

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/31/2015
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NAME OF PROVIDER OR SUPPLIER CHESTERTON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00189580. This visit resulted in a Partially Extended Survey-Immediate Jeopardy.</p> <p>Complaint IN00189580- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F206, F224, F325, and F327.</p> <p>Survey date: December 23 & 28, 2015 Extended dates: December 29, 30, and 31, 2015</p> <p>Facility number: 000150 Provider number: 155246 AIM number: 100267000</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census Payor type: Medicare: 9 Medicaid: 50 Other: 12 Total: 71</p> <p>Sample: 5 Extended sample: 4</p>	F 0000	<p>Chesterton Nursing Home respectfully requests a face to face IDR process to review the tags F157, F206, F224, F325, and F327, resulting from the complaint survey findings dated December 31, 2015, to introduce new information. We feel we are able to show evidence to support deletion of the deficiencies. Therefore, we respectfully request the deletion of said deficiencies. The representative for Chesterton Manor Nursing Home is the Administrator Benjamin Gehrman. Ben can be contacted via e-mail: chesterton.admin@imgcares.com or U.S. mail at Chesterton Manor Nursing Home, 110 Beverly Drive, Chesterton, Indiana, 46304, or via phone- 219-926-8387. Chesterton Manor intends to have counsel present.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0157 SS=D Bldg. 00	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on January 8, 2015.</p> <p>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).</p>			

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	<p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's Physician and Healthcare Representative (HCR) in a timely manner, related to a decrease intake of food and fluids, which resulted in the resident being transferred to the hospital and admitted with a diagnoses of severe dehydration and acute kidney injury (acute kidney failure) for 1 of 9 residents reviewed for Physician/family notification in a total sample of 5 and extended sample of 4. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 12/23/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, history of stroke, and anemia.</p> <p>The Registered Dietitian's Full</p>	F 0157	<p>Chesterton Nursing Home respectfully requests a face to face IDR process to review the tags F157, F206, F224, F325, and F327, resulting from the complaint survey findings dated December 31, 2015, to introduce new information. We feel we are able to show evidence to support deletion of the deficiencies. Therefore, we respectfully request the deletion of said deficiencies. The representative for Chesterton Manor Nursing Home is the Administrator Benjamin Gehrman. Ben can be contacted via e-mail: chesterton.admin@imgcares.com or U.S. mail at Chesterton Manor Nursing Home, 110 Beverly Drive, Chesterton, Indiana, 46304, or via phone- 219-926-8387. Chesterton Manor intends to have counsel present. F-157 Resident B discharged from the facility as the family elected to move her to another State. The facility reviewed all</p>	01/01/2016

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	<p>Assessment, dated 12/14/15, indicated the resident's caloric needs were 1670-2004 calories per day and an estimated milliliters (ml) of fluid needs of 2004 ml daily. The resident had fair to poor meal intakes 25-50% for breakfast, 25-75% for lunch and 0-75% at supper. Supplements were in place and the resident would continue to be monitored for weights and status.</p> <p>The Medication Administration Record, dated 12/2015, indicated the resident was to receive a Magic Cup (nutritional supplement) with lunch and supper, Carnation Instant Breakfast 240 milliliters three times a day with meals, and four ounces of pudding at bedtime.</p> <p>The intake of the Magic Cup, at lunch, dated 12/17/15 and 12/18/15, was 25% and, 12/19/15 through 12/22/15, the resident had not consumed any of the Magic Cup. The intake at supper, indicated on 12/17/15 through 12/21/15 the resident had not consumed the Magic Cup.</p> <p>The Carnation Instant Breakfast intake was as follows: 12/17/15-60 milliliters (ml) for breakfast and lunch and 10 ml for supper 12/18/15-60 ml for breakfast and lunch and 80 ml for supper</p>		<p>resident records to identify changes in condition and physician and family notifications. All residents' in the facility were assessed for changes in conditions and potential neglect. Facility Nurses' were inserviced on ensuring physician notification of any change in condition and neglect. All direct care staff were inserviced related to provision of care to residents and change in condition. The facility inserviced staff for neglect, physician notification, hydration, and nutrition. An audit tool has been initiated that will review residents who have had a change of condition and the physician and family have been notified. The Director of Nursing, or designee, is responsible for the completion of the tool. The tool will randomly review 8 residents to assure that the resident is receiving proper care and that proper notification has taken place. This tool will be completed weekly x 3 weeks, monthly x 3 months, and then quarterly x 3 quarters. This tool will be reviewed as part of the QA process with additional recommendations as needed based on the outcome of the tool. Nursing Administration, or designee will be reviewing the 24 hour reports daily to assure that any changes occurring with the resident were reported to the physician timely and that appropriate interventions have been implemented in an</p>	

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	<p>12/19/15-60 ml for breakfast, 20 ml for lunch, and 20 ml for supper</p> <p>12/20/15-50 ml breakfast, sips for lunch and supper</p> <p>12/21/15-50 ml breakfast and sips for lunch and supper</p> <p>12/22/15-none was taken for breakfast</p> <p>The four ounces of pudding was not consumed at bedtime from 12/16/15 through 12/21/15.</p> <p>The Dietary Consumption Records, dated 12/2/15 through 12/14/15, indicated the average intake for breakfast (B) was 26-50%, lunch (L) was 26-50%, and supper (S) was 26-75%.</p> <p>The Dietary Consumption Records, dated 12/15/15 through 12/22/15, indicated the following intakes of food:</p> <p>12/15/15-(B) 51-75%, (L) 26-50%, (S) 51-75%</p> <p>12/16/15-(B) 0-25%, (L) 0-25%, (S) 0-25%</p> <p>12/17/15-(B) 0-25%, (L) 0-25%, (S) 0-25%</p> <p>12/18/15-(B) refused, (L) 0-25%, (S) 0-25%</p> <p>12/19/15-(B) 0-25%, (L) 0-25%, (S) 0-25%</p> <p>12/20/15- (B) 0-25%, (L) 51-75%, (S) 0-25%</p> <p>12/21/15- (B) 0-25%, (L) 0-25%, (S)</p>		acceptable manner.	

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	<p>0-25% 12/22/15- (B) refused</p> <p>The fluid intakes for December 2015, indicated the following milliliters per day:</p> <p>12/4/15- 240 12/6/15- 240 12/10/15- 840 12/11/15- 720 12/12/15- 960 12/13/15- 690 12/14/15- 570 12/15/15-1080 12/16/15- 480 12/17/15- 360 12/18/15- 135 12/19/15- 360 12/20/15- 360 12/21/15- 240</p> <p>A Speech Therapy Note, dated 12/15/15, indicated, "...Dietary spoke with therapist today regarding patient's progress with current diet...Therapist also informed dietary that amount consumed by patient is decreased d/t (due to) difficulty initiating swallow...which creates concern for patient meeting daily nutritional/hydration needs."</p> <p>A Speech Therapy Note, dated 12/17/15, indicated, "Therapist education to LPN (Licensed Practical Nurse) as patient was</p>			

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	<p>placed in a semi laying position in an attempt to feed her. This was being done to prevent anterior spillage to increase intake. Unfortunately, irregardless of position, the patient was unable to consume an adequate amount of food for nutrition/hydration. Consulted with nursing on feeding techniques including the possible use of a controlled bolus via a syringe. Nursing to track intake for the next 4 days and will speak with family about alternative feeding if patient continues to display an inability to swallow sufficiently to maintain weight and hydration...This appears to be related to an overall decline in medical status related to advancing dementia."</p> <p>The Nurses' Progress Notes indicated: 12/17/15 at 7:54 p.m.- "resident consumed 0-25% of her evening meal...." 12/18/15 at 2:01 p.m.- (Written by LPN #1) "Resdient (sic) did not eat at am (morning) meal, kept pushing food out of her mouth. Resident did eat approx. (approximately) 50% of noon meal." 12/18/14 at 10:06 p.m.- (Written by RN, Registered Nurse, #4) "Res. (resident) ate only a couple of bites at dinner. She pushes food out of her mouth and takes in very little." 12/19/15 at 4:04 p.m.- (Written by LPN #1) "Resident ate approx 50% of am meal, at noon meal resident did not</p>			

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	<p>swallow any food writer put in her mouth, resident held head down and food slid out of mouth."</p> <p>12/19/15 at 10:16 p.m.- (Written by RN #4) "Res. had poor food consumption this shift. She ate only bites at dinner even with many attempts to get her to eat. Res. had some sips of liquid but only very little. Res. had a dry brief at the end of shift...Res. has poor skin turgor as evidenced by tenting (skin pinched up) of the hands and sternum greater than a (sic) 3 second return (amount of time it takes for skin to return to normal after being pinched up) (test for dehydration); fluids were offered and resident did not drink well...."</p> <p>12/20/15 at 2:26 a.m.- (Written by RN #5) "No food consumption on this shift. She did take sips of fluids this shift....She has poor skin turgor as evidenced by tenting of the hands and sternum greater than 3 seconds return...."</p> <p>12/20/15 at 12:52 p.m.- (Written by LPN #1) "REsident (sic) ate and swallowed a few bites for am meal, resident took and swallowed meds [medications], at noon meal resident opened mouth to take food but would not swallow the food, writer attempted to encourage resident to swallow but she did not, writer had to remove the food from residents mouth."</p> <p>12/21/15 at 2:50 a.m.- (no progress note from 12:52 p.m. to this note) (Written by</p>			

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	<p>RN #6) "Refused intake this shift. No output..."</p> <p>12/21/15 at 2:39 p.m.- (Written by LPN #1) "REsident (sic) ate 3 bites including medication for am meal, after the first three bites, resident just held food in her mouth and would not swallow, any fluids attempted to be administered ran back out of her mouth. Resident ate two bites at noon meal and then would not swallow any more food, any fluids attempted to be administered ran back out of residents mouth."</p> <p>12/21/15 at 10:34 p.m.- (Written by RN #4) Two staff assisted resident with her dinner. One staff helped hold up resident's head while the other staff attempted to feed resident. Res. took only a few bites before the food began to fall back out of her mouth. Res. was given several spoons of liquid to encourage her to drink more fluids. Res. did swallow some. Mostly the liquids drained out of her mouth even with her head up. Res. had a wet brief after dinner and her skin turgor was less than 3 seconds on her hands and sternum. Res. sons were called to give them an update on how the resident was doing and to let them know she was not eating or drinking much. (Son #1's Name) phone would not accept calls. (Son #2's Name) phone was not answered and his mailbox was not set up. So neither son could be contacted. MD</p>			

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	<p>(Medical Doctor) was contacted just to give him report about the resident and situation. MD aware."</p> <p>12/22/15 at 4:33 a.m.- (Written by RN #5) "Resident took in sips of water and did void one time so far this shift...Skin turgor was less than 3 seconds on her hands and sternum...."</p> <p>12/22/15 at 11:15 a.m.- (Written by LPN #3) "Resident resting in bed at this time. Resident continues to not eat or drink fluids offered by staff at meal times. Resident was unable to take meds this AM and medications rolled out of mouth. MD called and informed of residents (sic) status. New orders received and noted to send to (Hospital Name) for evaluation and treatment. This nurse attempted to contact (Son #1 and #2's Names). (Son #1's Name) number stated that it was unable to receive incoming calls and [Son #2's name] number stated that there was no voicemail box set up."</p> <p>12/22/15 at 12:10 p.m.- "Resident left facility at this time in stable condition. Report called to (Hospital ER)."</p> <p>12/22/15 at 12:19 p.m.- "Writer (Social Service Director) called and spoke with resident's POA (Power of Attorney) (Son #1) on the telephone to inform him that his mother will be transported to (Hospital Name). He was then transferred to the nurse for clinical information."</p>			

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	<p>The Emergency Room Physician's Note, dated 12/22/15 at 1:01 p.m., indicated the resident had an associated diagnosis of dehydration and character symptoms were failure to thrive. The resident's sodium was 181 (normal 135-147), potassium was 4.1 (normal 3.5-5), BUN (kidney function) 156 (normal 7-22), and Creatinine (kidney function) 3.6 (normal 0.4-1.5).</p> <p>The hospital History and Physical, dated 12/23/15, indicated the resident had severe hypernatremia (high sodium level), lethargy/metabolic encephalopathy (disease of the brain), severe dehydration/AKI (acute kidney injury) (kidney failure), and leukocytosis (elevated white blood cells).</p> <p>During an interview on 12/23/15 at 1 p.m., the Hospital Physician indicated the resident was very dehydrated upon admission to the ICU. He indicated this was due to not enough fluid intake.</p> <p>During an interview on 12/23/15 at 3:22 p.m., the Assistant Director of Nursing (ADoN) indicated the resident's Physician and POA should have been notified when the resident's food and fluid consumption had decreased and when the resident first started showing signs of dehydration.</p>			

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	<p>During an interview on 12/23/15 at 4:07 p.m., the ADoN indicated she was unsure why the resident's Physician and POA were not called when the resident had started to decline and exhibit symptoms of dehydration.</p> <p>During an interview on 12/28/15 at 8:26 a.m., LPN #1 indicated the first few days the resident was at the facility she ate well, then she started pushing the food out of her mouth and the last few days she was at the facility she would spit the food out or it would drool from her mouth. LPN #1 indicated no one had reported she wasn't eating. LPN #1 indicated the last week before she was sent out was when he found out the resident was not eating. LPN #1 indicated the Physician and/or POA had not been notified when he was aware the resident had not been eating or drinking well.</p> <p>During an interview on 12/28/15 at 9:52 a.m., LPN #3 indicated usually with a change in condition the Nurse would call the Physician and family/POA. LPN #3 indicated she had contacted the family on 12/22/15.</p> <p>During an interview on 12/28/15 at 11:22 a.m., RN #4 indicated she had been</p>			

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	<p>informed by the past Director of Nursing (DoN) that if a resident was showing signs of dehydration, she no longer had to call the Physician and only document if the resident accepted or did not accept fluids. RN #4 indicated she was told the "State" doesn't require us to call the Physician. RN #4 indicated she notified the resident's Physician on 12/21/15 and informed the Physician the resident was not eating or drinking at all and the Physician indicated he would be in the building the next morning to see the resident.</p> <p>A Hospital Physician's Progress Note, dated 12/28/15, indicated, "...Hypernatremia from severe water deficit-now better. Severe azotemia (elevated BUN and creatinine levels) and AKI (acute kidney injury) on admit from volume depletion...."</p> <p>A Hospital Physician's Progress Note, dated 12/29/15, indicated, "...Hypernatremia...AKI: improving; Likely prerenal azotemia and possible ATN (acute tubular necrosis) from poor oral intake...."</p> <p>A facility policy, dated 04/2012, titled, "Change in a Resident's Condition or Status", received from the Director of Nursing as current, indicated, "Our</p>			

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F 0206 SS=D Bldg. 00	<p>facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status..."</p> <p>This Federal Tag relates to Complaint IN00189580.</p> <p>3.1-5(a)(2)</p> <p>483.12(b)(3) POLICY TO PERMIT READMISSION BEYOND BED-HOLD A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services. Based on observation, record review and interview, the facility failed to follow their written policy to ensure a resident</p>	F 0206	Chesterton Nursing Home respectfully requests a face to face IDR process to review the	01/01/2016

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	<p>who was transferred and discharged to a hospital was readmitted to the facility when a bed was available in the facility, for 1 of 5 residents reviewed for transfers/discharges in a total sample of 5 and extended sample of 4. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 12/23/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, history of stroke, and anemia. Resident #B's payor source was Medicaid.</p> <p>A Physician's Telephone Order, dated 12/22/15 at 11:10 a.m., indicated to transfer the resident to the Emergency Room for evaluation and treatment.</p> <p>A Notice of Transfer or Discharge form, dated 12/22/15, was sent with the transfer papers for the resident. The Notice of Transfer or Discharge form also included the facility's Bed Hold Policy, which indicated, "...If a Bed Hold is not requested, a Resident receiving Medicaid may be readmitted to the first available semi-private bed if the resident requires nursing home level care and is eligible for Medicaid..."</p> <p>The hospital information form, indicated</p>		<p>tags F157, F206, F224, F325, and F327, resulting from the complaint survey findings dated December 31, 2015, to introduce new information. We feel we are able to show evidence to support deletion of the deficiencies. Therefore, we respectfully request the deletion of said deficiencies. The representative for Chesterton Manor Nursing Home is the Administrator Benjamin Gehrman. Ben can be contacted via e-mail: chesterton.admin@imgcares.com or U.S. mail at Chesterton Manor Nursing Home, 110 Beverly Drive, Chesterton, Indiana, 46304, or via phone- 219-926-8387. Chesterton Manor intends to have counsel present. F-206 Resident B discharged from the facility as the family elected to move her to another State. Administrative Staff and Nurses were inserviced regarding the Bed Hold Policy and when the resident and/or family member receives notice of that policy. Administrative Staff is reviewing current residents on Bed Hold at morning stand-up. Review includes morning stand-up minutes for monitoring and will be utilized as an ongoing basis as part of the morning stand-up meeting.</p>	

