STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155158		03/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF THE WILLOWS	1000 ELIZABETH DR VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Bldg. 00	This visit was for the Investigation of Complaint IN00167640. Complaint IN00167640-Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F242, F282, F312, F325, Unrelated deficiency cited. Survey dates: February 28, 2015 and March 2, 2015 Facility number: 000078 Provider number: 155158 AIM number: 100289310 Survey team: Regina Sanders, RN, TC Census bed type: SNF/NF: 61 Total: 61 Census Payor type: Medicare: 16 Medicaid: 40 Other: 05 Total: 61 Sample: 3	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 4, 2015, by Janelyn Kulik, RN.			
F 157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or			

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	roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify a resident's Physician and family of a change in condition, related to a significant weight loss for 1 of 3 residents reviewed for weight loss in a total sample of 3. (Resident #B) Finding includes: Resident #B's record was reviewed on 03/02/15 at 8:30 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, peritoneal dialysis, and congestive heart failure. The Admission Nurses' Assessment, dated 02/02/15, indicated the resident's weight was 178.4 The resident's Peritoneal Dialysis Daily Record indicated the following weights: 02/02/15-178.4 02/03/15-178.4 02/04/15- 172.8 02/05/15- 170.4 02/06/15- 158 (11.37% weight loss in	F 157	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The affected resident no longer resides in the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Full facility audit related to resident weights and dietary recommendations from the previous 6 months were reviewed to ensure that physician and family notification were completed in a timely manner. No issues were identified via this audit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed Nursing Staff will be in serviced by 3/21/2015 by the Staff Development Coordinator regarding the facility policy referencing physician/family notification and completing dietary recommendations in a timely manner. Dietary Manager will be in serviced by the Dietary	04/01/2015

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	three days) 02/07/15- 159 02/08/15- 156.1 02/09/15- 155.4 02/10/15- 149.8 02/11/15- 149.2 02/12/15- 140.5 (21.24% weight loss in nine days) The Nutrition Intervention Program (NIP) notes, dated 02/05/15 at 2:35 p.m. indicated the resident's current weight was 167 (6.39% weight loss in three days), oral intake of diet was 25-100%, had peritoneal dialysis every night, all were aware, and the facility would continue to monitor. The NIP notes, dated 02/12/15 at 2:03 p.m., indicated, "NIP notes from 02/09/15. dietician (sic) here and reviewed res (resident) chart...curent (sic) wt (weight) 167. meal intake varies. will continue in NIP, family and Dr. aware." The NIP notes, dated 02/05/15, and the Nurses' Notes, dated 02/05/15 through 02/12/15, indicated the resident's Physician and family were not notified of the significant weight change. During an interview on 03/02/15 at 2:30 a.m., the West Unit Manager indicated the resident went to the Dialysis Center		Consultant on utilizing the correct weights for Nutritional Intervention Program meeting by 3/23/2015. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** During the Nutritional Intervention Program meeting held once a week Nursing Administration will audit the daily / weekly / monthly weights and dietary recommendations and will notify the family and physician regarding weight losses of 5% in 30 days, 7.5 % in 90 days and 10% in 180 days. Nursing Administration will also review any resident on daily weights and have said residents re-weighed for verification as deemed necessary and notify physician if a 5 pound weight loss is noted within a 3 day time frame Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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	on 02/11/15 and they should have seen the weights. During an interview on 03/02/15 at 3:05 p.m., the Director of Nursing indicated the Physician and the family had not been made aware of the weight loss until 02/12/15. An undated facility policy, titled, "Changes in Resident's Condition or Status", received from the Administrator as current on 03/02/15 at 1:30 p.m., indicated, "...Nursing services will be responsible for notifying the resident's attending physician when:...b. There is significant change in the resident's physical...status...d. there is a need to alter the resident's treatment or medications significantly...f. Deemed necessary or appropriate in the best interest of the resident. 2. Nursing services will be responsible for notifying the resident, his/her next of kin/or representative...b. There is a significant change...4. All notifications must be made as soon as practical, but in no case will such notification exceed twenty-four (24) hours. 5. All changes in the resident's medical condition must be properly recorded in the resident's medical record..." This Federal Tag relates to Complaint			

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	IN00167640. 3.1-5(a)(2)			
F 242 SS=D Bldg. 00	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. Based on record review and interview, the facility failed to ensure residents right to choose schedules were followed, related to bathing, for 2 of 3 residents reviewed for resident rights in a total sample of 3. (Resident #B and #D) Findings include: 1. Resident #B's record was reviewed on 03/02/15 at 8:30 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, peritoneal dialysis, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 02/09/15, indicated the resident's cognition was intact, was very important to choose the type of bathing while in the facility,	F 242	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice All residents were interviewed and found to be satisfied with their current shower / bathing schedule and oral care status and regimen. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Full facility audit related to shower / bathing preference and oral care was completed by nursing administration and no other residents were affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	04/01/2015

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	required extensive assistance of two for transfers, locomotion, personal hygiene, and bathing. A care plan, dated 02/13/15, indicated the resident expressed it was important to her to receive a shower daily. The approaches included to offer showers daily. The Monthly Flow Report, dated 02/15, indicated the resident had not received a shower on 02/03/15, 02/04/15, refused a shower on 02/05/15, received a sponge bath on 02/06/15, no shower on 02/07/15, 02/08/15, 02/09/15, 02/10/15, 02/11/15, a bed bath on 02/12/15, no shower on 02/13/15, a sponge bath on 02/14/15, and a sponge bath on 02/15/15. During an interview on 03/02/15 at 3:05 p.m., the West Unit Manager indicated the resident did not want a shower daily, and preferred a bed bath. She indicated there was no documentation to indicate this. 2. Resident #D's record was reviewed on 03/02/15 at 1:05 p.m. The resident's diagnoses included, but were not limited to fractured right femur and dementia. The Admission MDS assessment, dated 01/15/15, indicated the resident's		Nursing staff will be in serviced by 3/21/2015 by the Staff Development Coordinator regarding the facility policy referencing resident shower preference and oral care and required documentation for both care areas. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Director of Nursing / designee will audit 5 random residents weekly to ensure that residents are receiving their showers per their preference and that oral care is being completed. This will be an ongoing audit for 6 months. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed ne	

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	cognition was severely impaired, was very important to the resident to choose the type of bathing she would receive, was dependent on two of more staff for transfers, required extensive assistance for personal hygiene and bathing. The care plan, dated 01/21/15, indicated the resident's family expressed the important part of the resident's customary routine, which included showers three times a week in the morning. The approaches included to provide the resident showers at least three times a week if possible. The Shower Schedule indicated the resident was scheduled for showers on the day shift on Monday, Thursday, and Saturday. The Monthly Flow Report, dated 02/15, indicated the resident did not receive a shower on 02/09/15, 02/12/15, 02/16/15, and received a bed bath 02/19/15. During an interview on 03/02/15 at 2:30 p.m., the East Unit Manager indicated the resident had not received the showers three times a week. This Federal Tag relates to Complaint IN00167640.			

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	3.1-3(u)(1)			
F 282 SS=D Bldg. 00	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, the facility failed to follow Physician's Orders, related to peritoneal dialysis, for 1 of 2 residents reviewed for peritoneal dialyses, in a total sample of 3. (Resident #B) Finding Includes: Resident #B's record was reviewed on 03/02/15 at 8:30 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, peritoneal dialysis, and congestive heart failure. A Physician's Order, dated 02/06/15, indicated to administer two 5 liter red bags (4.25% dextrose) (color of the stopper on the bag) and one 2 liter red bag for the resident's peritoneal dialysis, tonight only.	F 282	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides in the facility. Resident C's physician was updated on 3/12/2015 regarding the omitted peritoneal dialysis order and a clarification order was written. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Facility Audit was completed by the Director of Nursing on 3/12/2015 to identify any other residents having issues related to physician orders relevant to peritoneal dialysis. No further	04/01/2015

