

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/06/2013
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00136311.</p> <p>Complaint number #IN00136311 Substantiated. Federal/State deficiencies cited at F157 and F323.</p> <p>Survey dates: October 30, 31, November 1, 4, 5, 6, 2013</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 100266240</p> <p>Survey team: Amy Wininger, RN, TC Terri Walters, RN Dorothy Watts, RN Sylvia Martin, RN October 30, 31, and November 1, 2013</p> <p>Census bed type: SNF: 5 SNF/NF: 59 Total: 64</p> <p>Census payor type: Medicare: 13 Medicaid: 41 Other: 10</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective December 3, 2013 to the annual licensure survey conducted on October 30, 2013 through November 6, 2013. We also request that these corrections be reviewed for paper compliance. The facility will respectfully submit any additional information as needed.</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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	<p>Total: 64</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>			
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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the attending physician was notified of a significant change, in</p>	F000157	It is the practice of Transcendent Healthcare of Boonville to assure that the physician/family is notified properly when there is a change of condition. The correction action taken for those	12/03/2013

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	<p>that, the attending physician was not notified when a resident, who was identified as at risk for hydration issues, did not consume the recommended daily fluid intake for 16 days and failed to ensure a resident's family was notified of a new order, in that, a resident's family was not notified when a new order was received for lab testing and for a catheterization procedure to obtain the lab specimen for 2 of 22 residents reviewed in the Stage 2 sample. Resident A, Resident M</p> <p>Findings include:</p> <p>1. On 10/30/13 at 8:00 A.M., Resident A was observed to have dry, cracked lips with several areas of dark red slits and was observed to be calling out for water.</p> <p>The clinical record of Resident A was reviewed on 11/01/13 at 9:30 A.M. The record indicated the diagnoses of Resident A included, but were not limited to, UTI (Urinary Tract Infection), urinary retention, anorexia, and weight loss.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 09/26/13 indicated, Resident A experienced moderate cognitive</p>		<p>residents found to be affected by the deficient practice include: Resident A attending physician has been made aware of the issue of the resident not consuming adequate fluids. Resident M was a closed record and no longer resides in the facility. Other residents that have the potential to be affected have been identified by: All residents have been reviewed for any change of condition to assure that physician has been notified. In addition, a system has been implemented to assure that families are notified properly. Please see below for those system changes. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted with all nurses related to physician notification and family notification related to significant changes or order changes. The IDT team reviews the 24-hour report as well as all physician orders each business day. The IDT team will be reviewing for any changes to assure that the physician was notified properly. In addition, the IDT team will be reviewing the physician orders to assure that it identifies that the family has also been notified of necessary changes. The corrective action taken to monitor performance to assure compliance through quality assurance is: A</p>				

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	<p>impairment, required the extensive assist of one staff for drinking, and had experienced fever and vomiting during the assessment period.</p> <p>A Care Plan for "Recent Alteration in Patterns of Elimination" dated 10/27/13 included, but was not limited to, interventions of "Monitor fluid intake and output as needed...notify MD with significant change in status..."</p> <p>The October 2013 Physician Order Recap included, but was not limited to, orders for "...encourage fluid intake at least 1000 ml [milliliters] /day..."</p> <p>An Initial Nutritional Assessment dated 01/23/13 indicated "...Problem: Potential for Alteration in ...Hydration r/t [related to] BMI [Body Mass Index] of 16.1 [underweight] ...daily needs: ...1575-1750 cc fluid..."</p> <p>The October 2013 Consumption Record and MAR indicated the total daily fluid intake of Resident A was:</p> <table border="0"> <tr> <td>10/16/13</td> <td>1120 ml</td> </tr> <tr> <td>10/17/13</td> <td>610 ml</td> </tr> <tr> <td>10/18/13</td> <td>915 ml</td> </tr> <tr> <td>10/19/13</td> <td>940 ml</td> </tr> <tr> <td>10/20/13</td> <td>520 ml</td> </tr> </table>	10/16/13	1120 ml	10/17/13	610 ml	10/18/13	915 ml	10/19/13	940 ml	10/20/13	520 ml		<p>Performance Improvement Tool has been initiated that randomly observes 5 residents that have changes in condition or the plan of care/services to assure that the physician/family have been notified appropriately . The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions or training as needed based on the outcome of the PI tool.</p>			
10/16/13	1120 ml															
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	<p>10/21/13 610 ml</p> <p>10/22/13 830 ml</p> <p>10/23/13 950 ml</p> <p>10/24/13 890 ml</p> <p>10/25/13 720 ml</p> <p>10/26/13 640 ml</p> <p>10/27/13 590 ml</p> <p>10/28/13 520 ml</p> <p>10/29/13 970 ml</p> <p>10/30/13 890 ml</p> <p>10/31/13 925 ml</p> <p>The Nursing Notes from 10/14/13 through the last nursing note on 10/30/13 were reviewed and lacked any documentation the physician had been notified of Resident A not consuming the recommended amount of fluid.</p> <p>During an interview on 11/06/13 at 10:10 A.M. the DON indicated the physician had not been notified of the resident not meeting required fluid needs.</p> <p>The ADON (Assistant Director of Nursing) indicated 11/06/13 at 11:41 A.M., no documentation could be found to indicate the attending physician of Resident A had been notified that the fluid requirements had not been met from 10/16/13 through 10/31/13 (16 days).</p>			

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	<p>2. The clinical record of Resident M was reviewed on 10/31/13 at 11:00 A.M.</p> <p>Resident M's nursing note of 11/4/12 at 11:30 A.M., indicated, "Dr.[Dr's name] was called & new order received to do a I [in] & O [out] cath [catheterization] to collect urine specimen for UA [urinalysis] C [culture] S [sensitivity]."</p> <p>Nursing note of 11/4/12 at 6:00 P.M., indicated, "I & O cath done s [without] problems. Urine specimen collected & placed on ice. Call placed to lab to come in AM et pick [arrow up symbol] ."</p> <p>Nursing note dated 11/5/12 at 6:00 P.M., indicated, "Dr. [Dr's name] aware of UA [urinalysis] results et [and] is awaiting for cultured sensitivity."</p> <p>A physician's telephone order dated 11/4/12, indicated, " 1. May I & O cath. PRN [if necessary] to collect urine specimen." The telephone order had a box to be checked for family and resident notification. The</p>			

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	<p>box had been left unchecked for family and for resident notification.</p> <p>On 11/5/13 at 12:50 P.M., the Assistant Director of Nursing (ADON) was made aware that documentation was lacking in the clinical record of family notification of urinalysis and the in and out catheterization done on 11/4/13. The nursing notes of 11/4/13 and 11/5/13 and the telephone order of 11/4/13 were reviewed with the ADON on 11/5/13 at 12:50 P.M. The ADON indicated at that time families need to be notified of physician orders.</p> <p>The Policy and Procedure for Physician Notification provided by the HFA (Health Facility Administrator) on 11/06/13 at 1:30 p.m. indicated, "...It is the policy of this facility to assure that the resident's physician/POA [Power of Attorney]/Guardian/or Interested family member is kept aware of change in resident's condition. Procedure: ...2. If at any time there is a change in the residents' conditions, it is the nurses' responsibility to assure that the physician, as well as, the POA/Guardian/Interested family member are notified of the changes...3. Examples of areas (not all inclusive) are identified below:</p>			