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	<p>the resident had been admitted into the hospital on 12/22/15.</p> <p>The Discharge Planning Note from the hospital, dated 12/28/15 at 3:40 p.m., indicated the hospital's Discharge Planning had spoke with the facility's Admission Coordinator and the Admission Coordinator informed Discharge Planning, the resident's family had not wanted the resident to return to the facility and the facility was not accepting the resident back for re-admission.</p> <p>During an interview on 12/29/15 at 8:23 a.m., the Facility Administrator indicated the facility had attempted to work with the family to get the admission paperwork signed, had attempted to set up meetings with the family, sent paperwork by e-mail and certified mail. The Administrator indicated the family had been uncooperative and had not yet signed the paperwork. The Administrator indicated the facility would not accept the resident back as a readmission and had offered to assist the hospital in finding other long term care placement.</p> <p>A Hospital Discharge Planning Note, dated 12/29/15 at 10:36 a.m., indicated, "...Called (Son #1's Name) spoke to him regarding his concerns...(Son #1) stated</p>			

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	<p>that he never told (Facility Name) that they didn't want his Mom to return there on discharge and that he would want his Mom to return there since she has Alzheimer's and an abrupt change in environment would not be good for her. He stated that it wasn't our business if they wanted his mom to go to another facility on discharge..."</p> <p>A Hospital Discharge Planning Note, dated 12/29/15 at 12:35 p.m., indicated Son #1 stated, "he didn't think that the SNF (skilled nursing facility) could refuse the patient since the patient had Medicaid."</p> <p>A Hospital Discharge Planning Note, dated 12/29/15 at 2 p.m., indicated the facility's Admission Coordinator stated the facility was unable to take the resident back because the family had refused to sign paperwork and were being uncooperative.</p> <p>During an interview on 12/30/15 at 1:07 p.m., the Admissions Coordinator indicated she had informed the hospital the facility could not readmit the resident until the family signed the paperwork and the family met with the facility.</p> <p>During an observation on 12/30/15 at 2 p.m., Resident #B's room was still</p>			

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F 0224 SS=J Bldg. 00	<p>available and the resident's personal items remained in the room and the resident's name was still posted at the door.</p> <p>This Federal Tag relates to Complaint IN00189580.</p> <p>3.1-12(a)(27)(A) 3.1-12(a)(27)(B)</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure a resident's care was not neglected related to, not implementing new interventions when a resident's food and fluid intake decreased, the resident exhibited increased swallowing problems, not following Speech Therapy's recommendations of notifying the family for directions on alternate ways for food and fluid consumption, and not notifying the resident's Physician and Health Care Representative (HCR) in a timely manner of the decrease in food and fluid intake</p>	F 0224	<p>Chesterton Nursing Home respectfully requests a face to face IDR process to review the tags F157, F206, F224, F325, and F327, resulting from the complaint survey findings dated December 31, 2015, to introduce new information. We feel we are able to show evidence to support deletion of the deficiencies. Therefore, we respectfully request the deletion of said deficiencies. The representative for Chesterton Manor Nursing Home is the Administrator Benjamin Gehrman. Ben can be contacted via e-mail:</p>	01/01/2016

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	<p>for 1 of 7 residents reviewed for neglect in a total sample of 5 and extended sample of 4. (Resident #B).</p> <p>The Immediate Jeopardy began on 12/17/15 when the resident had increased swallowing problems and food and fluid intake decreased. The resident exhibited signs of dehydration (poor skin turgor and decreased output), on 12/19/15, 3 days prior to the resident's Physician being notified of the signs and symptoms of the dehydration and 5 days prior to the resident being transferred to the Emergency Room. The resident was admitted into the Intensive Care Unit at the hospital with diagnoses of, but not limited to, severe dehydration, acute kidney injury and severe hypernatremia (critically high sodium level). The Administrator and Director of Nursing (DoN) were notified of the Immediate Jeopardy on 12/29/15 at 9:14 a.m.</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 12/23/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, history of stroke, and anemia.</p> <p>The resident had a "State of Indiana Out of Hospital Do Not Resuscitate</p>		<p>chesterton.admin@imgcares.com or U.S. mail at Chesterton Manor Nursing Home, 110 Beverly Drive, Chesterton, Indiana, 46304, or via phone- 219-926-8387. Chesterton Manor intends to have counsel present. F-224 Resident B discharged from the facility as the family elected to move her to another State. The facility reviewed all resident records to identify changes in condition and physician and family notifications. All residents' in the facility were assessed for changes in conditions and potential neglect. Facility Nurses' were inserviced on ensuring physiannotification of any change in condition and neglect. All direct care staff were inserviced related to provision of care to residents and change in condition. The facility inserviced staff for neglect, physician notification, hydration, and nutrition. An audit tool has been initiated that will review residents for assuring that services are being provided in an acceptable manner. The Director of Nursing, or designee, is responsible for the completion of the tool. The tool will randomly review 8 residents to assure that the resident isreceiving proper care and that proper interventions are implemented. Any issues identified will be immediately addressed. This tool will be completedweekly x 3 weeks, monthly x 3 months, and then</p>		

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	<p>Declaration and Order," signed by the HCR (Health Care Representative) on 03/05/14, which indicated the resident chose not to have cardiopulmonary resuscitation administered. The Advance Directive Information, signed by the HCR on 10/19/12, indicated the resident did not have a Living Will.</p> <p>An Admission Minimum Data Set assessment, dated 12/10/15, indicated the resident's cognition had not been assessed. The resident's decision making skills were severely impaired. The resident was dependent on staff for eating and all other activities of daily living. The resident did not have swallowing disorders.</p> <p>A care plan, dated 12/17/15, indicated the resident was a risk for dehydration related to a poor oral intake. The goal indicated the resident would exhibit no signs and symptoms of dehydration. The interventions included, "Encourage to consume all fluids offered at mealtime...Observe for s/sx (signs and symptoms) dehydration (i.e. (example): dry oral mucosa/lips, skin tenting, dark/foul smelling urine), Offer and encourage between meal fluid consumption...."</p> <p>An undated dietary care plan, indicated</p>		<p>quarterly x 3 quarters. This tool will be reviewed as part of the QA process with additional recommendations as needed based on the outcome of the tool.</p>	

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	<p>the resident required a therapeutic diet with thickened fluids. The interventions included, provide diet/fluids as prescribed, supplements, record meal consumption and report signs and symptoms of swallowing problems.</p> <p>The Registered Dietitian's Full Assessment, dated 12/14/15, indicated the resident's caloric needs were 1670-2004 calories per day and an estimated milliliters (ml) of fluid needs of 2004 ml daily. The resident had fair to poor meal intakes 25-50% for breakfast, 25-75% for lunch and 0-75% at supper. Supplements were in place and the resident would continue to be monitored for weights and status.</p> <p>The Medication Administration Record, dated 12/2015, indicated the resident was to receive a Magic Cup (nutritional supplement) with lunch and supper, Carnation Instant Breakfast 240 milliliters three times a day with meals, and four ounces of pudding at bedtime.</p> <p>The intake of the Magic Cup, at lunch, dated 12/17/15 and 12/18/15, was 25% and, 12/19/15 through 12/22/15, the resident had not consumed any of the Magic Cup. The intake at supper, indicated on 12/17/15 through 12/21/15 the resident had not consumed the Magic</p>			

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	<p>Cup.</p> <p>The Carnation Instant Breakfast intake was as follows: 12/17/15-60 milliliters (ml) for breakfast and lunch and 10 ml for supper 12/18/15-60 ml for breakfast and lunch and 80 ml for supper 12/19/15-60 ml for breakfast, 20 ml for lunch, and 20 ml for supper 12/20/15-50 ml breakfast, sips for lunch and supper 12/21/15-50 ml breakfast and sips for lunch and supper 12/22/15-none was taken for breakfast</p> <p>The four ounces of pudding was not consumed at bedtime from 12/16/15 through 12/21/15.</p> <p>The Dietary Consumption Records, dated 12/2/15 through 12/14/15, indicated the average intake for breakfast (B) was 26-50%, lunch (L) was 26-50%, and supper (S) was 26-75%.</p> <p>The Dietary Consumption Records, dated 12/15/15 through 12/22/15, indicated the following intakes of food: 12/15/15-(B) 51-75%, (L) 26-50%, (S) 51-75% 12/16/15-(B) 0-25%, (L) 0-25%, (S) 0-25% 12/17/15-(B) 0-25%, (L) 0-25%, (S)</p>			