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	The MAR, dated 02/15, indicated on 02/06/15, two 5 liter red bags and one 3 liter green bag (2.5% dextrose) (color of the stopper on the bags) had been administered to the resident for peritoneal dialysis. The Dialysis Daily Record, dated 02/15, indicated the resident received two 6 liters red bag one 3 liter green bag on 02/06/15. During an interview on 03/02/15 at 2:30 p.m., the West Unit Manager indicated the dialysis was not administered as ordered on 02/06/15. This Federal Tag relates to Complaint IN00167640. 3.1-35(g)(2)		issues were identified. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Staff Development Coordinator will in-service Licensed Nursing Staff by 3/21/2015 on following / writing physician orders and ensuring the orders are transcribed correctly onto the corresponding MAR/TAR. Licensed Nursing staff will also be in serviced on how to correctly discontinue an order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** DON / designee will perform random audits on 10 physician orders weekly to ensure that orders are being followed and transcribed / discontinued accurately. This will be an ongoing audit for 6 months. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correct developed and implemented as deemed necessary.	

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F 312 SS=D Bldg. 00	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. Based on observation, record review, and interview, the facility failed to provide the necessary assistance with bathing and oral care for 3 of 3 residents in a total sample of 3. (Resident #B, #C, and #D) Findings include: 1. Resident #B's record was reviewed on 03/02/15 at 8:30 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, peritoneal dialysis, and congestive heart failure. The Admission Minimum Data Set assessment, dated 02/09/15, indicated the resident's cognition was intact, required extensive assistance of two for transfers, locomotion, personal hygiene, and bathing. A care plan, dated 02/13/15, indicated the resident expressed it was important to her to receive a shower daily. The approaches included to offer showers daily.	F 312	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice All residents were interviewed and found to be satisfied with their current shower / bathing schedule and oral care status and regimen. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Full facility audit related to shower / bathing preference and oral care was completed by nursing administration and no other residents were affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff will be in serviced by 3/21/2015 by the Staff Development Coordinator regarding the facility policy referencing resident shower preference and oral care and required documentation for both care areas. **How the corrective action(s)**	04/01/2015

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	A care plan, dated 02/13/15, indicated the resident had an ADL (activities of daily living) deficit. The approaches included to provide the amount of assistance/supervision that is needed. The Monthly Flow Report, dated 02/15, indicated the resident had not received a shower on 02/03/15, 02/04/15, refused a shower on 02/05/15, received a sponge bath on 02/06/15, no shower on 02/07/15, 02/08/15, 02/09/15, 02/10/15, 02/11/15, a bed bath on 02/12/15, no shower on 02/13/15, a sponge bath on 02/14/15, and a sponge bath on 02/15/15. The Monthly Flow Report, dated 02/15, indicated the resident had not received oral care daily between 02/03/15 and 02/15/15. During an interview on 03/02/15 at 3:05 p.m., the West Unit Manager indicated the resident did not want a shower daily, and preferred a bed bath. She indicated there was no documentation to indicate this. 2. Resident #C's record was reviewed on 03/02/15 at 11:25 a.m. The resident's diagnoses included, but were not limited to, peritoneal dialysis, end stage renal disease, and stroke.		**will be monitored to ensure the deficient practice will not recur:** Director of Nursing / designee will audit 5 random residents weekly to ensure that residents are receiving their showers per their preference and that oral care is being completed. This will be an ongoing audit for 6 months. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed ne	

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	A Significant Change MDS assessment, dated 01/09/15, indicated the resident's cognition was severely impaired, had no behaviors, choosing types of bathing was very important, was extensive assistance of two or more for bed mobility, dependant for transfers, extensive assistance for locomotion, personal hygiene and bathing. A care plan, dated 01/13/15, indicated the resident had expressed the importance of his customary routine to receive a shower two times a week. The approaches included to offer the resident a shower at least two times a week. The shower schedule indicated the resident was scheduled for a shower on Monday and Thursday evenings. The Monthly Flow Report, dated 02/15, indicated the resident received a bed bath on 02/02/15, no shower on 02/05/15, a bed bath on 02/09/15, a bed bath 02/16/15, no shower on 02/19/15 and no shower on 02/23/15. The Monthly Flow Report, dated 02/15/, indicated the resident had not received oral care daily. During an interview on 03/02/15 at 2:30 p.m., the East Unit Manager indicated a			

