STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENNINGS HEALTHCARE CENTER	701 HENRY ST NORTH VERNON, IN 47265

(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
F0000	This visit was for the Investigation of Complaint IN00122533. Complaint IN00122533 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282 and F325. Survey dates: January 28 and 29, 2013 Facility number: 010996 Provider number: 155665 AIM number: 200232210 Survey Team: Penny Marlatt, RN Census bed type: SNF/NF: 111 Total: 111 Census payor type: Medicare: 11 Medicaid: 89 Other: 11 Total: 111 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

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

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

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	Quality review 2/05/13 by Suzanne Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to promptly notify the attending physician of a resident's severe weight loss for 1 of 3 residents reviewed for weight loss	F0157	F157 SS=D Criteria #1 1. Resident A was discharged on 1/6/2013	02/15/2013

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	and physician notification in a sample of 3. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 1-18-13 at 11:30 a.m. Her diagnoses included, but were not limited to, cerebrovascular disease, high blood pressure, atrial fibrillation (irregular heart rhythm), scleroderma, encephalopathy, complex partial seizure disorder, anxiety, depression, dementia and fibromyalgia. Admission physician orders indicated to obtain daily weights. The daily weights were acknowledged on the resident's admission care plan, dated 10-23-12, under areas of concern related to dehydration/fluid management and nutrition status/diet. A separate nutrition/hydration management care plan, dated 10-23-12, had a goal for the resident to maintain the current (admission) weight without a significant change through the next revision, scheduled in January 2013. Interventions were indicated to weigh the resident weekly for 4 weeks, and then to weigh monthly. This care plan did not indicate, at the care plan revision meeting on 1-5-13, to resume resident weights on a weekly or daily basis, but did indicate a dietary		Criteria #2 1. Residents requiring daily weights were reviewed by IDT to validate weights were obtained. 1/28/2013 audit completed on all residents requiring daily weights were reviewed by IDT. 2. IDT reviewed for validation of daily , weekly, and monthly weights 3. Care plans reviewed and revised as indicated by the IDT. 4. All residents reviewed for IBW (Idea Body Weight) upon initial RD (Registered Dietician) assessment. 5. After completion of weights for current resident census, IDT will review for any significant weight loss occurring compared to the January 2013 monthly weights. 6. Any significant findings will be reported to the physician. Care plan reviewed and revised. Criteria #3 1. License staff re-educated by the DCS/ADCS on physician notification guidelines. 2. Certified Nursing Assistants to obtain daily, weekly, & monthly weights and report to the licensed nurse and DSM (Dietary Service Manager). 3. The licensed nurse will review and report to the physician as indicated. 4. Daily weights will be reviewed	

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	supplement had been ordered on 1-5-13. Resident #A's weight, as indicated on the admission Minimum Data Set (MDS) assessment, dated 10-30-12, was 105 pounds. Daily weights were obtained and documented on the Medication Administration Record (MAR) from admission through November 2012. The December 2012 MAR indicated only 6 documented weights on December 7, 8, 9, 21, 22 and 31. Additional weights were provided by the Dietary Manager on 1-28-13 at 5:30 p.m. on a document entitled, "Weight Information Menu," which indicated weights were obtained on December 1, 16, and 19, for a total of 9 weights obtained in December 2012. Weights for December were indicated as follows: 12-1-12 was 106.2 pounds (#); 12-7-12 was 97.4 #; 12-8-12 was 96.0 #; 12-9-12 was 96.0 #; 12-16-12 was 87.4 #; 12-19-12 was 84.2 #; 12-21-12 was 83.1 #; 12-22-12 was 83.2 #; 12-31-12 was 85.6 #. The weight loss from 12-1-12 to 12-7-12 indicated a weight loss of 8.8 pounds or 8.27 %, typically considered to be classified as more than significant weight loss, but considered severe weight loss as this		5x week in daily operations/clinical review by IDT 5. Weekly/monthly weights will be reviewed weekly during weight meetings. Criteria #4 1. DCS will QI monitor weights weekly X 4 weeks for 3 months to ensure documentation of physician notification related to weight loss/gain. 2. Findings will be brought to QAPI (Quality assurance performance improvement) for review and development of action plan to ensure physician is notified of weight loss/gain.	