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	<p>0-25% 12/18/15-(B) refused, (L) 0-25%, (S) 0-25% 12/19/15-(B) 0-25%, (L) 0-25%, (S) 0-25% 12/20/15- (B) 0-25%, (L) 51-75%, (S) 0-25% 12/21/15- (B) 0-25%, (L) 0-25%, (S) 0-25% 12/22/15- (B) refused</p> <p>The fluid intakes for December 2015, indicated the following milliliters per day: 12/4/15- 240 12/6/15- 240 12/10/15- 840 12/11/15- 720 12/12/15- 960 12/13/15- 690 12/14/15- 570 12/15/15-1080 12/16/15- 480 12/17/15- 360 12/18/15- 135 12/19/15- 360 12/20/15- 360 12/21/15- 240</p> <p>A Speech Therapy Note, dated 12/15/15, indicated, "...Dietary spoke with therapist today regarding patient's progress with current diet...Therapist also informed dietary that amount consumed by patient</p>			

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	<p>is decreased d/t (due to) difficulty initiating swallow...which creates concern for patient meeting daily nutritional/hydration needs."</p> <p>A Speech Therapy Note, dated 12/17/15, indicated, "Therapist education to LPN (Licensed Practical Nurse) as patient was placed in a semi laying position in an attempt to feed her. This was being done to prevent anterior spillage to increase intake. Unfortunately, irregardless of position, the patient was unable to consume an adequate amount of food for nutrition/hydration. Consulted with nursing on feeding techniques including the possible use of a controlled bolus via a syringe. Nursing to track intake for the next 4 days and will speak with family about alternative feeding if patient continues to display an inability to swallow sufficiently to maintain weight and hydration...This appears to be related to an overall decline in medical status related to advancing dementia."</p> <p>The Nurses' Progress Notes indicated: 12/17/15 at 7:54 p.m.- "resident consumed 0-25% of her evening meal...." 12/18/15 at 2:01 p.m.- (Written by LPN #1) "Resdient (sic) did not eat at am (morning) meal, kept pushing food out of her mouth. Resident did eat approx. (approximately) 50% of noon meal."</p>			

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	<p>12/18/14 at 10:06 p.m.- (Written by RN, Registered Nurse, #4) "Res. (resident) ate only a couple of bites at dinner. She pushes food out of her mouth and takes in very little."</p> <p>12/19/15 at 4:04 p.m.- (Written by LPN #1) "Resident ate approx 50% of am meal, at noon meal resident did not swallow any food writer put in her mouth, resident held head down and food slid out of mouth."</p> <p>12/19/15 at 10:16 p.m.- (Written by RN #4) "Res. had poor food consumption this shift. She ate only bites at dinner even with many attempts to get her to eat. Res. had some sips of liquid but only very little. Res. had a dry brief at the end of shift...Res. has poor skin turgor as evidenced by tenting (skin pinched up) of the hands and sternum greater than a (sic) 3 second return (amount of time it takes for skin to return to normal after being pinched up) (test for dehydration); fluids were offered and resident did not drink well...."</p> <p>12/20/15 at 2:26 a.m.- (Written by RN #5) "No food consumption on this shift. She did take sips of fluids this shift....She has poor skin turgor as evidenced by tenting of the hands and sternum greater than 3 seconds return...."</p> <p>12/20/15 at 12:52 p.m.- (Written by LPN #1) "REsident (sic) ate and swallowed a few bites for am meal, resident took and</p>			

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	<p>swallowed meds (medications), at noon meal resident opened mouth to take food but would not swallow the food, writer attempted to encourage resident to swallow but she did not, writer had to remove the food from residents mouth." 12/21/15 at 2:50 a.m.- (no progress note from 12:52 p.m. to this note) (Written by RN #6) "Refused intake this shift. No output...."</p> <p>12/21/15 at 2:39 p.m.- (Written by LPN #1) "REsident (sic) ate 3 bites including medication for am meal, after the first three bites, resident just held food in her mouth and would not swallow, any fluids attempted to be administered ran back out of her mouth. Resident ate two bites at noon meal and then would not swallow any more food, any fluids attempted to be administered ran back out of residents mouth."</p> <p>12/21/15 at 10:34 p.m.- (Written by RN #4) Two staff assisted resident with her dinner. One staff helped hold up resident's head while the other staff attempted to feed resident. Res. took only a few bites before the food began to fall back out of her mouth. Res. was given several spoons of liquid to encourage her to drink more fluids. Res. did swallow some. Mostly the liquids drained out of her mouth even with her head up. Res. had a wet brief after dinner and her skin turgor was less than 3 seconds on her</p>			

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	<p>hands and sternum. Res. sons (Son #1 and #2) were called to give them an update on how the resident was doing and to let them know she was not eating or drinking much. (Son #1's Name) phone would not accept calls. [Son #2's Name] phone was not answered and his mailbox was not set up. So neither son could be contacted. MD (Medical Doctor) was contacted just to give him report about the resident and situation. MD aware."</p> <p>12/22/15 at 4:33 a.m.- (Written by RN #5) "Resident took in sips of water and did void one time so far this shift...Skin turgor was less than 3 seconds on her hands and sternum...."</p> <p>12/22/15 at 11:15 a.m.- (Written by LPN #3) "Resident resting in bed at this time. Resident continues to not eat or drink fluids offered by staff at meal times. Resident was unable to take meds this AM and medications rolled out of mouth. MD called and informed of residents (sic) status. New orders received and noted to send to (Hospital Name) for evaluation and treatment. This nurse attempted to contact (Son #1 and #2's Name). (Son's #1's Name) number stated that it was unable to receive incoming calls and (Son #2's Name) number stated that there was no voicemail box set up."</p> <p>12/22/15 at 12:10 p.m.- "Resident left facility at this time in stable condition.</p>			

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	<p>Report called to (Hospital ER)." 12/22/15 at 12:19 p.m.- "Writer (Social Service Director) called and spoke with resident's POA (Power of Attorney) (Son #1) on the telephone to inform him that his mother will be transported to (Hospital Name). He was then transferred to the nurse for clinical information." 12/22/15 at 12:30 p.m.- (Written by LPN #3) "...This nurse writer gave son (Son #1) update on mothers (sic) condition...then asked son for direct phone number where he could be reached to be updated on mothers (sic) condition a the hospital but the son refused to give this nurse the number."</p> <p>The Weight and Vitals Summary in the record, indicated resident's weights were 12/02/15-147 pounds, 12/09/15-146.8 pounds, 12/16/15-144.6 pounds at the facility.</p> <p>The Emergency Room Admission Notes, dated 12/22/15 at 1:01 p.m. indicated the residents weight was 144 pounds.</p> <p>The Emergency Room Physician's Note, dated 12/22/15 at 1:01 p.m., indicated the resident had an associated diagnosis of dehydration and character symptoms were failure to thrive. The laboratory tests, dated 12/22/15 at 3:56 p.m., indicated the resident's white blood count</p>			

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	<p>was 14.9 (normal 4.8-10.8), urine was yellow and cloudy, negative for glucose (sugar), ketones (made when body breaks down fat for energy), and leukocytes (white blood cells). The resident's sodium was 181 (normal 135-147), potassium was 4.1 (normal 3.5-5), BUN (kidney function) 156 (normal 7-22), and Creatinine (kidney function) 3.6 (normal 0.4-1.5).</p> <p>The hospital History and Physical, dated 12/23/15, indicated the resident had severe hypernatremia (high sodium level), lethargy/metabolic encephalopathy (disease of the brain), severe dehydration/AKI (acute kidney injury) (kidney failure), and leukocytosis (elevated white blood cells). The plan indicated intravenous fluids, "do not want to lower the Na (sodium) to acutely (cerebral edema would be a concern)...."</p> <p>During an interview on 12/23/15 at 1 p.m., the Hospital Physician indicated the resident was very dehydrated upon admission to the ICU. He indicated this was due to not enough fluid intake.</p> <p>During an interview on 12/23/15 at 3:22 p.m., the Assistant Director of Nursing (ADoN) indicated the resident's Physician and POA should have been notified when the resident's food and</p>			

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	<p>fluid consumption had decreased and when the resident first started showing signs of dehydration.</p> <p>During an interview on 12/23/15 at 4:07 p.m., the Dietary Manager indicated the Registered Dietician saw the resident on 12/14/15, and the resident had received supplements which she had consumed.</p> <p>During an interview on 12/23/15 at 4:07 p.m., the ADoN indicated she was unsure why the resident's Physician and POA were not called when the resident had started to decline and exhibit symptoms of dehydration.</p> <p>During an interview on 12/28/15 at 8:26 a.m., LPN #1 indicated the first few days the resident was at the facility she ate well, then she started pushing the food out of her mouth and the last few days she was at the facility she would spit the food out or it would drool from her mouth. LPN #1 indicated no one had reported she wasn't eating. LPN #1 indicated the last week before she was sent out was when he found out the resident was not eating. LPN #1 indicated the Physician and/or POA had not been notified when he was aware the resident had not been eating or drinking well.</p>			

