

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/06/2012
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NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 3, 4, 5, and 6, 2012</p> <p>Facility number: 000310 Provider number: 155443 AIM number: 100288970</p> <p>Survey team: Karen Lewis, RN, TC Delinda Easterly, RN Betty Retherford, RN Ginger McNamee, RN</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 8 Medicaid: 59 Other: 2 Total: 69</p> <p>Stage 2 Sample: 35</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	Preparation and/or execution of this Plan of Correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws.	

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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	Quality review completed on January 11, 2012 by Bev Faulkner, RN			
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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of a change in resident condition for 1 of 3 residents reviewed for physician notification of a condition change in a stage 2 sample of 35. (Resident #33)</p>	F0157	<p>It is the intention of this facility to ensure the primary physician is notified of a change in condition for all residents. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. The nurse responsible for not notifying the MD of the</p>		02/05/2012		

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	<p>Findings include:</p> <p>1.) The clinical record for Resident #33 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Resident #33's current diagnoses included, but were not limited to, heart disease, osteoarthritis, depression, macular degeneration, chronic obstructive pulmonary disease, dementia, anemia, protein malnutrition, hypertension, ischemic bowel disease and debility.</p> <p>A nursing note entry, dated 12/30/11 at 8:15 p.m., indicated the following, " This nurse was alerted to res [resident] bathroom per CNA. Pt [patient] was sitting on toilet c/o [complains of] "being hot" et [and] "head hurting." Pts head dropped; it was noted pts eyes rolled back et then closed et pt was drooling from nose et mouth. Pt barely responded to her name being called et gently shaking her shoulder. Pt was placed back into w/c [wheelchair] per 2 x [times] assist et put into bed per assists x 2 ...."</p> <p>The clinical record lacked any indication the physician was made aware of the incident noted above.</p>		<p>change of condition was counseled and educated in proper nursing procedure for any change of condition of a resident. Resident #33's physician was notified of residents condition with no new orders received. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all residents was completed with no other residents identified. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. All licensed nursing staff will be re-educated on physician notification on 1/31/12. The 24 Hour Nursing Report will be received by DON/designee daily to ensure proper notification of resident condition changes. Any resident condition change to be found, not reported to the physician, will be immediately reported. Upon review of the 24 Hour Report the DON/designee will sign the report as indication of review. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. Results of</p>				

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	<p>During an interview with the Director of Nursing on 1/5/12 at 2:20 p.m., she indicated she could find no information to indicate the nursing staff had called Resident #33's physician on 12/30/11 to notify him of the change in the residents medical condition. She further indicated she had read the nursing note entry and she indicated the incident was something the staff should have reported to the physician.</p> <p>2.) Review if the current facility policy, titled "Physician Notification of Resident Change of Condition," dated 7/1/11, provided by the Director of Nursing on 1/5/12 at 3:30 p.m., indicated the following,</p> <p>"Guideline:</p> <p>It is the intent of the facility for the attending physician to be notified of a change in a resident's condition by licensed personnel as warranted.</p> <p>Responsibility:</p> <p>All licensed personnel</p> <p>Procedure:</p> <p>1. Physician notification is to include, but is not limited to: ...</p>		<p>the daily 24 Hour Report audits will be presented by the DON/designee at the quarterly QA Committee Meetings to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>Any accident or incident</p> <p>Change in level of consciousness.</p> <p>Unusual behavior...</p> <p>2. Make an entry into nurses notes regarding condition / physician notification and change in physician's orders."</p> <p>3.1-5(a)(2)</p>			
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F0159 SS=C	<p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act;</p>	F0159		

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	<p>and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and observation, the facility failed to ensure residents had ready access to their personal account funds managed by the facility for 1 of 15 sampled residents interviewed for ready access of personal account funds in a stage 2 sample of 35. (Resident #24)</p> <p>Findings include:</p> <p>1.) During a resident interview on 1/3/12 at 4:06 p.m., Resident #24 indicated resident personal funds were not accessible on the weekends.</p> <p>2.) A sign posted outside of the business office listed the banking hours as Monday-Friday, 10 a.m. to 4 p.m.</p> <p>3.) During an interview with the Administrator on 1/5/12 at 12:40 p.m., he indicated the facility did not have banking hours on the weekends or the holidays.</p> <p>3.1-6(f)(1)</p>		<p>It is the intent of this facility for all residents to have access to their personal funds at a minimum of normal/routine banking hours.</p> <p>I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. Resident #24 was asked if she needed to withdrawl resident funds at this time and she stated she did not.</p> <p>II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. Banking hours will be expanded to seven days per week. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. The banking hours sign posted outside the Business Office has been update to include Saturday and Sunday 11:00 a.m. to 1:00 p.m. The facility Weekend Manager will distribute funds to residenets who desire access to their personal funds on</p>	02/05/2012

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			weekends. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. Compliance and resident satisfacion will be monitored through review of Resident Council Meeting Minutes and facility grievance log by the facility Administrator. Negative results will be presented by the Administrator during quarterly QA Committee Meegtings. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.		

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F0242 SS=D	<p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to allow 1 resident (Resident #14) in a stage 2 sample of 35 to follow her normal sleep habit of sleeping late in the morning.</p> <p>Findings include:</p> <p>Resident #14's family member was interviewed on 1/3/12 at 12:56 p.m. During the interview, the resident's family member indicated the resident had never been a morning person and had always slept late in the morning. She indicated the resident always skipped breakfast. She indicated she had informed the facility of this during the resident's health care plan conference and she wanted the facility to continue to let the resident to do this. She indicated the facility was not letting the resident sleep in. She said the resident was gotten up before breakfast every morning.</p> <p>During an interview with the Social Service Director on 1/5/12 at 1:55</p>	F0242	<p>The facility's intent is for all resident's choices/preferences be honored and care planned accordingly. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. Resident # 14 was removed from the "Third Shift Get Up List" and is allowed to sleep later in the morning per her request. Resident #14's Care Plan was reviewed and update to reflect her desire to "skip breakfast and sleep in". II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. Resident preferences will be Care Planed and honored. A 100 % Care Plan audit was completed on 1/17/12 and all resident Care Plans were updated as appropriate. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient</p>		02/05/2012		

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	<p>p.m., she indicated she was aware of the resident being a late sleeper and had a care plan for the resident to not be gotten up early.</p> <p>During an interview with CNA #3 on 1/6/12 at 9:40 a.m., she indicated the resident was up when she came on duty that morning at 6:00 a.m.</p> <p>During an interview with day shift LPN #2 on 1/6/12 at 9:45 a.m., she indicated Resident #14 was up in her wheelchair, dressed and sitting in the lounge every morning when she comes in to work. LPN #2 provided the "Third Shift Get Up List" for review during the interview and the resident was on the list for third shift to get up in the mornings.</p> <p>3.1-3(u)(3)</p>		<p>practice does not recur, including any in-services. All staff will be in-serviced on 1/31/12, on resident preferences/normal routine, honoring their preferences, and care planning accordingly. The facility DON/designee will audit/review all new admissions to ensure appropriate identification of routine/preferences of all residents residents are honored and care planned accordingly. This will be an on-going process. MDS Coordinator/IDT will review all residents at a minimum of quarterly to audit/review resident preference. This will be an on-going process. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. