

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155409	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF INDIANAPOLIS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 20, 21, 22, 23, and 24, 2014</p> <p>Facility number: 000537 Provider number: 155409 AIM number: 100267270</p> <p>Survey team: Karyn Homan, RN-TC Patti Allen, SW Dottie Plummer, RN Marcy Smith, RN</p> <p>Census bed type: SNF/NF: 55 Total: 55</p> <p>Census payor type: Medicare: 6 Medicaid: 48 Other: 1 Total: 55</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 29, 2014 by Cheryl Fielden, RN.</p>	F000000	<p><b>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000282 SS=E	<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, interview, and record review, the facility failed to monitor fluid intake and daily weights for a resident receiving dialysis, (Resident #59), failed to control pain for a resident experiencing pain continuously, (Resident #87), failed to implement a splint program for a resident with a contractures (fixed or high resistance of movement of a muscle or joint), (Resident #66), and failed to provide nail care to 1 of 3 residents reviewed for provision of Activities of Daily Living (ADLs). (Resident #21)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #59, reviewed on 10/22/14 at 10:40 a.m., indicated the resident had diagnoses including, but were not limited to, end stage renal disease.</p> <p>A review of the recapitulation of physician's orders dated 10/1/14 - 10/31/14, indicated the resident had a</p>	F000282	<p><b>F282</b> 1. The fluid intake of Resident #59 is collected and monitored by licensed nursing staff. Weights are recorded and evaluated daily by the licensed nurse and notification is made as indicated by physician order. The resident's care plan has been updated to include specific interventions. Resident #87 has been re-evaluated for pain and her pain has been again addressed by the nurse practitioner. A care plan has been developed to include specific non-pharmacological interventions to assist with pain relief. The fingernails of Resident #21 were trimmed and filed on October 23, 2014. A plan to maintain the good grooming of Resident #21 has been implemented. A restorative nursing plan including splint use has been written and implemented for Resident #66.2. All residents with fluid restrictions, daily weights as ordered to be monitored by the physician, having unrelieved pain, dependent on staff members for ADL care, and having a restorative program</p>	11/23/2014
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	<p>fluid restriction of 1500 ml (milliliters) in 24 hours related to fluid retention (edema/swelling). The start date of the fluid restriction was 9/9/14. The orders indicated nursing staff provided 220 ml of fluids each shift for a total of 660 ml. The orders indicated the resident received dialysis but lacked an indication of when and where the resident received the services.</p> <p>A review of the written plans of care included a plan of care with a start date of 8/22/14 indicating the resident had dialysis 3 times a week. The plan of care lacked an intervention for the fluid restriction. Interventions included, but were not limited to, "monitor intake and output."</p> <p>Another plan of care addressed a therapeutic diet including diabetic precautions, double protein 3 times a day with meals, and a fluid restriction of 1500 ml each day. The date initiated for the plan of care was 9/9/14. The plan of care indicated the resident was at times non compliant with the fluid restriction and staff or the resident would come to the kitchen to get extra fluids. Interventions included, but were not limited to, "encourage resident to be compliant with diet and fluid restrictions." The plan of care lacked the</p>		<p>recommended by the therapy department have the potential to be affected. Residents requiring a fluid restriction and daily weight monitoring as ordered by a physician have been identified with care plans updated to reflect the necessary interventions. Residents with unrelieved pain have been identified and pain addressed by the attending physician. Non-pharmacological interventions have been identified and added to the plan of care. The nails of all dependent residents have been examined and care provided to those identified as requiring assistance and additional care is provided as requested by the Activity Staff. Future therapy recommendations for restorative programs including splint use will be reviewed and signed by both the therapy director and the Restorative Nurse Coordinator to ensure appropriate communication and implementation. 3. An educational offering will be provided to Nursing and Activity Staff regarding the monitoring and recording of fluid intake as well as weight monitoring on November 19, 2014. The educational offering will include the need to notify the physician of weight gain and resident noncompliance. Administrative nursing staff will review the documentation of completion of these tasks in the interdisciplinary team meeting. An educational</p>	