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	<p>...Presence of potential infection, decreased hydration intake...".</p> <p>This Federal tag relates to Complaint #IN00136311.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>				

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F000246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents, whose care required the use of call lights, had their call lights placed within reach for 4 of 35 residents reviewed during Stage 1. Resident #57, Resident #62, Resident H, Resident #24</p> <p>Findings included:</p> <p>1. During 2 separate observations on 11/4/13 at 9:35 A.M. and 10:55 A.M., Resident #57 was observed in his room, lying on his bed with the head of the bed elevated. Resident #57's call light cord was draped over the arm of his reclining chair. Resident #57's reclining chair was located 5 feet away from Resident #57's bed.</p> <p>During an observation on 11/4/13 at 11:55 A.M., CNA #4 entered Resident #57's room and asked if he wanted</p>	F000246	<p>It is the practice of Transcendent Healthcare of Boonville to assure that call lights are accessible to the residents. The correction action taken for those residents found to be affected by the deficient practice include: Residents #24, #57, #62 and H have their call lights accessible and have frequent monitoring. Other residents that have the potential to be affected have been identified by: All residents have their call lights in place and have frequent monitoring. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The policy related to call lights has been amended to include accessibility of the call lights to residents while in their rooms. All nursing staff has been in-serviced related to assuring that residents have call lights accessible in accordance to the policy. In addition, all staff has been in-serviced related to observing to assure that call lights are in place as all personnel can observe for call lights as they are performing their duties in accordance with the facility</p>	12/03/2013			

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	<p>the head of the bed lowered. CNA #4 exited the room after lowering the head of the bed.</p> <p>During an interview with CNA #4 in Resident #57's room on 11/4/13 at 12:00 P.M., CNA #4 indicated that Resident #57 would sometimes use his call light to call for assistance. Upon making CNA #4 aware the call light was located on the arm of the reclining chair, CNA #4 indicated the call light should be placed within Resident #57's reach on the bed, and CNA #4 stated, " It usually is." CNA #4 exited the room without placing the call light within Resident #57's reach on the bed. CNA #4 proceeded down the hall to the nurses ' station.</p> <p>During an observation on 11/4/13 at 12:42 A.M., Resident #57 had the call light button in his hand.</p> <p>On 11/6/13 at 9:14 A.M., the clinical record for Resident #57 was reviewed. Diagnoses included, but were not limited to, the following: dementia with behaviors, anxiety, depression, coronary artery disease and hypertension. Resident #57's admission date was 8/13/13.</p> <p>An MDS (Minimum Data Set)</p>		<p>policy. In addition, nursing administration is making random rounds throughout the facility to assure that call lights are accessible. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly review 5 residents to assure that the call light is accessible per observation. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools.</p>				

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	<p>assessment dated 9/28/13 indicated Resident #57 needed the assistance of one person for his activities of daily living which included the following: Transferring from the bed to chairs, dressing and toileting.</p> <p>A CNA assignment sheet dated 10/31/13 indicated Resident #57 needed the assistance of one person with his "...ADL CARE and TRANSFER/MOBILITY..."</p> <p>2. During an interview with Resident #62 on 10/31/13 at 2:45P.M., Resident #62 was lying on her bed . Resident #62 was running her hands along the sheets of her bed and indicated she was looking for the call light. Resident #62 indicated that when the CNA's sometimes forgot to put the call light on the bed, Resident #62 would yell for the CNA's to come and help. Resident #62 said, "Oh yeah, it happens." (Resident #62 was referring to the failure of CNA's to place the call light within reach on the bed.)</p> <p>The call light was observed to be draped over 2 blue mats located behind the head of Resident #62's bed. The call light was not within reach of Resident #62.</p>			

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	<p>On 11/6/13 at 8:34 A.M., Resident #62's clinical record was reviewed. Her diagnoses included, but were not limited to, right intertrochanteric hip fracture, hypertension, breast cancer and depression. Resident #62's admission date was 6/15/2012. Nurses notes dated 9/14/13 were reviewed and read as follows"...Alert and oriented et (and) uses call light for assistance..." Quarterly Nursing assessment dated 9/15/13 was reviewed and documented that Resident #62 was alert and oriented. The call light policy provided by the DON on 11/6/13 at 8:33 A.M. did not include any instructions or documentation to provide a call light to the resident in a way which enabled the resident to use it properly and effectively.</p> <p>3. During an observation of Resident H on 10/30/13 at 10:53 A.M., Resident H's call light was hanging on the wall. The call light was out of Resident H's reach.</p> <p>During an interview on 10/30/13 at 10:55 A.M., CNA #10 indicated Resident H needed to have his call</p>			

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	<p>light placed within reach and she would take the necessary action to accommodate his needs.</p> <p>On 11/5/13 at 10:55 A.M., the clinical record for Resident H was reviewed.</p> <p>The Care plan for Falls, dated 09/25/13, included, but was not limited to, interventions of "...keep call light and most frequently used personal items within reach..."</p> <p>The MDS dated 08/17/13 indicated Resident H experienced moderate cognitive impairment.</p> <p>4. During an observation of Resident #24 on 10/30/13 at 10:43 A.M., Resident #24 was sitting in her wheelchair at her bedside. The call light button was clipped to her pillow. Resident #24 was unable to reach her call light to call staff. Resident #24 requested that her call light be moved from her pillow (where it was out of her reach) to the side of her bed where she could reach it while still in her wheelchair.</p> <p>During an interview on 10/30/13 at 10:55 A.M., CNA #10 indicated that Resident #24 needed to have her call light placed within reach.</p>						

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	<p>On 11/6/13 at 10:34 A.M., Resident #24's clinical record was reviewed. Her diagnoses included, but were not limited to, over active bladder, diabetes mellitus 2, bipolar disorder and hypertension.</p> <p>The call light policy provided by the DON on 11/6/13 at 8:33 A.M., lacked any documentation related to providing a call light to resident capable of using it.</p> <p>During an interview on 11/5/13 at 1:30 P.M., the Director of Nursing (DON) indicated when a resident was unattended a call light should be within reach.</p> <p>3.1-3(v)(1)</p>			

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents observed during medication administration received medications according to acceptable standards of nursing practice, in that a transdermal patch was not rotated and applied as directed by the manufacturer. Resident #53</p> <p>Findings include:</p> <p>During the medication pass on 11/5/13 at 10:39 A.M., Resident #53 indicated that her Exelon patch had fallen off and had been replaced on 11/04/13. The Exelon patch was observed to be placed on Resident #53's upper right chest. That patch placement was documented with the date 11/4/13. While pointing with her hand to the upper left and right sides of her chest, Resident #53 indicated that patches were always placed on her left or right side.</p> <p>During an interview with LPN #13 on 11/5/13 at 10:49 A.M., LPN #13 indicated there was no documentation</p>	F000281	<p>It is the practice of this facility to assure that patches are rotated appropriately in accordance with the manufacturer's guidelines. The correction action taken for those residents found to be affected by the deficient practice include: Resident #53 is receiving the Exelon Patch in accordance with the manufacturer's guidelines. The rotating of sites is identified on the MAR. Other residents that have the potential to be affected have been identified by: All residents have been reviewed. Those with orders for patches are receiving them in a manner in accordance with the manufacturer's guidelines. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The nurses/QMAs have been in-serviced related to assuring that they are documenting the site applications for patches. The in-service also included that any new orders for patches should automatically have a site rotation included. In addition, the IDT team reviews physician orders each business day. The team will also assure that any new orders related to patches have rotation sites</p>	12/03/2013

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	<p>on the Medication Administration Record (MAR) as to the placement location for any of the Exelon transdermal patches.</p> <p>The clinical record of Resident #53 was reviewed on 11/5/13 at 1:02 P.M. The record indicated the diagnoses of Resident #53 included, but were not limited to, dementia, migraine, bipolar, diabetes mellitus.</p> <p>The Plan of Care dated 8/19/13 lacked any documentation related to the Exelon transdermal patch placement being monitored to the manufacturer's specifications.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 07/9/13 indicated Resident #53 was cognitive intact.</p> <p>The October 2013 Physician's Order read as follows: "Exelon (a medication used to treat mild to moderate dementia) 4.6 mg [milligram/24hr [hour] patch. Apply patch every 24 hours. Remove old patch when applying new one."</p> <p>The October and November 2013 Medication Administration Record (MAR) indicated the Exelon patch had been administered daily to Resident</p>		<p>documented on the MAR. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will randomly review 5 residents with orders for patches (if applicable) to assure the documentation identifies rotation of site per manufacturer's guidelines. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.</p>				

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	<p>#53 from October 1st, 2013 through November 4th, 2013. The MAR lacked any documentation related to the placement of the Exelon patch on the body of Resident #53.</p> <p>The Nursing 2013 Drug Handbook 33rd edition page 1203 indicated: "Exelon...Administration...transdermal s...change the site daily, and don't use the same site within 14 days..."</p> <p>During an interview with the DON on 11/5/13 10:55 A.M., the DON indicated she consulted with the pharmacist about issues of Exelon patch placement and rotation. The DON said that the pharmacist suggested the placement and rotation of the Exelon patch be documented on the MAR according to the manufacturer's recommendations. The DON indicated that a correction to the MAR providing for such documentation would be made on 11/05/13.</p> <p>3.1-35(g)(1)</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, interview, and record review the facility failed to ensure a resident at risk for hydration issues was monitored according to the plan of care, in that, a resident with a history of recent dehydration was not comprehensively monitored for fluid intake for 1 of 22 residents in the Stage 2 sample. Resident A</p> <p>Findings include:</p> <p>On 10/30/13 at 8:00 A.M., on 10/31/13 at 8:30 A.M., and on 11/1/13 at 8:36 A.M., Resident A was observed to have dry, cracked lips with several areas of dark red slits and was observed to be calling out for water.</p> <p>The clinical record of Resident A was reviewed on 11/01/13 at 9:30 A.M. The record indicated the diagnoses of Resident A included, but were not limited to, UTI (Urinary Tract Infection), urinary retention, anorexia, and weight loss.</p>	F000282	<p>It is the practice of Transcendent Healthcare of Boonville to assure that services are provided in accordance with the plan of care. The correction action taken for those residents found to be affected by the deficient practice include: Resident A is receiving fluid monitoring in accordance with the plan of care. Other residents that have the potential to be affected have been identified by: All residents have been reviewed and are receiving services in accordance with the plan of care related to hydration. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The nurses have been in-service related to assuring that residents receive services in accordance with the plan of care. The in-service included assuring that hydration intake is monitored appropriately for those residents that they identify to have poor intakes or have any indicators of adequate hydration issues. The IDT team will also be actively involved with assuring that any resident that has hydration issues is monitored adequately in accordance with the plan of care.</p>	12/03/2013			

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	<p>A Care Plan for "Recent Alteration in Patterns of Elimination" dated 10/27/13 included, but was not limited to, interventions of "Monitor fluid intake and output as needed...notify MD with significant change in status..."</p> <p>The October 2013 Physician Order Recap included, but was not limited to, orders for "Pureed Diet with Regular liquids...encourage fluid intake at least 1000 ml [milliliters] /day..."</p> <p>The October 2013 MAR lacked any comprehensive documentation the actual fluid intake of Resident A had been monitored.</p> <p>A handwritten accounting of Resident A fluid intake for October 16, 2013 through October 31, 2013 was provided by the DON [Director of Nursing] on 11/06/13 at 10:00 A.M. During an interview, at that time, the DoN indicated the accounting had been prepared on 11/05/13 and the fluid intake of Resident A had not been accurately monitored and should have been monitored more closely.</p> <p>During an interview on 11/01/13 at</p>		<p>The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to hydration and monitoring of intake as deemed appropriate in accordance with the plan of care. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools.</p>		

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	<p>10:43 A.M., LPN #16 indicated the fluid intake of Resident A had not been not monitored.</p> <p>During an interview on 11/06/13 at 10:10 A.M., the DON indicated the physician had not been notified of the resident not meeting required fluid needs.</p> <p>The ADON (Assistant Director of Nursing) indicated 11/06/13 at 11:41 A.M., no documentation could be found to indicate the attending physician of Resident A had been notified that the fluid requirements had not been met from 10/16/13 through 10/31/13 (16 days).</p> <p>During an interview on 11/06/13 at 11:47 A.M. the DON indicated, there was no specific policy to monitor fluid intake and output.</p> <p>The policy and procedure for Physician Notification provided by the HFA (Health Facility Administrator) on 11/06/13 at 1:30 p.m. indicated, "...It is the policy of this facility to assure that the resident's physician/POA [Power of Attorney]/Guardian/or Interested family member is kept aware of change in resident's condition. Procedure: ...2. If at any time there is a change in the</p>			

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	<p>residents' conditions, it is the nurses' responsibility to assure that the physician, as well as, the POA/Guardian/Interested family member are notified of the changes...3. Examples of areas (not all inclusive) are identified below: ...Presence of potential infection, decreased hydration intake..."</p> <p>3.1-35(g)(2)</p>			