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	<p>During an interview on 12/28/15 at 9:28 a.m., Speech Therapist (ST) #2 indicated she had spoke with the nurse (LPN #3) when the resident was first declining and informed the nurse intake of food/fluid consumption would be needed and also to contact the family/POA to determine what they would like done and to explain the progression of the disease process. ST #2 indicated they always spoke to the nurse taking care of the resident so they could contact the family/POA and then contact the Physician.</p> <p>During an interview on 12/28/15 at 9:52 a.m., LPN #3 (ST spoke to) indicated she added the resident "to the board" so everyone would know they needed to document intakes. LPN #3 indicated ST said they would notify the family. LPN #3 indicated usually with a change in condition the Nurse would call the Physician and family/POA. LPN #3 indicated she had contacted the family on 12/22/15.</p> <p>During an interview on 12/28/15 at 10:24 a.m., the Dietary Manager indicated the resident was reviewed by the Nutrition at Risk (NAR) committee. A note received from the Dietary Manager, dated 12/18/15, indicated, the resident was starting to have a decrease in food/fluid consumption and to have the staff</p>			

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	<p>monitor and notify the family in a few days for their decision for either a feeding tube or for comfort measures.</p> <p>During an interview on 12/28/15 at 11:22 a.m., RN #4 indicated she had not initiated interventions for the decrease of food and fluid intake. She indicated she had not known if it was a change. She indicated she kept an eye on the resident. RN #4 indicated she had been informed by the past Director of Nursing (DoN) that if a resident was showing signs of dehydration, she no longer had to call the Physician and only document if the resident accepted or did not accept fluids. RN #4 indicated she was told the "State" doesn't require us to call the Physician. RN #4 indicated she had passed the information on to the next shift on 12/19/15 to ensure the staff attempted to give the resident fluids. RN #4 indicated when she worked on 12/21/15 she reported to the Social Service Director the resident was not eating or drinking enough and had attempted to notify the resident's family/POA and was unable to. RN #4 indicated she then notified the resident's Physician and informed the Physician the resident was not eating or drinking at all and the Physician indicated he would be in the building the next morning to see the resident.</p>			

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	<p>During an interview on 12/28/15 at 11:38 a.m., LPN #3 indicated the resident's Physician had not been in to see the resident prior to her being transferred to the hospital.</p> <p>A Hospital Physician's Progress Note, dated 12/28/15, indicated, "...Hypernatremia from severe water deficit-now better. Severe azotemia (elevated BUN and creatinine levels) and AKI (acute kidney injury) on admit from volume depletion...."</p> <p>A Hospital Physician's Progress Note, dated 12/29/15, indicated, "...Hypernatremia...AKI: improving; Likely prerenal azotemia and possible ATN (acute tubular necrosis) from poor oral intake...."</p> <p>An undated Facility Policy, titled, "Abuse Prevention Program," received from the Director of Nursing as current on 12/29/15 at 10 a.m., indicated, "...It is the policy of this facility to prevent resident abuse, neglect...On a regular basis, supervisors will monitor the ability of the staff to meet needs of residents, staff understanding of individual resident care needs and situations...Neglect/Mistreatment: means the failure to provide or willful withholding of adequate medical</p>			

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	<p>care...personal care or assistance with activities of daily living that is necessary to avoid physical harm...."</p> <p>The immediate jeopardy that began on 12/17/15 was removed on 12/31/15 when the facility reviewed all resident records to identify changes in condition and physician and family notifications. All residents' in the facility were assessed for changes in conditions and potential neglect. Facility Nurses' were inserviced on ensuring physician notification of any change in condition and neglect. All direct care staff were inserviced related to provision of care to residents and change in condition. The facility inserviced staff for neglect, physician notification, hydration, and nutrition. Staff were interviewed and were knowledgeable of the policies and protocols. An audit tool was reviewed to ensure physician and family notifications were being completed, but the noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility will continue to audit all residents with changes of condition and decreased food and fluid intakes to ensure the policies are followed and the residents are not neglected.</p>			

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F 0325 SS=G Bldg. 00	<p>This Federal Tag relates to Complaint IN00189580.</p> <p>3.1-27(a)(3)</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 record review and interview, the facility failed to ensure a resident maintained an acceptable nutritional status, related to a decrease in dietary intake with no new interventions initiated, which caused weight loss for 1</p>	F 0325	Chesterton Nursing Home respectfully requests a face to face IDR process to review the tags F157, F206, F224, F325, and F327, resulting from the complaint survey findings dated December 31, 2015, to introduce	01/01/2016

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	<p>of 4 residents reviewed for nutrition in a total sample of 5 and extended sample of 4. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 12/23/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, history of stroke, and anemia.</p> <p>An Admission Minimum Data Set assessment, dated 12/10/15, indicated the resident's cognition had not been assessed. The resident's decision making skills were severely impaired. The resident was dependent on staff for eating and all other activities of daily living. The resident did not have swallowing disorders.</p> <p>An undated dietary care plan, indicated the resident required a therapeutic diet with thickened fluids. The interventions included, provide diet/fluids as prescribed, supplements, record meal consumption and report signs and symptoms of swallowing problems.</p> <p>The Registered Dietitian's Full Assessment, dated 12/14/15, indicated the resident's caloric needs were 1670-2004 calories per day and an</p>		<p>new information. We feel we are able to show evidence to support deletion of the deficiencies. Therefore, we respectfully request the deletion of said deficiencies. The representative for Chesterton Manor Nursing Home is the Administrator Benjamin Gehrman. Ben can be contacted via e-mail: chesterton.admin@imgcares.com or U.S. mail at Chesterton Manor Nursing Home, 110 Beverly Drive, Chesterton, Indiana, 46304, or via phone- 219-926-8387. Chesterton Manor intends to have counsel present.</p> <p>F-325 Resident B discharged from the facility as the family elected to move her to another State. Residents with a significant weight loss or at high risk for weight loss according to this facility's policy will be included in the Nutrition at Risk (NAR) program and reviewed weekly until weight gain is noted or stabilized, unless otherwise ie. Unavoidable weight loss. The Registered Dietician will review residents with weight loss or at high risk for weight loss, weekly with the NAR team, the NAR team includes dietary, and recommend interventions which will be presented to the physician in a timely manner. Documentation of residents reviewed, recommendations, and progress will be kept by the NAR team (Monitoring System)</p>	

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	<p>estimated milliliters (ml) of fluid needs of 2004 ml daily. The resident had fair to poor meal intakes 25-50% for breakfast, 25-75% for lunch and 0-75% at supper. Supplements were in place and the resident would continue to be monitored for weights and status.</p> <p>The Medication Administration Record, dated 12/2015, indicated the resident was to receive a Magic Cup (nutritional supplement) with lunch and supper, Carnation Instant Breakfast 240 milliliters three times a day with meals, and four ounces of pudding at bedtime.</p> <p>The intake of the Magic Cup, at lunch, dated 12/17/15 and 12/18/15, was 25% and, 12/19/15 through 12/22/15, the resident had not consumed any of the Magic Cup. The intake at supper, indicated on 12/17/15 through 12/21/15 the resident had not consumed the Magic Cup.</p> <p>The Carnation Instant Breakfast intake was as follows: 12/17/15-60 milliliters (ml) for breakfast and lunch and 10 ml for supper 12/18/15-60 ml for breakfast and lunch and 80 ml for supper 12/19/15-60 ml for breakfast, 20 ml for lunch, and 20 ml for supper 12/20/15-50 ml breakfast, sips for lunch</p>		<p>Chesterton Manor has policy on Acute Hydration and Nutritional Supplement in which nursing staff has been educated. Assessments are initiated upon admission, quarterly, and with a change of condition. New Admissions and Changes of Condition are monitored daily via the 24 hour report sheet and signed by the DON or designee</p>	

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	<p>and supper 12/21/15-50 ml breakfast and sips for lunch and supper 12/22/15-none was taken for breakfast</p> <p>The four ounces of pudding was not consumed at bedtime from 12/16/15 through 12/21/15.</p> <p>The Dietary Consumption Records, dated 12/2/15 through 12/14/15, indicated the average intake for breakfast (B) was 26-50%, lunch (L) was 26-50%, and supper (S) was 26-75%.</p> <p>The Dietary Consumption Records, dated 12/15/15 through 12/22/15, indicated the following intakes of food: 12/15/15-(B) 51-75%, (L) 26-50%, (S) 51-75% 12/16/15-(B) 0-25%, (L) 0-25%, (S) 0-25% 12/17/15-(B) 0-25%, (L) 0-25%, (S) 0-25% 12/18/15-(B) refused, (L) 0-25%, (S) 0-25% 12/19/15-(B) 0-25%, (L) 0-25%, (S) 0-25% 12/20/15- (B) 0-25%, (L) 51-75%, (S) 0-25% 12/21/15- (B) 0-25%, (L) 0-25%, (S) 0-25% 12/22/15- (B) refused</p>			