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	weight loss occurred in less than one month. Review of Resident #A's dietary intake log for December 2012, indicated of 30 breakfasts served, she refused 2 and had an intake of less than 25% for 16 breakfasts. It indicated for 30 lunches provided, she had an intake of less than 25% for 24 and refused 9 lunches. It indicated for 31 suppers served, she had an intake of less than 25% for 16 and refused 3. It indicated of 29 evening snacks offered, she refused 11 and accepted 18. In interview with CNA #1 on 1-28-13 at 2:15 p.m., she indicated Resident #A, "was very skinny," and was a weekly weight. In interview with CNA #2 on 1-28-13 at 2:29 p.m., she indicated Resident #A was a weekly weight. She indicated Resident #A's husband "was concerned about her weight; he couldn't get her to eat either." In interview with CNA #3 on 1-28-13 at 2:45 p.m., she indicated Resident #A "was losing weight...wouldn't eat...very skinny." She indicated Resident #A was a weekly weight.			

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	In interview with the Administrator on 1-28-13 at 4:20 p.m., she indicated upon admission, Resident #A's spouse indicated the resident had lost a significant amount of weight (amount not known). She indicated he did not clarify if the weight loss had occurred prior to, or during, a recent hospitalization. In interview with the Administrator on 1-29-13 at 2:50 p.m., she indicated, "Anyone on weekly or daily weights should be in the weekly or SWAT (Skin, Weight, Admission, Transfer Review) meeting. So far, I've only found one SWAT meeting note for her." Review of nursing progress notes and medical progress notes did not reflect notification of the physician until a notation by the Nurse Practitioner on the back of a 12-17-12 progress note. This notation indicated, "Start appetite stimulant." Nursing progress notes, dated 12-18-12, indicated the appetite stimulant, Megace, was changed as it was a "non-covered med." It indicated it was changed to Remeron 7.5 milligrams daily for 30 days "due to Failure to thrive [sic]." The MAR indicated this medication was initiated on 12-19-12.			

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	The Administrator provided a copy of a document entitled, "Change in Condition," with a revision date indicated as 1-1-13. This policy indicated, "The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible...With change of resident status, the Nurse is responsible to complete an assessment of the resident's condition...must document the date, time, party's notified, findings and details of the notification in the Nurse's Notes." This federal tag relates to complaint IN00122533. 3.1-5(a)(2)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow the attending physician's written orders to weigh a resident daily with a severe weight loss occurring for this resident during the month of December 2012 when weights were not obtained, for 1 of 3 residents reviewed for physician's orders in a sample of 3. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 1-18-13 at 11:30 a.m. Her diagnoses included, but were not limited to, cerebrovascular disease, high blood pressure, atrial fibrillation (irregular heart rhythm), scleroderma, encephalopathy, complex partial seizure disorder, anxiety, depression, dementia and fibromyalgia. Admission physician orders indicated to obtain daily weights. The daily weights were acknowledged on the resident's admission care plan, dated 10-23-12, under areas of concern related to dehydration/fluid management and nutrition status/diet.	F0282	F282 Criteria #1 1. Resident A was discharged on 1/6/2013 Criteria #2 1. Residents requiring daily weights were reviewed by IDT to validate weights were obtained. 1/28/2013 audit completed on all residents requiring daily weights were reviewed by IDT. 2. IDT reviewed for validation of daily, weekly, monthly weights obtained, variances, or fluctuations of weights communicated to physician. 3. Care plans reviewed and revised as indicated by the IDT. 4. All residents reviewed for IBW (Idea Body Weight) upon initial RD (Registered Dietician) assessment. 5. After completion of weights for current resident census, IDT will review for any significant weight loss occurring compared to the January 2013 monthly weights. 6. Any significant findings reported to the physician. Care Plans reviewed and revised as indicated. Criteria #3	02/15/2013