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	<p>amount of fluids to be provided with meals.</p> <p>During an interview with the Director of Nursing (DON) on 10/20/14 at 9:10 a.m., the DON indicated the facility did not have a specific policy for dialysis, "We just follow the physician's orders."</p> <p>During a Stage 1 interview on 10/21/14 at 3:10 p.m., Resident #59 was observed eating ice from a filled pitcher of ice.</p> <p>During an interview with Licensed Practical Nurse (LPN) #2 on 10/22/14 at 11:51 a.m., LPN #2 indicated the intake for the resident was recorded on the Medication Administration Record (MAR) and included fluids provided by nursing staff. LPN #2 indicated the staff knew Resident #59 had a fluid restriction and knew not to provide additional fluids.</p> <p>During an interview with the Registered Dietician (RD) on 10/22/14 at 4:30 p.m., the RD indicated the nursing staff determined how much fluid dietary was to provide to the resident and then dietary determined what types of fluid would be provided. The RD indicated the resident received a health shake with each meal and then 1 other fluid of the resident's choice. The RD indicated the resident received received 240 ml with breakfast</p>		<p>offering will be provided to both licensed and non-licensed nursing staff regarding the management of pain and the use of non-pharmacological interventions for pain relief on November 19, 2014. Licensed nurses will continue to assess residents, as per policy, for pain. An educational offering will be provided to Nursing and Activity Staff regarding the completion of nail care and proper documentation on November 18, 2014. The nails of dependent residents will be observed by interdisciplinary team members on daily rounds and problems reported to nursing personnel. Additionally Certified Nursing Assistants will document nail care on twice weekly shower sheets. An educational offering will be provided to the Therapy Director and the Restorative Nursing Coordinator on November 12, 2014 regarding the process for communicating therapy recommendations for restorative programs. Additionally therapy recommendations will be reviewed by the interdisciplinary team in the weekly therapy meeting. 4. The Director of Nursing and/or her designee will review fluid intake recording and documentation regarding resident noncompliance and physician notification as well as weight monitoring and physician notification five times weekly for one month and then twice weekly</p>	

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	<p>and 300 ml with lunch and dinner.</p> <p>During an interview with the DON on 10/23/14 at 9:51 a.m., the DON indicated the facility kept track of fluid intake for Resident #59 on the MARs and outputs were not monitored. The DON indicated the fluids provided by dietary were recorded by the certified nursing assistants (CNAs) with meal consumption. The DON indicated fluids were not tracked and totaled on a daily basis for the resident. The DON indicated the facility did not have a specific policy for monitoring intake and output.</p> <p>During an interview with the DON on 10/23/14 at 10:20 a.m., the DON indicated a total daily intake was not maintained for the resident. "The staff know how much she can have and they don't give her any more than that."</p> <p>2. The clinical record of Resident #59, reviewed on 10/22/14 at 10:40 a.m., indicated the resident had diagnoses including, but were not limited to, end stage renal disease.</p> <p>A review of the recapitulation of physician's orders dated 10/1/14 - 10/31/14, indicated the resident had an order to be weighed daily and to notify</p>		<p>for two months and then weekly for four months. The Director of Nursing will report the findings of these reviews monthly to the Quality Assurance Committee. The Director of Nursing and/or her designee will review the pain assessments and care plans of five randomly selected residents each week for six months to ensure care plan interventions have been implemented. The Director of Nursing and/or her designee will report the findings of these reviews monthly to the Quality Assurance Committee. The Director of Nursing and/or her designee will monitor the nail care of five randomly selected dependent residents twice weekly for one month and then weekly for two months. Monitoring will continue twice monthly for four months. The Director of Nursing will report the findings of these reviews monthly to the Quality Assurance Committee. The Administrator and/or her designee will review recommendations for restorative programs suggested by the Therapy Department five times weekly for communication and signatures in the interdisciplinary team meeting for two months and then once weekly for four months. The Administrator will report the findings of these reviews monthly to the Quality Assurance Committee. 5. November 23, 2014</p>	

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	<p>the physician of a weight gain of 3 pounds or more in 1 day or 5 pounds in 1 week. The start date for the order was 8/28/14.</p> <p>A review of the written plans of care indicated the resident received dialysis 3 times a week. Interventions included, but were not limited to, "obtain weight per protocol."</p> <p>A review of the Weight Log for September 2014 for Resident #59 indicated the resident had a recorded weight on 9/5/14 of 142.4 pounds, 9/10/14 of 143.8 pounds, 9/11/14 of 147 pounds, and 9/12/14 of 148.2 pounds. The nursing progress notes lacked physician notification of the weight increase of 7 pounds in 1 week.</p> <p>The resident had a recorded weight on 9/14/14 of 144 pounds. The weight recorded on 9/15/14 was 148.6. The nursing progress notes lacked documentation of physician notification of the weight gain of 4.6 pounds in 1 day.</p> <p>The resident had a recorded weight on 9/20/14 of 140 pounds. The weight recorded on 9/21/14 was 144.2, a gain of 4.2 pounds in 1 day. The weight recorded on 9/22/14 was 148.4, a gain of an additional 4.2 pounds in 1 day. The</p>			

