated Fluid Restriction Worksheet for Resident #107 had not been initiated until that morning. She provided an updated worksheet for the resident, dated 2/17/15 at 10:35 a.m.</p> <p>On 2/16/15 at 3:40 p.m., the Director of Nursing indicated, "We don't keep track of fluid intake for residents on fluid</p>		<p>program will be put into place; 1. The DCDs will review the fluid restriction worksheet and location in the MAR weekly until there are four (4) weeks of zero negative findings. 2. Residents who are noted to have significant weight change will be reviewed monthly by the RD and DCDs to ensure MD notification and intervention are completed. 3. A report of this monitoring will be presented to by the D.O.N. to the QA Committee during Monthly QA Meeting. The Administrator will be responsible to assign any additional action necessary.</p>	

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	<p>restriction. The Medication Administration record indicates how much fluid they can have in a day and if the nurse initials [the MAR] they are saying the resident had the right amount."</p> <p>On 2/17/15 at 10:26 a.m., Resident #107 indicated she was aware her fluid restriction was 1500 mls. per day but, "I don't follow it like I should. They put so many liquids in front of me, they're always offering them and I have a hard time turning them down. I know how much I should take in but I can't follow it like I should. They used to monitor me, but they don't anymore."</p> <p>2. The clinical record of Resident #53 was reviewed on 2/13/15 at 2:55 p.m. Diagnoses for the resident included, but were not limited to, dementia, chronic kidney disease and depressive disorder.</p> <p>A current care plan, initiated 10/3/13, indicated Resident #53 was at risk for potential weight loss related to history of involuntary weight loss, mechanically altered diet, and being on hospice. Interventions included, "Review weights and notify physician...of significant weight change."</p> <p>A Nutrition/Weight progress note, dated 1/8/15, indicated, "Resident with noted</p>			

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	<p>16.1% wt [weight] loss..."</p> <p>Review of the resident's weights indicated a weight of 201 on 12/4/14, and a weight of 181 on 1/8/15. This was a 20% weight loss in approximately 1 month and would be considered a significant weight change.</p> <p>No documentation was found in the resident's record which indicated the physician had been notified of this significant weight change at the time it occurred.</p> <p>On 2/17/15 at 12:30 p.m., the Registered Dietician indicated she was not able to find any information which indicated the physician had been notified of Resident #53's significant weight change at the time it occurred.</p> <p>A physician's progress note addressed the weight loss approximately 1 month after it occurred, on 2/12/15.</p> <p>3. The clinical record review of Resident #8, completed on 2/13/15 at 9:41 a.m., indicated the resident had diagnoses including, but not limited to, congestive heart failure.</p> <p>A current physician's order dated 1/6/15, indicated the resident was to be weighed</p>			

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F000309 SS=D	<p>daily and the results faxed to the physician once a week.</p> <p>On 2/17/15 at 11:10 a.m., the Treatment Administration Record (TAR) for February 2015, lacked documentation of daily weights.</p> <p>During an interview with the Director of Care Delivery (DCD) #8 on 2/17/15 at 11:15 a.m., the DCD #8 indicated daily weights were recorded on the TARs. The DCD #8 indicated the resident should have been weighed daily and the weights recorded on the TAR. "They must have gotten left off of the TAR when we did the cross over at the end of the month."</p> <p>3.1-35(g)(2)</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>Based on record review and interview, the facility failed to ensure a resident on dialysis, with a fluid restriction, received the necessary care and services to maintain/monitor/promote their fluid</p>	F000309	I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; Resident #107's fluid restriction worksheet was placed in the front of the MAR on 2/17/15. The	03/19/2015	

