

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/19/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 13, 14, 15, 16 and 19, 2015</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census payor type: Medicare: 2 Medicaid: 53 Other: 5 Total: 60</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on October 26, 2015.</p>	F 0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies</p>	
F 0241 SS=D	483.15(a) DIGNITY AND RESPECT OF			

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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Bldg. 00	<p>INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to provide care for a resident to enhance dignity, related to failing to assist a dependent resident to the bathroom upon request during lunch. (Resident # 6)</p> <p>Findings include:</p> <p>During a continuous observation on 10/16/15 from 11:59 a.m. until 12:21 p.m. in the doorway of the East Dining Room, the following was observed:</p> <p>At 11:59 a.m. Resident #6 was seated in her wheelchair in the East Dining Room at the table calling out "help me, help me-someone help me, I have to go to the bathroom." At that time, Activities #1 was present in the dining room and went and spoke to the resident. The resident indicated she had to use the bathroom. At that time, Activities #1 spoke to CNA #1 and indicated Resident #6 had to use the bathroom.</p> <p>At 12:01 p.m. CNA #1 stated she was going to the main dining room and left the floor. CNA #1 did not take Resident</p>	F 0241	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #6 was provided check and change of brief immediately after lunch meal due to preferring to wait until meal was completed. She was offered a bed pan as well and she refused. CNA #1, #2, #6, SDC, ADON and LPN #1 interviewed and then educated / disciplined on 10/16/15 by Tami Adams Executive Director regarding Dignity, Resident Rights and Abuse and Neglect. 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:</p> <p>A facility audit related to assistance for toileting during meal times was completed on 10/16/2015 and 10/19/2015 Dee Dee Colvin RN and Sabra Coons RN and no other resident was affected by the deficient practice.</p>	11/18/2015
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	<p>#6 to the bathroom.</p> <p>Also at 12:01 p.m. CNA #2 delivered a food cart and left the dining room, while Resident #6 had called out "help me, help me."</p> <p>During an interview at 12:02 p.m. with Activities #1, she indicated the CNA was notified that the resident needed to use the bathroom.</p> <p>At 12:03 p.m., CNA #2 walked in and out of the dining room and then went with CNA #3 down the hall to another resident's room. Resident #6 had called out continuously "help me, help me, I need to go to the bathroom."</p> <p>At 12:06 p.m., the SDC (Staff Development Coordinator) had passed out food trays, and at that time, Resident #6 indicated to the SDC she had to use the bathroom. The SDC walked away to another resident and did not assist her to the bathroom.</p> <p>At 12:08 p.m., Resident #6 called out again, "please help me," while the ADON (Assistant Director of Nursing) passed out a food tray at another table.</p> <p>At 12:09 p.m., CNA #2 walked behind Resident #6 and past her while the</p>		<p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:</p> <p>Staff was in-serviced on 10/23/15 by Social Service Director regarding Resident Rights and dignity, Abuse and Neglect.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Director of Nursing / designee will audit the 10 resident/staff interactions though out the facility on all 3 shifts randomly 7 x week for 4 weeks then 3 x a week for 4 weeks then weekly to complete 6 months at various meals to ensure that dependent residents are receiving dignity with all areas of care. 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 necessary. QA committee will determine after 6 months if further auditing in necessary.</p>	

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	<p>resident was calling out "help me, I have to go to the bathroom."</p> <p>At 12:10 p.m., Resident #6 still called out for help to use the bathroom, at that same time the SDC was at Resident #6's table, talking to another resident.</p> <p>At 12:17 p.m., Resident #6 called out for help to use the bathroom, as LPN #1 served the resident her lunch tray. LPN #1 did not take the resident to the bathroom.</p> <p>At 12:21 p.m. the resident fed herself lunch.</p> <p>Interview at 12:23 p.m. with Activities #1, indicated she was told by CNA #1 the resident could just go in the pad that was underneath her.</p> <p>Interview at 12:25 p.m. with CNA #1, indicated staff was to distract the resident when asking to use the bathroom, she can go in her brief. The resident was a Hoyer lift and can use the bathroom. CNA #1 further indicated, she (the resident) always says she needs to use the bathroom and then she does not urinate.</p> <p>Interview at 12:29 p.m. with the DON (Director of Nursing) indicated, Resident #6 used a bed pan, was incontinent of</p>			

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	<p>urine and had a care plan for urinary incontinence. The DON further indicated, the CNA should have taken the resident to the bathroom.</p> <p>Interview at 12:32 p.m. with the ADON, indicated she did not hear the resident calling out while the other residents were assisted with their food trays.</p> <p>During an observation and interview on 10/16/15 at 12:48 p.m. with CNA #5 indicated, Resident #6 was a check and change every 2 hours, and the resident was changed an hour before lunch due to the resident had a wet brief and had a bowl movement. CNA #6 and CNA #5, changed resident's brief and provided peri-care. Both CNA's agreed the resident's brief was 50% saturated with urine and the resident had a small bowl movement. The resident indicated at that time, "I don't think I made it." CNA offered bed pad, resident declined.</p> <p>Resident #6's record was reviewed on 10/19/15 at 3:30 p.m. and indicated, the last MDS (Minimum Data Set) assessment on 8/25/15 was a significant change. The resident was cognitively impaired, always incontinent of bowel and bladder, and an extensive, 2 person assist with toileting.</p>			

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F 0278 SS=D Bldg. 00	<p>3.1-3(t)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to accurately document resident medications on the MDS (Minimum Data Set) assessments for 2 of</p>	F 0278	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 3 and #</p>	11/18/2015

