

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/16/2013
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NAME OF PROVIDER OR SUPPLIER  BLAIR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 269 MEADOWVIEW DR PERU, IN 46970
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 12, 13, 14, 15, and 16, 2013</p> <p>Facility number: 012565 Provider number: 155791 AIM number: 201021970</p> <p>Survey team: Lora Swanson, RN-TC Julie Wagoner, RN Deb Kammeyer, RN Sharon Ewing, RN Shauna Carlson, RN (8/15, 8/16, 2013)</p> <p>Census bed type: SNF: 32 SNF/NF: 20 Total: 52</p> <p>Census payor type: Medicare: 17 Medicaid: 15 Other: 20 Total: 52</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on August 16, 2013. Please accept this Plan of Correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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	Quality Review completed on August 24, 2013, by Brenda Meredith, R.N.			

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interviews, the facility failed to provide an ongoing, individualized activity program for 2 of 3 residents who met the criteria. (Resident #40 and #49)</p> <p>Finding includes:</p> <p>1. Resident #40 was observed to spend almost all of her daytime hours, from 8:30 A.M. - 3:00 P.M., on 08/13/13 - 08/15/13, in her room either lying in her bed or sitting in her recliner. The resident was only noted out of her room for meals. Resident #40 was not observed to participate in any of the facility's scheduled activities except a "Humor Me" activity provided in the dining room, on 08/15/13, while residents were waiting on their meals.</p> <p>Resident #40 was specifically observed at the following times:</p> <p>On 08/14/13 at 8:30 A.M., the</p>	F000248	<p>F248 What corrective actions will be accomplished for residents found to have been affected by the deficient practice: 1) Resident #49 resident preferences reviewed. Sensory basket has been created for #49 to assist with in room stimulation. Resident care plan updated to reflect current preferences for activities and goals. Activity staff will make 2x daily visits to ensure television and lights are turned on if preferred by the resident and sensory basket is within reach. 2) Resident #40 resident preferences reviewed. Resident will be placed on a 1:1 1x weekly to ensure social interaction with encouragement from activity staff to attend group activities of residents interest. Resident care plan updated to reflect current preferences for activities and goals. Activity staff will make 2x daily visits to ensure her paper is within reach if she chooses to read it and lights are turned on, television is on with volume at residents preference. How other residents having the potential to be affected by the same deficient practice will be identified and</p>	09/15/2013			

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	<p>resident was seated at the dining room table finishing a cup of thickened coffee.</p> <p>On 08/14/13 at 10:00 A.M., the resident was awake in her room in a recliner. Resident #40 was drinking a glass of supplement, was bundled in a blanket, and had a newspaper unopened on her lap. Activity assistant, Employee #10, entered the room and invited Resident #40 and her roommate to Bingo, however, both resident's declined to attend. There was also a Bible study, held in the Assisted Living section of the facility at 10:00 A.M., but Resident #40 was not specifically invited to the activity.</p> <p>On 08/14/13 at 11:00 A.M., the resident was sleeping in her recliner. The newspaper, which still appeared unopened, was lying in her lap. There was no television or light on in the room.</p> <p>On 08/14/13 at 1:56 P.M., the resident was in her bed awake. No television or music was on in the room.</p> <p>On 08/14/13 at 3:00 P.M., she was observed lying in her bed awake. The television was not on, and there was</p>		<p>what corrective actions will be taken: 1) Activity participation log will be reviewed for residents with decreased participation. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1) Activity Director will in-service activity staff on residents interest . Activity Director has created a list for Activity staff to focus on when doing friendly visits 2x daily. Activity staff will initial spreadsheet to verify tasks have been completed with each friendly visit. Audit will be conducted by Activity Director and/or designee to include activity log participation one time per week to ensure visits are completed and initialed by staff on spreadsheet regarding participation. Audit to include monitoring of care plans to ensure resident preferences and goals are up to date and being met. Activity Director will in-service activity staff on resident interest on Skilled care based on cognitive level as stated on the last completed assessment How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: 1) Activity Director will audit daily participation logs weekly x4 weeks and monthly x5 months by initialing. If decline is noticed over a period of time resident will be placed on a 2x</p>				

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	<p>no music playing in her room.</p> <p>On 08/15/13 at 10:00 A.M., she was observed sitting up awake in her recliner. The television was on in the room and the resident indicated she was watching the TV but she could not hear it and did not know what show was playing.</p> <p>On 08/15/13 at 11:00 A.M., an exercise activity was noted. There were 6 residents in the activity but Resident #40 was not at the activity.</p> <p>On 08/15/13 at 2:00 P.M. in her room in bed asleep, lying on her back.</p> <p>On 08/15/13 at 2:29 P.M., Bingo was held in the Assisted Living side of building. Interview with activity staff indicated there were 4 healthcare residents attending the Bingo. There were also 2 residents sitting at the ice cream parlor in healthcare eating ice cream. Resident #40 was not playing Bingo or eating ice cream.</p> <p>The clinical record for Resident #40 was reviewed on 08/14/13 at 2:45 P.M. Resident #40 was admitted to the facility on 07/05/11, with diagnosis, including but not limited to, history of right hip fracture, systolic heart failure, kyphosis, dysphagia,</p>		<p>daily friendly visit to ensure needs are being met. The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: 09/15/13</p>				

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	<p>loss of weight, constipation, osteoporosis, hypertension, anemia and hyperlipidemia.</p> <p>The initial Activity assessment, titled, "Resident Preferences for Customary Routine and Activities Interview Worksheet," completed on 07/03/12, indicated it was very important to the resident to keep up with news and do thing with groups of people and somewhat important to have books, papers and magazines to read, listen to music, do her favorite activities, go out and get fresh air when the weather is good, and participate in religious services. Watching television was listed as a favorite activity.</p> <p>There was no specific care plan, on the paper chart, regarding a plan for activities for Resident #40. Interview with the Activity Director, Employee #2, on 08/16/13 at 9:40 A.M., indicated there was an "iplan," an electronic care plan for activities for Resident #40. The plan indicated the resident's goal was to "remain engaged in activities that I enjoy daily." Some of the interests documented included reading the newspaper each day, family visits, getting her hair done, watching television, group activities, especially</p>				

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	<p>exercise, linens and cooking.</p> <p>An Activity progress notes, dated 06/26/13, indicated the resident attended cooking, beauty shop, pet therapy, coffee time, linens, nails and exercise. and her family visits. It also indicated she attended social hours and special programming, read her newspaper daily. It indicated her goal for activities was to remain engaged in activities that brought her pleasure. The note indicated they would continue to monitor.</p> <p>Review of the August activity participation log for Resident #40 and interview with Employee #2, the Activity Director, on 08/16/13 at 9:00 A.M., indicated the resident in the past 4 days had declined one invitation to Bingo, had participated in one exercise activity, had been documented as actively participating in "reading activity" three of the last four days. Employee #2 indicated the reading activity was reading the newspaper daily in her room on her own. The resident was also documented as having actively participated in TV/Radio. Interview with Employee #2 indicated the radio was played during the meal time as background music and since the resident ate in the dining room it was</p>				

