

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2015
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00163165.</p> <p>Survey dates: January 26, 27, 28, 29, 30 and February 2, 2015</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Survey team: Karen Lewis, RN TC Toni Maley, BSW Tina Smith-Staats, RN Ginger McNamee, RN</p> <p>Census bed type: SNF: 18 SNF/NF: 127 Total: 145</p> <p>Census payor type: Medicare: 15 Medicaid: 101 Other: 29 Total: 145</p> <p>These deficiencies also reflect state</p>	F000000	<p>The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p>	
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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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F000241 SS=E	<p>findings cited in accordance with 410 IAC 16.2-3.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to serve meals to dependent residents in a manner to promote dignity regarding lengthy meal waits and the use of disposable glasses for 13 of 13 residents observed for dignity while dining (Resident #100, #2, #182, #65, #21, #30, #135, #143, #150, #48, #113, #17 and #180).</p> <p>Findings include:</p> <p>1. During a 1/26/15, 12:06 p.m. to 1:10 p.m., observation of lunch in the Family Tree Dining Room, the following concerns regarding lengthy meal waits were observed:</p> <p>At 12:06 p.m. six dependent residents were already seated facing the dining</p>	F000241	<p>F 241 SS=E Dignity & Respect of Individuality</p> <p>It is the practice of this center to comply with F 241: Dignity & Respect Of Individuality</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>-</p> <p>Resident(s) # 100, 2, 182, 65, 21, 30, 135, 143, 150, 48, 113, 17, and 180 medical records were reviewed and no negative outcome was noted.</p>	03/04/2015

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	<p>room table as if ready to dine. The TV was located on the side of the room opposite form where the dependent residents were seated. None of the dependent residents were seated in a manner to observe the TV. The area lacked any diversionary materials such as, games, books, magazines or manipulative devices. Residents #21, #2, #100 were included in the group of six seated at the tables at 12:06 p.m. Nine dependent residents sat facing the table with no form of stimulation for a period of 38 to 59 minutes before their meals were served.</p> <p>Resident #21 waited at the table from 12:06 p.m. to 1:00 p.m. at which time her meal was served (54 minutes).</p> <p>Resident #2 waited at the table form 12:06 p.m. to 1:05 p.m. at which time her meal was served (59 minutes).</p> <p>Resident #100 waited at the table from 12:06 p.m. to 12:53 p.m. at which time her meal was served (46 minutes).</p> <p>2. During a 1/29/15, 11:28 p.m. to 1:00 p.m., observation of lunch in the Family Tree Dining Room, the following concerns regarding lengthy meal waits were observed:</p>		<p>Dietary Director was re-educated on proper Tableware and the concern was corrected following the center being informed of issue (1/29/2015).</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>-</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>An Audit was completed in the dietary department to ensure that proper tableware was available and in use per facility policy.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>-</p> <p>Facility Staff have been re-educated regarding Resident</p>	

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	<p>At 11:28 a.m., staff began to escort in dependent residents and seated them facing the dining room table as if ready to dine. The TV was located on the side of the room opposite from where the dependent residents were seated. None of the dependent residents were seated in a manner to observe the TV. The area lacked any diversionary materials such as, games, books, magazines or manipulative devices. Eight dependent residents waited from 38 minutes to 1 hour and 22 minutes for their meals to be served. Residents #2, #65, #21, #100 and #182 were included in the group of eight residents who waited for the meal.</p> <p>Resident #2 was escorted in at 11:28 a.m. and seated at the table. Resident #2's meal was served at 12:50 p.m.(a wait of 1 hour 22 minutes).</p> <p>Resident #65 was escorted in at 11:33 a.m. and seated at the table. Resident #65's meal was served at 12:37 p.m. (a wait of 1 hour and 5 minutes).</p> <p>Resident #21 was escorted in at 11:40 a.m. and seated at the table. At 12:53 p.m., Resident #21 stated "I am hungry." Resident #21's meal was served at 12:53 p.m.(a wait of 1 hour and 13 minutes).</p> <p>Resident #100 was escorted in at 12:09</p>		<p>Dignity.</p> <p>Dietary Staff and Nursing Staff have been re-educated Meal Schedules & Guidelines.</p> <p>Dietary Staff has been re-educated on proper Dining Service Guidelines: Tableware & Dining Environment & Tray Audit Checks.</p> <p><u>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 in place?</u></p> <p>-</p> <p>Dietary Director or Designee will audit 5 Meals weekly x 4 weeks to ensure proper tableware is being used & meal schedules are being followed per center guidelines.</p> <p>Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further</p>	

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	<p>p.m. and seated at the table. Resident #100's meal was served at 12:32 p.m.(a wait of 28 minutes).</p> <p>Resident #182 was hand held escorted in at 12:09 p.m. and assisted to sit facing the table. Resident #182 was served at 12:41 p.m. (a wait of 32 minutes).</p> <p>3. Resident #21's clinical record was reviewed on 01/30/2015 at 9:04:23 a.m. Resident #21's current diagnoses included, but were not limited to, back pain, anxiety and dementia with behaviors, aggravation, aggression and paranoia.</p> <p>Resident #21 had a current, 1/19/15, quarterly, Minimum Data Set assessment (MDS) which indicated was moderately cognitively impaired and required cuing and supervision for decision making, required staff assistance for mobility and required extensive staff assistance for eating.</p> <p>Resident #21 had a current, 10/24/14, care plan problem/need regarding paranoia. The target date to meet the care plan goal was 2/22/15. The goal for this problem was "Resident will have no distress related to paranoia."</p> <p>Resident #21 had a current, 10/24/14,</p>		<p>monitoring and/or education per the QAA process.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>-</p> <p>March 4th , 2015</p>	

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	<p>care plan problem/need regarding the need for assistance with activities of daily living. The target date to meet the care plan goal was 2/22/15. The goal for this problem was "Will receive assistance necessary to meet ADL [activities of daily living] needs.</p> <p>Resident #21 had a current, 10/24/14, care plan problem/need regarding cognitive loss due to dementia. The target date to meet the care plan goal was 2/22/15.</p> <p>Resident #21 had a current, 10/24/14, care plan problem/need regarding nutritional risk. The target date to meet the care plan goal was 2/22/15. Approaches to this problem included, but was not limited to, "Encourage and assist as needed to consume food..."</p> <p>Resident #21 had a current, 10/24/14, care plan problem/need regarding nutritional risk. The target date to meet the care plan goal was 2/22/15. Approaches to this problem included, but was not limited to, "Encourage and assist as needed to consume food..."</p> <p>During dining observations, Resident #21, who was dependent on staff for mobility and dining, waited 54 minutes for her meal to be served on 1/26/15 and</p>			

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	<p>waited 1 hour and 13 minutes on 1/29/15 for her meal to be served.</p> <p>4. Resident #2 clinical record was reviewed on 01/30/2015 at 10:02 a.m. Resident #2's current diagnoses included, but were not limited to, Alzheimer's disease and degenerative joint disease.</p> <p>Resident #2 had a current, 12/27/14, annual, Minimum Data Set assessment (MDS) which indicated the resident did not speak, was severely cognitively impaired and rarely or never made decisions, was totally dependent on staff assistance for locomotion and eating.</p> <p>Resident #2 had a current, 12/27/14, care plan problem/need regarding cognitive impairment. The target date to complete the care plan goal was 4/17/15. Approaches to this problem included, but was not limited to, "Assist resident to benefit from cognitive stimulation opportunities..."</p> <p>Resident #2 had a current, 12/27/14, care plan problem/need regarding cognitive impairment and memory loss. The target date to complete the care plan goal was 4/17/15. Approaches to this problem included, but was not limited to," Support current memory level through cognitive stimulation..."</p>			

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	<p>Resident #2 had a current,12/27/14, care plan problem/need regarding a self care deficit in activities of daily living due to dementia. The target date to complete the care plan goal was 4/17/15. Approaches to this problem included, but was not limited to, assist with eating as needed</p> <p>During dining observations, Resident #2, who was dependent on staff for mobility and dining, waited 59 minutes for her meal to be served on 1/26/15 and waited 1 hour and 22 minutes on 1/29/15 for her meal to be served.</p> <p>5. Resident #100's clinical record was reviewed on 01/28/2015 at 1:26:33 p.m. Resident #100's current diagnoses included, but were not limited to, Alzheimer's disease, anxiety and psychosis.</p> <p>Resident #100's had a current, 11/24/14, quarterly, Minimum Data Set assessment (MDS) which indicated the resident sometimes understood, sometimes understands, was cognitively impaired and rarely or never made decisions, required staff assistance for mobility off the unit and staff supervision and set up for eating.</p> <p>Resident #100 had a current,11/24/14</p>			

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	<p>care plan problem/need regarding delusional thinking due to psychosis. The goal target date for this problem was 3/25/15. Approaches to this problem included, but were not limited to, "Encourage to wind yarn as distraction/ fold clothes/ watch birds."</p> <p>Resident #100 had a current, 11/24/14 care plan problem/need regarding nutritional risk due to Alzheimer's disease. The goal target date for this problem was 3/25/15.</p> <p>Resident #100 had a current, 11/24/14 care plan problem/need regarding an activities of daily living deficit. The goal target date for this problem was 3/25/15. Approaches to this problem included, but were not limited to, "Assist with...eating as needed."</p> <p>During dining observations, Resident #100, who was dependent on staff for mobility and dining, waited 46 minutes for her meal to be served on 1/26/15 and waited 28 minutes on 1/29/15 for her meal to be served.</p> <p>6. Resident #65's clinical record was reviewed on 02/02/2015 at 9:41 a.m. Resident # 65's current diagnoses included, but were not limited to, Alzheimer's disease, depression, debility,</p>			

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	<p>and history of falls.</p> <p>Resident #65 had a current, 10/16/14, quarterly, Minimum Data Set assessment (MDS) which indicated the resident was severely cognitively impaired, required staff assistance for mobility and required staff supervision and set up for eating.</p> <p>Resident #65 had a current, 10/16/14, care plan problem/need regarding nutritional risk due to dementia. The target goal date for this problem was 2/15/15. Approaches to this problem included, but were not limited to, "Provide prescribed diet, ... Provide supplements as ordered."</p> <p>Resident #65 had a current, 10/16/14, care plan problem/need regarding a deficit in activities of daily living. The target goal date for this problem was 2/15/15.</p> <p>During dining observations, Resident #65, who was dependent on staff for mobility and dining, waited 1 hour and 5 minutes for her meal to be served on 1/29/15.</p> <p>7. Resident #182's clinical record was reviewed on 01/30/2015 at 12:49 p.m. Resident #182's current diagnoses included, but were not limited to,</p>			

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	<p>Alzheimer's disease, down syndrome, and insomnia.</p> <p>Resident #182 had a current, 12/19/13, "OBRA PASARR level II" report (an evaluation completed for individuals with developmental disability or mental illness to ensure their needs are meet in a long term care setting) which indicated the following:</p> <p>"4. [Resident's name] may benefit form physical, occupational and Speech therapy evaluations and treatment, if necessary."</p> <p>"6. [Resident's name] may benefit from opportunities for leisure activities that promote cognitive stimulation, socialization, and community involvement."</p> <p>Resident #182 had a current, 12/8/14, annual, Minimum Data Set assessment (MDS) which indicated the resident was cognitively impaired and rarely or never made independent decisions, required staff assistance for mobility and needed limited assistance for eating.</p> <p>Resident #182 had a current, 12/8/14, care plan problem/need regarding a deficit in activities of daily living due to Alzheimer's Disease. The target goal date for this problem was 4/02/15. Approaches to this problem included, but</p>			

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	<p>were not limited to, assist with ...eating as needed.</p> <p>Resident #182 had a current, 12/8/14, care plan problem/need regarding nutritional risk due to a history of weight loss. The target goal date for this problem was 4/2/15. Approaches to this problem included, but were not limited to, "Provide diet as ordered, Provide snacks as ordered, Provide supplements as ordered."</p> <p>Resident #182 had a current, 12/8/14, care plan problem/need regarding aggravation regarding assistance at meal times. The target goal date for this problem was 4/2/15. Approaches to this problem included, but were not limited to, "Asses for unmet needs and assist [with] ADLs [activities of daily living] as needed."</p> <p>Resident #182 had a current, 12/8/14, care plan problem/need regarding assistance with eating to restore function for eating due to dementia. The target goal date for this problem was 4/2/15. Approaches to this problem included, but were not limited to, "Position as upright as possible for meals."</p> <p>During dining observations, Resident #182, who was dependent on staff for</p>			

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	<p>mobility and dining, waited 32 minutes for her meal to be served on 1/29/15. The following observations of the Arcadia Unit dining room were made on the following dates and times:</p> <p>8. 1/26/15 at 12:32 p.m., Resident #'s 135, 143, 150, 48, 30, 113, 17, and 180 were served milk in disposable plastic cups. All of the residents' trays were set up by staff and the residents fed themselves.</p> <p>Resident #180 was observed at 12:46 p.m., eating her food with her knife in place of a fork or spoon. Three staff members were present in the dining room at the time talking to one another. LPN #1 indicated the resident did not normally eat with her knife. The LPN redirected the resident to use her fork.</p> <p>9. 1/27/15 at 7:55 a.m., Resident #'s 135, 143, 150, 48, 30, 113, 17, and 180 were served milk in disposable plastic cups. All of the residents' trays were set up by staff and the residents fed themselves.</p> <p>10. 1/29/15 at 7:57 a.m., Resident #'s 135, 143, 150, 48, 30, 113, 17, and 180 were served milk in disposable plastic cups. All of the residents' trays were set up by staff and the residents fed themselves.</p>			

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	<p>Resident #30 was observed from 8:08 a.m. to 8:39 a.m., with her food in front of her without any encouragement to eat. Staff was observed standing in the room with no interaction with the residents.</p> <p>11. Resident #135's clinical record was reviewed on 2/2/2015 at 10:06 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and dementia.</p> <p>The resident's had a 11/4/14, annual Minimum Data Set [MDS] assessment. The assessment indicated the resident had severe cognitive impairment and required the assistance of one to eat.</p> <p>12. Resident #143's clinical record was reviewed on 2/2/15 at 12:30 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, depression and anxiety.</p> <p>The resident had a 12/17/14, quarterly MDS assessment. The assessment indicated the resident had severe cognitive impairment and needed setup and supervision at meal time.</p> <p>13. Resident #150's clinical record was reviewed on 2/2/15 at 12:43 p.m. The resident's diagnoses included, but were</p>			

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	<p>not limited to, Alzheimer's disease and dementia.</p> <p>Resident #150 had a 11/7/14, quarterly MDS assessment. The assessment indicated the resident had severe cognitive impairment and required setup and supervision at meals.</p> <p>14. Resident #48's clinical record was reviewed on 2/2/15 at 12:45 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and depression.</p> <p>The resident had a 11/28/14, quarterly MDS assessment. The assessment indicated the resident had severe cognitive impairment and required setup and the assistance of one at meals.</p> <p>15. Resident #30's clinical record was reviewed on 1/29/15 at 8:53 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and depression</p> <p>The resident had a 10/28/14, significant change MDS assessment. The assessment indicated the resident had severe cognitive impairment and required setup and supervision at meals.</p> <p>16. Resident #113's clinical record was</p>			

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	<p>reviewed on 2/2/15 at 12:55 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and dementia.</p> <p>The resident had a 12/29/14, annual MDS assessment. The assessment indicated the resident had severe cognitive impairment and required setup and supervision at meals.</p> <p>17. Resident #17's clinical record was reviewed on 2/2/15 at 12:58 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and dementia.</p> <p>The resident had a 12/15/14, annual MDS assessment. The assessment indicated the resident had severe cognitive impairment and required setup and the assistance of one at meals.</p> <p>18. Resident #180's clinical record was reviewed on 2/2/15 1:02 p.m. The resident's diagnoses included, but were not limited to dementia.</p> <p>The resident had a 11/3/14, quarterly MDS assessment. The assessment indicated the resident had severe cognitive impairment and required setup and supervision at meals.</p>			

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	<p>19. During an interview with the Administrator on 1/29/15 at 3:30 p.m., he indicated he was not aware of the residents not receiving glasses for their milk from the dietary department. He indicated the facility had enough glassware available and the residents should have been receiving glasses on their trays for the milk to be served in.</p> <p>20. During an interview with the Speech Therapist #3 on 1/30/15 at 8:50 a.m., She indicated residents with cognitive impairment would have difficulty drinking out of milk cartons and the disposable cups were too flimsy. She indicated straws would not be a good alternative because they were not safe for everyone to use.</p> <p>During an 1/30/15, 9:30 a.m., interview, the Administrator indicated, He does not like lengthy meal waits. His desire would be for a meal to be served 5 minutes after the resident was seated at the table. He also indicated the 1/26/15 and 1/29/15 lengthy waits were not acceptable.</p> <p>A current, undated, facility policy, titled "Resident Rights", which was provided by the Administrator on 1/30/15 at 9:30 a.m., indicated the following: " Dignity: The facility must promote care for residents in a manner and in an environment that maintains or enhances</p>			

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F000246 SS=D	<p>each resident's dignity and respect in full recognition of his or her individuality."</p> <p>3.1-3(t)</p> <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. Based on observation, interview and record review, the facility failed to make seating accommodations for a resident of short stature to allow the resident to sit with his feet touching the floor for 1 of 1 resident reviewed for dining positioning (Resident #182).</p> <p>Findings include:</p> <p>1. During an, 1/26/15, observation, Resident #182 sat at a dining room table from 12:10 p.m. to 1:00 p.m. Resident #182 was of short stature and his feet were approximately 4 inches from the floor. He sat with his toes pointed down. He moved restlessly in his chair and pulled his feet up in the seat from time to time.</p>	F000246	<p>F 246 SS=D Reasonable Accommodation of Needs/Preferences</p> <p>It is the practice of this center to comply with F 246 Reasonable Accommodation of Needs/Preferences</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>-</p> <p>Resident # 182's medical record</p>	03/04/2015

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	<p>During an, 1/29/15, observation, Resident #182 sat at a dining room table from 12:09 p.m. to 12:41 p.m. Resident #182 was of short stature and his feet were approximately 4 inches from the floor. He sat with his toes pointed down. He moved restlessly in his chair and pulled his feet up in the seat from time to time.</p> <p>Resident #182's clinical record was reviewed on 01/30/2015 at 12:49 p.m. Resident #182's current diagnoses included, but were not limited to, Alzheimer's disease, Down syndrome, and insomnia. Resident #182's height was 56 inches (4 feet 6 inches).</p> <p>Resident #182 had a current, 12/8/14, annual, Minimum Data Set assessment (MDS) which indicated was the resident was cognitively impaired and rarely or never made independent decisions, and required staff assistance for mobility and needed limited assistance for eating.</p> <p>Resident #182 had a current, 12/19/13, "OBRA PASARR level II" (an evaluation completed for individuals with developmental disability or mental illness to ensure their needs were met in a long term care setting) report which indicated the following: "4. [Resident's name] may benefit from Physical, Occupational and Speech</p>		<p>was reviewed. The center is currently testing assistive devices with RES # 182 and will update medical record with successful intervention.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>-</p> <p>Residents of short stature have the potential to be affected by this deficient practice.</p> <p>An Audit was completed to identify those residents in the center that potentially could be affected by the height of the centers dining tables or chairs.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Dietary Staff and Nursing Staff have been re-educated on Adaptive Eating Devices with focus on resident set-up to</p>	

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	<p>therapy evaluations and treatment, if necessary."</p> <p>Resident #182 had a current, 12/8/14, care plan problem/need regarding assistance with eating to restore function for eating due to dementia. The target goal date for this problem was 4/2/15. An approach to this problem included, but was not limited to, "Position as upright as possible for meals."</p> <p>Resident #182's record lacked an assessment for seating and positioning when dining.</p> <p>During an, 1/30/15, 10:40 a.m., observation and interview with Family Tree Unit Manager #4, Unit Manager #4 requested and assisted Resident #182 to sit in a dining room chair in the Family Tree Dining Room. Unit Manager #4 indicated Resident #182's feet were dangling and did not touch the floor. Unit Manager #4 indicated all the chairs in the Family Tree Dining Room were the same size and all chairs would fit Resident #182 the same. Unit Manager #4 indicated it was not good for a resident's feet to dangle when seated in a chair. It was best for a person to be able to plant his feet to the floor for good positioning and comfort. The Unit Manager #4 indicated she had been</p>		<p>promote independent dining.</p> <p>Table and Chairs to accommodate the needs of resident(s) of short stature has been put into dining area (2/12/15)</p> <p><u>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 in place?</u></p> <p>-</p> <p>Director of Care Delivery or designee will audit 5 Meals weekly x 4 weeks to ensure adaptive table and chairs are available.</p> <p>Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p>	

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F000271 SS=D	<p>unaware Resident #182's feet did not touch the floor when seated in the dining room chair.</p> <p>A 2/2/15, 1:50 p.m., observation of the Family Tree Dining Room chairs indicated the seat of each chair was 18 inches hip to thigh and the leg of each chair was 17 inches seat to floor which totaled 35 inches. In order for a resident to sit with his/her feet planted on the ground, the individual would need to be 35 inches or more from waist to feet.</p> <p>During a 2/2/15, 1:35 p.m. interview, the Director of Nursing indicated the facility did not have a policy or procedure regarding positioning.</p> <p>3.1-3(v)1</p> <p>483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. Based on record review and interview, the facility failed to have timely signed physician orders at time of admission for 1 of 5 residents reviewed for signed physician orders. (Resident #244)</p> <p>Findings include:</p>	F000271	<p><u>By what date the systemic changes will be completed?</u></p> <p>-</p> <p>March 4th , 2015</p> <p>Tag F 271 Admission Physician orders for immediate care</p>	03/04/2015

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	<p>The clinical record for Resident #244 was reviewed on 1/28/15 at 3:04 p.m. Diagnoses for Resident #244 included, but were not limited to, chronic renal failure, hypertension, and heart disease.</p> <p>The clinical record did not contain signed physician orders for Resident #244. Resident #244 had been admitted to the facility on 1/6/15.</p> <p>During an interview with the Intermediate Unit Manager #5 on 2/2/15 at 10:23 a.m., additional information regarding signed physician orders for Resident #244 was requested.</p> <p>During an interview with the Intermediate Unit Manager #5 on 2/2/15 at 1:16 p.m., she indicated Resident #244 had no signed physician orders.</p> <p>Review of the current, 08/2009 policy, titled "MINIMUM RECORD CONTENT", provided by the Director of Nursing on 2/2/15 at 1:50 p.m., included, but was not limited to, the following:</p> <p>"PHYSICIAN ORDERS</p> <p>At the time of admission, the center receives physician orders from the immediate care of the patient that</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 244: Clinical record was reviewed and updated to include signed physician admission orders.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents admitted to the facility have the potential to be affected by the alleged deficient practice.</p> <p>The clinical records for all residents currently in the facility have been reviewed and updated when needed to reflect current signed admission orders by their physician.</p>				

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	<p>include, at a minimum, orders for diet, medication and routine care to maintain or improve the patients's functional abilities....</p> <p>...Current orders are validated on a physician order recapitulations (recaps) form at the first of each month. Recaps reflect orders received during the month including additions, discontinuations and modifications to medications or treatments....</p> <p>...After the physician reviews, signs and dates the recapitulation orders, the nurse noting the orders signs and dates the form as listed above...."</p> <p>3.1-19(a)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nursing staff and Medical Records has been re-educated on the medical records guideline to include timely review and signing of the physician orders upon admission.</p> <p>The ADNS or Designee will conduct and audit 3 times a week (Monday, Wednesday, Friday) of all admissions to ensure the physician has signed the admission orders and record findings on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p>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;</p> <p>Audit findings will be presented to the QAA Committee weekly for 4</p>	

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure bowel monitoring was completed for 1 of 5 resident reviewed for bowel monitoring. (Resident #101)</p> <p>Findings include:</p> <p>The clinical record for Resident #101 was reviewed on 1/29/15 at 7:36 a.m. Diagnoses for Resident #101 included, but were not limited to, Alzheimer's disease, constipation, and</p>	F000309	<p>weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p> <p>By what date the systemic changes will be completed? March 4th, 2015</p> <p>Tag F309 Provide Care/Services for highest wellbeing.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>	03/04/2015

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	<p>schizo-affective disorder.</p> <p>Resident #101 had current, signed physician orders for the following:</p> <p>a. Docusate (a stool softener) 100 milligrams (mg) one tablet by mouth two times a day.</p> <p>b. Miralax (a laxative) 17 Grams by mouth daily.</p> <p>c. Senna (a laxative) 8.6 mg one tablet by mouth two times a day.</p> <p>d. Milk of Magnesia (a laxative) 30 milliliters (ml) by mouth daily as needed for constipation.</p> <p>e. Bisacodyl (a laxative) 10 mg suppository rectally as needed for constipation.</p> <p>f. Bisacodyl (a laxative) 5 mg 1 tablet by mouth two times a day as needed for constipation.</p> <p>Review of the MCHS (Manorcare Health Services) Anderson Documentation Survey Report for January 2015, indicated Resident #101 did not have a documented bowel movement from January 2, 2015 to January 7, 2015. Six days without a documented bowel</p>		<p>Resident 101: Clinical record was reviewed and reflects current monitoring of bowel status with assessments and interventions completed as needed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents with constipation have the potential to be affected by the same alleged deficient practice.</p> <p>The clinical record for all residents in the facility has been reviewed to include review of their BM documentation for episodes of constipation. Their records were updated to reflect assessment and intervention if needed per the change in condition guideline.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not</p>	

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	<p>movement.</p> <p>Review of the January 2015 Medication Administration Record (MAR) indicated no "as needed" medications for constipation had been given to Resident #101 from January 2, 2015 through January 12, 2015.</p> <p>A nurse's note, dated 1/5/15, indicated Resident "received prn [as needed] laxative per MD [physician] orders".</p> <p>During an interview with the Intermediate Unit Manager #5 on 2/2/15 at 10:15 a.m., she indicated she did not know why the "as needed" medication was not documented on the MAR. She further indicated there was not a protocol which instructed the staff which laxative to use first for a resident.</p> <p>3.1-37(a)</p>		<p>recur;</p> <p>Licensed Nurses and C.N.A.s have been re-educated on the Change in condition guidelines(GI care path) to include documentation, review of alerts on Point Click Care for no BM in 3 days, and appropriate assessment and interventions.</p> <p>The ADNS or Designee will conduct daily audits of the alert charting system to identify residents that trigger for No BM in a 3 day period to ensure there is appropriate assessment and intervention per the Bowel Monitoring guidelines. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p>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;</p> <p>Audit findings will be presented to the QAA Committee weekly for 4</p>		

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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to ensure PEG [Percutaneous Endoscopic Gastrostomy] tube feedings were performed correctly for 1 of 1</p>	F000322	<p>weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p> <p>By what date the systemic changes will be completed? March 4, 2015</p> <p>Tag F322 NG Treatment/services, restore eating skills.</p>	03/04/2015

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	<p>observation. [Resident #181, LPN #1]</p> <p>Findings include:</p> <p>Resident #181's PEG tube feeding administration was observed on 1/30/15 at 7:53 a.m. LPN #1 check the tube placement with air and for residual. The LPN filled the barrel of a 60 cc syringe with Jevity 1.5 [a PEG tube feeding formula] four times and used the plunger on the syringe to push the feeding through the tube each time. He flushed the tube at the end of the feeding with 70 cc's of water. He did not flush the tube at the start of the feeding.</p> <p>Resident #181's clinical record was reviewed on 1/28/14 at 1:12 p.m. The resident's diagnoses included, but were not limited to, anoxic brain damage, anxiety disorder, epilepsy, dysphasia, and bipolar.</p> <p>The resident had a 1/6/15, physician's order for a bolus feeding of Jevity 1.5 - 240 ml's 6 times daily. 1440 ml/day flush tube with 35 mls water before and after each feeding. Residual checks prior to feeding and medication administration.</p> <p>The resident had a 10/23/14, care plan focus for "Need for feeding tube/potential for complications of feeding tube use</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 181: no longer resides at the facility.</p> <p>LPN #1 completed re-education on the bolus feeding process.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents that receive bolus feeding (feeding to gravity) have the potential to be affected by the same deficient practice.</p> <p>An audit was completed to identify those residents in the facility that have orders for feedings to be administered via gravity.</p>	
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	<p>related to aspiration potential." An intervention for this problem was "Administer type feeding formula, hydration, and flushes per order."</p> <p>During an interview with the Director of Nursing on 1/30/15 at 8:45 a.m., she indicated water flushes should be done prior to administering the feeding and after completing the feeding. She indicated bolus feedings should be done to gravity [fill the barrel of the syringe and hold it above the abdomen and allow the fluid to flow by gravity through the tube] and not pushed through with a syringe. She indicated the facility did not have a policy related to tube feedings.</p> <p>3.1-44(a)(2)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nurses were re-educated on the guidelines for providing a tube feeding administered via gravity.</p> <p>The ADNS or Designee will conduct observations 3 times a week of residents that required tube feeding administered via gravity to ensure proper technique is followed per guidelines. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p>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;</p>	