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F000310 SS=D	<p>483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>Based on observation, interview, and record review, the facility failed to ensure bathroom facilities were available to a resident, in that, a bathroom was not available to a continent resident for 1 of 3 residents in a sample of 5 who met the criteria for review of urinary incontinence decline. This practice resulted in the resident experiencing 3 (three) episodes of bowel incontinence and 2 (two) episodes of bladder incontinence during October 2013.</p> <p>Resident #29</p> <p>Findings include:</p> <p>During an interview with Resident #29 in her room on 11/1/13 at 10:00 A.M., Resident #29 said, "I'm angry. I've s--- my pants and p---- on myself because I can't get into the bathroom."</p>	F000310	<p>It is the practice of this facility to assure that the all residents receive services in a manner that prohibits a decline in ADLs when preventable. The correction action taken for those residents found to be affected by the deficient practice include: Resident #29 continence needs are being met. The resident is aware where the shower room bathrooms are located as well as per this resident's agreement; a bedside commode has been placed in the room for emergency occasions. T Other residents that have the potential to be affected have been identified by: All residents have been reviewed to assure that they believe that they have access to their restrooms as needed. No additional residents voiced being affected at this time. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The nursing staff has been in-serviced related to assuring</p>	12/03/2013

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	<p>Resident #29 indicated that there was always another resident in the bathroom. Resident #29 indicated sometimes she would need to find an empty room and use the bathroom in that room to avoid being incontinent. Resident #29 said, "I can go to the bathroom by myself. I don't need help. I've told everybody who will listen about this, but it is hard to get anything done around here."</p> <p>During the interview with Resident #29 in her room on 11/1/13 at 10:00 A.M., Resident #53 (who resided in the adjacent room but shared a bathroom with Resident #29) was in the bathroom, opened the bathroom door and said, "I heard you talking. I live in the room next door and three women share this bathroom. Many times I have to stop my bath and put my gown on and leave the bathroom so she can go to the toilet."</p> <p>During an interview with CNA #3 on the East Hall on 11/1/13 at 10:29 A.M., CNA #3 indicated that Resident #29 was continent of bowel and bladder and that Resident #29 wore underwear, not briefs. CNA #3 indicated that sometimes Resident #29 could not get into her bathroom because the other two residents in the adjacent room shared the</p>		<p>that residents have access to their bathrooms as needed. The in-service included assuring that if residents are identified to have any episode of incontinence related to not being able to immediately utilize the restroom facilities that this needs to be communicated to nursing administration so that interventions can be implemented appropriately. Please see monitoring systems below to assure that this issue does not reoccur. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will randomly reviews 5 residents to assure that services are provided in a manner that does not cause a decline in ADL status including the ability to have no decline in continence. The form will interview alert oriented residents to assure that services provided to them are acceptable including bathroom accessibility and will review elimination records of continent residents to assure that any episodes of incontinence were identified and evaluated as to possible cause. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled</p>		

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	<p>bathroom with her. CNA #3 indicated that there were occasions when Resident #29 would accidentally urinate and/or defecate in her pants because one or the other of the two residents from the adjoining room were in the bathroom, preventing Resident #29 from accessing the bathroom.</p> <p>The clinical record was reviewed on 11/4/13 at 10:37 A.M. The clinical diagnoses included, but were not limited to, acute pancreatitis with severe epigastric pain, renal insufficiency, cardiomegaly, congestive heart failure, hypertension, gout, and depression.</p> <p>The most recent MDS (Minimum Data Set Assessment) dated 09/20/13 indicated Resident #29 experienced no cognitive impairment and occasional incontinence of bowel and bladder.</p> <p>The October 2013 Physician's Orders were as follows, but not limited to, "...Lasix (a diuretic) 20 mg once a day...Activities level up ad lib..."</p> <p>A Quarterly Nursing Assessment dated 09/13/13 indicated that Resident #29 was continent of bladder and bowels and no program</p>		meeting following the completion of the tool with recommendations as needed based on the outcome of the audit.				

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	<p>was needed.</p> <p>The CNA assignment sheet was reviewed on 11/1/13 at 1:30 P.M. It indicated that Resident #29 was continent of bladder and bowels.</p> <p>The CNA BM (bowel movement) log for October, 2013 indicated, Resident #29 experienced bowel incontinence on October 17, 19, and 25, 2013.</p> <p>The CNA Treatment Record for October 2013 indicated, Resident #29 experienced bladder incontinence on October 8, and 30, 2013.</p> <p>During an interview with the DON (Director of Nursing) on 11/5/13 at 3:10 P.M., the DON indicated she had not been informed that Resident #29 had not been able on various occasions to access her bathroom. The DON indicated she would immediately make Social Services aware of this circumstance.</p> <p>3.1-38(a)(2)(C)</p>				

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F000323 SS=E	<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.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure interventions to prevent falls were effective, and/ or adequate supervision had been provided to prevent falls for 1 of 3 residents reviewed for falls. Resident H</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure that the residents' environment in 1 of 1 shower room located on West Hall was free of potentially hazardous materials which were being stored in an unlocked cabinet. These hazardous materials had the potential to impact 9 of the 22 residents residing on West Hall who were cognitively impaired. Resident Z, Resident P, Resident Q, Resident K, Resident W Resident Y, Resident R, Resident V, Resident J</p> <p>Findings include: A. On 11/1/13 at 10:10 A.M.,</p>	F000323	<p>It is the practice of this facility to assure that adequate supervision is provided to prevent incidents as well as interventions implemented appropriately if an incident occurs to assist with preventing future incidents. In addition, it is the practice of the facility to assure that chemicals are stored appropriately in a locked area. The correction action taken for those residents found to be affected by the deficient practice include: Resident H has been reviewed and proper interventions are in place to assist with the prevention of falls. There are no longer chemicals stored in a cabinet in the west shower room. Other residents that have the potential to be affected have been identified by: All residents have been reviewed that are identified as being at risk for falls. Each of these residents has appropriate interventions in place to assist with the prevention of falls All areas where chemicals are stored have been reviewed to assure that the chemicals are properly secured. The measures or systematic changes that have been put into place to ensure that</p>	12/03/2013