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	<p>5 residents reviewed for Unnecessary Medications of the 5 who met the criteria for Unnecessary Medications. (Residents #42 and #3)</p> <p>Findings include:</p> <p>1. Resident #42's record was reviewed on 10/15/15 at 2:49 p.m. Diagnoses included, but were not limited to, hemiplegia, atrial fibrillation, vascular dementia, diabetes mellitus, cerebrovascular disease, and dementia with behavioral disturbance.</p> <p>Review of the Quarterly MDS dated 7/25/15 indicated the resident was severely cognitively impaired. Documentation indicated Resident #42 received an antipsychotic medication on 7 of the past 7 days and an antidepressant medication on 7 of the last 7 days. The MDS did not indicate the resident had received an anticoagulant (blood thinning) medication.</p> <p>Review of the July 2015 MAR (Medication Administration Record) indicated Resident #42 received Xarelto (an anticoagulant medication) daily in July 2015.</p> <p>Interview on 10/16/15 at 2:34 p.m. with the MDS Coordinator, indicated the lack</p>		<p>42 MDS assessments were modified on 10/21/15 and transmitted on 11/2/15 by Michelle Correy LPN to include the omitted antidepressant and anticoagulant medication. 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: A full facility audit for the preceding 6 months for all current residents on antidepressants and anticoagulants was completed on 11/6/2015 by Dee Dee Colvin RN and Sabra Coons RN to ensure that all current MDS's were accurately coded for section N. A full facility audit will be done for the preceding 6 months on all MDS's completed to ensure that all sections are accurately coded. Facility will audit the preceding 6 months of MDS's starting with ARD date of June 1, 2015 by auditing 10 MDS's a week starting on Monday November 16, 2016 and completing audit by February 16, 2016. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: MDS Coordinator was in-serviced on 11/3/2015 by the Regional Clinical Reimbursement Specialist Lisa Chubb RN on accurate coding of section N and G of the MDS to ensure accurate coding of</p>		

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	<p>of documentation of anticoagulant use on the most recent MDS was a coding error and should have been marked as received for 7 of the last 7 days.</p> <p>2. The record for Resident #3 was reviewed on 10/14/15 3:26 p.m. The resident's diagnoses included, but were not limited to bipolar, dementia, CHF (Congestive Heart Failure), CAD (Coronary Artery Disease), and HTN (high blood pressure). The resident's readmission date into the facility was 11/18/14.</p> <p>The Annual MDS (Minimum Data Set) assessment on 8/23/15 lacked documentation that the resident received antidepressant (mood enhancer) and anticoagulant (blood thinner) medications in the last 7 days.</p> <p>The August MAR (Medication Administration Record) 2015 indicated Resident #3 received and given as ordered, bupropion hcl (hydrogen chloride) SR (sustained release) 150 mg (milligrams) tablet, (a medication classified as an antidepressant) 1 tab PO (by mouth) daily for bipolar disorder. The start date for the bupropion was 11/19/14. The August MAR also indicated Eliquis (a blood thinner) 2.5 mg tablet BID (twice a day) was received and given as ordered for the diagnosis of</p>		<p>anticoagulants and antidepressants. Regional Clinical Reimbursement Specialist Lisa Chubb RN will in-service MDS Coordinator on accurate coding of all sections of the MDS on 11-16-15 . How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Director of Nursing / RN Coordinator will audit 5 MDS's weekly prior to signing for accurate coding of the completed MDS 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 necessary. QA committee will determine after 6 months if further auditing is necessary.</p>	

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F 0282 SS=E Bldg. 00	<p>Coronary arteriosclerosis (hardening of the heart arteries). The start date of the Eliquis was not indicated on the August MAR.</p> <p>The POS (Physician Order Summary) for October 2015 indicated the start date for Eliquis was 7/8/15 and bupropion was 11/19/14.</p> <p>Interview with the MDS Coordinator on 10/16/15 at 2:34 p.m. indicated the MDS assessment on 8/23/15 was a coding error, the medications classified as an antidepressant and an anticoagulant should have been marked.</p> <p>3.1-31(d)</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to follow the plan of care related to the lack of an assessment and monitoring of a discoloration, a dialysis fistula assessment, and nutritional monitoring for 4 of 17 residents whose plans of care</p>	F 0282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #35 was assessed by nurse on 10/14/15 and discoloration was addressed</p>	11/18/2015

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	<p>were reviewed. (Residents #35, #87, #6, and #51)</p> <p>Findings include:</p> <p>1. On 10/13/15 at 10:54 a.m., Resident #35 was sitting in his wheelchair by the nursing station. The resident was observed to have a dark purple discoloration to the top of his left hand.</p> <p>On 10/14/15 at 2:31 p.m., Resident #35 was laying in his bed. The resident was observed to have a dark purple discoloration to the top of his left hand.</p> <p>Record review for Resident #35 was completed on 10/14/15 at 1:57 p.m. The residents diagnoses included, but were not limited to, anemia, hypertension, and heart failure.</p> <p>A Care Plan dated 2/25/15, indicated the resident was at risk for abnormal bleeding, bruising or hemorrhage because of Aspirin usage. An approach included for all staff to observe for and report to the nurse any unusual bruising.</p> <p>The record lacked any indication the discoloration had been observed.</p> <p>Interview with CNA #4 on 10/14/15 at 2:45 p.m., indicated the resident needed</p>		<p>with the physician on 10/14/15 family was notified and corresponding facility documentation was completed in accordance with facility protocol.</p> <p>Resident #87 AV fistula was assessed on 10/13/15 in the nurse's notes and thrill and bruit was added to the TAR on 10/19/15 to ensure every shift assessment. A post dialysis assessment was completed on 10/19/15 after her dialysis appointment.</p> <p>Resident #6 will continue to be followed in the NIP meeting and dietary recommendation was reviewed with the physician on 10/16/15 with new orders received</p> <p>Resident #51 will continue to be followed in the NIP meeting and dietary recommendation was reviewed with the physician on 10/16/15 with new orders received.</p> <p>Care plans were reviewed and updated as indicated and physician's orders were validated to ensure compliance.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	

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	<p>assistance with dressing and someone should have noticed the discoloration and informed the nurse. She further indicated she was unaware the resident had the discoloration to the top of his left hand.</p> <p>Interview with RN #1 on 10/14/15 at 2:48 p.m., indicated when the CNAs did the resident's care someone should have noticed the discoloration and reported it to the nurse. She further indicated she was unaware the resident had the discoloration to the top of his left hand.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 10/14/15 at 3:14 p.m., indicated she did not have any documentation the discoloration to the top of the resident's left hand had been assessed.</p> <p>2. The record for Resident #87 was reviewed on 10/16/15 at 9:23 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, and diabetes mellitus. The resident was admitted to the facility on 10/2/15.</p> <p>Review of the October 2015 Physician Order Summary indicated an order to monitor AV fistula (dialysis access site) for bruit/thrill three times daily.</p> <p>Review of the Treatment Administration</p>		<p>action(s) will be taken:</p> <p>A full facility audit of current resident's nutritional consumption using RITA was completed on 11/5/2015.</p> <p>Full facility skin inspection audit was completed on 10/14/2015 by Nursing Administration to identify any residents having skin related issues. Findings were immediately addressed per facility protocol and interventions implemented as indicated.</p> <p>Dialysis audit was completed on 10/19/2015 and Resident # 87 post dialysis assessment / thrill and bruit was audited until discharged from facility on 10/24/15</p> <p>Care plans were reviewed and updated as indicated and physician's orders were validated to ensure compliance.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:</p> <p>The Staff Development Coordinator will conduct in-service education to the facility staff on adhering to the resident's plan of care with regard to reporting any new skin</p>	