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	<p>nursing progress notes lacked documentation of physician notification of the weight gain.</p> <p>The resident had a recorded weight on 9/28/14 of 144.8 pounds, indicating a gain of 3 pounds from the last recorded weight on 9/26/14 of 141.8 pounds. The weight recorded on 9/29/14 was 149.8, a gain of 5 pounds in 1 day and 8 pounds in 2 days. The nursing progress notes lacked documentation of physician notification of the weight gain.</p> <p>A review of the Weight Log for Resident #59 for October 2014 indicated the resident was not weighed daily as ordered. The log lacked recorded weights on 10/2, 10/9, 10/11, and 10/14/14.</p> <p>The resident had a recorded weight on 10/10/14 of 145.1 pounds. The next recorded weight on 10/13/14 indicated a weight gain of 6 pounds. The nursing progress notes lacked documentation of physician notification of the weight gain.</p> <p>During an interview with Licensed Practical Nurse (LPN) #2 on 10/22/14 at 11:51 a.m., LPN #2 indicated the daily weights for the resident were recorded on the Weight Log. LPN #2 indicated the resident occasionally refused to be</p>			

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	<p>weighed but was not sure why the sheet had weights missing for some days.</p> <p>During an interview with the Director of Nursing on 10/23/14 at 9:51 a.m., the DON indicated the facility did not have a specific policy for daily weights and physician notification, "We just follow the physician's orders."</p> <p>3. The clinical record of Resident #87 was reviewed on 10/23/14 at 11:42 a.m. Diagnoses for the resident included, but were not limited to, spinal stenosis, muscle spasms, anxiety disorder, depression, and morbid obesity.</p> <p>On 10/20/14 at 10:19 a.m., Resident #87 indicated she had pain everywhere. She indicated she took pain medications but the pain never completely went away.</p> <p>A care plan for Resident #87, dated 9/30/14, indicated, "Resident has a diagnosis of arthritis, muscle spasms and chronic pain which can cause episodes of discomfort." The goal was, "Resident will have pain managed daily through next quarterly review." Interventions included, "Give scheduled pain medications as ordered...Offer alternative interventions for pain management such as dim lights, reposition, back rubs, light exercise...Observe and monitor for</p>			

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	<p>effectiveness of alternative interventions an document...Offer as needed pain medication if alternative interventions are not effective...Review and adjust medications as needed with MD/NP [medical doctor, nurse practitioner] to maintain comfort level."</p> <p>A recapitulated physician's order for October, 2014, with an original date of 9/24/14, indicated Resident #87 could have Percocet (a narcotic pain medication) 10/325 mg 1 tablet every 4 hours as needed for pain.</p> <p>A review pf Controlled Drug Receipt/Record/Disposition forms indicated between 9/23/14 and 10/22/14 (with the exception of 10/15/14) Resident #87 received Percocet 4 - 6 times every day.</p> <p>No documentation was found in the resident's record which indicated any alternative interventions had been attempted prior to giving her the Percocet. On 10/23/14 at 2:40 p.m., the Director of Nursing (DON) indicated alternative interventions would probably not work with this resident due to her psychiatric issues.</p> <p>4. The clinical record of Resident #66,reviewed on 10/22/14 at 3:31 p.m.,</p>			

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	<p>indicated the resident had diagnoses including, but were not limited to, cerebral vascular accident (CVA/stroke) and non-dominate hemiparesis (paralysis of one side of upper and lower extremities).</p> <p>A quarterly Minimum Data Set (MDS) assessment completed 10/2/14 assessed Resident #66 as having a functional limitation of range of motion (ROM) of both an upper and lower extremity. The MDS assessment indicated the resident had received restorative nursing programs of active range of motion (AROM) to all extremities 7 out of 7 days, 2 days out of 7 for a walking program, and dressing and grooming program 7 out of 7 days. The MDS lacked documentation of a restorative splint program.</p> <p>A review of the written plans of care indicated the resident had a restorative program for AROM to all extremities related to CVA and hemiplegia with a start date of 9/29/13.</p> <p>A care plan for hemiplegia with a start date of 6/11/13 lacked interventions of ROM or splints. Interventions included, but were not limited to, monitor labs as ordered, pain management as needed, and therapies to evaluate and treat as ordered.</p>			