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	<p>Resident H was observed sitting in his wheelchair with a pressure pad alarm in his wheelchair.</p> <p>The clinical record of Resident H was reviewed on 11/05/13 at 10:55 A.M. The record indicated Resident H had been admitted to the facility on 5/8/13. His diagnoses included but were not limited to: dementia with behavior problem, depression, anxiety, coronary artery disease, and Alzheimer's disease.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 05/20/13 indicated, Resident H required extensive assistance of one staff for transfers, limited assistance of one staff for ambulation, and experienced severe cognitive impairment.</p> <p>The most recent quarterly MDS dated 08/17/13 indicated, Resident H required extensive assistance of two staff for transfers and ambulation, and experienced severe cognitive impairment.</p> <p>His current care plan included a problem of at risk for falls which had been initiated on 5/8/13. Interventions included, but were not limited to: encourage resident to call when needing assistance, keep call</p>		<p>the deficient practice does not recur include: Residents will be assessed at the time of admission, with a significant change, and quarterly thereafter for fall risk. If a resident is identified as being at risk for falls, the IDT will review to assure there are proper interventions in place for fall prevention. If a fall occurs, the nurse is responsible for the immediate intervention. This fall is then reviewed by the IDT where a thorough investigation is conducted as to possible root cause of the fall with appropriate interventions to assist with the prevention of reoccurrence. Special care will occur to assure that no intervention is implemented that may have been previously implemented. The nurses have been in-serviced related to immediate interventions to assist with the prevention of falls. The IDT team has been in-serviced related to assuring that interventions implemented to assist with the prevention of reoccurrence have not been previously utilized or attempted. All staff has been in-serviced related to assuring that chemicals are stored and secured appropriately. The nurses are responsible for assuring that any chemicals are stored properly on their designated shifts. Facility administration will also be making rounds to assure that chemicals are secured properly. The corrective action taken to monitor</p>				

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	<p>light and most frequently used items in reach, and the bed in the lowest position...</p> <p>A physician's order dated 6/27/13 indicated a pressure pad alarm had been ordered for the resident's wheelchair.</p> <p>Fall #1: A facility's Incident/Accident Report dated 8/2/13 at 7:00 P.M., indicated Resident H had fallen in the front lounge of the facility. The report indicated the fall had been unwitnessed. "...Resident stood from the wheelchair while staff attending other residents. Alarm sounded & he was found on floor on right side. Cried in pain when ROM [range of motion]on RUE [right upper extremity]. Skin tear Rt [right] elbow 3 cm x 0.5 cm. Bruise 6 x 6 cm inner aspect elbow..."</p> <p>An IDT dated 8/5/13 indicated, "Resident had fell from w/c [wheelchair] while sitting in lobby- He has impaired cognition- attempts to ambulate without assist, however impaired balance & weakness. Chair alarm was sounding. He had just eaten dinner. Staff to assist Res [resident] to bed after dinner as fall intervention."</p>		<p>performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that reviews 5 residents (if applicable) related to falls and proper interventions. The tool will specifically observe for new interventions as needed to assist with fall prevention related to the possible root cause. The tool will also observe for proper storage of chemicals via rounds and assurance that they are secured properly. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools.</p>		

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	<p>Fall #2: Another fall occurred on 8/16/13. A facility Incident/Accident Report dated 8/16/13 at 8:40 P.M., indicated Resident H had fallen in his room. "...Resident found on floor after staff responded to alarm but were unable to stop fall. No new injuries. Moves limbs x 4."</p> <p>A facility IDT note dated 8/16/13, indicated, "Resident had fall from bed. Has impaired cognition. Attempts transfers without assist. Staff to toilet res [resident] prior to bed time. Also, perimeter mattress place [sic]."</p> <p>Fall #3: A facility Incident/Accident Report dated 9/14/13 indicated a fall had occurred at 10:50 P.M., in the resident's room. The report indicated the fall had been unwitnessed. "...Resident found on floor beside bed. Abrasions to back- left 10 cm x 7.8 cm, right 28 cm x 6.5 cm..."</p> <p>A 9/15/13 IDT note indicated, "Res has impaired cognition & will attempt to get up without assist. Unable to state what he was attempting to do. Alarm placed on bed to alert staff to assist as needed."</p> <p>Fall #4: A facility Incident/accident Report dated 9/16/13 at 3:00 A.M.,</p>						

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	<p>indicated a fall had occurred in Resident H's room. The report indicated, "...Resident got out of bed into w/c [wheelchair] et fell. A 3 cm by 2 cm S/T [skin tear] noted on left upper arm et 2 cm by 2 cm S/T [skin tear] Rt [right] elbow..." The report indicated the alarm had not sounded. "...The cord was not attached to pad..."</p> <p>An IDT note dated 9/17/13, indicated, "Res [resident] attempted self transfer from bed to w/c [wheelchair] resulting in fall. It was noted that alarm cable was broken. Res assisted to bed c [with] new bed alarm placed."</p> <p>Fall #5: Another fall occurred on 9/17/13. A facility Incident/Accident Report dated 9/17/13 at 10:30 P.M., indicated Resident H had fallen in his room. "...Resident had been in bed x 2 hours. Sleeping. CNA heard noise-bed alarm- resident found on floor beside bed. Area of mild contusion noted on mid thoracic back area..."</p> <p>A 9/18/13 IDT note indicated, "Resident observed on floor. Was sleeping in bed earlier. Currently has bed alarm in place- Will place low bed as intervention."</p> <p>Fall # 6: A facility Incident/Accident</p>			

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	<p>Report dated 9/24/13 at 4:00 P.M., indicated Resident H had fallen in his room. "...Resident in wheelchair in his room & attempted to stand s [without] assist. Sustained no injuries..." The report indicated the fall had been unwitnessed.</p> <p>An IDT note dated 9/25/13 indicated, "Res [resident] fell from w/c [wheelchair] while in room. Res wife had just visit & left res unattended in w/c in room. Alarm was sounding. Wife instructed to notify staff when leaving so res can seated [sic] in lobby for closer supervision."</p> <p>Fall #7: Another fall occurred on 10/25/13. A facility Incident/Accident Report dated 10/25/13 at 4:55 P.M., in the main dining room indicated, "...Resident stood up in DR [dining room] attempting to transfer self et [and] sat on floor. Inc [incontinent] of bladder. 0 [zero] injury noted fall witnessed by staff. ROM [range of motion] good. 0 [zero] c/o [complaints] voiced. 0 [zero] S/S [signs and symptoms] distress. Skin W/D [warm and dry] et intact..."</p> <p>Facility Incident Documentation dated 10/25/13, indicated an immediate intervention was to implement a toileting schedule.</p>			

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	<p>On 11/5/13 at 2:15 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed regarding Resident H's fall history. The DON and ADON were made aware the same intervention of a bed alarm had been implemented as an intervention after the 9/16/13 fall when it had been ineffective in preventing the 9/16/13 fall. The DON indicated the same type of bed alarm had been reapplied after the 9/16/13 fall due to the facility utilizing only one type of bed alarms.</p> <p>On 11/5/13 at 2:30 P.M., the ADON provided an admission bowel and bladder assessment dated 8/5/13. The documentation indicated Resident was incontinent of bladder. The form also indicated, "...Determination: Resident would benefit from planned toileting..."The DON and ADON were also made aware the intervention of a toileting program had been initiated after the 8/16/13 fall in regard to toileting before bedtime. The DON indicated, at that time, Resident H had been toileted by staff before bed time, but had not been on a routine toileting program thru out the day until after the 10/25/13 fall.</p>			