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	<p>counted as an activity. Resident #40 was also documented as actively participating in the pre-meal activity in the dining room.</p> <p>During an interview on 08/16/13 at 9:00 A.M., the Activity Director indicated Resident #40 had been more active in the past, but lately had not been as active. She indicated the resident used to accept at least the exercise class invitations. She indicated the resident did read her newspaper daily. There was no revision to the resident's care plan and no individual activities other than the newspaper for this resident who had decreased her involvement with groups.</p> <p>2. Resident #49 was observed, during the daytime hours between 8:30 A.M. - 3:00 P.M. on 08/14-08/16/13, in her room sleeping in her bed, or standing by her television adjusting the waistband of her pants or rearranging miscellaneous items on a bench beside her television.</p> <p>Resident #49 was observed at the following times, engaged in the following activities:</p> <p>On 08/14/13 at 8:35 A.M., the resident was in her room, dressed</p>			

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	<p>and walking around. Resident indicated something did not feel good when asked how she was doing. Most of the resident's conversation was nonsensical. She was noted to smile when she talked and seemed cheerful. She was also noted to be holding a dry washcloth.</p> <p>On 08/14/13 at 10:00 A.M., she was seated in her room awake. She did not go to the Bingo activity.</p> <p>On 08/14/13 at 11:00 A.M., the resident was seated in her room awake. She was talking but had a hard time understanding and responding appropriately to questions. She did point to a book, pair of reading glasses, crossword puzzle book and word search book stacked in three different stacks on her bench beside her television. She was not observed engaged in any of those activities just pointed to them. No television was noted to be on in the room but the television remote was noted on the built in bench cushion with her other supplies.</p> <p>On 08/14/13 at 1:54 P.M., she was in her room sitting in a chair. She had a pen and television remote in her hand and was adjusting the waistband of her sweatpants. Resident #49</p>			
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	<p>indicated she was "just sitting here." Her television was not on in her room and no music was playing.</p> <p>On 08/14/13 at 3:00 P.M., she was observed in her room holding TV remote and a piece of folded paper in her hands. The television was not on in her room.</p> <p>On 08/15/13 at 10:00 A.M., the resident was observed in her room in bed asleep.</p> <p>On 08/15/13 at 11:00 A.M., there were 6 residents in the day room for an exercise activity. Resident #49 was not in the activity. She was observed in her bed still asleep. The television was not on in her room.</p> <p>On 08/15/13 at 2:00 P.M., she was observed in her bed asleep. No television was on in the room.</p> <p>On 08/15/13 at 2:29 P.M., there was a Bingo activity in the assisted living section of the facility. There were also 2 residents eating ice cream at the ice cream parlor. Resident #49 was not involved in either activity</p> <p>The clinical record for Resident #49 was reviewed on 08/14/13 at 8:35 A.M. Resident #49 was admitted to</p>			

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	<p>the facility on 04/04/13 with diagnosis, including but not limited to debility, dementia, degenerative disc disease, compression fracture of the lumbar, history of kidney stones, increased confusion, weakness, hypertension, diabetes, seizure disorder, hypothyroidism, atrial fibrillation, anemia and depression.</p> <p>The initial assessment regarding activities, titled "Resident Preference for Customary Routine and Activities Interview Worksheet," completed on 04/06/13, indicated it was very important for the resident to keep up with the news, it was somewhat important to have books and magazines to read, be able to do her favorite activities, and participate in religious activities. The resident was identified as liking to watch Wheel of Fortune, Jeopardy, and ESPN on TV and do crosswords.</p> <p>The electronic care plan regarding activities, current through 10/22/13, indicated the resident preferred for her family to be involved, enjoyed getting outside for fresh air, enjoyed doing crossword puzzles, and watching her favorite television shows, Jeopardy and Wheel of Fortune. She also enjoyed watching ESPN. The plan indicated she might</p>			

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	<p>need assistance with television channels. The goal was for the resident to remain engaged in activities that brought her pleasure daily.</p> <p>The initial Activity progress note, dated 04/08/13, indicated the resident enjoyed watching her shows on TV and doing crosswords. Her goal was to continue to enjoy watching her favorite television shows each day and will invite to attend group activities.</p> <p>The most recent activities progress note, dated 07/01/13, indicated the resident enjoyed reading and completing puzzles, watching TV and getting her hair done. The goal remained the same as the initial goal.</p> <p>Review of the August 2013 activity participation attendance for Resident #49, and interview with Employee #2, the Activity Director, on 08/16/13 at 9:00 A.M., indicated the resident had participated in the pre-meal activities while waiting on her noon meal to be delivered to the table, and had attended one evening family night activity. She was documented on August 13 and 14, 2013, as having done word puzzles. The television/radio was also marked as a</p>			

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	<p>daily activity. However, Employee #2 indicated it could have been the radio background music played during the meal time.</p> <p>Interview with the Activity Director, on 08/16/13 at 9:00 A.M., indicated Resident #49 would generally decline invitations to group activities. She indicated the resident worked her crossword puzzles in her room. She indicated the walking, indicated in the previous week as an activity, could have been walking around independently. Although there was a plan to ensure the resident watched her television, the television was not noted to be on at all during the daytime hours. In addition, although the plan indicated the resident worked her crossword puzzles, she was not observed to activity work her puzzle books. There were no interventions to assure the resident was still able to work her crossword puzzles and watch her television shows. In addition, the goal of inviting the resident to group activities was not individualized.</p> <p>3.1-33(a)</p>				

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F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interviews, the facility failed to develop a comprehensive care plan related to pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. (Resident #77) In addition, the facility failed to develop comprehensive care plans related to antidepressant, antianxiety, and antipsychotic medications for 3 residents in a sample of 5 reviewed for medications. (Resident #8, Resident #9, Resident #38)</p>	F000279	F-279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1) Resident #77 a comprehensive care plan has been revised to include measurable objectives, prevention, documentation and interventions related to pressure wound. 2) Resident #8 has been discharged. Resident #9 and #38 comprehensive care plans have been revised to reflect the use of antidepressants, antianxiety, and/or antipsychotic medications. Identification of other residents having the potential to be affected by the same alleged deficient	09/15/2013	

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	<p>Findings include:</p> <p>1. Resident #77 was admitted to the facility on 07/03/13 with diagnosis, including but not limited to recent left hip fracture, end stage renal disease, near syncopal episode, dialysis, type 1 diabetes, hypertension, history of cerebral vascular accident, anemia, paroximal atrial fibrillation, history of methacillian resistant staph auerous infection, history of clostridium difficle infections and gastroesophageal reflux disorder.</p> <p>The Nursing admission assessment, completed on 07/03/13, indicated there was a pressure ulcer on the resident's coccyx but no wound documented on the heel. The initial care plan regarding pressure ulcers, initiated on the 07/03/13 admission assessment form, included the following interventions: "turn and reposition for comfort and with care, provide pressure relieving device in chair and in bed, explain consequences of refusal of treatments and/or prevention interventions, ensure resident is clean and dry, ensure adequate hydration, observe labs, observe nutritional intake, assist with positioning in bed and chair, provide treatments per physician order, administer</p>		<p>practice and corrective actions taken: 1) The medical records of all residents with pressure wounds have been reviewed to ensure care plans include interventions and all documented wounds. 2) The medical records of residents receiving psychoactive medications have been reviewed to ensure care plans are in place for the use of psychoactive medication and appropriate diagnosis related to its use are included. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: Licensed nursing staff were re-educated regarding the campus guidelines for interdisciplinary care plans on wounds and psychoactive medications. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance forms, and change in condition forms and telephone orders in the daily clinical meeting 5 days a week, ongoing. The review is to ensure the care plan have been initiated/updated as necessary through assessment of wounds, psychoactive medications and related diagnosis. The Daily Clinical Report will be completed to document the review of the above stated reports/forms. Audits</p>		