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	<p>Record (TAR) and Medication Administration Record (MAR) for October 2015, lacked documentation the dialysis access site had been assessed every shift.</p> <p>Review of the Pre/Post Dialysis Communication forms indicated a post dialysis assessment had not been completed on 10/14/15 or 10/16/15.</p> <p>Review of the Progress Notes for October 2015, lacked documentation the dialysis access site had been assessed every shift or a post dialysis assessment had been completed on 10/14/15 or 10/16/15.</p> <p>Resident #87 had an interim care plan, dated 10/2/15, for dialysis treatment/end stage renal disease. The nursing interventions included "...dialysis treatments 3 x (times) a week...AV fistula check tid (three times a day)..."</p> <p>Interview with LPN #2 on 10/19/15 at 3:23 p.m. indicated she usually checked the resident's vital signs and access site when the resident returned from dialysis.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 10/19/15 at 1:47 p.m. indicated she was unsure why a post dialysis assessment had not been not completed on 10/14/15 and 10/16/15.</p>		<p>redness, or discoloration to the nurse for appropriate follow up in a timely manner. This education was completed on 10/23/15. CNA's will be utilizing the Interact Stop and Watch Tool to notify nursing of any identified skin related issue. The Staff Development Coordinator will conduct in-service education to the licensed facility staff by 11/17/15 on the new RITA / ADL / Nutrition system that goes live on 11/17/15. This new system will now alert staff to any documentation that has not been completed prior to end of shift.</p> <p>The Staff Development Coordinator will conduct in-service training to Licensed Nurses by 11/11/15 on the facility policy related to the monitoring of the dialysis AV fistula including the thrill and bruit and the Post Dialysis Assessment</p> <p>The Staff Development Coordinator will conduct in-service training to Licensed Nurses by 11/17/15 on facility policies relating to following plan of care and physician's orders.</p>	

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	<p>She further indicated she could not find documentation the dialysis access site had been assessed every shift.</p> <p>3. Resident #6's record was reviewed on 10/15/15 at 11:25 p.m. Diagnoses included, but were not limited to, adult failure to thrive, palliative care, dysphagia (difficulty swallowing), muscle weakness, respiratory failure, and dementia.</p> <p>Review of the October 2015 POS (Physician Order Summary) indicated dietary orders for pureed diet with nectar thick liquids - liquids by spoon only, super cereal at breakfast, and super potatoes at breakfast and lunch.</p> <p>An order dated 10/16/15 indicated frozen nutritional treat [with] lunch and dinner.</p> <p>Review of Progress Notes indicated the following: " 9/1/15 RD (Registered Dietician) note Sig (significant) Change of Condition: Resident is on comfort measures only. Receives a puree diet with nectar thick liquids, liquids by spoon only. Meal intakes remain poor consuming 25% or less at most meals. Current monthly weight (9/1) 93# shows sig weight loss of 11#/ 10.6% since 6/8/15 (-3 months) and 13#/ 12.3% x 6 months. Weight loss</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Director of Nursing / designee will audit the nutritional consumption records of 10 residents weekly times 4 weeks, then 5 residents weekly times 4 weeks, then 3 residents weekly to complete 6 months. The Director of Nursing/ designee will perform random skin inspection audits on 5 residents weekly for 12 weeks, then 5 residents monthly for an additional 3 months. Director of Nursing / designee will audit any new admission with an AV fistula 3 times a week for 6 month to ensure completion of the Thrill and Bruit assessment and 3 times a week for 6 months to ensure the completion of the Post Dialysis Assessment. The Director of Nursing/ designee will perform random audits on physicians orders to ensure orders have been followed, transcribed properly and care plans updated to reflect new orders. 5 residents weekly for 12 weeks, then 5 residents monthly for an additional 3 months.</p>	

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	<p>likely unavoidable due to decline in health status and inadequate intakes from meals ... Meal intakes not meeting needs. Recommend add super cereal at breakfast and super potatoes at lunch. Provide diet per order. Monitor weights and intakes. Refer to RD prn (as needed)."</p> <p>"10/13/15 Dietary Note: RD note weight change: current monthly weight (10/5) 94# shows sig weight loss of 9#/ 8.74% x 3 months ... Recommend continue with current diet and interventions and add Frozen Nutritional Treat at lunch and dinner for additional calories daily due to low BW (body weight). Follow weights and meal intakes. Refer to RD prn."</p> <p>Review of Monthly Diet Logs since Resident #6's readmission after hospitalization on 8/11/15 indicated a lack of documentation of percentage consumed for 19 of 61 meals in August, 26 of 90 meals in September, and 13 of 54 meals in October. The record also lacked documentation of any substitutions given for food not consumed.</p> <p>Review of care plans indicated the resident was at nutrition risk as evidenced by leaves 25% or more of food uneaten at most meals, has a chewing problem, has a swallowing problem, and receives a</p>		<p>Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA committee will determine after 6 months if further auditing in necessary.</p>	

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	<p>mechanically altered diet including nectar thick liquids, liquids by spoon only, super cereal with breakfast, and super potatoes at lunch & dinner due to weight loss.</p> <p>Interventions included, but were not limited to, offer substitutes if 50% or less was consumed, provide/ observe intake of diet/ fluids, and report to nurse any s/s (signs/ symptoms) of chewing/ swallowing or other problems consuming meals such as eating less than 50% of meals.</p> <p>Interview with CNA #3 on 10/19/15 12:55 p.m., indicated meal intakes were recorded in the computer. She further indicated the CNAs were supposed to record intakes for every resident on their unit after every meal and for every snack.</p> <p>Interview with the DON on 10/19/15 at 1:59 p.m., indicated staff should record intakes after every meal in the computer for all residents.</p> <p>4. Resident #51's record was reviewed on 10/14/2015 at 2:01 p.m. Diagnoses included, but were not limited to, cerebrovascular disease, unspecified dementia with behavioral disturbance, diverticulitis, abdominal pain, diabetes mellitus, constipation, anxiety, reflux, and major depressive disorder.</p>			

