

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1649 SPY RUN AVENUE FORT WAYNE, IN 46805
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 24, 25, 26, 29, 30, & 31, 2013</p> <p>Facility number: 000167 Provider number: 155266 AIM number: 100273740</p> <p>Survey team: Sue Brooker RD TC Julie Call RN Angie Strass RN Virginia Terveer RN</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 5 Medicaid: 47 Other: 6 Total: 58</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 5, 2013 by Randy Fry RN.</p>	F000000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 08/23/2013</p>	

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

TITLE

(X6) DATE

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

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F000282 SS=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 follow physician orders for a fluid restriction for 1 resident (Resident #23) of 32 residents reviewed for physician orders. The facility also failed to follow a physician's order for completing wound care for 1 resident of 32 residents reviewed for following physician orders (Resident #62).</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #23 began on 7-29-2013 at 3:31 p.m., indicated the following diagnoses included but were not limited to, renal abscess, diabetes, depression, hypothyroidism and gastroesophageal reflux disease.</p> <p>A review of the Physician orders on admission from the hospital on 5-11-2013 indicated a fluid restriction of 1200 cc (cubic centimeters) daily.</p> <p>A review of the diet order and communication form completed by</p>	F000282	<p>F – 282 Service by Qualified person</p> <p>It is the policy of this facility to provide services by qualified persons in accordance with each plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #23 had order clarified for fluid restriction/distribution. The nutritional assessment was updated to include a fluid distribution between nursing and dietary. Dietary ticket was updated with current distribution amounts per each meal per dietary. Medication sheet was also updated with nursing amounts and times for administration. Resident #62 had no negative outcome.</p> <p>How will other residents having the potential be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>No other residents were identified at risk for fluid restriction. Other residents identified as having wound treatments are at risk. All residents with current physician orders for wound treatments were</p>	08/23/2013			

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	<p>nursing for dietary was dated 5-11-2013 and indicated a renal diet with 1200 cc daily fluid restriction.</p> <p>A review of the Physician orders for July 2013 and signed by the physician on 7-13-2013 indicated a 1200 cc fluid restriction.</p> <p>A review of Resident #23's physician orders for 7-2-2013, indicated Miralax (a laxative) was ordered daily with 6 ounces (180 cc) water daily.</p> <p>A review of the nutritional assessment completed by the Registered Dietitian on 5-15-2013, indicated Resident #23 had a regular renal diet with 1200 cc fluid restriction and received Pro Sup (protein supplement) 30 cc tid (3 times a day) and Nepro (protein supplement) 1 can BID (2 times a day). The nutritional assessment did not indicate a fluid distribution plan between dietary and nursing.</p> <p>A review of the dietary ticket for 7-30-2013 indicated a fluid restriction of 1200 cc daily, but did not include how to divide the fluids between meals</p> <p>During an interview on 7-30-2013 at 9:55 a.m., the Certified Dietary Manager (CDM) indicated dietary</p>		<p>audited for missing documentation.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff will be re-educated on policy of fluid restrictions, documentation of fluids, distribution of fluids and following physicians' orders for wound care by the SDC. Documentation of Fluid intakes and the following of physician orders are being monitored by DON/ADON/designee daily Monday thru Friday x 30 days, weekly x 4 weeks, monthly and x4 months.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will be not recur, i.e., what quality assurance program will be put into place; All monitoring of fluid restriction documentation and following physician orders is to be completed by DON/ADON/designee daily Monday thru Friday per schedule above. All non-compliant issues to be addressed monthly at PI meeting.</p> <p>By what date the systemic changes will completed – 08/23/2013</p>		

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	<p>provided 720 ml of fluids per day. The CDM indicated Resident #23 was provided with 240 ml of fluid for each meal per the resident choice, but the information was not printed on the dietary meal ticket.</p> <p>During an additional interview on 7-30-2013 at 11:05 a.m., the CDM indicated he was unable to provide a fluid distribution plan for Resident #23 and the Nurse Consultant indicated the fluid distribution plan was not on the MAR (Medication Administration Record or in the dietician's notes.</p> <p>A review of Resident #23's MAR for July 2013 indicated the resident received medication 4 times daily. No record of fluid intake by nursing was documented on the July 2013 MAR.</p> <p>During an interview on 7-30-2013 at 11:09 a.m., the Consultant Nurse and LPN #10 indicated fluid intake amounts for residents should be completed by the Certified Nursing Assistant (CNA) after meals and documented on the Life Care Center Fluid Monitoring sheet. Further interview with the Consultant Nurse and LPN #10 indicated Nursing should document fluid intake with the medication pass on a form in the MAR. The Nurse Consultant and</p>						

