

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for Investigation of Complaint IN00122069.</p> <p>Complaint IN00122069 Substantiated. Federal/state deficiencies related to the allegations are cited at F327.</p> <p>Survey date: January 25, 2013</p> <p>Facility number: 000314 Provider number: 155478 Aim number: 100274210</p> <p>Survey team: Carole McDaniel RN</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census payor type: Medicare: 17 Medicaid: 46 Other: 17 Total: 80</p> <p>Sample size: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on January 29, 2013, by Jodi Meyer, RN</p>	F0000	<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 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0327 SS=G	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview, the facility failed to ensure adequate hydration for 1 of 3 residents discharged from the facility to the hospital. Resident A</p> <p>Findings include:</p> <p>The clinical record of Resident A was reviewed on 1/25/13 at 8:30 AM. Diagnosis included Mental Retardation, Dementia, CVA (Stroke) affecting the left side, Gastric Reflux, Esophagitis, Bacterial Pneumonia, Hypertension, Seizure disorder and Congestive Heart Failure. The resident had been admitted on 11/27/12. An undated admission hydration risk assessment scored the resident at a risk of 12 (a score of 10 or above being considered at risk).</p> <p>On 11/28/12 the Dietary Service Manager DSM assessed the resident fluid requirement, based on height and weight, to be 1612.5 cc (cubic centimeters) to 1935 cc. That had been calculated by the standard of 30 cc/KG of body weight/24 hours.</p>	F0327	<p>It is the facility's intent to provide each resident with sufficient fluid intake to maintain proper hydration and health. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -No immediate corrective action could be taken for Resident A as he had been discharged from the facility 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? All residents have the potential to be affected. All residents' hydration assessments were reviewed for being complete and accurate. All residents' hydration assessments will be evaluated by the IDT upon admission or readmission to the facility, with a significant change, quarterly, annually, and as needed to determine their hydration risk. Current and future residents identified as being at risk per their hydration assessment will be monitored to ensure their daily fluid intake is adequate. Those residents found to be at risk will be placed on a 3 day hydration monitoring system. Each resident's total fluid intake will be</p>	02/13/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A three day 24 hour fluid intake summary from 11/27, 28, 29, 30/2012 was recorded and totaled to be 600 cc, 300 cc, 720 cc, and 960 cc, respectively.</p> <p>On 11/27/12, a Care Plan was initiated and addressed the "risk for fluid imbalance due to : infection, swallowing difficulty, needs assist with food and fluids, on thickened liquids, unable to ask for fluids, routine laxatives, use of 9 or more medications, cognitive deficits." It indicated a goal of "Resident will be free from signs and symptoms of fluid volume deficit." Approaches included: "encourage fluids" and "notify MD of signs and symptoms of fluid volume deficit..."</p> <p>The 24 hour totals (totalled at time of review) in days prior to the Registered Dietician's (RD) progress report on 12/06/12 were below the minimal calculated need of 1612.5 cc as follows: 12/01/12- 960 cc, 12/02/12- 600 cc, 12/03/12 documentation errors prevented calculation, 12/04/12-1080 cc, 12/05/12-480 cc. The RD progress note of 12/06/12 did not address the hydration status of the resident.</p> <p>The 24 hour totals (totalled at the time of review) in the days prior to hospitalization on 1/01/13 were as</p>		<p>evaluated and individual hydration plans will be implemented accordingly. Their care plans will be written to include interventions to match their hydration needs. The facility staff will in-serviced on February 12, 2013.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a. All residents' hydration assessments will be evaluated by the IDT upon admission or readmission to the facility, with a significant change, quarterly, annually, and as needed to determine their hydration risk. Those residents found to be at risk will be placed on a 3 day hydration monitoring system. Each resident's total fluid intake will be evaluated and individual hydration plans will be implemented accordingly. Their care plans will be written to include interventions to match their hydration needs. b. Fresh water, both thin and thickened, will be passed to all residents, unless medically contraindicated, on each shift. Additional fluids will be offered at various times throughout each shift i.e. medication pass, activities, and resident request. Nursing staff is responsible for documenting fluid intake at mealtime. Nursing staff is responsible for documenting all other fluid intake for his/her assigned residents on each shift. c. 24 hour fluid totals will only be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>follows: 12/21/12-480 cc, 12/22- 690 cc, 12/2- 480 cc, 12/24-480 cc, 12/25-600 cc, 12/26-720 cc, 12/27-720 cc, 12/28 lacked any documentation, 12/2- 680 cc, 12/3- 600 cc, and 12/3- 680 cc.</p> <p>The physician discharge summary on 1/07/13 for the 1/01/13 hospitalization indicated the resident "Discharge diagnosis: 1. Acute toxic metabolic encephalopathy secondary to critical hypernatremia (high blood sodium level usually resulting from dehydration) and pneumonia present on admission...Chemistry panel was remarkable for severe hypernatremia with sodium level 177 on admission; it is 148 on discharge (normal range 137-145). The BUN (blood urea nitrogen) and creatinine were elevated; BUN was 95 on admission and it is 10 on discharge (normal range 9-20); the creatinine was 2.07 on admission and is 0.7 on discharge (normal range 0.6-1.25).</p> <p>Documentation was lacking to indicate staff were assessing fluid intake data collected or informing the physician of the inadequate fluid intake. The Care plan interventions were not changed or developed after admission to address the continued deficit of fluid. The care plan continued to fail to specify goal ranges by which to assess results of "encourage</p>		<p>calculated for those residents on a fluid restriction or as ordered by physician. The facility staff will be in-serviced on February 12, 2013. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS or designee will perform an audit of the Hydration Program using the Hydration Management CQI audit tool once a week for four weeks, biweekly for two months, monthly for three months and quarterly thereafter. If the threshold of 95% is not met, an action plan will be developed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013	
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>fluid" intervention.</p> <p>On 1/25/13 at 2:30 P.M., the RD and DSM were interviewed regarding Resident A and the hospitalization. The RD indicated she had not reviewed the status of hydration on 12/06/12 when addressing the resident nutrition status. She indicated she was aware of the fluid needs calculated by the DSM. The DSM indicated she relied on nursing to assess the status of the hydration and she was responsible for the weight status.</p> <p>On 1/25/13 at 3:00 P.M., the Director of Nursing (DON) was interviewed. She indicated the admission 3 day fluid intake summary noted above should have been reviewed in the IDT (Interdisciplinary Team) meeting but it was not. She also indicated there had not been specific analysis of fluid intake data or 24 hour totaling on a periodic, routine or ongoing basis although implementation of those services was in progress.</p> <p>The facility Policy and Procedure for Hydration originated in 11/01 and was most recently revised in 6/12. It was reviewed on 1/25/13 at 3:30 P.M. It contained the following directives: "...3. New admissions scoring 10 or more on the Hydration assessment will be placed on a hydration plan and proceed</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>with IDT review and documentation...6. A comprehensive care plan will be written after completion of the Hydration assessment and review by IDT with Specific resident needs and preferences as deemed necessary by IDT assessment....13. 24 hour fluid totals will only be calculated for those residents on a fluid restriction or as ordered by physician."</p> <p>This federal tag relates to complaint #IN00122069</p> <p>3.1-46(b)</p>			