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	medications per physician order, observe for signs of pain with skin condition." There were no specific interventions to protect the resident's foot. A care plan regarding alteration in skin integrity, initiated on 07/23/13, due to the resident's pressure ulcers on his coccyx and left outer food, included the following: "examine skin daily for signs of redness, discoloration..., provide peri-care after each incontinent episode, elevate HOB (head of bed) 30 degrees or less, pressure reducing mattress on bed, pressure reducing cushion on chair, utilize pillows/pads to prevent skin to skin contact and enhance position, monitor labs as ordered by MD, nutritional risk assessment per R.D. (registered dietician), monitor meal consumption, provide with meal replacements if intake less than 50 percent, vitamin/mineral supplement of vitamin C, treatment per MD, educate resident regarding risks associated with non-compliance of treatment and repositioning regarding pressure reduction and development/worsening of skin condition, weekly skin assessment by licensed nurse, notify MD and responsible part of changes in skin status." Again, there was no specific intervention regarding protection of the resident's left foot.		and/or observations related to wounds and psychoactive medications will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: 09/15/13	

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	<p>Resident #77 was observed, on 08/14/13 at 11:30 A.M., sitting in wheelchair. A stump shrinker apparatus was noted on his right leg stump and a sock was noted on his left foot. His left foot was resting on the wheelchair pedal.</p> <p>Resident #77 was observed, on 08/15/13 at 9:26 A.M., in his wheelchair. He had a gripper sock on his left foot, his left shin had notable dry skin. Resident #77 indicated he was not sure when the spot on his heel developed but the sore on his coccyx developed at the hospital and was as big as a "tramp stamp." He indicated he thought the coccyx sore was getting better. Resident #77 was noted to be sitting on a thick black cushion in his wheelchair.</p> <p>The pressure ulcers for Resident #77 were observed on 08/15/13 at 10:40 A.M. The resident had a quarter sized wound on his left outer foot. The area was brown around the outer edge with a thick black eshcar center. The resident was noted to be wearing a gripper sock on his left foot. The skin surrounding the wound was extremely dry and scaly.</p> <p>Interview with the DON (Director of</p>						

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	<p>Nursing), on 08/15/13 at 10:00 A.M., indicated although the intervention was not put on either care plan, the resident was placed on an air bed on 07/05/13.</p> <p>The Pressure ulcer wound documentation for Resident #77, received from the DON, on 08/13/13 at 11:00 A.M., indicated a wound sheet for a left outer heel wound which indicated it was identified on 07/11/13. The documentation indicated the wound was 3 by 2 cm (centimeter) dk (dark) red, black stage 2. There was also documentation of a 7.3 by 5.1 cm wound with a .1 depth on the coccyx, stage 2, red in color. The documentation indicated the coccyx wound was initially identified, on 07/03/13, when the resident was admitted to the facility.</p> <p>2. On 8/15/13 at 9:39 AM, review of Resident #8's record indicated she was admitted to the facility on 5/8/13. Review of the Mental Health Wellness Circumstance, Assessment and Intervention indicated " ...Date/time of behavior 6-19-13. Type of incident: ...crying ...Current psychopharmacological medications: [zero with a line through it indicating none] started on fluoxetine [Prozac- a</p>			

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	<p>medication for depression] 10 mg [milligram] dly [daily] 6-19-13 ...signs of depression: sad/pain expression ...crying ...anxious .... " MD [Medical Doctor] orders indicated " ...Fluoxetine HCL 10 mg cap [capsule] ...give 1 capsule by mouth once a day for depression ...6/19/2013 ... " MD progress notes indicated " ...staff noticing pt [patient] frequently crying .... " Social Service Progress Notes " ...6/19/13 N.O. [New Order] Fluoxetine Dx: [diagnosis] depression .... " Review of Resident #8's record did not show any care plan for depression or for the resident being started on an anti-depressant medication.</p> <p>3. On 8/16/13 on 10:03 AM, review of Resident #9's record indicated she was admitted to the facility on 6/26/13. Review of the Diagnosis List for this resident indicated her diagnoses included but were not limited to " ...insomnia unspecified ...anxiety state .... " Review of the MD orders indicated " ...Mirtazapine [Remeron- medication for depression, used as an appetite stimulant] 15 mg tablet give 1 tablet orally every</p>			

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	<p>bedtime .... " and " ...Alprazolam [Xanax- medication for anxiety] 0.25 mg tablet ...give 1 tablet orally three times daily as needed for anxiety .... " Review of the electronic " iPlan " printout of " resident profile ....mood/behavior " indicated " ...I [Resident #9] have a diagnosis of anxiety and I am currently taking Xanax PRN [as needed] for my anxiety diagnosis .... " No further mention or discussion of anxiety or depression was indicated on this printout. Review of Resident #9's paper record did not show any care plan for anxiety or of her being on a antianxiety or antidepressant medication.</p> <p>4. On 8/15/13 at 2:08 PM, review of Resident #38's record indicated he was admitted to the facility on 9/4/12. Review of the Diagnosis List for this resident indicated his diagnoses included but were not limited to " ...depression, dementia with behaviors .... " Review of the MD orders indicated " ...Fluoxetine HCL 10 mg give 1 capsule by mouth once a day for depression ...Risperidone [Risperdal- antipsychotic medication]</p>				

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	<p>0.5 mg give 1 tablet orally twice daily for dementia with behaviors .... " Review of the electronic " iPlan " printout of " resident profile ...mood/behavior " indicated " ...I have a depression dx and currently taking Prozac for my dx. I also have a dx of Dementia with Behavioral Disturbances and I am taking Risperidone for my dx .... " No further mention or discussion of behaviors or depression was indicated on this printout. Review of Resident #38's paper record did not indicate any care plan for depression, behaviors, or being on an antidepressant or antipsychotic medication. On 8/16/13 at 11:00 AM, interview with LPN #1 indicated she and the DHS (Director of Health Services) are the ones responsible for developing care plans. The morning IDT (interdisciplinary team) is the time when new issues, infections, and medication changes are brought up and a care plan is implemented on the "iPlan " electronic record. Further interview at 11:15 AM with LPN #1 indicated there was no further evidence or care plans to produce for</p>				

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	<p>Resident #8, Resident #9 or Resident #38.</p> <p>On 8/16/13 1:32 PM, review of the current Interdisciplinary Team Care Plan Guideline, dated 1/06 and updated 1/08, received from LPN #1 indicated the care plan should include " ...Problem areas should identify the relative concern, goals should be measurable and attainable, interventions should be reflective of the individual ' s needs and risk influence ...4. Each discipline shall be responsible for establishing a plan of care of acute problems as they occur ...New problem areas should be printed and added to the existing care plans ...Care plans should be filed in the 'Care Plan' section of the resident medical record...."</p> <p>3.1-35(a)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to update a care plan and implement an intervention after a fall for 1 of 3 residents reviewed for falls/accidents. (Resident #14)</p> <p>Findings include:</p> <p>The clinical record for Resident # 14 was reviewed on 8-14-13 at 2:10 P.M. The diagnoses included but were not limited to: right sided cerebrovascular accident, hemiplegia, dementia, hypertension, renal insufficiency and osteopenia.</p>	F000280	F-280 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #14 care plans have been reviewed/ revised to include all current fall interventions are in place. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents who are identified as a fall risk, care plans have been reviewed/ revised as deemed necessary to include appropriate interventions are in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: :	09/15/2013	