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	<p>ADON indicated they had no explanation on the missing fluid intake amounts for July 2013 on the Fluid Monitoring sheet or for the MAR.</p> <p>During an interview on 7-30-2013 at 11:10 a.m., LPN #8 indicated he used a blue cup which contained 120 cc water per medication pass and the resident received medications 4 times daily except on dialysis days. In addition, LPN #8 indicated the resident received Miralax in 6 ounces (180 cc) of water daily.</p> <p>A review of the Life Care Center Fluid Monitoring sheet for July 2013 indicated documentation of fluid intake was not recorded for the following dates for the breakfast and lunch meals: July 1, 2, 3, 5, 6, 7, 8, 10, 15, 16, 17, 18, 19, 20, 21, 23, 24, 25, 26, 27, 29, 2013 or for the supper meal and hs (bedtime) snack: July 6, 7, 9, 15, 16, 17, 19, 20, 21, 22, 25, 26, 2013.</p> <p>A review of the Life Care Center Fluid Monitoring sheet for June 2013 indicated the following fluid intake amounts in excess of the 1200 cc daily fluid restriction: 1780 cc for June 1, 4, 5, 6, 7, 8, 12, 26 and 28; 1820 cc for June 2, 3 and 11; 1420 cc</p>			

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	<p>for June 9 and 12; 1660 cc for June 10, 16 and 27; 2620 cc for June 14; 1300 cc for June 15; 1560 cc for June 17, 18, 20, 21, 22, 24 and 29; 1440 cc for June 19; 1680 cc for June 23 and 25; and 2400 cc for June 30.</p> <p>A review of the Care Directive (resident information for the aides) for Resident #23 dated 7-24-2013 and an updated Care Directive on 7-29-2013 indicated the resident had an 1800 cc fluid restriction, with the dietary amount at 1440 cc and the nursing amount at 360 cc.</p> <p>During an interview on 7-30-2013 at 11:15 a.m., the Nurse Consultant indicated she was unable to explain why the fluid restriction of 1800 cc was listed on the Care Directive on 7-24-2013 and for the Care Directive updated 7-29-2013 when the physician order was for 1200 cc daily.</p> <p>During an observation and interview on 7-30-2013 at 1:30 p.m., CNA #9 was observed obtaining a large cup of ice for Resident #23. She took it to her room and filled the large cup with a 12 ounce can of diet Pepsi. CNA #9 indicated the resident usually drank 2 diet Pepsis on her shift and she documented the Pepsi intake on the Fluid Monitoring sheet in addition</p>			

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	<p>to the fluids the resident received at meals.</p> <p>During an interview on 7-30-2013 at 1:35 p.m., the DON and the Nurse Consultant indicated there was not a specific facility policy on fluid restrictions. The DON and the Nurse Consultant were unable to explain how the staff documented the fluid intake on the Fluid Monitoring sheet.</p> <p>A policy "Hydration" dated 3-1-2013 and provided by the DON on 7-30-2013 at 1:12 p.m., indicated "...nursing and the Director of Food and Nutrition Services determines the amount of fluid to be provided by each department whenever there are orders for fluid restrictions...."</p> <p>2. Review of the clinical record for Resident #62 began on 7-29-2013 at 10:19 a.m. indicated diagnoses included but were not limited to, cerebral vascular accident, hypertension, dementia, muscle spasms, hypothyroidism, benign prostatic hyperplasia, depression, insomnia, gastroesophageal reflux disease, bile duct stenosis and allergic rhinitis.</p> <p>Review of physician orders indicated the initial orders for the treatment on</p>				

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	<p>the pressure area were dated 6-17-2013 and were to be completed twice a day and as needed.</p> <p>Review of physician orders on 6-24-2013 indicated a treatment change with treatments to be completed twice a day and as needed.</p> <p>Review of physician orders on 6-28-2013 indicated a treatment change with treatments to be completed daily an as needed.</p> <p>Review of the TAR (treatment administration record) for June 2013 indicated missing initials for treatments on 6-19, 21, 24, 26, 27 and 29.</p> <p>Review of physician orders on 7-8-2013 indicated a treatment change with treatments to be completed twice a day and as needed.</p> <p>Review of the TAR for July 2013 indicated the twice a day dressing change from the 6-24-2013 order and the 6-28-2013 treatment change order for a daily dressing change for the same wound were both carried over and documented on the July 2013 TAR. The twice a day dressing</p>			