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to ensure nutritionally at risk residents were served nutrient-dense and/or calorie-dense food items as planned, cognitively impaired dependent residents were encouraged to eat and nutritional supplements were monitored for consumption and effectiveness for 3 of 5 residents</p>	F000325	<p>Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p> <p>By what date the systemic changes will be completed? March 4, 2015</p> <p>Tag F 325 maintains nutrition status unless unavoidable.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>	03/04/2015	

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	<p>reviewed for nutrition and weight management (Residents # 65, #182 and #30).</p> <p>Findings include:</p> <p>1. During an, 1/29/15, lunch meal observation, Resident #65's meal card indicated serve "Extra Items: Ice cream." Resident #65 was served her meal and set up to dine on 1/29/15 at 12:37 p.m. Resident #65 was not served any ice cream. When informed of the missing ice cream on 1/29/15 at 12:39 p.m., the Family Tree Unit Manager #4 indicated this was an error and obtained ice cream for Resident #65. Resident #65 did consume part of the ice cream after it was obtained.</p> <p>Resident #65's clinical record was reviewed on 02/02/2015 at 9:41 a.m. Resident # 65's current diagnoses included, but were not limited to, Alzheimer's disease, depression, debility, and history of falls.</p> <p>Resident #65 had a current, 10/16/14, quarterly, Minimum Data Set assessment (MDS) which indicated the resident was severely cognitively impaired, required staff assistance for mobility and required staff supervision and set up for eating.</p>		<p>Resident 65: Clinical record was reviewed and resident has had stable weight for 6 months. Registered dietician assessment/recommendations and physician orders were reviewed and validated that resident is receiving prescribed diet.</p> <p>Resident 182: Clinical record was reviewed and resident has had stable weight for 6 months. Registered dietician assessment/recommendations and physician orders were reviewed and validated that resident is receiving prescribed diet.</p> <p>Resident 30: Clinical record was reviewed and resident has had stable weight for 6 months. Registered dietician assessment/recommendations and physician orders were reviewed and validated that resident is receiving prescribed diet.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p>	

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	<p>Resident #65 had a current, 10/16/14, care plan problem/need regarding nutritional risk due to dementia. The target goal date for this problem was 2/15/15. Approaches to this problem included, but were not limited to, "Provide prescribed diet, ... Provide supplements as ordered."</p> <p>Resident #65 had a current, 11/16/15, "Quarterly Nutritional Review" which indicated the resident was to be served ice cream at lunch and dinner due to varied intake form 25% to 100% and a desire to maintain a stable weight.</p> <p>2. During an, 1/29/15, lunch meal observation, Resident #182's meal card indicated serve "Extra Items: ... Ice cream..." Resident #182 was served his meal and set up to dine on 1/29/15 at 12:41 p.m. Resident #65 was not served any ice cream. When informed of the missing ice cream on 1/29/15 at 12:45 p.m., the Family Tree Unit Manager #4 indicated this was an error and obtained ice cream for Resident #182. Resident #182 did consume part of the ice cream after it was obtained.</p> <p>Resident #182's clinical record was reviewed on 01/30/2015 at 12:49 p.m. Resident #182's current diagnoses included, but were not limited to,</p>		<p>Residents that receive supplements have the potential to be affected by the alleged deficient practice.</p> <p>The clinical records for all residents that receive nutritional supplements have been reviewed to ensure proper documentation is present in the clinical record for consumption and supplement acceptance per facility policy.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed nursing staff and C.N.A.s have been educated on the documentation of meal consumption to include documentation and notification when supplements are not consistently consumed.</p> <p>The ADNS or designee will conduct meal observations and chart reviews for a total of 30 per week to validate accuracy of meal intake and supplement documentation. Findings will be recorded on the QAA</p>	

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	<p>Alzheimer's disease, Down syndrome, and insomnia.</p> <p>Resident #182 had a current, 12/8/14, annual, Minimum Data Set assessment (MDS) which indicated the resident was cognitively impaired and rarely or never made independent decisions, required staff assistance for mobility and needed limited assistance for eating.</p> <p>Resident #182 had a, 12/9/14, "Nutrition Statement/Summary" which indicated the resident had a history of weight loss and had currently become stable with his weights. The summary also indicated "Recommend continuing supplements and snacks."</p> <p>Resident #182 had a current, 12/8/14, care plan problem/need regarding nutritional risk due to a history of weight loss. The target goal date for this problem was 4/2/15. Approaches to this problem included, but were not limited to, "Provide diet as ordered, Provide snacks as ordered, Provide supplements as ordered."</p> <p>Resident #182 had a current, 12/8/14, care plan problem/need regarding a deficit in activities of daily living due to Alzheimer's Disease. The target goal date for this problem was 4/02/15. An</p>		<p>monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p>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;</p> <p>Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p> <p>By what date the systemic changes will be completed? March 4, 2015</p>	

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	<p>approaches to this problem included, but was not limited to, "assist with ...eating as needed."</p> <p>3. On 1/29/15, Resident #30 was observed from 8:08 a.m. to 8:39 a.m., with her food in front of her without any encouragement to eat. Staff was observed standing in the room with no interaction with the residents. At 8:39 a.m. LPN #2 asked the resident if she was going to eat her oatmeal and the resident said "no it is cold." LPN #2 then sent a CNA to the kitchen to obtain a fresh bowl of oatmeal. The resident did not eat the eggs and toast on her plate. She consumed oatmeal and coffee for the meal.</p> <p>Resident #30's clinical record was reviewed on 1/29/15 at 8:53 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and depression.</p> <p>The resident had current physician's orders for a mechanical soft, no added salt diet. The resident was to receive Ensure chocolate only two times per day in the afternoon and at bedtime.</p> <p>The resident had a 10/28/14, significant change MDS assessment. The assessment indicated the resident had severe cognitive impairment and required</p>			

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	<p>setup and supervision at meals.</p> <p>Review of the resident's weights were as follows:</p> <p>10/14/14 108.6 pounds 10/22/14 92.8 pounds 10/29/14 89.2 pounds 11/3/14 89 pounds 11/22/14 92.8 pounds 12/9/14 94 pounds 12/16/14 96 pounds 12/23/14 100.8 pounds 12/30/14 96.5 pounds 1/6/15 93.6 pounds 1/8/15 95.8 pounds 1/13/15 96.2 pounds 1/20/15 93.2 pounds 1/27/15 94 pounds</p> <p>A 1/27/15, 11:02 a.m., Nutrition/Weight Progress Note for quarterly nutrition review indicated the resident was at nutritional risk due to diagnoses of Congestive Heart Failure, dementia, history of myocardial infarction, hypertension, polypharmacology, diuretic, need for altered diet consistency, therapeutic diet, recent significant weight loss, underweight status, and abnormal labs. The note indicated the resident's intake was 25% to 100% and she continued to receive chocolate Ensure Plus two times a day to supplement diet for increased protein, calories, and fluid</p>			

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	<p>due to weight status. Weight status was underweight for height. Recent 10% weight loss since 10/14/14, for a total of 14.6 pounds. Weight fluctuations occurred due to diuretic prescription. Resident was receiving extra 700 calories and 26 grams protein through supplementation at this time. Supplementation should have met resident's remaining calorie and protein needs when intake was poor. The summary also indicated "Recommend to continue current diet order and continue snacks per her preferences between meals and Ensure Plus two times a day."</p> <p>The resident had a 1/16/15, revised care plan focus for being at nutritional risk. An intervention for the focus was to encourage and assist as needed to consume foods and/or supplements and fluids offered.</p> <p>Review of the meal intakes for January 1, 2015, and ending at breakfast on January 29, 2015, indicated the resident was served 82 meals. The resident refused 6 of the meals, ate less than 25% on 20 occasions, and consumed 50% 26 times.</p> <p>Review of the documentation for the Ensure indicated Resident #30 accepted it everyday at 2:00 p.m. and 8:00 p.m. The documentation did not indicate the</p>			

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	<p>amount of the supplement the resident consumed.</p> <p>During an interview with the Speech Therapist #3 on 1/30/15 at 8:50 a.m., she indicated the resident had a two to three minute attention span and would need frequent prompting at meals.</p> <p>During an interview with the Director of Nursing on 1/29/15 at 11:09 a.m., she indicated the facility did not document the amount of the supplements residents consumed. She indicated the documentation system the facility used did not allow for the percentage of supplements consumed to be tracked. She indicated residents with weight loss were encouraged to eat in the dining rooms so staff would be available to get them more engaged and encourage them to eat.</p> <p>During a 1/29/15, 3:35 p.m., interview with CNA #15, she indicated she had given Resident #30 her Ensure at 2:00 p.m., and the resident accepted it. She indicated she later checked on the resident and found the resident pouring the Ensure down the drain of the sink in the resident's room. She indicated she did not know how much the resident had drunk of the supplement.</p>			

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	<p>During a 1/30/15, 10:45 a.m., interview with the Registered Dietician [RD], she indicated the resident showed a significant weight loss due to having a lot of edema on her original admission. The resident was sent to the hospital and returned after diuretics were given and had a 15.8 pound weight loss due to fluid loss. She indicated she had talked with the resident's physician and the resident had a history of being underweight. She indicated the resident had been stable but had recently lost a couple of pounds. She indicated she expected some fluctuations due to the use of diuretics. The 1/29/15, breakfast consumption indicated the resident had eaten 50%. The RD indicated oatmeal and coffee should have been documented as 25% consumed. She indicated she needed the staff to accurately document the meal consumption because she used the information for interventions for weight loss.</p> <p>4. A current, 2/2011, facility policy titled "Weight Management Practice Guide", which was provided by the Director of Nursing on 1/29/15, 1:09 p.m., included, but was not limited to, the following:</p> <p>"...the initial plan of care is developed and initiated to meet the patient's individual needs. ...Initial interventions may include...individual menu items and</p>			

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F000431 SS=E	<p>snacks selections that are both nutrient-dense and calorie-dense." "For residents with low oral intake, several studies suggest that verbal prompting, encouragement and even generalized social interaction can significantly improve many patients food and fluid consumption both during mealtimes and between meals."</p> <p>3.1-46(a)(1)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked,</p>			

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	<p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure drugs and biologicals used in the facility were labeled and discarded in accordance with the accepted professional principles, and recognized the appropriate expiration date. This deficient practice impacted current Residents #136, #38, and #92</p> <p>Findings include:</p> <p>During the medication storage observation on 1/30/15 at 10:38 a.m., the following concerns were noted on the Family Tree Unit:</p> <p>Two opened bottles of Novolog Insulin were noted with no open date for Resident #136.</p> <p>The Intermediate Unit had the following concerns:</p> <p>Medication Cart #3 had two opened bottles of Levemir Insulin with no open date for Resident #38.</p> <p>One pint bottle of Lactulose solution 10g/15ml with no open date for Resident</p>	F000431	<p>Tag F 431 Drug Records, label/store drugs and biologicals</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident 136: no longer resides at the facility.</p> <p>Resident 38: The storage of this resident's medication was reviewed and all items are properly labeled and dated per facility guidelines.</p> <p>Resident 92: The storage of this resident's medication was reviewed and all items are properly labeled and dated per facility guidelines.</p> <p>Resident #50: no longer resides at the facility. Medication destruction was completed per facility guidelines.</p> <p>Resident #61: no longer resides at</p>	03/04/2015

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	<p>#92.</p> <p>The Intermediate Unit Treatment Cart had one 1 ounce bottle of Nystain Powder for Resident #50, two had been discharged.</p> <p>One tube of Bacitracin ointment for Resident #61, who had expired.</p> <p>One bottle of Nystain powder for Resident #94, who had been discharged.</p> <p>One tube of Hydrocortisone, unlabeled.</p> <p>One tube of Bacitracin unlabeled.</p> <p>During an interview on 2/2/15 at 2:35 p.m., the Unit Manager indicated the medications should have been removed from the medication carts and treatment carts at time of discharge. The Unit Manager also indicated all medications should be labled and marked with an opened date after opening.</p> <p>Review of the current facility policy, dated 1/1/13, titled "Disposal/Destruction of Expired or Discontinued Medications", provided by the Director of Nursing on 2/2/15 at 12:50 p.m., included, but was not limited to, the following:</p> <p>"Applicability: This Policy 8.2 sets forth the procedures relating to medication disposal and destruction.</p> <p>Procedure:</p> <p>1. Facility staff should destroy and dispose of medications in accordance</p>		<p>the facility. Medication destruction was completed per facility guidelines.</p> <p>Resident #94: no longer resides at the facility. Medication destruction was completed per facility guidelines.</p> <p>The two unlabeled items located in the treatment cart were removed and disposed of per facility guidelines.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents with medications and treatments stored on site have the potential to be affected by the same alleged deficient practice.</p> <p>An audit was completed on all medication carts, treatment carts, medication rooms to validate that all items are properly labeled and dated when opened per the facility policy and corrective action taken for any identified concerns.</p> <p>What measures will be put into</p>				

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	<p>with Facility policy and Applicable Law, and applicable environment regulations.</p> <p>...</p> <p>2. Facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. ..."</p> <p>Review of te current facility policy, dated 1/1/13, titled ..."Storage and Expiration of Medications, Biologicals, Syringes and Needles", provided by the Director of Nursing on 2/2/15 at 12:05 p.m., included, but was not limited to, the following:</p> <p>"Applicability: This Policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles.</p> <p>Procedure:</p> <p>... 5. Once any medication or biological package is opened, Facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.</p> <p>...15. Facility should ensure that medications and biological for expired or</p>		<p>place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>The Licensed Nursing staff has been educated on the Medication Storage Guidelines for the facility with focus on proper labeling, dating and removal of medications for those patients who have discharged.</p> <p>The ADNS or Designee will conduct audits of the medication carts, treatment carts and medication storage rooms 3 times a week to ensure proper labeling and dating of items stored and that discharged patients have been removed per policy. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p>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;</p> <p>Audit findings will be presented to the QAA Committee weekly for 4</p>				

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F000465 SS=E	<p>discharged residents are stored separately, away from use, until destroyed or returned to the provider. ..."</p> <p>3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure ceiling and ceiling vents were safe and in good repair for 1 of 4 dining rooms observed (Family Tree Dining Room) and 1 of 1 kitchen observed. This deficient practice had the potential to impact 124 Residents who attended activities or ate in the Family Tree dining room.</p> <p>Findings Included: During an observation on 1/26/15 at 12:25 p.m, two square sections of the ceiling in the Family Tree dining room was noted to be missing. The sections</p>	F000465	<p>weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p> <p>By what date the systemic changes will be completed? March 4, 2015</p> <p>F 465 SS=E Safe/Functional/Sanitary/Comfortable Environment</p> <p>It is the practice of this center to comply with F 465 SS=E Safe/Functional/Sanitary/Comfortable Environment</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p>	03/04/2015

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	<p>were approximately 3 feet by two feet and 2 feet by 2 feet. Pipes and insulation were visible. The area was directly over a section of the room where residents ate and food was distributed.</p> <p>During a kitchen observation on 1/26/15 at 10:07 a.m., the ceiling vent next to the food preparation area was noted to be bent with a piece hanging down from the ceiling.</p> <p>During a lunch observation on 1/26/15 at 12:25 p.m., three residents were observed seated under the area of the Family Tree dining room with missing ceiling tile and exposed insulation while waiting for meals to be served. At 12:35 p.m., the Food Service Supervisor directed the staff to move the residents from under the open areas. This was prior to their meals being served.</p> <p>During an observation on 1/27/15 at 9:33 a.m., breakfast in the Family Tree dining room was ending. Some residents remained at their tables, insulation continued to be exposed through the open areas in the Family Tree Dining room ceiling. No residents were seated under the open areas.</p> <p>During a confidential interview on 1/26/15 at 10:15 a.m., Resident #B</p>		<p>-</p> <p>The Ceiling in the Family Tree Dining Room has been fixed and/or replaced as of 2/2/2015.</p> <p>The Vent in the Kitchen has been fixed as of 1/27/2015.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>-</p> <p>All residents that eat meals or attend activities in the family tree dining room have the potential to be affected by this deficient practice.</p> <p>An Audit was completed to identify and correct any other environmental concerns.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>-</p>		

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	<p>indicated the ceiling had fell in about 3 months ago and that open area had been patched. Resident #B indicated the ceiling in the Family Tree dining room had fallen in 2 times and the current open area had been present for about a month.</p> <p>During an interview on 1/26/15 at 10:10 a.m., the Food Services Supervisor indicated the vent had been bent for awhile and believed the facility was waiting on a part. The food preparation machinery had been moved so it was no longer under the vent.</p> <p>During an interview on 1/27/15 at 12:52 p.m., the Maintenance Supervisor indicated the open areas would be repaired after lunch.</p> <p>During an interview on 1/27/15 at 3:30 p.m., the Administrator was informed of the concerns regarding the open areas in the Family Tree dining room ceiling. The Administrator indicated the open areas would be repaired by the end of the next day. due. In order to repair the sprinkler systems</p> <p>During an confidential interview on 1/29/15 at 10:26 a.m., an employee indicated there had been concerns with open areas and exposed insulation "on and off all month."</p>		<p>Maintenance Director & Staff has been re-educated on F-Tag 465 and the Environmental Observations Checklists.</p> <p>Maintenance Director will continue to follow Preventive Maintenance Program in relation to environmental observation and securing worksite areas.</p> <p>The IDT Team has been re-educated on Environmental Unit Round tools and securing worksite areas.</p> <p><u>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 in place?</u></p> <p>-</p> <p>Maintenance Director or designee will complete 3 Environmental Observation Tools a week x 4 weeks to ensure a Safe/Functional/Sanitary/Comfort able Environment is maintained. Any findings will be corrected.</p> <p>Audit findings will be presented to</p>		

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F000502 SS=D	<p>During an interview on 2/2/15 at 12:56:49 p.m., the Administrator indicated, "on Monday one person was sitting under the hole but was moved before food was served, per my conversation with the CNA's. It sounds like we should have roped off the area. I don't know if anyone sat there for diner."</p> <p>During an interview on 2/2/15 at 1:01 p.m., the Administrator indicated the vent in the kitchen had been in need of repair and hanging down at the time he had begun to work at the facility, 12/3/14. The Administrator also indicated the open areas in the ceiling were a concern for the residents who ate or attended activities in the Family Tree dining room.</p> <p>Review of Facility Census form indicated the total census for the facility was 145. The total census on the secured unit (21 residents) was subtracted from the total facility census. The residents from the secured unit do not normally attend activities in the Family Tree dining room.</p> <p>3.1-19(f)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory</p>		<p>the QAA Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>- March 4th, 2015</p>	

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	<p>services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to ensure an urine culture was obtained when ordered to assess pain for 1 of 4 residents reviewed for pain management (Resident #244).</p> <p>Finding include:</p> <p>The clinical record for Resident #244 was reviewed on 1/28/15 at 3:04 p.m. Diagnoses for Resident #244 included, but were not limited to, chronic renal failure, hypertension, and heart disease.</p> <p>Resident #244 had a order, dated 1/19/15, for an urine analysis and culture and sensitivity (urine tests). Diagnosis for the order was pain. The clinical record lacked any results for an urine analysis and culture and sensitivity.</p> <p>A nurse's note, dated 1/23/15, indicated note was a later entry from 1/22/15. The note indicated Resident #244 complained of pain and a pain pill was given.</p> <p>A social services note, dated 1/23/15, indicated Resident #244 refused evening care numerous times on 1/22/15 and the staff were unable to redirect the resident.</p>	F000502	<p>Tag F 502 Administration</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #244: Clinical record was reviewed and updated to reflect the physician's notification that the Urinalysis was not completed as ordered and there is no further orders.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Resident with orders for lab services have the potential to be affected by the same alleged deficient practice.</p> <p>A 30 day look back was completed</p>	03/04/2015

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	<p>A nurse's note, dated 1/24/15, indicated Resident #244 was out to the dialysis unit. The note further indicated the resident had been slow to respond this shift.</p> <p>During an interview with the Intermediate Unit Manager #5 on 2/2/15 at 10:23 a.m., additional information was requested regarding the result for the urine analysis and culture and sensitivity ordered on 1/19/15.</p> <p>During an interview with the Intermediate Unit Manager #5 on 2/2/15 at 1:16 p.m., she indicated the urine analysis and culture and sensitivity had not been obtained. She further indicated a laboratory requisition had not been completed for the urine tests.</p> <p>3. Review of the current, revised 08/2014 policy, titled "LABORATORY TRACKING GUIDELINES", provided by the Director of Nursing on 2/2/15/ at 1:50 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To establish guidelines to track the completion, reporting and monitoring of laboratory (lab) tests and results.... ...Lab tests, and or services are provided:...</p>		<p>on all charts to ensure that physician orders were followed and labs obtained as ordered with physician notification of results. Any identified discrepancies were communicated to the physician and new orders obtained as applicable.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nursing staff were re-educated on the medical records guidelines related processing physician orders.</p> <p>Licensed Nursing staff were re-educated on the lab tracking guidelines.</p> <p>The ADNS or designee will conduct 30 chart reviews per week to ensure that physician orders were followed and labs obtained as ordered with physician notification of results. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified</p>	