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	<p>Another plan of care indicated the resident required a walk to dine restorative program to restore or maintain the ability to ambulate. Interventions included, but were not limited to, assist resident to walk to all meals.</p> <p>A recapitulation of physician's orders dated 10/1/14 - 10/31/14, indicated the resident had been receiving Physical Therapy (PT) 3 times a week for 4 weeks with a start date of 9/17/14.</p> <p>A review of the Occupational Therapy (OT) Discharge Summary dated 8/25/14, indicated the resident was discharged with a restorative nursing program (RNP), "To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT (Interdisciplinary Team): splint or brace Care and ROM (Active).</p> <p>During an interview with the MDS Coordinator on 10/23/14 at 3:15 p.m., the MDS Coordinator indicated the resident had been receiving a restorative program for AROM but had not used a splint in a long time. When asked about the OT discharge summary recommendation for a RNP for a splint, indicated she would</p>			
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	<p>check on the recommendation. The MDS Coordinator indicated the facility did not write orders for restorative programs when the recommendation was received from therapy the recommendation was added to the assignments for the restorative aides.</p> <p>The MDS Coordinator indicated during an interview on 10/23/14 at 3:45 p.m., the restorative splint program was not implemented as recommended on 8/25/14.</p> <p>5. The clinical record of Resident #21 was reviewed on 10/22/14 at 11:25 a.m. Diagnoses for the resident included, but were not limited to, altered mental status and chronic leg pain.</p> <p>On 10/20/14 at 10:35 a.m., some of Resident #21's fingernails were observed to be long, jagged, with fading finger nail polish.</p> <p>On 10/23/14 at 10:03 a.m., Resident #21's finger nails were observed to be long, jagged and irregularly shaped.</p> <p>A quarterly Minimum Data Set assessment, dated 8/7/14, indicated Resident #21 was severely cognitively impaired and needed the assistance of staff for activities of daily living (ADL's).</p>			

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F000309 SS=D	<p>A care plan for Resident #21, dated 6/11/14, and current through 11/18/14, indicated the resident required limited to extensive assistance with Activities of Daily Living. The goal was, "Resident will have all ADL needs met by staff daily through next quarterly review."</p> <p>On 10/23/14 at 10:05 a.m., the Director of Nursing indicated nail care is not documented when it is done. It is often done in activities or hospice provides this service. A hospice bathing checklist form, dated 10/14/14, indicated the hospice Certified Nursing Assistant did not cut the resident's fingernails because the resident was diabetic. The form indicated, "Charge Nurse was informed that nails need to be cut." On 10/23/14 at 10:20 a.m., with the DON, Resident #21's fingernails were observed to be trimmed, but not filed. At that time, the DON spoke with the Activity Director, who indicated she would see that the resident's fingernails were filed.</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</p>			

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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure necessary care and services were provided to maintain physical, mental, and psychosocial well-being according to residents' plans of care for 1 of 3 residents reviewed for pain in that the resident had unrelieved pain without alternative interventions used (Resident #87) and 1 of 1 dialysis residents reviewed in that there was a lack of monitoring of an ordered fluid restriction and lack of physician notification of weight gain. (Resident #59)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #87 was reviewed on 10/23/14 at 11:42 a.m. Diagnoses for the resident included, but were not limited to, spinal stenosis, muscle spasms, anxiety disorder, depression, and morbid obesity.</p> <p>On 10/20/14 at 10:19 a.m., Resident #87 indicated she had pain everywhere. She indicated she took pain medications but the pain never completely went away.</p> <p>A care plan for Resident #87, dated 9/30/14, indicated, "Resident has a</p>	F000309	<p>F309 1. The fluid intake of Resident #59 is collected and monitored by licensed nursing staff. Weights are recorded and evaluated daily by the licensed nurse and notification is made as indicated by physician order. The resident's care plan has been updated to include specific interventions. Resident #87 has been re-evaluated for pain and her pain has been again addressed by the nurse practitioner. A care plan has been developed to include specific non-pharmacological interventions to assist with pain relief. 2. All residents with fluid restrictions, daily weights as ordered to be monitored by the physician, having unrelieved pain, dependent on staff members for ADL care, and having a restorative program recommended by the therapy department have the potential to be affected. Residents requiring a fluid restriction and daily weight monitoring as ordered by a physician have been identified with care plans updated to reflect the necessary interventions. Residents with unrelieved pain have been identified and pain addressed by the attending physician. Non-pharmacological interventions have been identified and added to the plan of care. 3. An educational offering will be</p>	11/23/2014

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	<p>diagnosis of arthritis, muscle spasms and chronic pain which can cause episodes of discomfort." The goal was, "Resident will have pain managed daily through next quarterly review." Interventions included, "Give scheduled pain medications as ordered...Offer alternative interventions for pain management such as dim lights, reposition, back rubs, light exercise...Observe and monitor for effectiveness of alternative interventions an document...Offer as needed pain medication if alternative interventions are not effective...Review and adjust medications as needed with MD/NP [medical doctor, nurse practitioner] to maintain comfort level."</p> <p>A recapitulated physician's order for October, 2014, with an original date of 9/24/14, indicated Resident #87 could have Percocet (a narcotic pain medication) 10/325 mg 1 tablet every 4 hours as needed for pain.</p> <p>A review pf Controlled Drug Receipt/Record/Disposition forms indicated between 9/23/14 and 10/22/14 (with the exception of 10/15/14) Resident #87 received Percocet 4-6 times every day.</p> <p>No documentation was found in the resident's record which indicated any</p>		<p>provided to Nursing and Activity Staff regarding the monitoring and recording of fluid intake as well as weight monitoring on November 19, 2014. The educational offering will include the need to notify the physician of weight gain and resident noncompliance. Administrative nursing staff will review the documentation of completion of these tasks in the interdisciplinary team meeting. An educational offering will be provided to both licensed and non-licensed nursing staff regarding the management of pain and the use of non-pharmacological interventions for pain relief on November 19, 2014. Licensed nurses will continue to assess residents, as per policy, for pain.</p> <p>4. The Director of Nursing and/or her designee will review fluid intake recording and documentation regarding resident noncompliance and physician notification as well as weight monitoring and physician notification five times weekly for one month and then twice weekly for two months and then weekly for four months. The Director of Nursing will report the findings of these reviews monthly to the Quality Assurance Committee. The Director of Nursing and/or her designee will review the pain assessments and care plans of five randomly selected residents each week for six months to ensure care plan interventions</p>	

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	<p>alternative interventions had been attempted prior to giving her the Percocet. On 10/23/14 at 2:40 p.m., the Director of Nursing (DON) indicated alternative interventions would probably not work with this resident due to her "psychiatric issues."</p> <p>2a. The clinical record of Resident #59, reviewed on 10/22/14 at 10:40 a.m., indicated the resident had diagnoses including, but were not limited to, end stage renal disease.</p> <p>A review of the recapitulation of physician's orders dated 10/1/14 - 10/31/14, indicated the resident had a fluid restriction of 1500 ml (milliliters) in 24 hours related to fluid retention (edema/swelling). The start date of the fluid restriction was 9/9/14. The orders indicated nursing staff provided 220 ml of fluids each shift for a total of 660 ml. The orders indicated the resident received dialysis but lacked an indication of when and where the resident received the services.</p> <p>A review of the written plans of care included a plan of care with a start date of 8/22/14 indicating the resident had dialysis 3 times a week. The plan of care lacked an intervention for the fluid restriction. Interventions included, but</p>		<p>have been implemented. The Director of Nursing and/or her designee will report the findings of these reviews monthly to the Quality Assurance Committee. 5. November 23, 2014</p>	

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	<p>were not limited to, "monitor intake and output."</p> <p>Another plan of care addressed a therapeutic diet including diabetic precautions, double protein 3 times a day with meals, and a fluid restriction of 1500 ml each day. The date initiated for the plan of care was 9/9/14. The plan of care indicated the resident was at times non compliant with the fluid restriction and staff or the resident would come to the kitchen to get extra fluids. Interventions included, but were not limited to, "encourage resident to be compliant with diet and fluid restrictions." The plan of care lacked the amount of fluids to be provided with meals.</p> <p>During an interview with the Director of Nursing (DON) on 10/20/14 at 9:10 a.m., the DON indicated the facility did not have a specific policy for dialysis, "We just follow the physician's orders."</p> <p>During a Stage 1 interview on 10/21/14 at 3:10 p.m., Resident #59 was observed eating ice from a filled pitcher of ice.</p> <p>During an interview with Licensed Practical Nurse (LPN) #2 on 10/22/14 at 11:51 a.m., LPN #2 indicated the intake for the resident was recorded on the</p>			