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	<p>change lacked initials for one of the treatments on July 1, 5, 6, and 7, 2013. The daily dressing change lacked initials for the daily treatments on July 1, 6 and 7, 2013.</p> <p>Review of the June and July 2013 TAR, indicated no documentation of refusal of the treatment for the dressing change on the back page of the TAR.</p> <p>Review of the nurse's notes from 6-17-2013 through 7-8-2013 indicated no documentation of the resident's refusal of the treatment for the pressure ulcer.</p> <p>During an interview on 7-30-2013 at 1:55 p.m., the DON indicated the missing initials on the TAR indicated the treatments were not done or the nurse forgot to initial the TAR after the treatment was completed or the resident refused the treatment and there should be additional documentation regarding the refusal.</p> <p>During an interview on 7-30-2013 at 2:18 p.m., LPN #8 indicated he would document in the TAR after Resident #62's pressure ulcer treatment was completed. LPN #8 indicated if the resident refused treatment, he would indicate the refusal by placing a circle</p>			

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	<p>on the treatment date/time on the TAR, document the refusal in the nurse's note and notify the physician.</p> <p>An undated policy, "Wound Care" provided by the Nurse Consultant on 7-30-2013 at 2:46 p.m., indicated the following:</p> <p>"1. Medical treatments must be documented on a treatment record in the resident's medical record. 2. The nurse is responsible for administration and recording all treatments according to the physician orders. 3. Each nurse giving treatment will sign his or her name on the treatment form. Treatments are recorded on the proper form using the nurse's initials. Changes in a wound, refusal of a treatment...will be documented...."</p> <p>3.1-35(g)(2)</p>						

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F000371 SS=E	<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 staff washed their hands for the recommended amount of time, failed to use a paper towel as a protective barrier to turn off the water faucet, and failed to re-wash hands after touching contaminated items in 2 of 3 dining rooms potentially affecting 26 of 26 residents who ate their meals in the Beecher Hall dining room and the Denton Court dining rooms.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal on 7/25/13 at 11:50 a.m. in the Beecher Hall dining room, Speech Therapy staff #2 was observed to wash her hands for the recommended amount of time. She was not observed to use a paper towel as a barrier when turning off the water faucet. She was then observed to sit with a resident in the dining room and</p>	F000371	<p>F – 371 Hand Washing It is the policy of this facility to ensure all staff follows the policy on hand washing. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident was directly affected by this negative practice.</p> <p>How will other residents having the potential be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this negative practice. All staff were re-educated and audited for compliance in hand washing during meal service.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Facility staff were re-educated on policy and procedure of hand washing by the SDC. Department heads will monitor staff in dining rooms when serving food trays to</p>	08/23/2013	

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	<p>work with her on eating/drinking/swallowing skills.</p> <p>2. During an observation of the lunch meal on 7/29/13 in the Beecher Hall dining room, the following was observed:</p> <p>At 11:38 a.m., Business Office staff #1 was observed to wash her hands for the recommended amount of time. She was not observed to use a paper towel as a protective barrier when turning off the water faucet. After drying her hands with a paper towel, she was observed to touch the soiled rim of the wastebasket while throwing the paper towel away. She was not observed to re-wash her hands, but was immediately continued serving lunch trays.</p> <p>At 11:40 a.m., LPN #3 was observed to wash her hands for the recommended amount of time. She was not observed to use a paper towel as a protective barrier when turning off the water faucet. She immediately continued serving lunch trays.</p> <p>At 11:42 a.m., LPN #3 was observed to wash her hands for only 7 seconds. She immediately continued serving lunch trays.</p>		<p>ensure proper hand washing technique and timeliness.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will be not recur, i.e., what quality assurance program will be put into place; Monitoring of proper hand washing procedure will be completed daily Monday thru Friday X 4 weeks, weekly x 4 weeks, monthly X 4 months on 5 staff members by the SDC/designee. Any noncompliance issues noted during auditing will be addressed at monthly PI meetings.</p> <p>By what date the systemic changes will completed – 08/23/2013</p>		