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F000505 SS=D	<p>...when specifically ordered by the attending physician or physician extender....</p> <p>...Center will establish, maintain and monitor a lab tracking system...</p> <p>...Additional considerations...</p> <p>...labs not drawn as ordered are reported to the attending physician for further directions and reported through the incident management system...."</p> <p>3.1-49(a)</p> <p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</p> <p>The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to notify the physician of radiology results for 1 of 6 residents</p>	F000505	<p>concerns in which the expectations were not achieved as outlined above.</p> <p>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;</p> <p>Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p> <p>By what date the systemic changes will be completed? March 4, 2015</p> <p>Tag F 505 Promptly notify physician of Lab results</p>	03/04/2015

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	<p>reviewed for laboratory services. (Resident #244)</p> <p>Findings include:</p> <p>The clinical record for Resident #244 was reviewed on 1/28/15 at 3:04 p.m. Diagnoses for Resident #244 included, but were not limited to, chronic renal failure, hypertension, and heart disease.</p> <p>Resident #244 had an abdomen x-ray report, dated 1/19/15, in his clinical record. The result had no documentation from the physician as having been reviewed. There was no documentation of the physician having been notified of the abdomen x-ray report in the clinical record for Resident #244.</p> <p>During an interview with the Intermediate Unit Manager #5 on 2/2/15 at 10:23 a.m., additional information was requested regarding physician notification of the abdomen x-ray report dated 1/19/15, for Resident #244.</p> <p>During an interview with the Intermediate Unit Manager #5 on 2/2/15 at 1:16 p.m., she indicated the physician had not been notified of the abdomen x-ray. She further indicated they only notify the physician when the result is abnormal and the result of the abdomen</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 244: Medical record was reviewed and updated to reflect the physician's notification of lab results.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Resident with orders for lab services have the potential to be affected by the same alleged deficient practice.</p> <p>A 30 day look back was completed on all charts to ensure that physician orders were followed and labs obtained as ordered with physician notification of results.</p>	

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	<p>x-ray was normal.</p> <p>Review of the current, 2011 policy, titled "Change in Condition: When to report to the MD/NP/PA", provided by the Director of Nursing on 2/2/15 at 1:50 p.m., included, but was not limited to, the following:</p> <p>"...X-ray, Report Immediately, New or unsuspected finding, Report on Next Work Day, Old or long-standing finding, no change..."</p> <p>3.1-49(f)(2)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nursing staff were re-educated on the lab tracking guidelines.</p> <p>The ADNS or designee will conduct 30 chart reviews per week to ensure that physician orders were followed and labs obtained as ordered with physician notification of results. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p>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;</p> <p>Audit findings will be presented to the QAA Committee weekly for 4</p>	

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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, record review and interview, the facility failed to have complete and accurate clinical records in regards to communication between the dialysis center and the facility, and respiratory treatments and assessments for 2 of 42 residents reviewed for</p>	F000514	<p>weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p> <p>By what date the systemic changes will be completed? March 4, 2015</p> <p>Tag F514 Records complete/accurate/accessible</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the</p>	03/04/2015	

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	<p>complete and accurate records. (Residents #244, and #108)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #244 was reviewed on 1/28/15 at 3:04 p.m. Diagnoses for Resident #244 included, but were not limited to, chronic renal failure, hypertension, and heart disease. Resident #244 is to receive dialysis treatments on Tuesdays, Thursdays, and Saturdays.</p> <p>Additional chart review on 1/30/15 at 9:27 a.m., of the "dialysis binder" for Resident #244. The binder contained dialysis communication forms dated 1/13/15, 1/15/15, 1/17/15, 1/22/15, 1/27/15, and 1/29/15. The binder lacked dialysis communication forms for 1/8/15, 1/10/15, 1/20/15, and 1/24/15. The record was missing 4 dialysis communication forms out of 12 opportunities.</p> <p>During an interview with the Intermediate Unit Manager #5 on 2/2/15 at 10:23 a.m., she indicated the "dialysis binder" is to go with the resident to the dialysis center every time he goes for a treatment. She further indicated the top portion of the communication form is to be completed by the facility and the</p>		<p>deficient practice?</p> <p>Resident 244: Medical record was reviewed and reflects accurate documentation/communication pre and post dialysis treatment.</p> <p>Resident 108: Medical record was reviewed and reflects accurate documentation on the Medication Administration Record (MAR) of nebulizer treatments per the facility guidelines and any omissions were communicated to the physician and the patient was assessed and records updated to reflect current status.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents that receive dialysis treatment and nebulizer treatments have the potential to be affected by the same alleged deficient practice.</p> <p>The medical record for residents receiving dialysis therapy have been reviewed including the dialysis</p>	

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	<p>bottom portion of the communication form is to be completed by the dialysis staff. She did not know why the communication forms had not been completed on 1/8/15, 1/10/15, 1/20/15, and 1/24/15.</p> <p>2. Resident #108's clinical record was reviewed on 1/29/15 at 2:00 p.m. Resident #108's current diagnoses included, but were not limited to, severe chronic obstructive pulmonary disease, hypoxia, respiratory failure, asthma and anxiety disorder.</p> <p>Resident #10 had a current order dated 12/20/14 for IPRAT-ALBUT 0.5-3(2.5)mg/3 ml Duo Neb four times daily per nebulizer (a respiratory treatment).</p> <p>Review of the Medication Administration Record (MAR) for January 2015 indicated no documentation of nebulizer treatments being given on 1/5/15 at 6:00 a.m. and 1/6/15 at 12:00 a.m. Review of the Nursing Notes for January 2015, indicated no documentation of treatments on 1/5/15 at 6:00 a.m. and 1/6/15 at 12:00 a.m.</p> <p>Care plan review indicated a problem: "Has/At risk for respiratory impairment related to congested heart failure, asthma,, respiratory failure,</p>		<p>communication forms and validated to ensure any follow up was completed and physician updated with any concerns.</p> <p>The medical record for residents that receive nebulizer therapy have been reviewed and updated to reflect, going forward, accurate documentation of nebulizer treatments per the physician's orders.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nursing staff have been re-educated on the Dialysis Communication guidelines.</p> <p>Licensed Nursing staff have been re-educated on the Medication Administration guideline: Nebulizer treatments guidelines.</p> <p>The ADNS or designee will conduct an audit 3 times per week of residents that receive dialysis treatments to ensure the communication form is completed</p>				

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	<p>bronchiectasis, history pneumonia, history aspiration dated 11/26/14. Interventions for the problem included, but were not limited to, evaluate lung sounds and VS [vital signs] as needed. Administer medications/treatments per physician orders."</p> <p>3. Review of facility policy dated 8/2009, titled "Standards and Processes for Clinical Record Entries", provided by Director of Nursing on 2/2/15 at 12:50 p.m., indicated the following: "Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition.....Individuals charting in clinical records are expected to adhere to ethical principles and professional standards."</p> <p>3.1-50(a)(1)</p>		<p>per the facility guidelines. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p>The ADNS or designee will conduct audits 10 times per week of residents that receive Nebulizer treatments to ensure there is accurate documentation on the MAR of completion per physician orders. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p>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;</p> <p>Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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