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	<p>On 11/6/13 at 10:55 A.M., during interview with the DON, she was made aware of Resident H had been observed in bed on 10/30/13 at 10:53 A.M., with his call light out of reach hanging from the call light device on the wall above his bed. At that time Restorative CNA #1 had been made aware his call light was out of reach. Restorative CNA #1 indicated the resident needs his call light in reach and she would put it in reach. The DON was also made aware Resident H had a care plan initiated on 5/8/13 addressing fall risk. The care plan included but was not limited to an intervention: "...Keep call light and most frequent used personal items within reach..." The DON indicated at this time the call light not in reach and the delay in the toileting program after the admission assessment were valid issues. She indicated the resident almost needs to be supervised 1:1.</p> <p>B. During the initial tour of the facility on 10/30/13 at 9:16 A.M., an unlocked cabinet located in the shower room on West Hall contained the following items: Wintergreen Scent Disinfectant 25 ounce bottle, McKesson's Shaving Cream ,</p>			

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	<p>McKesson's Stay-Dri Performance Perineal and Skin Cleanser, McKesson's Anti-perspirant spray 2 ounce bottle, Dollar General Smooth and Silky lotion.</p> <p>Warning Labels located on the packaging of the above listed items were as follows:</p> <ol style="list-style-type: none"> 1. Wintergreen Scent Disinfectant 25 ounce bottle" ...Keep out of reach of children...irreversible eye damage and skin burns...corrosive, causes irreversible skin damage. ...harmful if swallowed, inhaled or absorbed thru skin, avoid breathing sprayed mist. do not get in eyes skin or on clothing, wear goggles or face shield...rubber gloves when handling..." 2. McKesson's Peri Fresh Perineal Cleaner "... Caution... for external uses only, avoid contact with eyes, keep out of reach of children..." 3. Three cans of McKesson's Shaving Cream "...Keep out of reach of children..." 4. One 32 ounce bottle of Dollar General Body Smooth and Silky conditioner " ... Warning... for external uses only, keep out of reach of children, avoid contact with eyes, if contact occurs rinse thoroughly with water..." 5. McKesson's Anti-perspirant 						

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	<p>"...Keep out of reach of children...warning... for external use only...do not use on broken skin...if swallowed contact poison control center immediately... or contact physician..."</p> <p>During an interview with CNA #7 on 11/5/13 at 2:30 P.M., CNA #7 indicated that the chemical storage cabinet must be locked when no one is in the shower room. CNA #7 also indicated that confused residents resided on this hall and that these residents could potentially walk into the shower room and access chemicals in an unlocked storage cabinet.</p> <p>During an interview with LPN #2 on 10/30/13 at 9:16 A.M., LPN #2 indicated there were 9 (nine) confused residents who resided on West Hall.</p> <p>The Policy and Procedure for Chemical Storage was provided by the DON (Director of Nursing) on 11/6/13 at 8:33 A.M. It read as follows: "... 6. Staff members utilizing the chemicals are responsible for assuring that when the chemicals are not in use they are stored in a secure manner."</p>			

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	<p>During an interview with the DON on 11/5/13 at 9:25 A.M., the DON indicated cabinets containing chemicals should be locked when not in use or were unattended. The DON indicated the cabinet had been removed from the shower room.</p> <p>This Federal tag relates to Complaint #IN00136311.</p> <p>3.1-45(a)(2)</p>			

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F000327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was provided adequate fluids, in that, a resident, who was identified as at risk for hydration issues, was not monitored to ensure the recommended amount of fluid was provided for 1 of 1 residents who met the criteria for review of hydration. Resident A</p> <p>Findings include:</p> <p>On 10/30/13 at 8:00 A.M., Resident A was observed to have dry, cracked lips with several areas of dark red slits and was observed to be calling out for water.</p> <p>On 10/31/13 at 8:30 A.M., Resident A was observed to have dry, cracked lips with several areas of dark red slits and during an interview, at that time, indicated she needed water.</p> <p>On 11/01/13 at 8:36 A.M., Resident A was observed to have dry, cracked lips with several areas of dark red slits. Resident A was observed to be</p>	F000327	<p>It is the practice of Transcendent Healthcare of Boonville to assure that resident receive proper monitoring for hydration The correction action taken for those residents found to be affected by the deficient practice include: Resident A is being monitored for fluid intake. The Dietician has also reviewed this resident and recalculated hydration needs based on body weight. The attending physician/family is aware of this resident's fluid intakes. Other residents that have the potential to be affected have been identified by: All residents have been reviewed related to hydration. For any resident identified to have decreased consumption, strict fluid monitoring will be initiated. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Residents are assessed for potential hydration issues on admission, if a significant change occurs, and quarterly. Those residents identified as being at risk for hydration will be identified as such on the plan of care. A policy has been implemented related to fluid monitoring including the need for strict intake monitoring</p>	12/03/2013	

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	<p>calling out for water.</p> <p>The clinical record of Resident A was reviewed on 11/01/13 at 9:30 A.M. The record indicated the diagnoses of Resident A included, but were not limited to, UTI (Urinary Tract Infection), urinary retention, anorexia, and weight loss.</p> <p>A Hospital History and physical examination dated 09/16/13 indicated Resident A had been treated, at that time, for Urinary Tract Infection with a high fever, vomiting, and dehydration.</p> <p>A Hydration Risk Assessment dated 09/18/13 indicated, Resident A was at risk of developing hydration issues.</p> <p>The October 2013 Late Loss ADL (Activities of Daily Living) flow sheet indicated Resident A required the extensive assist on one for drinking fluids.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 09/26/13 indicated, Resident A experienced moderate cognitive impairment, required the extensive assist of one staff for drinking, and had experienced fever and vomiting during the assessment period.</p>		<p>when indicated. Nurses are responsible for identifying and communicating to the IDT if a resident is identified to have indicators of hydration issues or is identified to have decreased fluid consumption. Those residents will be placed on strict intake monitoring. In addition, the IDT will be reviewing the dining consumption records for all residents at least weekly to assure that residents are consuming their fluids with meals and to assist with identifying any resident that may be inadequate in fluid intake and require further review or interventions such as strict intake monitoring. The nurses have been in-serviced related to the policy including indicators of hydration issues, implementation of intake monitoring, and communication with the IDT team. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to hydration and proper intake monitoring for any resident that is identified to not have adequate fluid intake. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance</p>		