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	<p>On 8-14-13 at 2:15 P.M., a review of a form titled "Fall Circumstance, Assessment and Intervention," dated 7-31-13, indicated the resident had an unwitnessed fall and was located on the floor near her bed. The report further indicated the resident was trying to transfer self, the bed wheels were locked and the resident's right arm was resting on alarm pad. Interventions indicated a dycem (non slip pad) was to be placed on the resident's wheelchair. The physician and family was notified of the incident. A review of the back of the form indicated the resident was assessed for 72 hours for vital signs, pain, neurochecks and fall interventions in place and being effective.</p> <p>On 8-14-13 at 2:22 P.M., review of a care plan, dated 12-11-13 and updated on 8-12-13, indicated, resident requires assistance with transfers. Another careplan, dated 9-11-13 and updated on 8-12-13, indicated resident was at risk for a fall due to confusion and unsteady gait. Use of assistance devices: walker. Interventions included but were not limited to: provide and monitor adaptive devices: walker, educate/remind family to request assistance prior to ambulation, bed</p>		<p>Nursing staff in-serviced about fall interventions and ensuring they are in place. The Nursing Leadership Team will review the 24 hour report, circumstance forms, Accident/Incident reports and telephone orders in the daily clinical meeting 5 days a week, ongoing. The review is to ensure the care plan have been initiated/updated as necessary through assessment falls and interventions. The Daily Clinical Report will be completed to document the review of the above stated reports/forms. Audits and/or observations related falls and interventions will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: DHS and or designee will forward the results of the audit and or observations to be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations Completion Date: 09/15/13</p>		

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	<p>and chair alarms and notify MD/responsible party of fall. The careplan did not include the dycem as an intervention to prevent further falls. There was no indication the resident no longer used a walker but was using a wheelchair.</p> <p>On 8-14-13 at 2:25 P.M., a review of a form titled "Resident First Conference Notes," dated 5-14-13, indicated the care plans were reviewed and update.</p> <p>Interview with LPN #14 on 8-14-13 at 2:30 P.M., indicated resident no longer used a walker, she uses a wheel chair. She could not indicate when the resident stopped using the walker but had been using the wheelchair "some time."</p> <p>An observation of the resident's wheelchair with LPN #13, on 8-14-13 at 2:35 P.M., indicated there was a chair alarm on the wheelchair seat but no dycem.</p> <p>During an interview on 8-15-13 at 8:50 A.M., the Director of Nursing (DON) indicated the resident had been using a wheelchair since January of 2013 and was unable to use the walker. The DON had no explanation as to why the careplan</p>			

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	<p>reflected that the resident was still using a walker for ambulation.</p> <p>On 8-15-13 at 4:00 P.M., a review of a policy titled "Falls Management Program Guidelines," dated 3/2008, indicated on line #7 "...the nursing assistant assignment sheet and resident care plan should be updated to reflect any new or change in interventions...."</p> <p>3.1-35(d)(2)(B)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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, record review and interviews, the facility failed to ensure physician's orders regarding diet and notification of weight gain were followed for 1 of 1 residents reviewed for dialysis. (Resident #77)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #77 was reviewed on 08/14/13 at 9:30 A.M. Resident #77 was admitted to the facility on 07/03/13, with diagnosis, including but not limited to, recent left hip fracture, end stage renal disease, near syncopal episode, dialysis, type 1 diabetes, hypertension, history of cerebral vascular accident, anemia, paroximal atrial fibrillation, history of methacillian resistant staph auerous infection, history of clostridium difficle infections, and gastroesophageal reflux disorder.</p> <p>The admission orders from an acute care facility, dated 07/03/13, included orders for the resident to have dialysis treatments on Mondays,</p>	F000282	F-282 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The Physician and responsible party were notified as per order in regards to the weight gain. Resident #77 diet clarified with physician and new order obtained. Nurse re-educated ensuring physician orders are accurate and carried out per order. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: There are no other residents whom are receiving dialysis, therefore no other residents were affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: Licensed nursing staff educated regarding communication binder put in place which includes communication from dialysis center that is to be reviewed by nursing staff upon return from dialysis. Licensed staff also educated regarding skilled nursing assessment and dialysis communication form which includes assessment of port site	09/15/2013			

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	<p>Wednesdays, and Fridays, a 3 gram sodium, limit high K (potassium) foods, and call the physician for weight gain of 5 pounds or more in 1 week</p> <p>A subsequent physician order, dated on 07/03/13, changed the diet to a No added salt, limit K (potassium) diet.</p> <p>Resident #77 was sent to an acute care facility on 07/31/13 and readmitted to the facility on 08/04/13.</p> <p>The physician's orders, on 08/04/13 , included orders for the No added salt, Limit K diet, dialysis treatments on Monday, Wednesday, and Friday, and notify the physician if there was a weight gain of 5 pounds or greater in one week</p> <p>The dietary progress notes, dated 08/12/13, indicated recommendation to add CCHO (consistent carbohydrate) restrictions to his No added Salt and Limited K (Potassium) foods diet already in place.</p> <p>On 08/13/13, the diet order was changed to a CCHO (consistent carbohydrate), No added Salt, Limit Vitamin K diet.</p> <p>Interview with Resident #77, on</p>		<p>for sign of infection, thrill/bruit, and physician notification of changes in condition or weight gains greater than 5%.. Nurses re-educated on clarifying any orders that may be misinterpreted. Audits will be conducted 2 times per week for 4 weeks then monthly times 5 months to ensure that orders are transcribed correctly, physician and responsible party are notified of weight gains greater than 5%, and documentation to validate notification is in place. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: DHS and or designee will forward the results of the audit and or observations to be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations Completion Date: 09/15/13</p>		

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	<p>08/13/13 at 11:00 A.M., indicated he was served foods he knew were not on his diet and he should not eat like cream pies and other foods. He indicated sometimes he resisted eating them but at other times, he figured he would just eat the foods.</p> <p>Resident #77 was observed on 08/15/13 at 12:00 P.M., sitting at dining room table served lasagna, ceasar salad, and a garlic bread stick. The resident was noted to eat the lasagna.</p> <p>Interview with Resident #77, on 08/16/13 at 8:30 A.M., indicated he had eaten an egg, french toast, and drank sugar free hot chocolate for breakfast The resident indicated he does know better than to drink orange juice and grape juice. He did say if they are going to serve him high carbohydrate and cream pies he was going to eat them even though it would make his blood sugar high. He indicated he supposed they were serving him the right amount. He indicated at home he would not tempt himself sweets. He did not seem to recognize tomatoes and tomato products as not being on his diet regarding the potassium.</p> <p>Review of the facility corporation "Diet</p>						

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	<p>Liberalization Thesaurus" policy, undated, included a "Renal/Potassium Restriction" diet which indicated the resident was to receive the following: "NAS (no added salt), No bananas, oranges, orange juice, prunes, non-boiled potatoes/sweet potatoes, melon, beans, yogurt, tomatoes or tomato juice."</p> <p>Interview with the FSS, Employee #5, on 08/16/13 at 11:00 A.M., confirmed there was a NAS diet on the spreadsheet but no Limited Potassium guidelines on the spreadsheet. He indicated he doubted there was any inservice documentation regarding what to serve to a Limited Potassium diet for his staff as they were all relatively new employees. He indicated the tray card would have some instructions for the dietary staff on restrictions for individual residents. Observation of the tray card for Resident #77, on 08/16/13 at 11:00 A.M., indicated an allergy to milk products, limit potassium, limit green leafy vegetables, and limit vita (vitamin) K intake were all on the card. The FSS indicated there was no guidelines and confirmed both the goulash, served for the noon meal on 08/12/13 and the lasagna, served for</p>						