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	shower had not been given on 02/05/15, 02/19/15, and 02/23/15. She indicated the resident had received bed baths on 02/02/15, 02/09/15, and 02/16/15. She indicated the oral care had not been signed as completed daily. 3. Resident #D's record was reviewed on 03/02/15 at 1:05 p.m. The resident's diagnoses included, but were not limited to fractured right femur and dementia. The Admission MDS assessment, dated 01/15/15, indicated the resident's cognition was severely impaired, was very important to the resident to choose the type of bathing she would receive, was dependent on two of more staff for transfers, required extensive assistance for personal hygiene and bathing. The care plan, dated 01/21/15, indicated the resident's family expressed the important part of the resident's customary routine, which included showers three times a week in the morning. The approaches included to provide the resident showers at least three times a week if possible. The Shower Schedule indicated the resident was scheduled for showers on the day shift on Monday, Thursday, and Saturday.			

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LIFE CARE CENTER OF THE WILLOWS	1000 ELIZABETH DR VALPARAISO, IN 46383

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	The Monthly Flow Report, dated 02/15, indicated the resident did not receive a shower on 02/09/15, 02/12/15, 02/16/15, and received a bed bath 02/19/15. The Monthly Flow Report, dated 02/15, indicated the resident had not received oral care daily. During an interview on 03/02/15 at 2:30 p.m., the East Unit Manager indicated the resident had not received the showers three times a week. She indicated the resident had not received oral care daily. An undated facility policy, titled, "Oral Hygiene: Conscious Resident", received from the West Unit Manager as current on 03/02/15 at 11:45 a.m., indicated, "...Provide dental care before breakfast and at bedtime..." This Federal Tag relates to Complaint IN00167640. 3.1-38(a)(3)(C)			

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F 325 SS=D Bldg. 00	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 record review and interview, the facility failed to ensure a resident maintained their nutritional status, related to a significant weight loss and failed to ensure a Registered Dietician's recommendations were followed in a timely manner for the significant weight loss, which the resident continued to have weight loss, for 1 of 3 residents reviewed for weight loss in a total sample of 3. (Resident #B) Finding includes: Resident #B's record was reviewed on 03/02/15 at 8:30 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, peritoneal dialysis, and congestive heart failure. The Physician's Admission Orders, dated 02/02/15, indicated the resident was	F 325	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The affected resident no longer resides in the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Full facility audit related to resident weights and dietary recommendations from the previous 6 months were reviewed to ensure that physician and family notification were completed in a timely manner. No issues were identified via this audit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed Nursing Staff will be in serviced by 3/21/2015 by the Staff Development Coordinator	04/01/2015

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	ordered a regular, no added salt diet. The Admission Nurses' Assessment, dated 02/02/15, indicated the resident's weight was 178.4 The Nutrition Data Collection/Assessment, dated 02/03/15, indicated the resident was on a no added salt, carbohydrate controlled, renal diet (no documentation to indicate this diet order), the current height was 60 inches, current weight 178 pounds, the usual body weight was 150-155 pounds, the resident's ideal body weight was 100 pounds, the resident's average food consumption was 50-75% for breakfast, less than 25-50% lunch and 100% at dinner. The Admission Minimum Data Set assessment, dated 02/09/15, indicated the resident's cognition was intact, required supervision for eating, extensive assistance of two for transfers and locomotion, weight was 178 pounds and had no significant weight loss of 5% in 30 days or 10% in the last six months. A care plan, dated 02/06/15, indicated the resident was a nutritional risk, due to the resident received a therapeutic diet. The approaches included to observe lab/diagnostics and report results to the		regarding the facility policy referencing physician/family notification and completing dietary recommendations in a timely manner. Dietary Manager will be in serviced by the Dietary Consultant on utilizing the correct weights for Nutritional Intervention Program meeting by 3/23/2015. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** During the Nutritional Intervention Program meeting held once a week Nursing Administration will audit the daily / weekly / monthly weights and dietary recommendations and will notify the family and physician regarding weight losses of 5% in 30 days, 7.5 % in 90 days and 10% in 180 days. Nursing Administration will also review any resident on daily weights and have said residents re-weighed for verification as deemed necessary and notify physician if a 5 pound weight loss is noted within a 3 day time frame Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.	