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	<p>Medication Administration Record (MAR) and included fluids provided by nursing staff. LPN #2 indicated the staff knew Resident #59 had a fluid restriction and knew not to provide additional fluids.</p> <p>During an interview with the Registered Dietician (RD) on 10/22/14 at 4:30 p.m., the RD indicated the nursing staff determined how much fluid dietary was to provide to the resident and then dietary determined what types of fluid would be provided. The RD indicated the resident received a health shake with each meal and then 1 other fluid of the resident's choice. The RD indicated the resident received received 240 ml with breakfast and 300 ml with lunch and dinner.</p> <p>During an interview with the DON on 10/23/14 at 9:51 a.m., the DON indicated the facility kept track of fluid intake for Resident #59 on the MARs and outputs were not monitored. The DON indicated the fluids provided by dietary were recorded by the certified nursing assistants (CNAs) with meal consumption. The DON indicated fluids were not tracked and totaled on a daily basis for the resident. The DON indicated the facility did not have a specific policy for monitoring intake and output.</p>			

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	<p>During an interview with the DON on 10/23/14 at 10: 20 a.m., the DON indicated a total daily intake was not maintained for the resident. "The staff know how much she can have and they don't give her any more than that."</p> <p>2b. The clinical record of Resident #59, reviewed on 10/22/14 at 10:40 a.m., indicated the resident had diagnoses including, but were not limited to, end stage renal disease.</p> <p>A review of the recapitulation of physician's orders dated 10/1/14 - 10/31/14, indicated the resident had an order to be weighed daily and to notify the physician of a weight gain of 3 pounds or more in 1 day or 5 pounds in 1 week. The start date for the order was 8/28/14.</p> <p>A review of the written plans of care indicated the resident received dialysis 3 times a week. Interventions included, but were not limited to, "obtain weight per protocol."</p> <p>A review of the Weight Log for September 2014 for Resident #59 indicated the resident had a recorded weight on 9/5/14 of 142.4 pounds, 9/10/14 of 143.8 pounds, 9/11/14 of 147 pounds, and 9/12/14 of 148.2 pounds.</p>			

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	<p>The nursing progress notes lacked physician notification of the weight increase of 7 pounds in 1 week.</p> <p>The resident had a recorded weight on 9/14/14 of 144 pounds. The weight recorded on 9/15/14 was 148.6. The nursing progress notes lacked documentation of physician notification of the weight gain of 4.6 pounds in 1 day.</p> <p>The resident had a recorded weight on 9/20/14 of 140 pounds. The weight recorded on 9/21/14 was 144.2, a gain of 4.2 pounds in 1 day. The weight recorded on 9/22/14 was 148.4, a gain of an additional 4.2 pounds in 1 day. The nursing progress notes lacked documentation of physician notification of the weight gain.</p> <p>The resident had a recorded weight on 9/28/14 of 144.8 pounds, indicating a gain of 3 pounds from the last recorded weight on 9/26/14 of 141.8 pounds. The weight recorded on 9/29/14 was 149.8, a gain of 5 pounds in 1 day and 8 pounds in 2 days. The nursing progress notes lacked documentation of physician notification of the weight gain.</p> <p>A review of the Weight Log for Resident #59 for October 2014 indicated the resident was not weighed daily as</p>			

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F000312 SS=D	<p>ordered. The log lacked recorded weights on 10/2, 10/9, 10/11, and 10/14/14.</p> <p>The resident had a recorded weight on 10/10/14 of 145.1 pounds. The next recorded weight on 10/13/14 indicated a weight gain of 6 pounds. The nursing progress notes lacked documentation of physician notification of the weight gain.</p> <p>During an interview with Licensed Practical Nurse (LPN) #2 on 10/22/14 at 11:51 a.m., LPN #2 indicated the daily weights for the resident were recorded on the Weight Log. LPN #2 indicated the resident occasionally refused to be weighed but was not sure why the sheet had weights missing for some days.</p> <p>During an interview with the Director of Nursing on 10/23/14 at 9:51 a.m., the DON indicated the facility did not have a specific policy for daily weights and physician notification, "We just follow the physician's orders."</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good</p>						