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	<p>A Care Plan for "Recent Alteration in Patterns of Elimination" dated 10/27/13 included, but was not limited to, interventions of "Monitor fluid intake and output as needed...notify MD with significant change in status..."</p> <p>A Care plan for "DX [diagnosis] GERD [Gastroesophageal Reflux Disease] [a gastrointestinal disorder] Symptoms" dated 06/05/13 included, but was not limited to, an intervention of "...monitor resident intake..."</p> <p>The October 2013 Physician Order Recap included, but was not limited to, orders for "Pureed Diet with Regular liquids...encourage fluid intake at least 1000 ml [milliliters]/day... 120 cc [cubic centimeters] [1[one] cc is equal to 1 ml [milliliter] Medpass [a high calorie supplement] by mouth twice daily...4 oz [ounce] House Supplement [a high calorie supplement] TID [three times a day] 1 hr [hour] AC [before meals]..."</p> <p>The October 2013 Consumption Record indicated the total fluid intake of Resident A during meals was:</p> <table border="0"> <tr> <td>10/16/13</td> <td>660 ml</td> </tr> <tr> <td>10/17/13</td> <td>360 ml</td> </tr> <tr> <td>10/18/13</td> <td>440 ml</td> </tr> </table>	10/16/13	660 ml	10/17/13	360 ml	10/18/13	440 ml		Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.	
10/16/13	660 ml									
10/17/13	360 ml									
10/18/13	440 ml									

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	10/19/13 600 ml			
	10/20/13 420 ml			
	10/21/13 360 ml			
	10/22/13 480 ml			
	10/23/13 660 ml			
	10/24/13 660 ml			
	10/25/13 420 ml			
	10/26/13 300 ml			
	10/27/13 480 ml			
	10/28/13 300 ml			
	10/29/13 580 ml			
	10/30/13 600 ml			
	10/31/13 660 ml			
	The October 2013 MAR (Medication Administration Record) indicated Resident A's total fluid intake of Medpass was:			
	10/16/13 170 ml			
	10/17/13 180 ml			
	10/18/13 160 ml			
	10/19/13 170 ml			
	10/20/13 50 ml			
	10/21/13 100 ml			
	10/22/13 180 ml			
	10/23 13 120 ml			
	10/24/13 180 ml			
	10/25/13 180 ml			
	10/26/13 240 ml			
	10/27/13 60 ml			
	10/28/13 120 ml			
	10/29/13 180 ml			
	10/30/13 180 ml			
	10/31/13 140 ml			

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	<p>The October 2013 MAR indicated Resident A's total fluid intake of the House Supplement was:</p> <table border="0"> <tr><td>10/16/13</td><td>290 ml</td></tr> <tr><td>10/17/13</td><td>70 ml</td></tr> <tr><td>10/18/13</td><td>315 ml</td></tr> <tr><td>10/19/13</td><td>170 ml</td></tr> <tr><td>10/20/13</td><td>50 ml</td></tr> <tr><td>10/21/13</td><td>150 ml</td></tr> <tr><td>10/22/13</td><td>170 ml</td></tr> <tr><td>10/23/13</td><td>170 ml</td></tr> <tr><td>10/24/13</td><td>50 ml</td></tr> <tr><td>10/25/13</td><td>120 ml</td></tr> <tr><td>10/26/13</td><td>100 ml</td></tr> <tr><td>10/27/13</td><td>50 ml</td></tr> <tr><td>10/28/13</td><td>100 ml</td></tr> <tr><td>10/29/13</td><td>210 ml</td></tr> <tr><td>10/30/13</td><td>110 ml</td></tr> <tr><td>10/31/13</td><td>125 ml</td></tr> </table> <p>The October 2013 MAR lacked any comprehensive documentation the actual fluid intake of Resident A had been monitored.</p> <p>An Initial Nutritional Assessment dated 01/23/13 indicated "...Problem: Potential for Alteration in ...Hydration r/t [related to] BMI [Body Mass Index] of 16.1 [underweight] ...daily needs: ...1575-1750 cc fluid..."</p> <p>The most recent Nutritional Progress</p>	10/16/13	290 ml	10/17/13	70 ml	10/18/13	315 ml	10/19/13	170 ml	10/20/13	50 ml	10/21/13	150 ml	10/22/13	170 ml	10/23/13	170 ml	10/24/13	50 ml	10/25/13	120 ml	10/26/13	100 ml	10/27/13	50 ml	10/28/13	100 ml	10/29/13	210 ml	10/30/13	110 ml	10/31/13	125 ml						
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	<p>Note dated 10/11/13 indicated Resident A received 120 ml Medpass bid [twice daily], 4 four] oz [ounce] House Supplement bid and with 8 oz supplement tid with meals. The note lacked any documentation r/t fluid intake monitoring or fluid needs.</p> <p>The clinical record indicated the total daily fluid intake of Resident A was:</p> <table border="0"> <tr><td>10/16/13</td><td>1120 ml</td></tr> <tr><td>10/17/13</td><td>610 ml</td></tr> <tr><td>10/18/13</td><td>915 ml</td></tr> <tr><td>10/19/13</td><td>940 ml</td></tr> <tr><td>10/20/13</td><td>520 ml</td></tr> <tr><td>10/21/13</td><td>610 ml</td></tr> <tr><td>10/22/13</td><td>830 ml</td></tr> <tr><td>10/23/13</td><td>950 ml</td></tr> <tr><td>10/24/13</td><td>890 ml</td></tr> <tr><td>10/25/13</td><td>720 ml</td></tr> <tr><td>10/26/13</td><td>640 ml</td></tr> <tr><td>10/27/13</td><td>590 ml</td></tr> <tr><td>10/28/13</td><td>520 ml</td></tr> <tr><td>10/29/13</td><td>970 ml</td></tr> <tr><td>10/30/13</td><td>890 ml</td></tr> <tr><td>10/31/13</td><td>925 ml</td></tr> </table> <p>The most recent lab report for CMP (Complete Metabolic Profile) (a blood test to measure fluid balance) dated 10/14/13 included, but was not limited to, the following results:</p> <p>"..BUN [Blood Urea Nitrogen] 42 mg</p>	10/16/13	1120 ml	10/17/13	610 ml	10/18/13	915 ml	10/19/13	940 ml	10/20/13	520 ml	10/21/13	610 ml	10/22/13	830 ml	10/23/13	950 ml	10/24/13	890 ml	10/25/13	720 ml	10/26/13	640 ml	10/27/13	590 ml	10/28/13	520 ml	10/29/13	970 ml	10/30/13	890 ml	10/31/13	925 ml						
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	<p>[milligram]/dL [deciliter]...High...Reference Range 8.0-26.0]...</p> <p>bun/creat [creatinine] ratio [a test that measures kidney function] 70 ... Reference Range...none indicated... Albumin [a test that measures blood protein levels] 3.0 g [grams]/dL... low...Reference Range [3.5-5.0]..."</p> <p>A Nursing Note dated 10/27/13 at 2130 (9:30 P.M.) indicated Resident A experienced an episode of anuria (no urination) during that shift.</p> <p>A handwritten accounting of Resident A fluid intake for October 16, 2013 through October 31, 2013 was provided by the DON [Director of Nursing] on 11/06/13 at 10:00 A.M. During an interview, at that time, the DON indicated the accounting had been prepared on 11/05/13. The accounting indicated the daily fluid intake of Resident A did not meet the dietician's recommendation from 10/16/13 through 10/31/13 and did not meet the Physician's ordered fluid intake for 15 of 16 days during the same time period. She further indicated, at that time, the fluid intake of Resident A had not been accurately monitored and should have been monitored more closely.</p>				