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	<p>Review of Physician Orders related to diet indicated the following:</p> <ul style="list-style-type: none"> - 10/6/15 Pureed diet, may have regular toast and eggs. D/C (discontinue) med pass 2.0 90 cc (cubic centimeters) BID (twice daily). Super soup at lunch and dinner. - 10/16/15 Add super cereal (cream of wheat) at breakfast. <p>Review of the Weight Log indicated the following:</p> <p>1/9/15 123# 2/7/15 122# 3/1/15 118# 4/5/15 115# 5/4/15 116# 6/8/15 118# 7/4/15 118# 8/2/15 116# 9/1/15 113# 10/5/15 109#</p> <p>Review of Progress Notes indicated a Dietary Note dated 10/13/15, "RD note weight change: current monthly weight (10/5) 109# shows weight loss of 4#/ 3/54% x 1 month, 7#/ 6.03% x 2 months, and sig (significant) wt (weight) loss of 9#/ 7.63% x 3 months. Recent nutritional interventions done on 10/6/15 included liberalizing diet to regular puree and adding super soup at lunch & dinner. Resident may also have eggs and toast at</p>			

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	<p>breakfast and receives Med Plus 2.0 supplement 90 cc BID which was taken well ... Recommend continue with current diet and interventions in place and add super cereal (cream of wheat) at breakfast daily. Recommend place on weekly weights x 4 weeks. Staff to offer substitutions for food not eaten. Refer to RD prn.</p> <p>Dietary interventions recommended on the Nutritional Data Collection/ Assessment dated 9/29/15 included, but were not limited to, follow weights and meal intakes.</p> <p>Review of Monthly Diet Logs for August, September and October 2015 indicated a lack of documentation of percentage consumed for 7 of 93 meals in August, 22 of 90 meals in September, and 8 of 54 meals in October. The record also lacked documentation of any meal supplementation for food not eaten.</p> <p>Review of Resident #51's care plans indicated the resident was nutritionally at risk related to a mechanically altered diet. Interventions included, but were not limited to, monitor daily intake and record.</p> <p>Interview with CNA #3 on 10/19/15 12:55 p.m., indicated meal intakes were</p>			

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F 0309 SS=E Bldg. 00	<p>recorded in the computer. She further indicated the CNAs were supposed to record intakes for every resident on their unit after every meal and for every snack.</p> <p>Interview with the DON on 10/19/15 at 1:59 p.m., indicated staff should record intakes after every meal in the computer for all residents.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of discolorations for 3 of 3 residents reviewed for non pressure related skin conditions of the 3 residents who met the criteria for non pressure related skin conditions, and a dialysis fistula assessment and post dialysis assessment for 1 of 1 residents reviewed for dialysis</p>	F 0309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #35 / 51 / 65 was assessed by nurse on 10/14/15 and discoloration was addressed with the physician and family on 10/14/15 and corresponding facility documentation was completed in accordance with facility protocol.</p>	11/18/2015	

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	<p>of the 1 resident who met the criteria for dialysis. (Residents #35, #51, #65, and #87)</p> <p>Findings include:</p> <p>1. On 10/13/15 at 10:54 a.m., Resident #35 was sitting in his wheelchair by the nursing station. The resident was observed to have a dark purple discoloration to the top of his left hand.</p> <p>On 10/14/15 at 2:31 p.m., Resident #35 was laying in his bed. The resident was observed to have a dark purple discoloration to the top of his left hand.</p> <p>Record review for Resident #35 was completed on 10/14/15 at 1:57 p.m. The residents diagnoses included, but were not limited to, anemia, hypertension, and heart failure.</p> <p>The Quarterly Minimum Data Set (MDS) assessment completed on 8/22/15, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 5 which indicated the resident was cognitively impaired. The assessment indicated the resident needed extensive 2+ person assist for bed mobility, transfers, dressing, and toileting.</p> <p>A Care Plan dated 2/25/15, indicated the</p>		<p>Resident #87 AV fistula was assessed on 10/13/15 in the nurses notes and thrill and bruit was added to the TAR on 10/19/15 to ensure every shift assessment. A post dialysis assessment was completed on 10/19/15 after her dialysis appointment.</p> <p>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:</p> <p>Full facility skin inspection audit was completed on 10/14/15 by Nursing Administration to identify any residents having skin related issues. Findings were immediately addressed per facility protocol and interventions implemented as indicated.</p> <p>Dialysis audit was completed on 10/19/2015 and Resident # 87 post dialysis assessments / thrill and bruit was audited until discharged from facility on 10/24/15.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:</p>	

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	<p>resident was at risk for abnormal bleeding, bruising or hemorrhage because of Aspirin usage. An approach included for all staff to observe for and report to the nurse any unusual bruising.</p> <p>Review of the October 2015 Physician Order Summary (POS) indicated the resident received Aspirin 81 mg (milligrams) daily.</p> <p>Review of Nursing Notes from October 1, 2015 through October 13, 2015 had no indication the discoloration was observed.</p> <p>A Weekly Skin Integrity Data Collection form indicated a skin check was completed on Resident #35 on October 9, 2015. The form indicated the resident's skin was intact with no bruising observed.</p> <p>The record lacked any indication the discoloration had been observed.</p> <p>Interview with CNA #4 on 10/14/15 at 2:45 p.m., indicated the resident needed assistance with dressing and someone should have noticed the discoloration and informed the nurse. She further indicated she was unaware the resident had the discoloration to the top of his left hand.</p>		<p>The Staff Development Coordinator conducted in-service education to the facility staff on 10/23/15 on adhering to the residents plan of care with regard to reporting any new skin redness or discoloration to the nurse for appropriate follow up in a timely manner. CNA's will be utilizing the Interact Stop and Watch Tool to notify nursing of any identified skin related issue.</p> <p>The Staff Development Coordinator will conduct in-servicing to Licensed Nurses by 11/11/15 on the facility policy related to the monitoring of the dialysis AV fistula including the thrill and bruit and the Post Dialysis Assessment</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>The Director of Nursing/ designee will perform random skin inspection audits on 5 residents weekly for 12 weeks, then 5 residents monthly for an additional 3 months.</p> <p>Director of Nursing / designee will audit any new admission with an AV fistula 3 times a week for 6 month to</p>	