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	A separate nutrition/hydration management care plan, dated 10-23-12, had a goal for the resident to maintain the current (admission) weight without a significant change through the next revision, scheduled in January, 2013. Interventions were indicated to weigh the resident weekly for 4 weeks, and then to weigh monthly. This care plan did not indicate, at the care plan revision meeting on 1-5-13, to resume resident weights on a weekly or daily basis, but did indicate a dietary supplement had been ordered on 1-5-13. Resident #A's weight, as indicated on the admission Minimum Data Set (MDS) assessment, dated 10-30-12, was 105 pounds. Daily weights were obtained and documented on the Medication Administration Record (MAR) from admission through November 2012. The December 2012 MAR indicated only 6 documented weights on December 7, 8, 9, 21, 22 and 31. Additional weights were provided by the Dietary Manager on 1-28-13 at 5:30 p.m. on a document entitled, "Weight Information Menu," which indicated weights were obtained on December 1, 16, and 19, for a total of 9 weights obtained in December, 2012.		1. License staff re-educated by the DCS/ADCS on physician notification guidelines and following the resident care plan . 2. Certified Nursing Assistants to obtain daily, weekly, & monthly weights and report to the licensed nurse. 3. The licensed nurse will review and report to the physician as indicated on fluctuation of any daily/weekly weights per order 4. Daily weights to be reviewed 5xweek in daily operations/clinical review by IDT. 5. Daily, weekly and monthly weights will be reviewed during the weekly weight meeting by the IDT. 6. Comprehensive resident care plan will be reviewed and or updated during the weekly weight meeting by the IDT. 7. DCS will QI monitor the daily, weekly, monthly weights for 3 months. Criteria #4 1. During the QI monitoring of the daily and weekly weights by the DCS, he/she will review the documentation that supports the physician notification of weight changes. 2. Findings will be brought to QAPI (quality assurance performance improvement) for review and development of action plan to ensure physician is notified of weight loss and review of the resident care plan.	

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	Weights for December were indicated as follows: 12-1-12 was 106.2 pounds (#); 12-7-12 was 97.4 #; 12-8-12 was 96.0 #; 12-9-12 was 96.0 #; 12-16-12 was 87.4 #; 12-19-12 was 84.2 #; 12-21-12 was 83.1 #; 12-22-12 was 83.2 #; 12-31-12 was 85.6 #. The weight loss from 12-1-12 to 12-7-12 indicated a weight loss of 8.8 pounds or 8.27 percent, typically considered to be classified as more than significant weight loss, but considered severe weight loss as this weight loss occurred in less than one month. In interview with the Assistant Director of Nursing on 1-28-13 at 4:20 p.m., she indicated she had reviewed the nursing notes and did not find any documentation of the resident refusing any weights from 12-9-12 to 12-21-12. She indicated the facility does not utilize a weight book or log, but the CNA's provide the weight information to the licensed nurse to document on the MAR for residents who have daily weights ordered. She indicated if a resident is on weekly weights, the Dietary Manager "puts out a sheet for these and tracks them." She indicated, "I assume the Dietary Manager tracks the daily weights in the same way. I'm not			

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	really sure how that works." In interview with the Dietary Manager on 1-28-13 at 4:20 p.m., she indicated, "I normally don't even know when someone is on daily weights." In interview with CNA #1 on 1-28-13 at 2:15 p.m., she indicated Resident #A, "was very skinny," and was a weekly weight. In interview with CNA #2 on 1-28-13 at 2:29 p.m., she indicated Resident #A was a weekly weight. She indicated Resident #A's husband "was concerned about her weight; he couldn't get her to eat either." In interview with CNA #3 on 1-28-13 at 2:45 p.m., she indicated Resident #A "was losing weight...wouldn't eat...very skinny." She indicated Resident #A was a weekly weight. In interview with the Administrator on 1-28-13 at 4:20 p.m., she indicated upon admission, Resident #A's spouse indicated the resident had lost a significant amount of weight (amount not known). She indicated he did not clarify if the weight loss had occurred prior to, or during, a recent hospitalization.			