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	<p>At 11:45 a.m., Business Office staff #1 was observed to wash her hands for only 8 seconds. She immediately continued serving lunch trays.</p> <p>At 11:46 a.m., Speech Therapy staff #2 was observed to wash her hands for the recommended amount of time. She was not observed to use a paper towel as a protective barrier when turning off the water faucet. She was then observed to sit with a resident in the dining room and work with her on eating/drinking/swallowing skills.</p> <p>At 11:47 a.m., LPN #3 was observed to wash her hands for only 9 seconds. She was not observed to use a paper towel as a protective barrier when turning off the water faucet. She immediately continued serving lunch trays.</p> <p>The Dietary Manager was interviewed on 7/30/13 at 2:30 p.m. During the interview he indicated staff assisting in the dining room were to wash their hands for 20 seconds and were to use a paper towel as a protective barrier when turning off the water faucet.</p> <p>3. During the initial dining observation in the Beecher Dining Room on</p>				

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	<p>7/24/13 from 11:40 a.m. until 12:20 p.m., RNA #11 was observed to wash her hands for only 10 seconds before assisting the residents with dining.</p> <p>4. During an observation of the lunch meal in the Denton dining room on 7-24-2013 from 11:23 a.m. through 11:41 a.m., the following was observed:</p> <p>-At 11:25 a.m. and 11:31 a.m., Certified Nursing Assistant (CNA) #5 was observed to wash hands for less than 15 seconds and began serving residents their meal.</p> <p>-At 11:32 a.m., LPN #6 was observed to wash hands for less than 10 seconds and proceeded to touch the paper towel dispenser with her hands that were just washed to obtain a paper towel to dry her hands. LPN #6 dried hands and continued to serve residents their meal.</p> <p>-At 11:34 a.m., LPN #6 was observed to use the phone and continued to serve residents their meal tray without washing her hands.</p> <p>-At 11:35 a.m. LPN #6 was observed to touch her face, move a chair, touch her ear and began feeding a resident without washing hands or performing</p>			

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	<p>hand hygiene.</p> <p>-At 11:39 a.m., CNA #5 was observed to wash her hands for less than 10 seconds, used a paper towel to dry her hands, lifted the trash can lid with her hand to throw the paper towel away and began assisting a resident to eat.</p> <p>-At 11:41 a.m., the ADON (Assistant Director of Nursing) was observed to wash her hands for 5 seconds and began assisting a resident to eat. The ADON was observed to touch her face and mouth and then proceeded to continue to assist resident with her meal.</p> <p>-At 11:46 a.m., the ADON was observed to answer the phone after touching the door handle to get into the nurse's station and returned to the table after touching the back of a chair and continued to assist a resident with their meal without performing hand washing or hand hygiene.</p> <p>5. During an observation of the lunch meal on 7-29-2013 from 11:13 a.m. through 11:23 a.m., the following was observed:</p> <p>-At 11:15 a.m., the Speech Therapist</p>			

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	<p>#2 was observed to wash hands for the appropriate length of time but used her hands to turn off water faucet and used her just washed hand on the paper towel dispenser handle to get the paper towels and proceeded to serve a resident their lunch tray.</p> <p>-At 11:16 a.m., LPN #6 was observed to wash her hands for 15 seconds, used her hand to push the handle on the paper towel dispenser to obtain paper towels and proceeded to serve residents their lunch trays.</p> <p>-At 11:17 a.m. and 11:23 a.m., CNA #4 was observed to wash her hands for 13 seconds, used her just washed hand on the paper towel dispenser handle to get the paper towels to dry her hands and continued to serve and assist residents with their meal.</p> <p>During an interview on 7-31-2013 at 9:14 a.m. the ADON indicated the handwashing policy for handwashing before serving meals to residents was to wash hands for 20 seconds. The ADON indicated the first step was to get the paper towels ready, turn on the water, wash with soap and water for 20 seconds and rinse, dry hands, turn off the faucet with the paper towel and use the foot pedal to open</p>			

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	<p>the trash container or use the paper towel to open the trash container lid and discard the paper towel.</p> <p>During an interview on 7-31-2013 at 9:20 a.m., CNA #5 indicated the procedure to wash hands prior to serving residents their meal was to get a paper towel ready, wash hands with soap and water for 10 seconds, dry hands, turn off the faucet with a paper towel and use the foot pedal to open the trash container and throw away the paper towel.</p> <p>During an interview on 7-31-2013 at 9:31 a.m., the Speech Therapist #2 indicated the procedure to wash hands prior to serving residents their meals was to get paper towels ready, wash hands with soap and water for 20 seconds, dry hands, turn off faucet with her elbow or a paper towel and throw away paper towel in trash container using the foot pedal to open the container.</p> <p>A current facility policy "Hand Hygiene", dated 6/5/12 and provided by the Regional Director of Clinical Services, indicated "...To decrease the risk of transmission of infection by appropriate hand hygiene...Wash well under running water for a minimum of 20 seconds, using a rotary motion</p>			