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	<p>During an interview on 11/06/13 at 10:10 A.M., the DON indicated the dietician's daily fluid need recommendation was in error because it did not take into account the resident weight. The DON further indicated, the daily fluid need of Resident A was 878 ml per day.</p> <p>During an interview on 11/01/13 at 10:43 A.M., LPN # 16 indicated it was the policy of the facility to monitor fluid intake only if a resident was on a fluid restriction or had a catheter. LPN #16 further indicated, at that time, there was a separate form that would be used to track fluid intake. LPN #16 then indicated, at that time, Resident A was not on a fluid restriction and did not have a catheter so the fluid intake of Resident A had not been not monitored.</p> <p>The ADON (Assistant Director of Nursing) indicated 11/06/13 at 11:41 A.M., there was no documentation to indicate the attending physician of Resident A had been notified of the fluid requirements not having been met from 10/16/13 through 10/31/13 (16 days.)</p> <p>During an interview on 11/06/13 at 11:47 A.M. the DON indicated, there was no specific policy to monitor fluid</p>			

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	<p>intake and output. She further indicated, at that time, CNA documentation was routinely reviewed and if a concern was identified related to fluid intake, the resident's intake and output would be monitored as a nursing measure.</p> <p>3.1-46(b)</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</p> <p>Based on observation, interview, and record review, the facility failed to ensure dietary equipment was clean and/ or food sanitation practices were in place for 2 of 2 kitchen observations. This had the potential to affect 64 of 64 residents who resided in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 10/30/13 at 8:15 A.M., the following was observed:</p> <ol style="list-style-type: none"> Two (2) large plastic containers were observed to contain opened sacks of flour and opened sacks of white rice and powdered milk. The containers had lids that were soiled with a large amount of the white food substances. The initial tour continued to the the area of the kitchen where the hand sink was located. The lower 	F000371	<p>It is the practice of Transcendent Healthcare of Boonville to assure that food is prepared, stored, and served in a manner that is within acceptable sanitation guidelines. The correction action taken for those residents found to be affected by the deficient practice include: There are no specific residents identified. The 2 large plastic containers storing flour, rice, and powdered milk have been cleaned. The hand sink bowl has been thoroughly cleaned and the trash can located under the sink has been cleaned. The chemical solution is being checked for proper strength with the test strips each time a new bucket of solution is made. The ice machine in the kitchen has been thoroughly cleaned. The 3 pots/pans identified have been discarded and new pots/pans ordered for replacement. The bottom shelf where the skillets and stock pots were stored has been thoroughly cleaned. The steam table has been thoroughly cleaned. Other residents that have the potential to be affected have been identified by: Potentially all residents could be</p>	12/03/2013			

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	<p>bowl area of the hand sink had areas of dark discoloration. The tan plastic trash can located under the hand sink had a lid with brown soilage and staining.</p> <p>3. On 10/30/13 at 8:22 A.M., Dietary Staff #1 was observed cleaning the top of a stainless steel food preparation area using a cloth from the food contact surface solution bucket. The Food Service Manager (FSM) was asked to check the chemical content of the food contact solution. She used a QT-10 paper strip to check the solution. The strip registered 0 (zero). The FSM indicated at that time the solution should not be 0 (zero) PPM (parts per million). Then at 8:24 A.M., the FSM made another bucket of the food contact solution and then checked the new solution. The solution strip indicated 200 PPM. The FSM indicated she wanted the solution to be in the 200 to 400 PPM range.</p> <p>During a second kitchen observation on 11/04/13 at 9:30 A.M., the following was observed:</p> <p>4. The inside lid edge of the kitchen ice machine had brown soilage when a paper towel was wiped along the lid edge. The FSM indicated at that time</p>		<p>affected. Please see systematic changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All dietary staff has been in-serviced related to assuring that the dietary is maintained properly related to cleaning schedules and expectation of sanitation. The Dietary Manager will be responsible for assuring that the kitchen is maintained properly and that staff is following the cleaning schedules as assigned. The Dietary Manager is also responsible for making daily rounds in the dietary to determine if any areas need additional cleaning above and beyond what is on the routine cleaning schedule. In addition, administration will make rounds in the kitchen at least weekly to assure that the dietary is clean and being maintained appropriately. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes the dietary department 2 times in a weekly period to assure that the areas is identified as clean. Specifics that were identified during the survey will be included in the review. The Dietary Manager, or designee, will</p>	

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	<p>the ice machine had soilage and needed cleaned.</p> <p>5. The 9:30 A.M., tour continued and aluminum pots and pans were observed stored on the bottom of a metal shelfe island. Two - 12 inch skillets and one (1)-10 inch skillet were observed to be completely covered with black burnt food build up inside and outside of the skillets. One large aluminum soup/stock pot was also observed to have a large amount of black burnt food debris on the outside of the pot. The FSM indicated at that time new pots and pans were needed due to the large amount of burnt on food debris and indicated she was removing the 3 pans and the pot.</p> <p>6. The bottom shelfe of the island where the 2 skillets and the stock/soup pot had been stored was observed to have a black sticky substance with dried food particles when a hand was wiped across the outer edge of the shelfe. The FSM indicated the shelfe was soiled.</p> <p>7. The 9:30 A.M., tour continued in the kitchen. The 4 compartment steam table was observed to have a large amount of white and brown food particles floating in a small amount of</p>		complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed for additional interventions as necessary.		

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	<p>water in each of the 4 compartments. The FSM indicated the steam table compartments were soiled with food particles.</p> <p>8. Next, the kitchen hand sink was observed to have a brown substance at the base of the sink facet and the bowl of the sink remained discolored. The tan trash can under the hand sink had staining and soilage on the lid as observed on 10/30/13 (four days prior).</p> <p>9. The 9:30 A.M., tour continued and the 2 large plastic containers of flour, powdered milk and rice continued to have a large amount of white food substance on the lids as observed on 10/30/13 (four days prior).</p> <p>10. On 11/5/13 at 1:50 P.M., during interview with the FSM, indicated she had been aware of a problem with the food contact solution on 10/30/13. She indicated a service staff member had been at the facility on 11/4/13 to check on the chemical used for the solution. The FSM indicated at that time the steam table needed to be drained and cleaned once a week and that had not been done.</p> <p>11. On 11/5/13 at 2:09 P.M., the FSM provided a copy of the facility</p>						

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	<p>kitchen cleaning schedule entitled Dietary Cleaning Schedule (no date). The cleaning schedule indicated, "...Procedure: all equipment will be identified for cleaning. The frequency and position assigned to the item is designated on the schedule..." The kitchen ice machine schedule indicated the frequency of the cleaning was monthly. The FSM indicated at that time the ice machine needed to be cleaned more than monthly.</p> <p>3.1-21(i)2 3.1-21(i)3</p>			