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	<p>the noon meal on 08/15/13 contained tomato products.</p> <p>Review of the weight record for Resident #77 indicated his admission weight, obtained on 07/03/13 was 111 pounds. The next documented weight, completed on 07/17/13, was 128 pounds. There was no explanation given as to why a weekly weight on 07/10/13 was not obtained and documented and no explanation why the physician was not notified of the extreme weight gain, of 17 pounds, from 07/03/13 - 07/17/13. Interview with RN #3, on 08/16/13 at 1:30 P.M. confirmed there was no documentation the physician was notified of Resident #77's weight gain.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 there was documentation that the communication from a dialysis center was reviewed and interventions were implemented, the care of a dialysis access site was consistently monitored, and physician orders regarding diet and weight gain were followed for 1 of 1 residents reviewed for dialysis needs. (Resident # 77)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #77 was reviewed on 08/14/13 at 9:30 A.M. Resident #77 was admitted to the facility on 07/03/13, with diagnosis, including but not limited to recent left hip fracture, end stage renal disease, near syncopal episode, dialysis, type 1 diabetes, hypertension, history of cerebral vascular accident, anemia, paroximal atrial fibrillation, history of methacillian resistant staph auerous infection,</p>	F000309	F-309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The Physician and responsible party were notified as per order in regards to the weight gain. Resident #77 diet clarified with physician and new order obtained. Nurse re-educated ensuring physician orders are accurate and carried out per order. MAR adjusted to include monitoring of access sites. Nurses are monitoring communication from dialysis center and reporting any dialysis concerns and/or weight gains greater than 5%. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: There are no other residents whom are receiving dialysis, therefore no other residents were affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: : Licensed nursing staff educated regarding communication binder	09/15/2013	

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	<p>history of clostridium difficle infections, and gastroesophageal reflux disorder.</p> <p>The admission orders from an acute care facility, dated 07/03/13, included orders for the resident to have dialysis treatments on Mondays, Wednesdays, and Fridays, a 3 gram sodium, limit high K (potassium) foods, and call the physician for weight gain of 5 pounds or more in 1 week</p> <p>A subsequent physician order, dated on 07/03/13, changed the diet to a No added salt, limit K (potassium) diet.</p> <p>Resident #77 was sent to an acute care facility on 07/31/13, and readmitted to the facility on 08/04/13.</p> <p>The physician's orders, on 08/04/13 , included orders for the No added salt, Limit K diet, dialysis treatments on Monday, Wednesday, and Friday, and notify the physician if there was a weight gain of 5 pounds or greater in one week</p> <p>The dietary progress notes, dated 08/12/13, indicated recommendation to add CCHO (consistent carbohydrate) restrictions to his No added Salt and Limited K (Potassium)</p>		<p>put in place which includes communication from dialysis center that is to be reviewed by nursing staff upon return from dialysis. Licensed staff also educated regarding skilled nursing assessment and dialysis communication form which includes assessment of port site for sign of infection, thrill/bruit, and physician notification of changes in condition or weight gains greater than 5%.. Nurses re-educated on clarifying any orders that may be misinterpreted. Audits will be conducted 2 times per week for 4 weeks then monthly times 5 months to ensure that communication from dialysis is reviewed, orders are transcribed correctly, physician and responsible party are notified of weight gains greater than 5%, and documentation to validate notification is in place How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: DHS and or designee will forward the results of the audit and or observations to be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations Completion Date: 09/15/13</p>		

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	<p>foods diet already in place.</p> <p>On 08/13/13, the diet order was changed to a CCHO (consistent carbohydrate), No added Salt, Limit Vitamin K diet.</p> <p>Interview with Resident #77, on 08/13/13 at 11:00 A.M. , indicated he was served foods he knew were not on his diet and he should not eat like cream pies and other foods. He indicated sometimes he resisted eating them but at other times, he figured he would just eat the foods.</p> <p>Resident #77 was observed on 08/15/13 at 12:00 P.M., sitting at dining room table served lasagna, ceasar salad, and a garlic bread stick. He was noted to eat the lasagna.</p> <p>Review of the facility corporation "Diet Liberalization Thesaurus" policy, undated, included a "Renal/Potassium Restriction" diet which indicated the resident was to receive the following: "NAS (no added salt), No bananas, oranges, orange juice, prunes, non-boiled potatoes/sweet potatoes, melon, beans, yogurt, tomatoes or tomato juice."</p> <p>Interview with the FSS, Employee #5,</p>						

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	<p>on 08/16/13 at 11:00 A.M., confirmed there was a NAS diet on the spreadsheet but no Limited Potassium guidelines on the spreadsheet. He indicated he doubted there was any inservice documentation regarding what to serve to a Limited Potassium diet for his staff as they were all relatively new employees. He indicated the tray card would have some instructions for the dietary staff on restrictions for individual residents. Observation of the tray card for Resident #77, on 08/16/13 at 11:00 A.M., indicated an allergy to milk products, limit potassium, limit green leafy vegetables, and limit vita (vitamin) K intake were on the card. The FSS indicated there was no guidelines and confirmed both the goulash, served for the noon meal on 08/12/13, and the lasagna, served for the noon meal on 08/15/13, contained tomato products.</p> <p>Interview with ADON, Employee #3, on 08/16/13 at 1:30 P.M. indicated she had incorrectly copied the dietary recommendations made on 08/12/13 to a physician's order form. She indicated the resident's diet was supposed to be a consistent carbohydrate, no added salt, and limit K (potassium) foods.</p>			

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	<p>Interview with RN #12, the unit manager, indicated she did not know where dialysis center documentation was kept as Resident #77 returned on the evening shift from dialysis. The clinical record was noted to have some dialysis center communication forms but none of them were recent forms. The most recent dialysis center communication forms, from August 2013, were located in the medical records nurse office.</p> <p>Review of the dialysis center communication note for 08/14/13 at 17:07 (5:07) P.M., indicated at the end of the treatment, the resident's blood pressure remained extremely elevated at 195/106. Review of facility nursing progress notes, daily skilled worksheet for 08/14/13, and physician orders for 08/14/13 and 08/15/13 indicated there was no note or order indicating the resident's elevated blood pressure was monitored by the facility after he returned from dialysis or the physician was notified of the elevated blood pressure issues.</p> <p>In addition, the medicare daily nursing progress notes, completed on a daily basis, had a section of the form to document the thrill and bruit and</p>						

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	<p>dialysis port site, and dressing. However, although the form was completed daily, the time the form was completed varied and was not necessarily coordinated and/or completed after the resident returned from dialysis to ensure the dialysis port site was assessed after the resident returned from having dialysis treatments.</p> <p>The facility policy, undated, titled "Guidelines for Dialysis Provider Communication" included the following: "...5. Upon return from the Dialysis Provider the campus shall: a. Provide ongoing monitoring (sic) of the shunt site for signs of complication. b. Review the Dialysis Provider paperwork for any necessary follow up requirements."</p> <p>Interview with ADON, RN #3, on 08/16/13 at 1:29 P.M., indicated prior to today, after reviewing the policy for dialysis and reviewing documentation regarding assessing of dialysis site and thrill and bruit, the only documentation was on medicare daily notes.</p> <p>In addition, review of the weight record for Resident #77 indicated his admission weight, obtained on 07/03/13 was 111 pounds. The next</p>				