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	and friction...Use a towel to turn off the faucet then discard...." 3.1-21(i)(1)			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to accurately document the fluids consumed for 1 resident (Resident #23) of 1 resident on a fluid restricted diet and failed to accurately document completed pressure ulcer treatments for 1 resident (Resident #62) of 3 residents who met the criteria for pressure ulcers.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #23 began on 7-29-2013 at 3:31 p.m., indicated the following diagnoses included but were not limited to, renal abscess, diabetes, depression, hypothyroidism and gastroesophageal reflux disease.</p>	F000514	<p>F – 514 Records complete/Accurate/Accessible It is the policy of this facility to maintain clinical records in accordance with accepted professional standards that are complete: accurately documented: readily accessible: and systematically organized</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #23 had order clarified for fluid restriction/distribution. The nutritional assessment was updated to include a fluid distribution between nursing and dietary. Dietary ticket was updated with current distribution amounts per each meal per dietary. Medication sheet was also updated with nursing amounts and times for</p>	08/23/2013			

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	<p>A review of the Physician orders on admission from the hospital on 5-11-2013 indicated a fluid restriction of 1200 cc (cubic centimeters) daily.</p> <p>A review of the diet order and communication form completed by nursing for dietary was dated 5-11-2013 and indicated a renal diet with 1200 cc daily fluid restriction.</p> <p>A review of the Physician orders for July 2013 and signed by the physician on 7-13-2013 indicated a 1200 cc fluid restriction.</p> <p>A review of Resident #23's physician orders for 7-2-2013, indicated Miralax (a laxative) was ordered daily with 6 ounces (180 cc) water daily.</p> <p>A review of the nutritional assessment completed by the Registered Dietitian on 5-15-2013, indicated Resident #23 had a regular renal diet with 1200 cc fluid restriction and received Pro Sup (protein supplement) 30 cc tid (3 times a day) and Nepro (protein supplement) 1 can BID (2 times a day). The nutritional assessment did not indicate a fluid distribution plan between dietary and nursing.</p> <p>A review of the dietary ticket for 7-30-2013 indicated a fluid restriction</p>		<p>administration. Resident #62 had no negative outcome.</p> <p>How will other residents having the potential be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other residents were identified at risk for fluid restriction. Other residents identified as having wound treatments are at risk. All residents with current physician orders for wound treatments were audited for missing documentation.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff will be re-educated on policy of fluid restrictions, documentation of fluids, distribution of fluids and following physicians' orders for wound care by the SDC. Documentation of Fluid intakes and the following of physician orders are being monitored by DON/ADON/ designee daily Monday thru Friday x 30 days, weekly x 4 weeks, monthly and x4 months.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will be not recur, i.e., what quality assurance program will be put into place; All monitoring of fluid restriction documentation and following</p>		

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	<p>of 1200 cc daily, but did not include how to divide the fluids between meals</p> <p>During an interview on 7-30-2013 at 9:55 a.m., the Certified Dietary Manager (CDM) indicated dietary provided 720 ml of fluids per day. The CDM indicated Resident #23 was provided with 240 ml of fluid for each meal per the resident choice, but the information was not printed on the dietary meal ticket.</p> <p>During an additional interview on 7-30-2013 at 11:05 a.m., the CDM indicated he was unable to provide a fluid distribution plan for Resident #23 and the Nurse Consultant indicated the fluid distribution plan was not on the MAR (Medication Administration Record or in the dietician's notes.</p> <p>A review of Resident #23's MAR for July 2013 indicated the resident received medication 4 times daily. No record of fluid intake by nursing was documented on the July 2013 MAR.</p> <p>During an interview on 7-30-2013 at 11:09 a.m., the Consultant Nurse and LPN # 10 indicated fluid intake amounts for residents should be completed by the Certified Nursing Assistant (CNA) after meals and</p>		<p>physician orders is to be completed by DON/ADON/designee daily Monday thru Friday per schedule above. All non-compliant issues to be addressed monthly at PI meeting.</p> <p>By what date the systemic changes will completed – 08/23/2013</p>		