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	<p>Interview with RN #1 on 10/14/15 at 2:48 p.m., indicated when the CNAs did the resident's care someone should have noticed the discoloration and reported it to the nurse. She further indicated she was unaware the resident had the discoloration to the top of his left hand.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 10/14/15 at 3:14 p.m., indicated she did not have any documentation the discoloration to the top of the resident's left hand had been assessed.</p> <p>2. Resident #51 was observed sitting in her wheelchair in her room on 10/13/15 at 10:39 a.m. A quarter sized dark discoloration was observed to the back of her left hand and a quarter sized purplish area was also noted to her right forearm. The resident was unsure what happened.</p> <p>On 10/14/15 at 2:33 p.m., Resident #51 was observed resting in her bed. Discolorations remained to the back of her left hand and right forearm.</p> <p>Interview with RN #2 on 10/14/15 at 3:09 p.m., indicated she was unaware of any current skin issues being monitored for Resident #51.</p> <p>An observation of Resident #51 was done</p>		ensure completion of the Thrill and Bruit assessment and 3 times a week for 6 months to ensure the completion of the Post Dialysis Assessment.				

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	<p>with RN #2 on 10/14/15 at 3:14 p.m. At that time, RN #2 indicated she was unaware of the discolorations to Resident #51's left hand or right forearm and the CNAs should have noticed them with care since the resident was dependent for all care. Continued interview with RN #2 indicated the resident bruised easily, especially with lab draws, so those sites were documented. The last lab draw that morning was obtained from the resident's right hand and nothing was documented recently for the resident's left hand or right forearm. She also indicated when a new area was noted, the nurse measures the area then fills out a 72 hour monitoring form.</p> <p>Resident #51's record was reviewed on 10/14/15 at 2:00 a.m. Diagnoses included, but were not limited to, dementia with behaviors, anemia, major depressive disorder, anxiety, and diabetes mellitus.</p> <p>Review of the Annual MDS (Minimum Data Set) assessment dated 9/8/15 indicated Resident #51 was severely cognitively impaired and an extensive assist for ADLs (Activities of Daily Living)</p> <p>Review of the October POS (Physician Order Summary) indicated an order for</p>			

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	<p>weekly skin checks on Saturday and for Aspirin (a medication with blood thinning properties) 81 mg (milligrams) chewable tablet daily.</p> <p>Review of the Progress Notes, TARs (Treatment Administration Records), and unit Skin books indicated a lack of documentation of any skin issues for Resident #51's left hand or right forearm.</p> <p>A Progress Note added on 10/14/15 at 6:21 p.m. indicated, "Charting for 6a-6p labs received and noted, MD (physician) notified and no new orders this time.</p> <p>New bruises noted to resident RFA (right forearm) and top of L (left) hand. No c/o (complaints of) pain or discomfort. MD notified and new order to monitor bruise q (every) shift until resolved. L hand 3x2cm (centimeters), and RFA 3x1.5cm."</p> <p>Review of Care Plans indicated Resident #51 was an extensive staff assist for all ADLs. The skin care plan indicated the resident "had very fragile skin, received insulin injections, and was at risk for skin tears/ bruising/ etc." Interventions included, but were not limited to, monitor skin with all care and notify nurse of any new area. The resident also had a care plan for "Anticoagulation: at risk for abnormal bleeding or hemorrhage because of anticoagulation use: ASA</p>			

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	<p>(aspirin)."</p> <p>3. During an interview with Resident #65 on 10/13/15 at 1:56 p.m., a small red discoloration on the back of the residents left hand by the upper part of the thumb and 2 small bruises on the left forearm were observed. The resident indicated she had fragile skin and had those marks since starting chemotherapy.</p> <p>During another observation and interview on 10/14/15 at 3:12 p.m., the resident still had small red discoloration on the back of the left hand by the upper part of the thumb and also a large brown discoloration on the back of the left hand. Also, on the residents left forearm, 2 small bruises were noted. The resident indicated, the spots were from the chemotherapy treatments.</p> <p>The resident's record was reviewed on 10/14/15 at 2:13 p.m. The resident was admitted to the facility on 5/14/15. The resident's diagnoses included, but were not limited to, stage 3 uterine cancer.</p> <p>The Physician's Progress note on 5/28/15 indicated the resident started chemotherapy on 6/11/15.</p> <p>The POS (Physician Order Summary) for October 2015 indicated skin check weekly on Tues (Tuesday) 7-3 p.m. (day</p>			

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	<p>shift). The POS did not indicate the resident was currently on any medications that would increase the risk of bruising.</p> <p>The Nurse's Progress notes from 9/21/15 through 10/14/15 lacked documentation of bruises or red mark.</p> <p>The Shower Sheets on 9/29/15 and 10/13/15 indicated "no new areas"</p> <p>The Weekly Skin Integrity Data Collection sheets on 10/6/15 indicated the skin was intact with no new redness or any new discolorations. On 10/12/15 the residents skin was intact and dry.</p> <p>The Quarterly Minimum Data Set assessment dated 9/14/15 indicated the resident needed supervision with toilet use, dressing and eating. The resident was a one person assist with personal hygiene.</p> <p>Interview with CNA #7 on 10/14/15 at 2:45 p.m., indicated any changes, bruises, or marks on the resident's skin are to be reported to the charge nurse.</p> <p>Interview on 10/14/15 at 3:16 p.m. with LPN #2, indicated she had noticed the brown discoloration on the back of her hand in the past, but did not document</p>			

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	<p>them. LPN #2 also indicated she had given medications to the resident today and did not notice the red mark on the back of the resident's left hand.</p> <p>The policy titled, "Chapter 2: Pressure Ulcer Prevention," received from the Administrator as current on 10/15/15 at 8:00 a.m., indicated "...Post-admission Weekly Skin Assessments...the results of the skin assessment are documented on the Weekly Skin Integrity Data collection form..."</p> <p>4. The record for Resident #87 was reviewed on 10/16/15 at 9:23 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, and diabetes mellitus. The resident was admitted to the facility on 10/2/15.</p> <p>Review of the October 2015 Physician Order Summary indicated an order to monitor AV fistula (dialysis access site) for bruit/thrill three times daily.</p> <p>Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) for October 2015, lacked documentation the dialysis access site had been assessed every shift.</p> <p>Review of the Pre/Post Dialysis</p>			