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	<p>documented weight, completed on 07/17/13, was 128 pounds. There was no explanation given as to why a weekly weight on 07/10/13, was not obtained and documented and why the physician was not notified of the extreme weight gain of 17 pounds. Interview with RN #3, on 08/16/13 at 1:30 P.M., confirmed there was no documentation the physician was notified of Resident #77's weight gain.</p> <p>3.1-37(a)</p>			

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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper placement of the Gastrostomy tube (a tube placed in the stomach for administration of food, fluids, and medications) prior to administering medications thru the Gastrostomy tube (G-tube). The facility also failed to record the amount of 1.5 Jevity (tube feeding formula) a resident received in a 24 hour period in 1 of 1 residents that had a G-tube tube. (Resident #39)</p> <p>Findings include:</p> <p>1. On 8-14-13 at 7:33 A.M., during an observation, LPN #9 did not check placement of the G-tube by</p>	F000322	F-322 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1) Immediately educated nurse in regards to guidelines for appropriate administration of food, fluids, and/or medications through gastrostomy tube. 2) New kangaroo pumps implemented that records amount of Jevity a resident receives in a 24 hr period. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: This practice did not affect any other resident, as this is the only gastrostomy tube resident. Measures put in place and systemic changes made to ensure the alleged deficient	09/15/2013	

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	<p>auscultating the abdomen while injecting air into the tube prior to administrating the medication thru the G-tube for Resident #39.</p> <p>During an interview on 8-14-13 at 7:46 A.M., LPN #9 indicated that she checked placement of the G-tube with the night nurse at shift change and didn't think she had to check placement again.</p> <p>During an interview on 8-14-13 at 8:45 A.M., the Director of Nursing indicated the nurse was to check placement prior to administrating medication in a feeding/G-tube.</p> <p>On 8-14-13 at 9:10 A.M., a review of the policy, titled "Guidelines for Administrating Gastric Tube Medications," indicated in bold print on line #34 "...Check placement in the stomach and residual gastric contents...." Review of another policy, titled "Guidelines for Verification of Feeding Tube Placement," indicated the purpose of verification was to ensure proper placement of the feeding tube to "...prevent aspiration during feedings...."</p> <p>2. On 8-15-13 at 10:49 A.M., a record review for Resident #39 indicated the</p>		<p>practice does not re-occur: 1) Licensed nurses re-educated on guidelines for checking proper placement prior to administration of foods, fluids, and/or medication. Audit will be conducted 2 times per week times 4 weeks, then monthly times 5 weeks to ensure proper procedures are used with the administration of food, fluids, and/or medications per gastrostomy tube. 2) Licensed nurses educated on kangaroo pump which records total feedings received in a 24 hour period. Licensed day shift nurse will review previous 24 hrs of feeding administered on kangaroo pump and document volume on MAR. Audit will be conducted 2 times per week times 4 weeks, then monthly times 5 weeks to ensure proper documentation of Jevity received during the previous 24 hour period. Also random visual checks will be conducted to ensure nurses are reading pumps and documenting correctly. Audit will also include random observations of gastrostomy tube placement checks conducted per policy. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: DHS and or designee will forward the results of the audits and/or observations on proper tube placement and Jevity documentation to be reported,</p>		

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	<p>G-tube tube had been placed, on 11-17-11, due to failure to thrive, malnutrition and altered mental stasis. The G-tube had been placed to maintain adequate nutrition and hydration.</p> <p>Dietician notes, dated 6-18-13, indicated that the dietician recommended 1.5 Jevity at 55 ml/hr (milliliters per hour) x 20 hours. The Jevity 1.5 product would provide 1650 kilocalories (Kcal), 70 grams protein, 836 ml free water (1436 ml with flushes). A physician order indicated "1.5 Jevity at 55 cc/hr (cubic centimeter per hour) per G-tube from 2:00P-10:00A (off from 10AM-2PM)."</p> <p>On 9-15-13 at 11:03 A.M., a review of the Medication Administration Record indicated the nurses were documenting with their initials G-tube pump off at 10 AM (stopping infusion of Jevity) and pump on at 2:00 PM (starting infusion of Jevity). The rate of infusion was 55 milliliters per hour for 20 hours which equals 1100 milliliters of Jevity given which equals 1600 Kcal. There was no documentation from nurse regarding the total amount of 1.5 Jevity infused in a 24 hour period or when a new Jevity container was hung for infusion.</p>		<p>reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations Completion Date: 09/15/13</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>During an interview on 8-15-13 at 2:12 P.M., with Assistant Director of Nursing (ADON) indicated there was no documentation of intake (amount) of Jevity given in a 24 hour period. The ADON further indicated there was no policy.</p> <p>During an interview on 8-15-13 at 2:50 P.M., the dietician indicated the resident's nutritional needs were being met by receiving 1.5 Jevity at 55 milliliters per hour for 20 hours, by way of the G-tube. She explained that 1.5 Jevity contained 1500 Kcal in 1000 milliliters of product, therefore the resident was receiving 1600 milliliters of the product. The dietician was unaware that there was no documentation that indicated the resident had received 1600 milliliters of 1.5 Jevity in a 24 hour period.</p> <p>On 8-16-13 at 8:45 A.M., a care plan, titled "Feeding Tube," related to insufficient calorie intake and failure to eat was reviewed. The interventions included but were not limited to: check tube placement by aspiration/auscultation every shift and with medication administration, keep head of the bed elevated at least 45 degrees during and 30 minutes after tube feeding, administer tube feeding</p>						

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	<p>and flushes as ordered, and registered dietician to monitor adequacy of tube feeding formula and flushes monthly or with change of status. Another careplan, titled "Alteration in Feeding," related to tube feeding was also reviewed. the interventions included but were not limited to: establish feeding schedule, bolus, pump, gravity, amount, how often, and product.</p> <p>On 8-16-13 at 10:22 A.M., LPN #9 was observed turning off the G-tube pump.</p> <p>On 8-16-13 at 2:00 P.M., the resident was observed in the lounge area in front of a TV with no G-tube infusing.</p> <p>On 8-16-13 at 2:15 P.M., the resident was in front of the TV without G-tube infusing.</p> <p>3.1-44(a)(2)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure fall interventions were followed to reduce the risk of an accident for 1 of 3 residents reviewed for falls. (Resident #62)</p> <p>Findings include:</p> <p>The clinical record for Resident #62 was reviewed on 8/15/13 at 2:10 P.M. Resident #62's diagnoses included but were not limited to "...diabetes type II, terminal lung cancer, hypertension, insomnia, depressive disorder and anxiety...."</p> <p>An admission MDS (Minimum Data Set) assessment, dated 4/10/13, indicated the resident was cognitively impaired, and required extensive assist of 2 staff members for transfers.</p> <p>A fall risk assessment, dated 4/3/13, indicated the resident had a terminal illness, incontinence, weakness, used assistive devices, and had impaired</p>	F000323	F-323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Dycem placed in chair as ordered. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Review of the medical records of residents who have had falls in the past 30 days to ensure interventions have been implemented and are in place according to the care plan. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: All nursing staff has been re-in serviced on hourly rounding, documentation, fall prevention, implementation of interventions addressed in the care plan process. . The following audits and or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure fall interventions are in place, functioning and effective. The Nursing Leadership Team will review the 24 hour report,	09/15/2013