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	<p>A Speech Therapy Note, dated 12/15/15, indicated, "...Dietary spoke with therapist today regarding patient's progress with current diet...Therapist also informed dietary that amount consumed by patient is decreased d/t (due to) difficulty initiating swallow...which creates concern for patient meeting daily nutritional/hydration needs."</p> <p>A Speech Therapy Note, dated 12/17/15, indicated, "Therapist education to LPN (Licensed Practical Nurse) as patient was placed in a semi laying position in an attempt to feed her. This was being done to prevent anterior spillage to increase intake. Unfortunately, irregardless of position, the patient was unable to consume an adequate amount of food for nutrition/hydration. Consulted with nursing on feeding techniques including the possible use of a controlled bolus via a syringe. Nursing to track intake for the next 4 days and will speak with family about alternative feeding if patient continues to display an inability to swallow sufficiently to maintain weight and hydration...This appears to be related to an overall decline in medical status related to advancing dementia."</p> <p>The Nurses' Progress Notes indicated: 12/17/15 at 7:54 p.m.- "resident consumed 0-25% of her evening meal...."</p>			

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	<p>12/18/15 at 2:01 p.m.- (Written by LPN #1) "Resdient (sic) did not eat at am (morning) meal, kept pushing food out of her mouth. Resident did eat approx. (approximately) 50% of noon meal."</p> <p>12/18/14 at 10:06 p.m.- (Written by RN, Registered Nurse, #4) "Res. (resident) ate only a couple of bites at dinner. She pushes food out of her mouth and takes in very little."</p> <p>12/19/15 at 4:04 p.m.- (Written by LPN #1) "Resident ate approx 50% of am meal, at noon meal resident did not swallow any food writer put in her mouth, resident held head down and food slid out of mouth."</p> <p>12/19/15 at 10:16 p.m.- (Written by RN #4) "Res. had poor food consumption this shift. She ate only bites at dinner even with many attempts to get her to eat. Res. had some sips of liquid but only very little..."</p> <p>12/20/15 at 2:26 a.m.- (Written by RN #5) "No food consumption on this shift..."</p> <p>12/20/15 at 12:52 p.m.- (Written by LPN #1) "REsident (sic) ate and swallowed a few bites for am meal, resident took and swallowed meds (medications), at noon meal resident opened mouth to take food but would not swallow the food, writer attempted to encourage resident to swallow but she did not, writer had to remove the food from residents mouth."</p>			

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	<p>12/21/15 at 2:50 a.m.- (no progress note from 12:52 p.m. to this note) (Written by RN #6) "Refused intake this shift..."</p> <p>12/21/15 at 2:39 p.m.- (Written by LPN #1) "REsident (sic) ate 3 bites including medication for am meal, after the first three bites, resident just held food in her mouth and would not swallow, any fluids attempted to be administered ran back out of her mouth. Resident ate two bites at noon meal and then would not swallow any more food, any fluids attempted to be administered ran back out of residents mouth."</p> <p>12/21/15 at 10:34 p.m.- (Written by RN #4) Two staff assisted resident with her dinner. One staff helped hold up resident's head while the other staff attempted to feed resident. Res. took only a few bites before the food began to fall back out of her mouth. Res. was given several spoons of liquid to encourage her to drink more fluids. Res. did swallow some. Mostly the liquids drained out of her mouth even with her head up...Res. sons were called to give them an update on how the resident was doing and to let them know she was not eating or drinking much. (Son #1's Name) phone would not accept calls. (Son #2's Name) phone was not answered and his mailbox was not set up. So neither son could be contacted. MD (Medical Doctor) was contacted just to give him report about</p>			

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	<p>the resident and situation. MD aware." 12/22/15 at 11:15 a.m.- (Written by LPN #3) "Resident resting in bed at this time. Resident continues to not eat or drink fluids offered by staff at meal times...MD called and informed of residents (sic) status. New orders received and noted to send to [Hospital Name] for evaluation and treatment..."</p> <p>The Weight and Vitals Summary in the record, indicated resident's weights were 12/02/15-147 pounds, 12/09/15-146.8 pounds, 12/16/15-144.6 pounds at the facility.</p> <p>The Emergency Room Admission Notes, dated 12/22/15 at 1:01 p.m. indicated the residents weight was 144 pounds.</p> <p>The Emergency Room Physician's Note, dated 12/22/15 at 1:01 p.m., indicated the resident had an associated diagnosis of dehydration and character symptoms were failure to thrive. The laboratory tests, dated 12/22/15 at 3:56 p.m., indicated the resident's albumin (protein in the blood) was 3.0 (normal 3.2-4.5).</p> <p>During an interview on 12/23/15 at 3:22 p.m., the Assistant Director of Nursing (ADoN) indicated the resident's Physician and POA should have been notified when the resident's food and</p>			

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	<p>fluid consumption had decreased.</p> <p>During an interview on 12/23/15 at 4:07 p.m., the Dietary Manager indicated the Registered Dietician saw the resident on 12/14/15, and the resident had received supplements which she had consumed.</p> <p>During an interview on 12/28/15 at 8:26 a.m., LPN #1 indicated the first few days the resident was at the facility she ate well, then she started pushing the food out of her mouth and the last few days she was at the facility she would spit the food out or it would drool from her mouth. LPN #1 indicated no one had reported she wasn't eating. LPN #1 indicated the last week before she was sent out was when he found out the resident was not eating. LPN #1 indicated the Physician and/or POA had not been notified when he was aware the resident had not been eating or drinking well.</p> <p>During an interview on 12/28/15 at 9:28 a.m., Speech Therapist (ST) #2 indicated she had spoke with the nurse (LPN #3) when the resident was first declining and informed the nurse intake of food/fluid consumption would be needed and also to contact the family/POA to determine what they would like done and to explain the progression of the disease process.</p>			

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	<p>ST #2 indicated they always spoke to the nurse taking care of the resident so they could contact the family/POA and then contact the Physician.</p> <p>During an interview on 12/28/15 at 9:52 a.m., LPN #3 indicated she added the resident "to the board" so everyone would know they needed to document intakes. LPN #3 indicated ST said they would notify the family.</p> <p>During an interview on 12/28/15 at 10:24 a.m., the Dietary Manager indicated the resident was reviewed by the Nutrition at Risk (NAR) committee. A note received from the Dietary Manager, dated 12/18/15, indicated, the resident was starting to have a decrease in food/fluid consumption and to have the staff monitor and notify the family in a few days for their decision for either a feeding tube or for comfort measures.</p> <p>During an interview on 12/28/15 at 11:22 a.m., RN #4 indicated she had not initiated interventions for the decrease of food and fluid intake. She indicated she had not known if it was a change. She indicated she kept an eye on the resident. RN #4 indicated when she worked on 12/21/15 she reported to the Social Service Director the resident was not eating or drinking enough and had</p>			

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	<p>attempted to notify the resident's family/POA and was unable to. RN #4 indicated she then notified the resident's Physician and informed the Physician the resident was not eating or drinking at all and the Physician indicated he would be in the building the next morning to see the resident.</p> <p>A Hospital Physician's Progress Note, dated 12/29/15, indicated, "...Hypernatremia (high sodium)...AKI (acute kidney injury): improving; Likely prerenal azotemia (elevated blood urea nitrogen and serum creatinine levels) and possible ATN (acute tubular necrosis) from poor oral intake...."</p> <p>A facility policy, dated 05/2011, titled, "Nutritional Supplements", received from the Director of Nursing as current, indicated, "...The following are examples of conditions/symptoms that may necessitate placing the resident on the NAR (Nutrition at Risk) program:...Residents who consume less than 50% of food served for 1 week...These residents and overall consumption of meals as well as nutritional supplements will be reviewed no less than bi-weekly during the facility's interdisciplinary NAR review meeting. 6. If a resident is not consuming the nutritional supplement or has poor</p>			

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F 0327 SS=J Bldg. 00	<p>tolerance to the product this will be reviewed and an alternative product will be provided..."</p> <p>This Federal Tag relates to Complaint IN00189580.</p> <p>3.1-46(a)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview, the facility failed to ensure a resident's fluid intake was sufficient to maintain proper hydration, related to a resident's decreased fluid intake and facility did not implement new interventions to increase the resident's fluid intake and did not</p>	F 0327	Chesterton Nursing Home respectfully requests a face to face IDR process to review the tags F157, F206, F224, F325, and F327, resulting from the complaint survey findings dated December 31, 2015, to introduce new information. We feel we are able to show evidence to support	01/01/2016