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	In interview with the Administrator on 1-29-13 at 2:50 p.m., she indicated, "Anyone on weekly or daily weights should be in the weekly or SWAT (Skin, Weight, Admission, Transfer Review) meeting. So far, I've only found one SWAT meeting note for her." This federal tag relates to complaint IN00122533. 3.1-35(g)(2)			

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F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to ensure a resident's weight was monitored according to physician's written orders, with a severe weight loss occurring when ordered weights were not obtained, and failed to promptly notify the physician of the significant weight loss and implement nutritional interventions, for 1 of 3 residents reviewed for weight loss in a sample of 3. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 1-18-13 at 11:30 a.m. Her diagnoses included, but were not limited to, cerebrovascular disease, high blood pressure, atrial fibrillation (irregular heart rhythm), scleroderma, encephalopathy, complex partial seizure disorder, anxiety, depression, dementia and fibromyalgia.	F0325	F325 SS=D Criteria #1 1. Resident A was discharged on 1/6/2013 Criteria #2 1. Residents requiring daily weights were reviewed by IDT to validate weights were obtained. 1/28/2013 audit completed on all residents requiring daily weights were reviewed by IDT. 2. IDT reviewed for validation of weights obtained, variances, or fluctuations of weights communicated to physician. 3. Care plans reviewed and revised as indicated by the IDT. 4. Baseline weight obtained for current resident census by restorative staff. 5. After completion of weights for current resident census, IDT will review for any significant weight loss occurring compared to the January 2013 monthly weights. 6. Any significant findings will be	02/15/2013

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	Admission physician orders indicated to obtain daily weights. The daily weights were acknowledged on the resident's admission care plan, dated 10-23-12, under areas of concern related to dehydration/fluid management and nutrition status/diet. A separate nutrition/hydration management care plan, dated 10-23-12, had a goal for the resident to maintain the current (admission) weight without a significant change through the next revision, scheduled in January 2013. Interventions were indicated to weigh the resident weekly for 4 weeks, and then to weigh monthly. This care plan did not indicate at the care plan revision meeting on 1-5-13 to resume resident weights on a weekly or daily basis, but did indicate a dietary supplement had been ordered on 1-5-13. Resident #A's weight, as indicated on the admission Minimum Data Set (MDS) assessment, dated 10-30-12, was 105 pounds. Daily weights were obtained and documented on the Medication Administration Record (MAR) from admission through November 2012. The December 2012 MAR indicated only 6 documented weights on December 7, 8, 9, 21, 22 and 31. Additional weights were provided by the Dietary		reported to the physician. Care plan reviewed and revised by IDT 7. Dietary will be notified of orders from a physician that requires a resident to be placed on daily and or weekly weights. Criteria #3 1. Licensed staff and certified nursing assistance were re-educated on the importance of following physicians orders 2. Licensed staff and certified nursing assistance were re-education on facility policy on weighing the resident and definition of the parameters of what is significant weight loss or specific parameters set forth by ordering physician. 3. During the review of the daily weights, dietary intake will be reviewed for any weight loss noted. 4 Licensed staff and certified nursing assistants were re-education on facility policy on weighing the resident per physician orders. 5 Licensed staff were re-educated on the importance of notifying the physician of a significant weight loss. Criteria #4 1. Daily and weekly weights will be reviewed by the RD (Registered Dietitian) during their weekly visit at facility. 2. The Administrator will QI monitor the RD (Registered Dietitian) weekly notes for 3 months.	

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	Manager on 1-28-13 at 5:30 p.m. on a document entitled, "Weight Information Menu," which indicated weights were obtained on December 1, 16, and 19, for a total of 9 weights obtained in December 2012. Weights for December were indicated as follows: 12-1-12 was 106.2 pounds (#); 12-7-12 was 97.4 #; 12-8-12 was 96.0 #; 12-9-12 was 96.0 #; 12-16-12 was 87.4 #; 12-19-12 was 84.2 #; 12-21-12 was 83.1 #; 12-22-12 was 83.2 #; 12-31-12 was 85.6 #. The weight loss from 12-1-12 to 12-7-12 indicated a weight loss of 8.8 pounds or 8.27 percent, typically considered to be classified as more than significant weight loss, but considered severe weight loss as this weight loss occurred in less than one month. In interview with the Assistant Director of Nursing on 1-28-13 at 4:20 p.m., she indicated she had reviewed the nursing notes and did not find any documentation of the resident refusing any weights from 12-9-12 to 12-21-12. She indicated the facility does not utilize a weight book or log, but the CNAs provide the weight information to the licensed nurse to document on the MAR for residents who have daily weights ordered. She		3. During the QI monitoring of the daily and weekly weights by the DCS, he/she will review the documentation that supports the physician notification of weight changes. 4. Findings will be brought to QAPI (quality assurance performance improvement) for review and development of action plan to ensure physician is notified of weight loss and review of the resident care plan.	

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	indicated if a resident is on weekly weights, the Dietary Manager "puts out a sheet for these and tracks them." She indicated, "I assume the Dietary Manager tracks the daily weights in the same way. I'm not really sure how that works." Review of Resident #A's dietary intake log for December, 2012, indicated of 30 breakfasts served, she refused 2 and had an intake of less than 25% for 16 breakfasts. It indicated for 30 lunches provided, she had an intake of less than 25% for 24 and refused 9 lunches. It indicated for 31 suppers served, she had an intake of less than 25% for 16 and refused 3. It indicated of 29 evening snacks offered, she refused 11 and accepted 18. In interview with the Dietary Manager on 1-28-13 at 4:20 p.m., she indicated, "I normally don't even know when someone is on daily weights." In interview with CNA #1 on 1-28-13 at 2:15 p.m., she indicated Resident #A, "was very skinny," and was a weekly weight. In interview with CNA #2 on 1-28-13 at 2:29 p.m., she indicated Resident #A was a weekly weight. She			

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	indicated Resident #A's husband "was concerned about her weight; he couldn't get her to eat either." In interview with CNA #3 on 1-28-13 at 2:45 p.m., she indicated Resident #A "was losing weight...wouldn't eat...very skinny." She indicated Resident #A was a weekly weight. In interview with the Administrator on 1-28-13 at 4:20 p.m., she indicated upon admission, Resident #A's spouse indicated the resident had lost a significant amount of weight (amount not known). She indicated he did not clarify if the weight loss had occurred prior to, or during, a recent hospitalization. In interview with the Administrator on 1-29-13 at 2:50 p.m., she indicated, "Anyone on weekly or daily weights should be in the weekly or SWAT (Skin, Weight, Admission, Transfer Review) meeting. So far, I've only found one SWAT meeting note for her." Review of nursing progress notes and medical progress notes did not reflect notification of the physician until a notation by the Nurse Practitioner on the back of a 12-17-12 progress note. This notation indicated, "Start			

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	appetite stimulant." Nursing progress notes, dated 12-18-12, indicated the appetite stimulant, Megace, was changed as it was a "non-covered med." It indicated it was changed to Remeron 7.5 milligrams daily for 30 days "due to Failure to thrive [sic]." The MAR indicated this medication was initiated on 12-19-12. A consult was ordered on 1-1-13 with the facility's dietitian. Review of the "Initial and Annual Nutrition Assessment," indicated a lack of documentation of the resident's admission height, weight, usual weight, BMI (body mass index), adjusted weight and target weight. Current diagnoses and current diet order of a regular diet were indicated. A notation, dated 11-6-12, by the Registered Dietitian (RD), indicated, "Current diet regular. Intake is good at meals...will complete assessment when info becomes available. RD to follow as needed." The next notation was dated 1-5-13 and signed by the Dietary Manager which indicated a new order for a dietary supplement. Documentation did not indicate any issues with severe weight loss. In interview with the Dietary Manager on 1-28-13 at 4:20 p.m., she indicated the RD is normally scheduled for 16			

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	hours each month, usually divided up as 4 hours each week. She indicated she "didn't catch her on 1-2-13, her usual day, because of the holiday, so her next day here was January 9th." (The resident discharged from the facility on 1-6-13.) The Administrator provided a copy of a document entitled, "Change in Condition," with a revision date indicated as 1-1-13. This policy indicated, "The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible...With change of resident status, the Nurse is responsible to complete an assessment of the resident's condition...must document the date, time, party's notified, findings and details of the notification in the Nurse's Notes." The Administrator provided a copy of a document entitled, "Weekly Resident Progress Interdisciplinary Conference" with an effective date of March 2012. This policy indicated, "Resident progress meetings will be held weekly, coordinated and led by Care Manager...The information presented by the clinicians should			

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	indicate current resident status, present problems, and projected plan of care that will meet the projected outcome. Alterations and or changes in the outcome projection will be discussed at this time. The resident progress tracking form is a permanent part of the resident record....review will be detailed as outlined below...Current medical status...Alterations in nutritional status, diet, appetite, weight..." This federal tag relates to complaint IN00122533. 3.1-46(a)(1)			