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	Physician, weigh and observe results. The resident's Peritoneal Dialysis Daily Record indicated the following weights: 02/02/15-178.4 02/03/15-178.4 02/04/15- 172.8 02/05/15- 170.4 02/06/15- 158 (11.37% weight loss in three days) 02/07/15- 159 02/08/15- 156.1 02/09/15- 155.4 02/10/15- 149.8 02/11/15- 149.2 02/12/15- 140.5 (21.24% weight loss in nine days) 02/13/15- 144.3 02/14/15- 140 02/15/15- 138 There was a lack of documentation to indicate the facility had assessed for possible reasons for the weight loss. The Dietary Intake Report, indicated the following dietary intake: 02/03/15- 50% breakfast, 50% lunch, 100% dinner 02/04/15- 75% breakfast, 75% lunch, 75% dinner 02/05/15- 50% breakfast, 50% lunch, nothing for dinner 02/06/15- nothing for breakfast, 50% for			

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	lunch, and nothing for dinner 02-07-15- 50% for breakfast, 50% for lunch, and 100% for dinner 02-08/15- 75% for breakfast, less than 25% for lunch and 100% dinner 02/09/15- 75% breakfast, 75% for lunch, nothing for dinner 02/10/15- 50% breakfast, 25% lunch, 100% dinner 02/11/15- 75% breakfast, 100% lunch, less than 25% dinner 02/12/15- nothing for breakfast, 25% lunch, 75% dinner 02/13/15- 25% dinner, 25% lunch, 100% dinner 02/14/15- nothing for breakfast, 50% lunch, 50% dinner 02/15/15- 25%, nothing for lunch, (resident transferred to hospital at 5 p.m.) The Nutrition Intervention Program (NIP) notes, dated 02/05/15 at 2:35 p.m. indicated the resident's current weight was 167 (6.39% weight loss in three days), oral intake of diet was 25-100%, had peritoneal dialysis every night, all were aware, and the facility would continue to monitor. The Registered Dietician's Nutritional Assessment, dated 02/09/15, indicated, "...Consumes a regular-NAS (no added salt) diet...Per diet slip CCHO (carbohydrate controlled), NAS, Renal			

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	diet in place 2/2/15, will clarify. 167# (pounds) (2/7/15)...Res (resident) reports decreased (arrow down) po (oral) intake related to diet restrictions. P (problem): increased nutrient needs. requests Ensure daily, Reg (regular) NAS diet...variable PO intake...albumin low, Reported decreased (arrow down) PRO (protein) intake...Nutrition Prescription (diet order): liberalize diet to Regular-NAS, chocolate Ensure once daily, 2 hard boiled eggs c/ (with) breakfast..." The NIP notes, dated 02/12/15 at 2:03 p.m., indicated, "NIP notes from 02/09/15. dietician (sic) here and reviewed res (resident) chart...curent (sic) wt (weight) 167. meal intake varies. will continue in NIP, family and Dr. aware." A Physician's Order, dated 02/09/15 with a line drawn through this date and 02/12/15 written above it, indicated an order for a regular-NAS diet and Ensure one time daily. A Hospital History and Physical, dated 02/16/15, indicated, "...40 pound weight loss in 12 days...has had an unspecified weight loss recently..." During an interview on 03/02/15 at 2:30 a.m., the West Unit Manager indicated the resident went to the Dialysis Center			