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	<p>notifying the resident's Physician of the decreased intakes. The resident was transferred and admitted into the hospital with a diagnosis of severe dehydration and acute renal injury (failure) for 1 of 7 residents reviewed for decreased fluid intake in a total sample of 5 and extended sample of 4. (Resident #B)</p> <p>The Immediate Jeopardy began on 12/17/15 when the resident had increased swallowing problems and fluid intake decreased. The resident exhibited signs of dehydration (poor skin turgor and decreased output) on 12/19/15, 3 days prior to the resident's Physician being notified of the signs and symptoms of the dehydration and 5 days prior to the resident being transferred to the Emergency Room. The resident was admitted into the Intensive Care Unit at the hospital with diagnoses of, but not limited to, severe dehydration, acute kidney injury and severe hypernatremia (critically high sodium level). The Administrator and Director of Nursing (DoN) were notified of the Immediate Jeopardy on 12/30/15 at 3:28 p.m.</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 12/23/15 at 2:00 p.m. The resident's diagnoses included, but were not limited</p>		<p>deletion of the deficiencies. Therefore, we respectfully request the deletion of said deficiencies. The representative for Chesterton Manor Nursing Home is the Administrator Benjamin Gehrman. Ben can be contacted via e-mail: chesterton.admin@imgcares.com or U.S. mail at Chesterton Manor Nursing Home, 110 Beverly Drive, Chesterton, Indiana, 46304, or via phone- 219-926-8387. Chesterton Manor intends to have counsel present.</p> <p>F-327 Resident B discharged from the facility as the family elected to move her to another State. Facility Nurses' were inserviced on ensuring physician notification for residents exhibiting signs and symptoms of dehydration and decreased fluid intake. All direct care staff were inserviced related to provision of care. The facility inserviced staff for physician notification and hydration. Nursing Administration or designee, will be making rounds through out the facility a minimum of daily to assure that the resident's needs are being met and that acceptable care is being provided. To assure ice water and other beverages are being provided an audit tool will be use to monitor 10 people daily x 4 weeks, then 3 x weekly x 1 month. This tool will be reviewed as part of the QA process with additional recommendations as</p>	

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	<p>to, dementia, history of stroke, and anemia.</p> <p>The resident had a "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order," signed by the HCR (Health Care Representative) on 03/05/14, which indicated the resident chose not to have cardiopulmonary resuscitation administered. The Advance Directive Information, signed by the HCR on 10/19/12, indicated the resident did not have a Living Will.</p> <p>An Admission Minimum Data Set assessment, dated 12/10/15, indicated the resident's cognition had not been assessed. The resident's decision making skills were severely impaired. The resident was dependent on staff for eating and all other activities of daily living. The resident did not have swallowing disorders.</p> <p>A Dehydration Assessment, dated 12/01/15, indicated the resident was at risk for dehydration with a score of 12 (higher than 10 at risk) and had swallowing difficulty, required assistance with food and fluids, Received thickened liquids, and was unable to ask for fluids.</p> <p>A care plan, dated 12/17/15, indicated the resident was a risk for dehydration</p>		needed based on the outcome of the tool.	

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	<p>related to a poor oral intake. The goal indicated the resident would exhibit no signs and symptoms of dehydration. The interventions included, "Encourage to consume all fluids offered at mealtime...Observe for s/sx [signs and symptoms] dehydration (i.e. (example): dry oral mucosa/lips, skin tenting, dark/foul smelling urine), Offer and encourage between meal fluid consumption...."</p> <p>An undated dietary care plan, indicated the resident required a therapeutic diet with thickened fluids. The interventions included, provide diet/fluids as prescribed, supplements, record meal consumption and report signs and symptoms of swallowing problems.</p> <p>The Registered Dietitian's Full Assessment, dated 12/14/15, indicated the resident's estimated milliliters (ml) of fluid needs of 2004 ml daily.</p> <p>The Medication Administration Record, dated 12/2015, indicated the resident was to receive Carnation Instant Breakfast 240 milliliters three times a day with meals, and four ounces of pudding at bedtime.</p> <p>The Carnation Instant Breakfast intake was as follows:</p>			

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	<p>12/17/15-60 milliliters (ml) for breakfast and lunch and 10 ml for supper 12/18/15-60 ml for breakfast and lunch and 80 ml for supper 12/19/15-60 ml for breakfast, 20 ml for lunch, and 20 ml for supper 12/20/15-50 ml breakfast, sips for lunch and supper 12/21/15-50 ml breakfast and sips for lunch and supper 12/22/15-none was taken for breakfast</p> <p>The four ounces of pudding was not consumed at bedtime from 12/16/15 through 12/21/15.</p> <p>The Dietary Consumption Records, dated 12/15/15 through 12/22/15, indicated the following intakes of food: 12/15/15-(B) 51-75%, (L) 26-50%, (S) 51-75% 12/16/15-(B) 0-25%, (L) 0-25%, (S) 0-25% 12/17/15-(B) 0-25%, (L) 0-25%, (S) 0-25% 12/18/15-(B) refused, (L) 0-25%, (S) 0-25% 12/19/15-(B) 0-25%, (L) 0-25%, (S) 0-25% 12/20/15- (B) 0-25%, (L) 51-75%, (S) 0-25% 12/21/15- (B) 0-25%, (L) 0-25%, (S) 0-25% 12/22/15- (B) refused</p>			

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	<p>The fluid intakes for December 2015, indicated the following milliliters per day:</p> <p>12/4/15- 240 12/6/15- 240 12/10/15- 840 12/11/15- 720 12/12/15- 960 12/13/15- 690 12/14/15- 570 12/15/15-1080 12/16/15- 480 12/17/15- 360 12/18/15- 135 12/19/15- 360 12/20/15- 360 12/21/15- 240</p> <p>A Speech Therapy Note, dated 12/15/15, indicated, "...Dietary spoke with therapist today regarding patient's progress with current diet...Therapist also informed dietary that amount consumed by patient is decreased d/t (due to) difficulty initiating swallow...which creates concern for patient meeting daily nutritional/hydration needs."</p> <p>A Speech Therapy Note, dated 12/17/15, indicated, "Therapist education to LPN (Licensed Practical Nurse) (LPN #3) as patient was placed in a semi laying position in an attempt to feed her. This</p>			

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	<p>was being done to prevent anterior spillage to increase intake. Unfortunately, irregardless of position, the patient was unable to consume an adequate amount of food for nutrition/hydration. Consulted with nursing on feeding techniques including the possible use of a controlled bolus via a syringe. Nursing to track intake for the next 4 days and will speak with family about alternative feeding if patient continues to display an inability to swallow sufficiently to maintain weight and hydration...This appears to be related to an overall decline in medical status related to advancing dementia."</p> <p>The Nurses' Progress Notes indicated: 12/17/15 at 7:54 p.m.- "resident consumed 0-25% of her evening meal...." 12/18/15 at 2:01 p.m.- (Written by LPN #1) "Resdient (sic) did not eat at am (morning) meal, kept pushing food out of her mouth. Resident did eat approx. (approximately) 50% of noon meal." 12/18/14 at 10:06 p.m.- (Written by RN, Registered Nurse, #4) "Res. (resident) ate only a couple of bites at dinner. She pushes food out of her mouth and takes in very little." 12/19/15 at 4:04 p.m.- (Written by LPN #1) "Resident ate approx 50% of am meal, at noon meal resident did not swallow any food writer put in her</p>			

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	<p>mouth, resident held head down and food slid out of mouth." 12/19/15 at 10:16 p.m.- (Written by RN #4) "Res. had poor food consumption this shift. She ate only bites at dinner even with many attempts to get her to eat. Res. had some sips of liquid but only very little. Res. had a dry brief at the end of shift...Res. has poor skin turgor as evidenced by tenting [skin pinched up] of the hands and sternum greater than a (sic) 3 second return (amount of time it takes for skin to return to normal after being pinched up) (test for dehydration); fluids were offered and resident did not drink well..."</p> <p>12/20/15 at 2:26 a.m.- (Written by RN #5) "No food consumption on this shift. She did take sips of fluids this shift....She has poor skin turgor as evidenced by tenting of the hands and sternum greater than 3 seconds return...."</p> <p>12/20/15 at 12:52 p.m.- (Written by LPN #1) "REsident (sic) ate and swallowed a few bites for am meal, resident took and swallowed meds (medications), at noon meal resident opened mouth to take food but would not swallow the food, writer attempted to encourage resident to swallow but she did not, writer had to remove the food from residents mouth." 12/21/15 at 2:50 a.m.- (no progress note from 12:52 p.m. to this note) (Written by RN #6) "Refused intake this shift. No</p>			