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	<p>Communication forms indicated a post dialysis assessment had not been completed on 10/14/15 or 10/16/15.</p> <p>Review of the Progress Notes for October 2015, lacked documentation the dialysis access site had been assessed every shift or a post dialysis assessment had been completed on 10/14/15 or 10/16/15.</p> <p>Resident #87 had an interim care plan, dated 10/2/15, for dialysis treatment/end stage renal disease. The nursing interventions included "...dialysis treatments 3 x (times) a week...AV fistula check tid (three times a day)..."</p> <p>Interview with LPN #2 on 10/19/15 at 3:23 p.m. indicated she usually checked the resident's vital signs and access site when the resident returned from dialysis.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 10/19/15 at 1:47 p.m. indicated she was unsure why a post dialysis assessment had not been not completed on 10/14/15 and 10/16/15. She further indicated she could not find documentation the dialysis access site had been assessed every shift.</p> <p>A facility policy, titled Dialysis, undated, and received from the ADON as current on 10/19/15, indicated "...The shunt site</p>			

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F 0315 SS=D Bldg. 00	<p>shall be checked on a daily basis with physician notification for any known or suspected problem...Post-Dialysis: 1. Obtain vital signs of resident upon return from dialysis...5. Monitor shunt site on a routine basis...."</p> <p>3.1-37(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with a urinary catheter received the necessary treatment and services to prevent urinary tract infections, related to the placement of the urinary catheter tubing and drainage bag for 1 of 3 residents reviewed for urinary catheters of the 3 residents who met the criteria for urinary catheters. (Resident #53)</p>	F 0315	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #53 catheter bag was changed on 10/15/15. The catheter tubing was adjusted so it no longer was touching the floor. 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: An</p>	11/18/2015

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	<p>Finding includes:</p> <p>On 10/13/15 at 10:30 a.m., Resident #53 was observed sitting in her wheelchair in the Therapy Gym. The resident's catheter tubing was observed to be lying on the floor under her wheelchair.</p> <p>On 10/13/15 at 11:59 a.m., Resident #53 was observed being wheeled down the hallway by a Therapy staff member. The resident's catheter tubing was observed dragging on the floor.</p> <p>Observation on 10/14/15 at 3:37 p.m., Resident #53 was observed laying in her bed. The resident's catheter bag was observed attached to the side of the bed and the bag was touching the floor.</p> <p>Observation on 10/15/15 at 1:25 p.m., Resident #53 was observed sitting in her wheelchair in her room watching television. The resident's catheter bag was observed under the wheelchair lying on the floor.</p> <p>Record review for Resident #53 was completed on 10/15/15 at 11:17 a.m. The residents diagnoses included, but were not limited to, hypertension, diabetes mellitus, and a history of a urinary tract infection (UTI) in the past 30 days.</p>		<p>audit was completed on 10/15/15 to ensure all current catheter bags and tubing are positioned properly to avoid contact with the floor. No further issues were identified during this audit. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: In coordination with nursing the OT therapist applied zip ties to all resident wheelchairs that have catheters to ensure that catheter bags and tubing do not touch the floor. The Staff Development Coordinator conducted in-service education with facility staff including the Guardian Angels on the proper catheter bag and tubing placement on both bed and wheelchair on 10/23/15. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Director of Nursing / designee will audit 3 urinary catheters to ensure compliance with the proper catheter bag / tubing placement. These audits will occur 3 days per week for 3 months then once weekly for an additional 3 months. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and</p>	

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	<p>The 5 day Minimum Data Set (MDS) assessment completed on 9/21/15, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 15 which indicated the resident was cognitively intact. The assessment indicated the resident had an indwelling urinary catheter.</p> <p>A Care Plan dated 9/14/15 indicated the resident had a urinary catheter and was at risk for developing a UTI do to the catheter use.</p> <p>Review of the October 2015 Physician Order Summary (POS), indicated the resident had a urinary catheter for wound healing.</p> <p>Review of a Nurse's Note on 9/14/15 at 10:45 p.m., indicated the resident was admitted to the facility with a urinary catheter.</p> <p>A Physician Order dated 9/15/15 at 7:40 a.m., indicated to continue with Keflex (antibiotic) 500 mg (milligrams) twice a day x 7 days for a UTI.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 10/15/15 at 1:30 p.m., indicated Resident #53 had a urinary catheter do to a surgical wound healing. She further indicated the</p>		implemented as deemed necessary. QA committee will determine after 6 months if further auditing in necessary.	

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F 0325 SS=D Bldg. 00	<p>catheter tubing and bag should not be touching the floor.</p> <p>A policy titled Daily Catheter Care and received from the ADON on 10/19/15 at 11:27 a.m., indicated, "Key Procedural Points:... 14. Make sure the catheter tubing and drainage bag are kept off the floor...."</p> <p>3.1-41(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to accurately monitor nutritional status for residents with significant weight loss for 2 of 4 residents reviewed for Nutrition of the 4 who met the criteria for Nutrition. (Residents #6 and #51)</p> <p>Findings include:</p>			F 0325	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #6 will continue to be followed in the NIP meeting and dietary recommendation was reviewed with the physician on 10/16/15 with new orders received</p>		11/18/2015