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	<p>nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident who was unable to carry out activities of daily living, received the necessary services to maintain good grooming for 1 of 8 residents who met the criteria for review of activity of daily living services. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record of Resident #21 was reviewed on 10/22/14 at 11:2 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, altered mental status and chronic pain.</p> <p>On 10/20/14 at 10:35 a.m., some of Resident #21's fingernails were observed to be long, jagged, with fading finger nail polish.</p> <p>On 10/23/14 at 10:03 a.m., Resident #21's finger nails were observed to be long, or jagged and irregularly shaped.</p> <p>A quarterly Minimum Data Set assessment, dated 8/7/14, indicated Resident #21 was severely cognitively impaired and needed the assistance of staff for activities of daily living (ADL's).</p>	F000312	<p>F312 1. The fingernails of Resident #21 were trimmed and filed on October 23, 2014. A plan to maintain the good grooming of Resident #21 was implemented.</p> <p>2. All residents that are unable to carry out activities of daily living related to grooming have the potential to be affected. The nails of all dependent residents have been examined and care provided to those identified as requiring assistance and additional care is provided as requested by the Activity Staff.</p> <p>3. An educational offering will be provided to Nursing and Activity Staff regarding the completion of nail care and proper documentation on November 18, 2014. The nails of dependent residents will be observed by interdisciplinary team members on daily rounds and problems reported to nursing personnel. Additionally Certified Nursing Assistants will document nail care on twice weekly shower sheets.</p> <p>4. The Director of Nursing and/or her designee will monitor the nail care of five randomly selected dependent residents twice weekly for one month and then weekly for two months. Monitoring will continue twice monthly for four months. The Director of Nursing will report the findings of these reviews monthly to the Quality Assurance Committee.</p> <p>5. November 23, 2014</p>	11/23/2014			

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F000318 SS=D	<p>A care plan for Resident #21, dated 6/11/14, and current through 11/18/14, indicated the resident required limited to extensive assistance with Activities of Daily Living. The goal was, "Resident will have all ADL needs met by staff daily through next quarterly review."</p> <p>On 10/23/14 at 10:05 a.m., the Director of Nursing indicated nail care was not documented when it was done. It was often done in activities or hospice provided this service. A hospice bathing checklist form, dated 10/14/14, indicated the hospice Certified Nursing Assistant did not cut the resident's fingernails because the resident was diabetic. The form indicated, "Charge Nurse was informed that nails need to be cut." On 10/23/14 at 10:20 a.m. with the DON, Resident #21's fingernails were observed to be trimmed, but not filed. At that time, the DON spoke with the Activity Director, who indicated she would see that the resident's fingernails were filed.</p> <p>3.1-38(3)(E)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to</p>			

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	<p>prevent further decrease in range of motion. Based on interview and record review, the facility failed to ensure a resident with limited range of motion (ROM) received appropriate treatment and services to increase or prevent further decrease in range of motion. (Resident #66)</p> <p>Findings include:</p> <p>The clinical record of Resident #66, reviewed on 10/22/14 at 3:31 p.m., indicated the resident had diagnoses including, but were not limited to, cerebral vascular accident (CVA/stroke) and non-dominate hemiparesis (paralysis of one side of upper and lower extremities).</p> <p>A quarterly Minimum Data Set (MDS) assessment completed 10/2/14 assessed Resident #66 as having a functional limitation of range of motion (ROM) of both an upper and lower extremity. The MDS assessment indicated the resident had received restorative nursing programs of active range of motion (AROM) to all extremities 7 out of 7 days, 2 days out of 7 for a walking program, and dressing and grooming program 7 out of 7 days. The MDS lacked documentation of a restorative splint program.</p>	F000318	<p>F318 1. A restorative nursing plan including splint use has been written and implemented for Resident #66. 2. All residents that require or may require the use of a device to prevent the range of motion have the potential to be affected. Six months of therapy recommendations for current residents requiring a restorative plan for the use of a device have been reviewed to ensure that programs have been implemented. Future therapy recommendations for restorative programs will be reviewed and signed by both the therapy director and the Restorative Nurse Coordinator to ensure appropriate communication and implementation. 3. An educational offering will be provided to the Therapy Director and the Restorative Nursing Coordinator on November 12, 2014 regarding the process for communicating therapy recommendations for restorative programs. Additionally therapy recommendations will be reviewed by the interdisciplinary team in the weekly therapy meeting. 4. The Administrator and/or her designee will review recommendations for restorative programs suggested by the Therapy Department five times weekly for communication and signatures in the interdisciplinary team meeting for two months</p>	11/23/2014

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	<p>A review of the written plans of care indicated the resident had a restorative program for AROM to all extremities related to CVA and hemiplegia with a start date of 9/29/13.</p> <p>A care plan for hemiplegia with a start date of 6/11/13 lacked interventions of ROM or splints. Interventions included, but were not limited to, monitor labs as ordered, pain management as needed, and therapies to evaluate and treat as ordered.</p> <p>Another plan of care indicated the resident required a walk to dine restorative program to restore or maintain the ability to ambulate. Interventions included, but were not limited to, assist resident to walk to all meals.</p> <p>A recapitulation of physician's orders dated 10/1/14 - 10/31/14, indicated the resident had been receiving Physical Therapy (PT) 3 times a week for 4 weeks with a start date of 9/17/14.</p> <p>A review of the Occupational Therapy (OT) Discharge Summary dated 8/25/14, indicated the resident was discharged with a restorative nursing program (RNP), "To facilitate patient maintaining current level of performance and in order to prevent decline, development of and</p>		<p>and then once weekly for four months. The Administrator will report the findings of these reviews monthly to the Quality Assurance Committee. 5. November 23, 2014</p>	

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F000387 SS=D	<p>instruction in the following RNPs has been completed with the IDT (Interdisciplinary Team): splint or brace Care and ROM (Active).</p> <p>During an interview with the MDS Coordinator on 10/23/14 at 3:15 p.m., the MDS Coordinator indicated the resident had been receiving a restorative program for AROM but had not used a splint in a long time. When asked about the OT discharge summary recommendation for a RNP for a splint, indicated she would check on the recommendation. The MDS Coordinator indicated the facility did not write orders for restorative programs when the recommendation was received from therapy the recommendation was added to the assignments for the restorative aides.</p> <p>The MDS Coordinator indicated during an interview on 10/23/14 at 3:45 p.m., the restorative splint program was not implemented as recommended on 8/25/14.</p> <p>3.1-42(a)(2)</p> <p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155409	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2014
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	<p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on interview and record review, the facility failed to ensure a resident was seen by the attending physician once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (Resident #59)</p> <p>Findings include:</p> <p>The clinical record of Resident #59, reviewed on 10/22/14 at 10:40 a.m., indicated the resident had diagnoses including, but were not limited to, end stage renal disease. The resident was admitted to the facility on 4/21/14.</p> <p>A review of the physician progress notes indicated the resident was seen by the attending physician on 5/15/14 and 6/30/14. No other attending physician progress notes were found in the clinical record.</p> <p>The resident had a hospital stay for pneumonia from 8/22/14 through 8/28/14 and was readmitted to the facility on 8/28/14.</p> <p>During an interview with the Director of Nursing (DON) on 10/23/14 at 9:51 a.m., the DON indicated the physician had just</p>	F000387	<p><b>F387</b></p> <ol style="list-style-type: none"> <li>1. Resident # 59 was seen by her attending physician on October 24, 2014. A physician visit audit has been implemented to notify physicians of necessary visits to maintain the timeliness and frequency of physician visits.</li> <li>2. All residents admitted to and residing in the facility have the potential to be affected. The medical records of all current residents have been audited to ensure compliance. No deficiencies were noted. Physician visits are monitored by the Medical Record Designee under the supervision of the Director of Nursing. The attending physician is notified ten days prior to the necessary visit date to ensure timeliness. The medical director is notified one day after the necessary visit date if the attending physician has failed to visit to allow sufficient time for the resident to be seen.</li> <li>3. An educational offering will be provided to the Medical Records Designee on November 12, 2014 regarding physicians' visits. The Medical Records Designee has available a monitoring tool to ensure</li> </ol>	11/23/2014

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	<p>been in the building yesterday (10/22/14) and would check for the progress note.</p> <p>During an interview with the DON and the attending physician on 10/24/14 at 1:30 p.m., the physician and the DON indicated the resident was not in the facility when the physician visited in July 2014 and was in the hospital when the physician visited in August 2014. The physician indicated the next visit was 10/22/14 when the resident was again out of the building. The physician indicated the resident had not been physically seen for a progress note since 6/30/14.</p> <p>3.1-22(d)(1)</p>		<p>that residents admitted to the facility are seen by a physician at thirty, sixty, and ninety days and then every sixty days thereafter.</p> <p>All newly admitted residents will be added to the monitoring checklist forty-eight hours after admission to ensure appropriately timed visits. Physician visits for all current residents are monitored five times weekly for timeliness. Any discrepancies are reported immediately to the Director of Nursing and/or Administrator for appropriate action.</p> <p>4. All newly admitted residents will be added to the monitoring checklist forty-eight hours after admission to ensure appropriately timed visits. Physician visits for all current residents are monitored five times weekly for timeliness. The Medical Records Designee will monitor the frequency and timeliness of physician's visits five times weekly for two months and then once weekly thereafter. The Medical Records Designee will report the findings of these reviews monthly to the Quality Assurance Committee.</p> <p>5. November 23, 2014</p>	