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	<p>output..."</p> <p>12/21/15 at 2:39 p.m.- (Written by LPN #1) "REsident (sic) ate 3 bites including medication for am meal, after the first three bites, resident just held food in her mouth and would not swallow, any fluids attempted to be administered ran back out of her mouth. Resident ate two bites at noon meal and then would not swallow any more food, any fluids attempted to be administered ran back out of residents mouth."</p> <p>12/21/15 at 10:34 p.m.- (Written by RN #4) Two staff assisted resident with her dinner. One staff helped hold up resident's head while the other staff attempted to feed resident. Res. took only a few bites before the food began to fall back out of her mouth. Res. was given several spoons of liquid to encourage her to drink more fluids. Res. did swallow some. Mostly the liquids drained out of her mouth even with her head up. Res. had a wet brief after dinner and her skin turgor was less than 3 seconds on her hands and sternum...MD (Medical Doctor) was contacted just to give him report about the resident and situation. MD aware."</p> <p>12/22/15 at 4:33 a.m.- (Written by RN #5) "Resident took in sips of water and did void one time so far this shift...Skin turgor was less than 3 seconds on her hands and sternum...."</p>			

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	<p>12/22/15 at 11:15 a.m.- (Written by LPN #3) "Resident resting in bed at this time. Resident continues to not eat or drink fluids offered by staff at meal times. Resident was unable to take meds this AM and medications rolled out of mouth. MD called and informed of residents (sic) status. New orders received and noted to send to (Hospital Name) for evaluation and treatment..."</p> <p>12/22/15 at 12:10 p.m.- "Resident left facility at this time in stable condition. Report called to (Hospital ER)."</p> <p>The Emergency Room Physician's Note, dated 12/22/15 at 1:01 p.m., indicated the resident had an associated diagnosis of dehydration and character symptoms were failure to thrive. The laboratory tests, dated 12/22/15 at 3:56 p.m., indicated the resident's white blood count was 14.9 (normal 4.8-10.8), urine was yellow and cloudy, negative for glucose (sugar), ketones (made when body breaks down fat for energy), and leukocytes (white blood cells). The resident's sodium was 181 (normal 135-147), potassium was 4.1 (normal 3.5-5), BUN (kidney function) 156 (normal 7-22), and Creatinine (kidney function) 3.6 (normal 0.4-1.5).</p> <p>The hospital History and Physical, dated 12/23/15, indicated the resident had</p>			

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	<p>severe hypernatremia (elevated sodium), lethargy/metabolic encephalopathy (disease of the brain), severe dehydration/AKI (acute kidney injury) (kidney failure), and leukocytosis (elevated white cells). The plan indicated intravenous fluids, "do not want to lower the Na (sodium) to acutely (cerebral edema would be a concern)...."</p> <p>During an interview on 12/23/15 at 1 p.m., the Hospital Physician indicated the resident was very dehydrated upon admission to the ICU. He indicated this was due to not enough fluid intake.</p> <p>During an interview on 12/23/15 at 3:22 p.m., the Assistant Director of Nursing (ADoN) indicated the resident's Physician and POA should have been notified when the resident's food and fluid consumption had decreased and when the resident first started showing signs of dehydration.</p> <p>During an interview on 12/23/15 at 4:07 p.m., the Dietary Manager indicated the Registered Dietician saw the resident on 12/14/15, and the resident had received supplements which she had consumed.</p> <p>During an interview on 12/23/15 at 4:07 p.m., the ADoN indicated she was unsure why the resident's Physician and POA</p>			

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	<p>were not called when the resident had started to decline and exhibited symptoms of dehydration.</p> <p>During an interview on 12/28/15 at 8:26 a.m., LPN #1 indicated the first few days the resident was at the facility she ate well, then she started pushing the food out of her mouth and the last few days she was at the facility she would spit the food out or it would drool from her mouth. LPN #1 indicated no one had reported she wasn't eating. LPN #1 indicated the last week before she was sent out was when he found out the resident was not eating. LPN #1 indicated the Physician and/or POA had not been notified when he was aware the resident had not been eating or drinking well.</p> <p>During an interview on 12/28/15 at 9:28 a.m., Speech Therapist (ST) #2 indicated she had spoke with the nurse (LPN #3) when the resident was first declining and informed the nurse intake of food/fluid consumption would be needed and also to contact the family/POA to determine what they would like done and to explain the progression of the disease process. ST #2 indicated they always spoke to the nurse taking care of the resident, so they can contact the family/POA and then contact the Physician.</p>			

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	<p>During an interview on 12/28/15 at 9:52 a.m., LPN #3 indicated she added the resident "to the board" so everyone would know they needed to document intakes. LPN #3 indicated ST said they would notify the family. LPN #3 indicated usually with a change in condition the Nurse would call the Physician and family/POA. LPN #3 indicated she had contacted the family on 12/22/15.</p> <p>During an interview on 12/28/15 at 10:24 a.m., the Dietary Manager indicated the resident was reviewed by the Nutrition at Risk (NAR) committee. A note received from the Dietary Manager, dated 12/18/15, indicated, the resident was starting to have a decrease in food/fluid consumption and to have the staff monitor and notify the family in a few days for their decision for either a feeding tube or for comfort measures.</p> <p>During an interview on 12/28/15 at 11:22 a.m., RN #4 indicated she had not initiated interventions for the decrease of food and fluid intake. She indicated she had not known if it was a change. She indicated she kept an eye on the resident. RN #4 indicated she had been informed by the past Director of Nursing (DoN) that if a resident was showing signs of dehydration, she no longer had to call the</p>			

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	<p>Physician and only document if the resident accepted or did not accept fluids. RN #4 indicated she was told the "State" doesn't require us to call the Physician. RN #4 indicated she had passed the information on to the next shift on 12/19/15 to ensure the staff attempted to give the resident fluids. RN #4 indicated when she worked on 12/21/15 she reported to the Social Service Director the resident was not eating or drinking enough and had attempted to notify the resident's family/POA and was unable to. RN #4 indicated she then notified the resident's Physician and informed the Physician the resident was not eating or drinking at all and the Physician indicated he would be in the building the next morning to see the resident.</p> <p>During an interview on 12/28/15 at 11:38 a.m., LPN #3 indicated the resident's Physician had not been in to see the resident prior to her being transferred to the hospital.</p> <p>A Hospital Physician's Progress Note, dated 12/28/15, indicated, "...Hypernatremia (elevated sodium) from severe water deficit-now better. Severe azotemia [elevated BUN and creatinine levels] and AKI [acute kidney injury] on admit from volume depletion...."</p>			

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	<p>A Hospital Physician's Progress Note, dated 12/29/15, indicated, "...Hypernatremia...AKI: improving; Likely prerenal azotemia and possible ATN (acute tubular necrosis) from poor oral intake...."</p> <p>A facility policy, dated 10/2012, titled, "Acute Hydration at Risk", received from the Director of Nursing as current, indicated, "To assure each resident receives adequate fluids to prevent dehydration to the extent the resident's condition makes this possible...Each resident shall be assessed for risk factors for dehydration within 72 hours of admission...A resident shall be deemed 'Hydration at Risk' under the following conditions:...Acute decline in fluid intake that lasts > (over) 48 hours. d. Presentation of signs/symptoms of dehydration...The Hydration at Risk/Nutrition at Risk committee will meet weekly and review those residents designated 'Hydration at Risk' for response to the developed Hydration at Risk plan of care..."</p> <p>The immediate jeopardy that began on 12/17/15 was removed on 12/31/15 when the facility reviewed all resident records to identify residents at risk for dehydration. All residents' in the facility were assessed for dehydration. Facility</p>			

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	<p>Nurses' were inserviced on ensuring physician notification for residents exhibiting signs and symptoms of dehydration and decreased fluid intake. All direct care staff were inserviced related to provision of care. The facility inserviced staff for physician notification and hydration. Staff were interviewed and were knowledgeable of the policies and protocols. The Nurses are to make rounds at least daily to ensure residents needs are being met and an audit tool will be utilized to assure services to are being provided, but the noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility will continue to audit all residents with changes of condition and decreased food and fluid intakes and to ensure the policies are followed and the residents at risk for dehydration are treated with sufficient fluid intake to prevent dehydration.</p> <p>This Federal Tag relates to Complaint IN00189580.</p> <p>3.1-27(a)(3)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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