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	<p>restriction, according to their plan of care, for 1 resident reviewed for dialysis care. (Resident #107)</p> <p>Findings include:</p> <p>The clinical record of Resident #107 was reviewed on 2/16/15 at 12:16 p.m. Diagnoses for the resident included, but were not limited to, end stage kidney disease.</p> <p>An admission Minimum Data Set assessment indicated Resident #107 was independent in her ability to make decisions.</p> <p>Resident #107 received hemodialysis every Monday, Wednesday, and Friday. Hemodialysis is a process where a machine removes waste material, fluids and salt from the body when the kidneys are no longer able to adequately perform this function.</p> <p>A care plan, dated 11/21/14, and current through 3/11/15, indicated the resident was at risk for alteration in hydration related to fluid restriction. The care plan indicated the resident selected her own fluids. Interventions included, "Maintain fluid restriction as ordered."</p> <p>A care plan for the resident, dated</p>		<p>Resident was not adversely affected by the absence of the worksheet. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken; Any resident with fluid restriction has the potential be affected by the alleged deficient practice. Residents with fluid restrictions will be reviewed by the DCDs and Registered Dietitian to verify that the worksheets are current, that worksheets are in front of the MARs and that care plans are current. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; Licensed nurses will be in-serviced by 3/19/15, regarding location of Fluid Restriction Worksheets in the MAR and proper documentation of on the MAR for fluid restrictions each shift. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place; The DCDs will review the Fluid Restriction worksheet and placement in the MAR weekly until there are three (3) zero negative findings. A report of this review will be reviewed at the monthly QA Committee until there are three (3) months of zero negative findings. Any additional</p>	

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	<p>11/21/14 and current through 3/11/15, indicated her nutritional status was at risk. Interventions included, "Fluid restrictions as ordered."</p> <p>Resident #107 had a physician's order, dated 11/28/14, which indicated she was to restrict her fluids to 2000 milliliters (mls) per day. A Fluid Restriction Worksheet, dated 12/10/14, indicated the resident could receive 1260 mls per day from the dietary department, and 246 mls per shift (total of approximately 740 mls) from the nursing staff.</p> <p>On 2/16/15, at 10:50 a.m., DCD (Director of Care Delivery) #8 indicated the Fluid Restriction Worksheet was supposed to be kept in the Medication Administration Record (MAR) book so the nursing staff would know how much fluid the resident could take in during each shift. An observation at that time did not indicate the worksheet was in the Medication Administration book. DCD #8 indicated, "It's not there."</p> <p>On 2/16/15 at 3:45 p.m., Licensed Practical Nurse #6 indicated she did not know how much fluid Resident #107 could receive on her shift. She indicated, "I just try not to give her too much." She indicated the amount of fluid the resident could receive was not told to her during</p>		action will be assigned by the Administrator.	

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	<p>the shift report.</p> <p>On 1/21/15, a physician's order indicated Resident #107 was to reduce her fluids to 1500 mls per day. A Hemodialysis Communication Form of that date indicated, "Needs to follow fluid restriction better!!"</p> <p>A Fluid Restriction Worksheet, updated with the new fluid restriction orders from 1/21/15, of 1500 mls per day, which would indicate how much fluid dietary and nursing staff could give the resident, was not found in the resident's record.</p> <p>On 2/16/15 at 3:00 p.m., DCD #8 indicated she was not able to find an updated Fluid Restriction Worksheet for Resident #107.</p> <p>On 2/17/15 at 12:20 p.m., the Registered Dietician indicated an updated Fluid Restriction Worksheet for Resident #107 had not been initiated until that morning. She provided an updated worksheet for the resident, dated 2/17/15 at 10:35 a.m.</p> <p>On 2/16/15 at 3:40 p.m., the Director of Nursing indicated, "We don't keep track of fluid intake for residents on fluid restriction. The Medication Administration record indicates how much fluid they can have in a day and if</p>			
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F000514 SS=D	<p>the nurse initials [the MAR] they are saying the resident had the right amount."</p> <p>On 2/17/15 at 10:26 a.m., Resident #107 indicated she was aware her fluid restriction was 1500 mls. per day, but, "I don't follow it like I should. They put so many liquids in front of me, they're always offering them and I have a hard time turning them down. I know how much I should take in but I can't follow it like I should. They used to monitor me, but they don't anymore."</p> <p>3.1-37(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to accurately document the provision of supplements to a resident who had weight loss for 1 of 3 residents</p>	F000514	I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; Resident #8 now has their supplements documented	03/19/2015