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	<p>mobility.</p> <p>Resident #62's fall and self care deficit care plans, dated 5/1/13 and no revision date, indicated "...dycem (non slip pad) to recliner chair...bed/chair alarms...weight bearing with assist of 1...."</p> <p>A physician's order, dated 6/19/13, indicated "dycem to top of recliner."</p> <p>A "Fall Circumstance, Assessment and Intervention", dated 5/29/13, indicated "...ambulating self from bed to bathroom lost balance...bed alarm pad not plugged into box...root cause: staff error...."</p> <p>A "Fall Circumstance, Assessment and Intervention", dated 7/13/13, indicated "...slid out of chair...dycem not in place as ordered..."</p> <p>A "Fall Circumstance, Assessment and Intervention", dated 7/20/13, indicated "...transferring self...chair alarm not sounding...."</p> <p>A nurse note, dated 8/13/13, indicated "...resident fell in bathroom during toileting [sic], staff member stepped outside BR (bathroom) door to get briefs, resident stood up by self, fell and hit head, VS (vital signs),</p>		<p>circumstances forms and accident/incident forms at the clinical meeting 5 days a week and ongoing. This review is to ensure that a new intervention has been implemented post fall and that the care plans are updated, and interventions are in place. Audit will also include random visual checks to ensure all interventions are in place as ordered. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: The DHS/designee will forward results of the audits to the Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: 09/15/13</p>				

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	<p>neuros WNL (within normal limits)...."</p> <p>On 8/15/13 at 2:55 P.M., an interview with Employee #8 indicated "...the resident should have an alarm on her bed, recliner and wheelchair at all times. I know when the alarms are on because a green light will show, if the red light is on it means the alarm is off or the battery is low. The resident should also have a dycem on her recliner seat and her wheelchair at all times...."</p> <p>On 8/15/13 at 4:00 P.M., record review of the current policy titled "Falls Management Program Guidelines" received from the Director of Nursing indicated "...Care plan interventions should be implemented that address the resident's risk factors...."</p> <p>3.1-45(a)(2)</p>						

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F000329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interviews, the facility failed to ensure 1 of 5 resident reviewed for unnecessary medications had adequate indications to support the continued use of the medication and had adequate monitoring of medical symptoms. (Resident #49)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #49 was reviewed on 08/14/13 at</p>	F000329	F-329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Physician notified for clarification regarding indications and diagnosis regarding continued use of Seroquel along with possible reduction. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Will review the medical records of all residents receiving psychoactive medications to ensure adequate	09/15/2013			

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	<p>8:35 A.M. Resident #49 was admitted to the facility on 04/04/13 with diagnosis, including but not limited to, debility, dementia, degenerative disc disease, compression fracture of the lumbar, history of kidney stones, increased confusion, weakness, hypertension, diabetes, seizure disorder, hypothyroidism, atrial fibrillation, anemia and depression.</p> <p>The current physician's orders for medications for August 2013, included the antipsychotic medication, Seroque (an antipsychotic) 50 mg (milligrams) to be given twice a day for dementia. The transfer physician's orders, from an acute care facility, on 04/04/13, included orders for the Seroquel 50 mg to be given twice a day</p> <p>The Admission Minimum Data Set (MDS) Assessment, completed on 04/11/13, indicated the resident had not displayed any physical, verbal, or socially inappropriate behaviors but had been noted 4 - 6 times in the observation period, but not daily, to reject care. The most recent MDS assessment, completed on 05/12/13, indicated the resident had not displayed any behaviors, including rejection of care.</p>		<p>indications to support the continued use of the medication and adequate monitoring of medical symptoms are in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: Implemented monthly behavior/intervention flow record and in serviced Licensed nursing staff on use. All staff re-educated regarding behavior documentation on kiosk to ensure proper documentation and interventions attempted. The following audits and or observations will be conducted by the SSD or designee 5 times per week and ongoing times 4 weeks, then weekly times 5 months to ensure proper documentation and follow-up regarding interventions attempted. Leadership team will review kiosk widgets related to behaviors and attempted interventions for appropriateness. Will review behavior flowsheets for interventions and side effect monitoring. Will also review behavior/intervention flow sheets for completeness. Will include monitoring of GDR per pharmacy recommendations and follow-ups with physicians. Audit will also include monitoring flowsheets for medical side effects related to medications and notification of physician when deemed necessary. How the corrective measures will be monitored to</p>		

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	<p>The current health care plans for Resident #49 included a plan to address an Adjustment disorder, Cognitive Function, Communication, Depression, and Noncompliance with Ambulation and ADL's (Activities of Daily Living).</p> <p>Review of the paper clinical record for Resident #49 indicated there was no specific behavior tracking. Interview with LPN #4 indicated he would fill out a behavior report and put it in the nurses note. He did not know about the medical symptom for the Seroquel use. After speaking with the Service Director, Employee #11, had indicated Resident #49 received the Seroquel for the diagnosis of "dementia with behaviors."</p> <p>Interview with SSD (Social Service Director), Employee #11, on 08/14/13 at 2:00 P.M., indicated she sometimes put care plans for the behaviors on the computer. She checked her computer but indicated she had no behavior care plans on the computer for Resident #49. In addition, she indicated any behaviors the resident exhibited were to be documented individually on the computer by the direct care staff. She indicated she had to print the</p>		ensure the alleged deficient practice does not reoccur: The DHS/designee will forward results of the audits to the Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: 09/15/13				

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	<p>documentation to tell what the behaviors were. She indicated the documentation would tell what interventions were attempted to address the behaviors.</p> <p>Review of behavior documentation, provided on 08/15/13 at 9:00 A.M., and interview with the Social Service Director, Employee #11, on 08/16/13 at 9:45 A.M., indicated the CNA's had documented 5 instances of rejection of care in June, July and August 2013. Three of the 5 behaviors surrounded showers. None of the behaviors indicated what interventions were attempted to address the behaviors. None of the behaviors documented indicated the resident had been verbally, physically, or socially inappropriate. The SSD, Employee #11 indicated the CNA's were "really bad" about not documenting interventions. She indicated she would try to catch the CNA's and ask them about their interventions. In addition, the SSD indicated each nurses station had a book with generalized behavior tips. She indicated there was no plan with specific individualized behavior interventions so the direct care staff knew what medical symptoms supported the use of Seroquel for Resident #49 and what interventions</p>			

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	<p>they were to consistently attempt when Resident #49 was resistant to care.</p> <p>On 08/16/13 at 9:45 A.M., the SSD, Employee #11, presented a hand written care plan for Resident #49, initiated on 04/12/13, which indicated the interventions she wanted the CNA's to try. She indicated Resident #49 was on the Seroquel for Dementia with behaviors unspecified. She indicated the resident was mostly refusing and rejecting care, specifically showers and changing clothes. She indicated at times, Resident #49 could get a little "mouthy" when rejecting care. The hand written plan, which was documented on the SSD's tracking record and not available to staff, indicated the interventions were to be "1:1, talk about family, explain all care before providing it, give adequate amount of time for res to process communication, approach at later time, attempt care with other staff members." The SSD, Employee #11 indicated Resident #49 had been admitted on the Seroquel and there was no documentation other than the Dementia with behaviors diagnosis to support the use of the medication and no indication specific behaviors were monitored consistently, and no</p>						