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	on 02/11/15 and they should have seen the weights. During an interview on 03/02/15 at 3:05 p.m., the Director of Nursing indicated the Physician and the family had not been made aware of the weight loss until 02/12/15. This Federal Tag relates to Complaint IN00167640. 3.1-45(a)(1)			
F 514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on record review and interview, the facility failed to ensure residents records were complete, accurately documented, and systematically organized, related to Physician's Orders	F 514	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides in the facility. Resident C's	04/01/2015

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	for peritoneal dialysis and a laxative and Medication Administration Records (MAR) for 2 of 3 residents reviewed for Physician's Orders in a total sample of 3. (Resident #B and #C) Findings include: 1. Resident #B's record was reviewed on 03/02/15 at 8:30 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, peritoneal dialysis, and congestive heart failure. A) The signed, Physician's Orders, dated 02/02/15, indicated an order for Dulcolax (laxative) 10 mg (milligram) rectal suppository as needed for constipation. The MAR, dated 02/15, indicated the Dulcolax had been discontinued. There was no documentation to indicate the date the Dulcolax had been discontinued on the MAR. The Physician's Orders lacked documentation to indicate an order for the Dulcolax to be discontinued. B) The MAR, dated 02/15, indicated the resident was administered two-6 liter green bags (2.5% dextrose) (color of stopper on bag) and one-3 liter green bag, tonight only per (Dialysis Nurse Name).		physician was updated on 3/12/2015 regarding the omitted peritoneal dialysis order and a clarification order was written. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Facility Audit was completed by the Director of Nursing on 3/12/2015 to identify any other residents having issues related to physician orders relevant to peritoneal dialysis. No further issues were identified. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Staff Development Coordinator will in-service Licensed Nursing Staff by 3/21/2015 on following / writing physician orders and ensuring the orders are transcribed correctly onto the corresponding MAR/TAR. Licensed Nursing staff will also be in serviced on how to correctly discontinue an order.	

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	There was a lack of a documentation a Physician's Order had been written for the dialysis order given by the Dialysis Nurse. The MAR, dated 02/15, lacked documentation the peritoneal dialysis had been completed on 02/10/15. There were no Physician's Orders written for 02/10/15 to indicate what fluid orders the resident should have received for dialysis. The Dialysis daily record indicated the resident received one- 6 liter green bag and one-5 liter green bag. There was a lack of documentation on the MAR, dated 02/15, to indicate the resident had received peritoneal dialysis on 02/14/15. There was a lack of documentation to indicate the resident had orders for the peritoneal dialysis on 02/14/15. The Dialysis Daily Record, dated 02/15, indicated the resident received two 6 liters of yellow (1.5% dextrose) (color of stopper on bag). During an interview on 03/02/15 at 2:30		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** DON / designee will perform random audits on 10 physician orders weekly to ensure that orders are being followed and transcribed / discontinued accurately. This will be an ongoing audit for 6 months. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correct developed and implemented as deemed necessary.	

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	p.m., The West Unit Manager indicated on 02/05/15, there were Physician's Orders were not documented. She acknowledged Physician's Orders were not written and the MARs were not signed to indicate the dialysis had been completed. 2. Resident #C's record was reviewed on 03/02/15 at 11:25 a.m. The resident's diagnoses included, but were not limited to, peritoneal dialysis, end stage renal disease, and stroke. The MAR, dated 02/15, indicated the resident received two 6 liters green bag and one 3 liter green bag on 02/03/15 for the peritoneal dialysis. There was a lack of documentation a Physician's Order had been written for the dialysis fluid order. There was a lack of documentation in the Physician's Orders to indicate the resident had an order for the peritoneal dialysis on 02/24/15. The MAR, dated 02/15, lacked documentation the resident had received peritoneal dialysis on 02/24/15. The Daily Dialysis Record, dated 02/15, indicated the resident received two-6			

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	liters green bag and one-3 liters green bag. During an interview on 03/02/15 at 2:30 p.m., the East Unit Manager indicated there was no Physician's Order written for the dialysis fluid on 02/03/15. She indicated the Daily Dialysis Record had documentation what fluids were used for the 02/24/15 treatment, but there was not a Physician's Order written and it was not documented on the MAR. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(4)			