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	<p>1. Resident #6's record was reviewed on 10/15/15 at 11:25 p.m. Diagnoses included, but were not limited to, adult failure to thrive, palliative care, dysphagia (difficulty swallowing), muscle weakness, respiratory failure, and dementia.</p> <p>Review of the October 2015 POS (Physician Order Summary) indicated dietary orders for pureed diet with nectar thick liquids - liquids by spoon only, super cereal at breakfast, and super potatoes at breakfast and lunch.</p> <p>An order dated 10/16/15 indicated frozen nutritional treat [with] lunch and dinner.</p> <p>Review of Progress Notes indicated the following: " 9/1/15 RD (Registered Dietician) note Sig (significant) Change of Condition: Resident is on comfort measures only. Receives a puree diet with nectar thick liquids, liquids by spoon only. Meal intakes remain poor consuming 25% or less at most meals. Current monthly weight (9/1) 93# shows sig weight loss of 11#/ 10.6% since 6/8/15 (-3 months) and 13#/ 12.3% x 6 months. Weight loss likely unavoidable due to decline in health status and inadequate intakes from meals ... Meal intakes not meeting needs.</p>		<p>Resident #51 will continue to be followed in the NIP meeting and dietary recommendation was reviewed with the physician on 10/16/15 with new orders received.</p> <p>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:</p> <p>A full facility audit of current resident's food consumption using RITA was completed on 11/5/15 by Dee Dee Colvin RN and Sabra Coons RN. Staff was educated regarding any omitted documentation.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:</p> <p>The Staff Development Coordinator will conduct in-service education to the Licensed facility staff by 11/17/15 on the new RITA / ADL / Nutrition monitoring system that goes live on 11/17/15. This new system will now alert staff to any documentation that has not been completed prior to end of shift.</p>	

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	<p>Recommend add super cereal at breakfast and super potatoes at lunch. Provide diet per order. Monitor weights and intakes. Refer to RD prn (as needed)."</p> <p>"10/13/15 Dietary Note: RD note weight change: current monthly weight (10/5) 94# shows sig weight loss of 9#/ 8.74% x 3 months ... Recommend continue with current diet and interventions and add Frozen Nutritional Treat at lunch and dinner for additional calories daily due to low BW (body weight). Follow weights and meal intakes. Refer to RD prn."</p> <p>Review of Monthly Diet Logs since Resident #6's readmission after hospitalization on 8/11/15 indicated a lack of documentation of percentage consumed for 19 of 61 meals in August, 26 of 90 meals in September, and 13 of 54 meals in October. The record also lacked documentation of any substitutions given for food not consumed.</p> <p>Review of care plans indicated the resident was at nutritional risk as evidenced by leaves 25% or more of food uneaten at most meals, has a chewing problem, has a swallowing problem, and receives a mechanically altered diet including nectar thick liquids, liquids by spoon only, super cereal with breakfast,</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Director of Nursing / designee will audit the nutritional consumption records of 10 residents weekly times 4 weeks, then 5 residents weekly times 4 weeks, then 3 residents weekly to complete 6 months.</p>	

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	<p>and super potatoes at lunch & dinner due to weight loss. Interventions included, but were not limited to, offer substitutes if 50% or less was consumed, provide/ observe intake of diet/ fluids, and report to nurse any s/s (signs/ symptoms) of chewing/ swallowing or other problems consuming meals such as eating less than 50% of meals.</p> <p>Interview with CNA #3 on 10/19/15 12:55 p.m., indicated meal intakes were recorded in the computer. She further indicated the CNAs were supposed to record intakes for every resident on their unit after every meal and for every snack.</p> <p>Interview with the DON on 10/19/15 at 1:59 p.m., indicated staff should record intakes after every meal in the computer for all residents.</p> <p>2. Resident #51's record was reviewed on 10/14/2015 at 2:01 p.m. Diagnoses included, but were not limited to, cerebrovascular disease, unspecified dementia with behavioral disturbance, diverticulitis, abdominal pain, diabetes mellitus, constipation, anxiety, reflux, and major depressive disorder.</p> <p>Review of Physician Orders related to diet indicated the following: - 10/6/15 Pureed diet, may have regular</p>			

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	<p>toast and eggs. D/c (discontinue) med pass 2.0 90 cc (cubic centimeters) BID (twice daily). Super soup at lunch and dinner.</p> <p>- 10/16/15 Add super cereal (cream of wheat) at breakfast.</p> <p>Review of the Weight Log indicated the following: 1/9/15 123# 2/7/15 122# 3/1/15 118# 4/5/15 115# 5/4/15 116# 6/8/15 118# 7/4/15 118# 8/2/15 116# 9/1/15 113# 10/5/15 109#</p> <p>Review of Progress Notes indicated a Dietary Note dated 10/13/15, "RD note weight change: current monthly weight (10/5) 109# shows weight loss of 4#/ 3/54% x 1 month, 7#/ 6.03% x 2 months, and sig wt loss of 9#/ 7.63% x 3 months. Recent nutritional interventions done on 10/6/15 included liberalizing diet to regular puree and adding super soup at lunch & dinner. Resident may also have eggs and toast at breakfast and receives Med Plus 2.0 supplement 90 cc BID which was taken well ... Recommend continue with current diet and</p>			

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	<p>interventions in place and add super cereal (cream of wheat) at breakfast daily. Recommend place on weekly weights x 4 weeks. Staff to offer substitutions for food not eaten. Refer to RD prn.</p> <p>Dietary interventions recommended on the Nutritional Data Collection/ Assessment dated 9/29/15 included, but were not limited to, follow weights and meal intakes.</p> <p>Review of Monthly Diet Logs for August, September and October 2015 indicated a lack of documentation of percentage consumed for 7 of 93 meals in August, 22 of 90 meals in September, and 8 of 54 meals in October. The record also lacked documentation of any meal supplementation for food not eaten.</p> <p>Review of Resident #51's care plans indicated the resident was Nutritionally at risk related to a mechanically altered diet. Interventions included, but were not limited to, monitor daily intake and record.</p> <p>Interview with CNA #3 on 10/19/15 12:55 p.m., indicated meal intakes were recorded in the computer. She further indicated the CNAs were supposed to record intakes for every resident on their</p>			

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F 0441 SS=D Bldg. 00	<p>unit after every meal and for every snack.</p> <p>Interview with the DON on 10/19/15 at 1:59 p.m., indicated staff should record intakes after every meal in the computer for all residents.</p> <p>A policy titled "Nutrition Intervention Program Overview" was provided by the DON (Director of Nursing) on 10/19/15 at 1:25 p.m. and deemed as current. The policy indicated ".... Food intake is recorded after each meal per facility policy"</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p>						

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	<p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to maintain proper infection control related to the storage and cleaning of a resident's urinal and respiratory equipment for 2 of 30 resident's whose rooms were observed. (Room E33A and Room W5B)</p> <p>Findings include:</p> <p>1. On 10/13/15 at 10:53 a.m. in Room E33A a urinal was observed uncapped, uncovered, and sitting on top the resident's bedside table.</p> <p>During the environmental tour on</p>	F 0441	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The urinal in room 33A was replaced with a urinal with a cap. The nebulizer mask in room 5 A was replaced and a new one was placed in a bag.</p> <p>How other residents having the potential to be affected by the same deficient practice will be</p>	11/18/2015

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	<p>10/19/15 at 2:00 p.m. with the Administrator and Environmental Services Manager, the urinal was again observed uncapped, uncovered, and sitting on top the resident's bedside table. The Administrator and the Environmental Services Manager indicated they were not aware the urinal should have been covered. Two residents resided in the room.</p> <p>2. On 10/14/15 at 9:31 a.m. in Room W5B, a mask used for nebulizer treatments was observed uncovered sitting on the resident's bedside table.</p> <p>During the environmental tour on 10/19/15 at 2:00 p.m. with the Administrator and Environmental Services Manager, the nebulizer mask was again observed uncovered. The Administrator and the Environmental Services Manager indicated the mask should have been covered. Two residents resided in the room.</p> <p>A facility policy, titled Respiratory Care Services Policy & Procedure Cleaning of Respiratory Equipment, undated, and received from the Assistant Director of Nursing (ADON) as current on 10/19/15, indicated "...Medication nebulizers:..b. Machines must be cleaned thoroughly after patient use with disinfectant and</p>		<p>identified and what corrective action(s) will be taken:</p> <p>A facility audit was completed on 10/19/15 to ensure all urinals had caps and all nebulizer respiratory masks were cleaned and stored properly. No further findings were noted</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:</p> <p>The Staff Development Coordinator conducted in-servicing to facility staff on 10/23/15 regarding maintaining proper infection control related to the storage and cleaning of urinals and nebulizer respiratory masks.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>The Director of Nursing / designee will observe 5 residents weekly during rounds to ensure that the urinals are capped and nebulizer masks are in bags. 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</p>	

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F 0465 SS=E Bldg. 00	<p>stored in bags..."</p> <p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred walls, discolored pull cords, and gouged bathroom doors throughout the facility. (East Wing and West Wing)</p> <p>Findings include:</p> <p>During an environmental tour with the Administrator and the Environmental Services Manager on 10/20/15 at 2:00 p.m. through 2:20 p.m., the following was observed:</p> <p>1. East Wing</p> <p>a. Room 29A: The inside of the bathroom door was gouged. Two residents resided in the room. Four residents shared the bathroom.</p>	F 0465	<p>developed and implemented as deemed necessary. QA committee will determine after 6 months if further auditing in necessary.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Director 10/20/2015 removed discolored pull cords and replaced with PVC vinyl cords to prevent discoloration of the cords in rooms 39B, 41A and room 40B. Repairs started 11/02/2015 on gouged doors and holes to be completed by 11/18/2015 for rooms 7A, 8A, 29A, 35A, 37A and B, 38B 39B, 40B, 44A and B, 46A, 47A, and 48A. Marred walls were repaired 10/26/2015 in rooms 31B, 37A and B, 39B. 41A Toilet Flange bowl caps were replace on 11/09/2015 facility audit conducted this is the only toilet with flange bowl caps in facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	11/18/2015

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	<p>b. Room 31B: The wall in between the sink and the bathroom door was marred. Two residents resided in the room.</p> <p>c. Room 35A: The bathroom door was marred. One resident resided in the room.</p> <p>d. Room 37A&B: The bathroom door was marred and gouged. There were nails in the wall behind bed B. The wall behind bed B was marred. The heat register was marred and discolored. Two residents resided in the room. Four residents shared the bathroom.</p> <p>e. Room 38B: The bathroom door was marred. Two residents resided in the room. Four residents shared the bathroom.</p> <p>f. Room 39B: The bathroom emergency call light pull cord was discolored. The corner edges of the bathroom door were marred and gouged. The wall by the bathroom door was marred and the bathroom door jamb was marred. Two residents resided in the room. Four residents shared the bathroom.</p> <p>g. Room 40B: The bathroom door was marred and gouged. The bathroom emergency call light pull cord was discolored. Two residents resided in the</p>		<p>actions(s) will be taken: Full facility audit was conducted of bathroom doors, pull cords and walls on 11/03/2015 to ensure all areas maintain a functional and safe environment. All areas identified are being put on a schedule to be repainted and repaired 5 rooms a week starting 11/2/2015 this will be recorded in the weekly TELS preventative maintenance system. Staff will be educated to document in the maintenance daily work order binder any marring/door damage/discolored call cords to ensure maintenance is aware and can fix areas timely to be completed by 11/18/2015.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director or designee will add to the T.E.L.S system (preventive maintenance system) to monitor 5 rooms which will be 10 bathroom doors 5 pull cords and 5 rooms for marring weekly for 6 months and then ongoing after that. Staff will be educated to document in the maintenance daily work order binder any marring/door damage/discolored call cords to ensure maintenance is aware and can fix areas timely education to be completed by 11/18/2015.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p>	

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	<p>room. Four residents shared the bathroom.</p> <p>h. Room 41A: The toilet flange bowl caps were missing from the toilet base. The bathroom emergency call light pull cord was discolored. Two residents resided in the room. Four residents shared the bathroom.</p> <p>i. Room 44A&B: The inside of the bathroom door was gouged. The resident in bed A's wheelchair had dried food on the arm rest and there was food debris on the seat. Two residents resided in the room. Four residents shared the bathroom.</p> <p>j. Room 46A: The inside of the bathroom door was gouged. Two residents resided in the room. Four residents shared the bathroom.</p> <p>k. Room 47A: The inside of the bathroom door was gouged. Two residents resided in the room. Four residents shared the bathroom.</p> <p>l. Room 48A: The inside and outside of the bathroom door was gouged. Two residents resided in the room. Three residents shared the bathroom.</p> <p>2. West Wing</p>		<p>The Director of Maintenance or designee will submit the weekly audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. The QA committee will review and determine at that time if audits need to continue.</p>				

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	<p>a. Room 7A: The inside bottom of the bathroom door was gouged. Two residents resided in the room. Three residents shared the bathroom.</p> <p>b. Room 8A: The inside bottom of the bathroom door was gouged. Two residents resided in the room.</p> <p>Interview with the Administrator and the Environmental Services Manager at the time of the tour indicated all the above areas were in need of repair.</p> <p>3.1-19(f)</p>				