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	<p>indication a reduction in the psychotropic medication had been considered.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(6)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interviews, the facility failed to ensure food was prepared and served under sanitary conditions. This potentially affected 52 of 53 residents in the facility who consumed food.</p> <p>Finding includes:</p> <p>1. During the kitchen sanitation tour, conducted on 08/12/13 between 7:50 A.M. - 8:15 A.M., the following was noted in the Healthcare kitchen:</p> <p>a. One of 5 steam table pans, stacked together on open cart, was visibly soiled with a white colored substance and was wet.</p> <p>b. One of 4 scoops, put away as clean was dirty with a red colored food substance.</p> <p>c. Cook #7 was observed preparing made to order eggs and other breakfast items. She was noted to put gloves on, touch a spatula, a</p>	F000371	F-371 What corrective actions will be accomplished for residents found to have been affected by the deficient practice: 1) Inservice will be conducted for all Dietary employees on proper procedures for food handling in regard to glove use; handwashing and contamination. Inservice will also be conducted on proper cleaning and storage of dishes, utensils and steam table pans. 2) Employees identified will be counseled with teachable moments related to glove use, handwashing; and contamination. 3) The dish and utensil items in question were promptly cleaned on 08/12/31 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Inservice will be conducted for all Dietary employees on proper procedures for food handling in regard to glove use; handwashing and contamination. Inservice will also be conducted on proper cleaning and storage of dishes, utensils and steam table pans.	09/15/2013			

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	<p>skillet handle, touch her apron, and then reached in a bread bag and grabbed two slices of bread with her gloved, contaminated hands. She then placed the bread slices on top of a folded pot holder on a counter while she reached and handled the outside of a container of eggs and spices. She then whisked the egg mixture then picked up the bread with her contaminated gloves and using her hands dipped the bread into the egg mixture touching the egg mixture with her contaminated gloved hands.</p> <p>During observation of the noon meal service, conducted on 08/12/13 between 12:00 P.M. - 12:20 P.M., the following was noted:</p> <p>a. Cook #8 was observed to put gloves on, then touch outside of baggies of fresh vegetables, a knife, the outside of bowls and then reach in directly with contaminated gloved hands to grab lettuce, tomatoes, onions, and cucumbers to make a salad.</p> <p>b. Cook #7 was then observed with gloves on going in and out of the kitchen and into the dining room where the steam table was located. She carried a long white board into the kitchen at one point, and then</p>		<p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>1) The DFS (Director of Food Service) or designee will document observations of food handling techniques by line staff 5 X per week and take corrective action as needed. Observations will be documented on a log. 2) The DFS or designee will make visual inspections of over-all dietary department sanitation 3 X per week and document on a log. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: 1) Results of the food handling and sanitation audits will be reported at least monthly to the QAA committee by the DFS. The results will be reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: 09/15/13</p>				

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	<p>carried a bowl of rolls out to the steam table.</p> <p>c. Cook #8 was noted to be in the process of dumping bags of rolls into a large clear bowl for cook #7. Cook #8 was noted to accidentally flop a large section of the rolls against her uniform while she was in the process of placing the rolls into the serving bowl..</p> <p>d. During the process of serving the noon meal from the steam table in the dining room, Cook #7, who had been wearing gloves was noted to handle spoon and scoop handles, plates, and touch her glasses and then handled the rolls directly with her contaminated gloved hands.</p> <p>Review of the facility policy and procedure, titled, Hand Washing, and dated 2009 indicated the employees were to wash their hands at the following times: "A. When entering the Nutrition Services Department...E. Before and after handling foods. F. After using the bathroom, sneezing, coughing, touching face or hair, scratching and using a handkerchief...K. Whenever soiled."</p> <p>Interview with the Food Service Supervisor, Employee #5, on</p>				

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	<p>08/16/13 at 11:00 A.M., indicated the facility also utilized the "Serv Safe" manual. Review of the Serv Safe manual regarding the use of gloves in food service indicated the following: "Gloves must never be used in place of handwashing! Hands must be washed before putting gloves on and when changing to a new pair...Foodhandlers should change their gloves: As soon as they become soiled or torn, Before beginning a different task..After handling raw meat and before handling cooked or ready-to-eat food."</p> <p>3.1-21(g)(3)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to record the amount of 1.5 Jevity (tube feeding formula) a resident received in a 24 hour period for 1 of 1 residents that had a G-tube tube. (Resident #39)</p> <p>Findings include:</p> <p>On 9-15-13 at 10:49 A.M., a record review indicated the G-tube tube had been placed on 11-17-11 due to failure to thrive, malnutrition, and altered mental stasis. The G-tube had been placed to maintain adequate nutrition and hydration.</p> <p>Dietician notes, dated 6-18-13, indicated that the dietician recommended 1.5 Jevity at 55 ml/hr</p>	F000514	F-514 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: New kangaroo pumps implemented that records amount of Jevity a resident receives in a 24 hr period. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: This practice did not affect any other resident, as this is the only gastrostomy tube resident. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur: Licensed nurses educated on kangaroo pump which records total feedings received in a 24 hour period. Licensed day shift nurse will review previous 24 hrs of feeding administered on kangaroo pump and document	09/15/2013			

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	<p>(milliliters per hour) x 20 hours. The Jevity 1.5 product would provide 1650 kilocalories (Kcal), 70 grams protein, 836 ml free water (1436 ml with flushes). Physician order indicated "1.5 Jevity at 55 cc/hr (cubic centimeter per hour) per G-tube from 2:00P-10:00A (off from 10AM-2PM)."</p> <p>On 8-15-13 at 11:03 A.M., a review of the Medication Administration Record indicated the nurses were documenting with their initials G-tube pump off at 10 AM (stopping infusion of Jevity) and pump on at 2:00 PM (starting infusion of Jevity). The rate of infusion was 55 milliliters per hour for 20 hours which equals 1100 milliliters of Jevity given which equals 1600 Kcal. There was no documentation from nurses regarding the total amount of 1.5 Jevity infused in a 24 hour period or when a new Jevity container was hung for infusion.</p> <p>During an interview on 8-15-13 at 2:12 P.M., with the Assistance Director of Nursing (ADON) indicated there was no documentation of intake (amount) of Jevity given in a 24 hour period. The ADON further indicated there was no policy.</p> <p>During an interview on 8-15-13 at</p>		<p>volume on MAR. Audit will be conducted 2 times per week times 4 weeks, then monthly times 5 weeks to ensure proper documentation of Jevity received during the previous 24 hour period. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: DHS and or designee will forward the results of the audits and/or observations on Jevity documentation to be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: 09/15/13</p>				

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	<p>2:50 P.M., the dietician indicated the resident's nutritional needs were being met by receiving 1.5 Jevity at 55 milliliters per hour for 20 hours, by way of the G-tube. She explained that 1.5 Jevity contained 1500 Kcal in 1000 milliliters of product, therefore the resident was receiving 1600 milliliters of the product. The dietician was unaware that there was no documentation that indicated the resident had received 1600 milliliters of 1.5 Jevity in a 24 hour period.</p> <p>On 8-16-13 at 8:45 A.M., a care plan titled "Feeding Tube" related to insufficient calorie intake and failure to eat was reviewed. The interventions included but were not limited to: check tube placement by aspiration/auscultation every shift and with medication administration, keep head of the bed elevated at least 45 degrees during and 30 minutes after tube feeding, administer tube feeding and flushes as ordered, and registered dietician to monitor adequacy of tube feeding formula and flushes monthly or with change of status. Another careplan titled "Alteration in Feeding" related to tube feeding was reviewed. The interventions included but were not limited to: establish feeding schedule, bolus, pump, gravity, amount, how</p>			

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	<p>often, and product.</p> <p>On 8-16-13 at 10:22 A.M., LPN #9 was observed turning off the G-tube pump.</p> <p>On 8-16-13 at 2:15 P.M., the resident was in front of the TV without G-tube infusing.</p> <p>3.1-50(a)(2)</p>			