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	<p>reviewed for significant weight loss. (Resident #8)</p> <p>Findings include:</p> <p>The clinical record review of Resident #8, completed on 2/13/15 at 9:41 a.m., indicated the resident had diagnoses including, but not limited to, congestive heart failure and gastrointestinal (GI) bleeding (bleeding anywhere in the GI tract from the mouth to the rectum).</p> <p>A Nutritional Progress Note dated 2/5/15, indicated the resident had a 7.3% weight loss in one month and had been receiving 2 house supplement shakes 3 times a day with meals. The note indicated the resident was unable to drink 2 shakes with every meal and the intervention was changed to 1 shake with meals and 1 shake between meals.</p> <p>On 2/13/15 at 2:20 p.m., the Director of Care Delivery (DCD) #8 provided the Activities of Daily Living (ADL) Flowsheet for February 2015. The documentation indicated the resident should receive a nutritional shake at 9:00 a.m., 10:00 a.m., 1:30 p.m., and 2:00 p.m. on the day shift.</p> <p>The documentation on the flowsheet indicated the resident received 4</p>		<p>accurately. Resident #8 was not adversely affected by the alleged deficient practice. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken; Residents who receive supplements have the potential to be affected by the alleged deficient practice. Residents who receive nutritional supplements have been reviewed by the DCDs to ensure the list is accurate. No other resident was found to be affected. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; The C.N.A.s who inaccurately coded the nutritional shake have been re-educated on accurate documentation. C.N.A.s will be in-serviced by 3/19/15 on accurate documentation. The DCDs will review documentation of supplements daily (M-F) until there are 4 consecutive weeks of no inaccurate documentation. Then weekly ongoing. The R.D. will review the list of residents who currently receive nutritional supplements to ensure that the supplements are appropriate. The R.D. will then update the list of residents weekly as changes occur to ensure that supplements which have been discontinued do not appear on the C.N.A. Flow Sheet. The R.D. and DCDs will report any inaccurate documentation to the D.O.N. IV.</p>	

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F009999	<p>nutritional shakes at 07:43 (7:43 a.m.) on 2/7/15.</p> <p>On 2/8/15, the documentation indicated the resident received 3 nutritional shakes at 07:38 (7:38 a.m.) and 1 at 10:50 (10:50 a.m.).</p> <p>On 2/9/15, the documentation indicated the resident received 4 nutritional shakes at 07:37 (7:37 a.m.).</p> <p>During an interview with the DCD #8 on 2/13/15 at 2:20 p.m., the DCD indicated the times documented should reflect the time the shake was given to the resident. The DCD #8 indicated the shakes were sent by dietary between meals and only 1 shake was sent at a time so the times documented could not be correct.</p> <p>3.1-50(a)(2)</p> <p>3.1-14 Personnel</p> <p>(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within</p>	F009999	<p>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place; The D.O.N. will report any inaccurate documentation to the QA Committee during monthly QA Meetings. These reports will continue until there are three (3) months of zero negative findings. The Administrator will be responsible to assign any additional action needed.</p> <p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No resident was found to be affected by the alleged deficient practice. II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what</p>	03/19/2015

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	<p>thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure nursing staff received the required annual three hours dementia training for 2014 for 5 of 13 employees files reviewed. (Employees #1, #14, #26, #34, and #44)</p> <p>Findings include:</p> <p>Employee files were reviewed on 2/16/15 at 10:00 a.m., with the following findings:</p> <p>Employee #1 Date of hire 04/19/2002 Title: Certified Nurse Aide. There was documentation of 1 hour and 40 minutes of dementia training on 10/16/2014.</p> <p>Employee #14 Date of hire 12/14/1998 Title: License Practical Nurse. There was documentation of 1 hour and 40 minutes of dementia training on 12/29/2014.</p>		<p>corrective action(s) will be taken; Any dementia resident has the potential to be affected by the alleged deficient practice. III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; Current employees will receive 1.5 hours of Dementia Training by 3/19/15. The additional 1.5 will be received through the facility online employee education programing by 12/31/15. IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place; The facility Human Resources Director will report status of employee Dementia Training to the QA Committee during monthly QA Meetings to ensure employees receive 3 hours per year. Any additional action will be assigned by the Administrator.</p>	

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	<p>Employee #26 Date of hire 02/02/2009 Title: Social Service. There was documentation of 1 hour and 40 minutes of dementia training on 10/03/2014.</p> <p>Employee #34 Date of hire 10/14/1998 Title: License Practical Nurse. There was documentation of 1 hour and 40 minutes of dementia training on 12/13/2014.</p> <p>Employee #44 Date of hire 01/07 Title: Certified Nurse Aide. There was documentation of 6 hours of dementia training on 01/09/2013, and no documentation of dementia training for 2014.</p> <p>The Administrator and the Human Resource Director were interviewed on 2/16/2015 at 2:30 p.m., and indicated they had provided all documentation for dementia training they had. They were unable to find any further dementia training for the above employees which was done during the past year. The above mentioned nursing staff had not received the required annual three hours dementia training for 2014.</p>			