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	<p>documented on the Life Care Center Fluid Monitoring sheet. Further interview with the Consultant Nurse and LPN #10 indicated Nursing should document fluid intake with the medication pass on a form in the MAR. The Nurse Consultant and ADON indicated they had no explanation on the missing fluid intake amounts for July 2013 on the Fluid Monitoring sheet or for the MAR.</p> <p>During an interview on 7-30-2013 at 11:10 a.m., LPN #8 indicated he used a blue cup which contained 120 cc water per medication pass and the resident received medications 4 times daily except on dialysis days. In addition, LPN #8 indicated the resident received Miralax in 6 ounces (180 cc) of water daily.</p> <p>A review of the Life Care Center Fluid Monitoring sheet for July 2013 indicated documentation of fluid intake was not recorded for the following dates for the breakfast and lunch meals: July 1, 2, 3, 5, 6, 7, 8, 10, 15, 16, 17, 18, 19, 20, 21, 23, 24, 25, 26, 27, 29, 2013 or for the supper meal and hs (bedtime) snack: July 6, 7, 9, 15, 16, 17, 19, 20, 21, 22, 25, 26, 2013.</p>			

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	<p>During an observation and interview on 7-30-2013 at 1:30 p.m., CNA #9 was observed obtaining a large cup of ice for Resident #23. She took it to her room and filled the large cup with a 12 ounce can of diet Pepsi. CNA #9 indicated the resident usually drank 2 diet Pepsis on her shift and she documented the Pepsi intake on the Fluid Monitoring sheet in addition to the fluids the resident received at meals.</p> <p>During an interview on 7-30-2013 at 1:35 p.m., the DON and the Nurse Consultant indicated there was not a specific facility policy on fluid restrictions. The DON and the Nurse Consultant were unable to explain how the staff documented the fluid intake on the Fluid Monitoring sheet.</p> <p>A policy "Hydration", dated 3-1-2013 and provided by the DON on 7-30-2013 at 1:12 p.m., indicated "...intake and output are recorded...if clinically indicated by a physician order...."</p> <p>2. Review of the clinical record for Resident #62 began on 7-29-2013 at 10:19 a.m. indicated diagnoses included but were not limited to, cerebral vascular accident, hypertension, dementia, muscle</p>			

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	<p>spasms, hypothyroidism, benign prostatic hyperplasia, depression, insomnia, gastroesophageal reflux disease, bile duct stenosis and allergic rhinitis.</p> <p>Review of physician orders indicated the initial orders for the treatment on the pressure area were dated 6-17-2013 and were to be completed twice a day and as needed.</p> <p>Review of physician orders for 6-24-2013 indicated a treatment change with treatments to be completed twice a day and as needed.</p> <p>Review of physician orders for 6-28-2013 indicated a treatment change with treatments to be completed daily and as needed.</p> <p>Review of the TAR (treatment administration record) for June 2013 indicated missing initials for treatments on 6-19, 21, 24, 26, 27 and 29.</p> <p>Review of physician orders for 7-8-2013 indicated a treatment change with treatments to be completed twice a day and as needed.</p>			

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	<p>Review of the TAR for July 2013 indicated the twice a day dressing change from the 6-24-2013 order and the 6-28-2013 treatment change order for a daily dressing change for the same wound were both carried over and documented on the July 2013 TAR. The twice a day dressing change lacked initials for one of the treatments on July 1, 5, 6, and 7, 2013. The daily dressing change lacked initials for the daily treatments on July 1, 6 and 7, 2013.</p> <p>Review of the June and July 2013 TAR, indicated no documentation of refusal of the treatment for the dressing change on the back page of the TAR.</p> <p>Review of the nurse's notes from 6-17-2013 through 7-8-2013 indicated no documentation of the resident's refusal of the treatment for the pressure ulcer.</p> <p>During an interview on 7-30-2013 at 1:55 p.m., the DON indicated the missing initials on the TAR indicated the treatments were not done or the nurse forgot to initial the TAR after the treatment was completed or the resident refused the treatment and there should be additional documentation regarding the refusal.</p>						

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	<p>During an interview on 7-30-2013 at 2:18 p.m., LPN #8 indicated after Resident #62's pressure ulcer treatment, he would document in the TAR. If the resident refused treatment, he would indicate the refusal by placing a circle on the treatment date/time on the TAR, document in the nurse's note and notify the physician.</p> <p>An undated policy, "Wound Care" provided by the Nurse Consultant on 7-30-2013 at 2:46 p.m., indicated the following:</p> <p>"1. Medical treatments must be documented on a treatment record in the resident's medical record. 2. The nurse is responsible for administration and recording all treatments according to the physician orders. 3. Each nurse giving treatment will sign his or her name on the treatment form. Treatments are recorded on the proper form using the nurse's initials. Changes in a wound, refusal of a treatment...will be documented...."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						

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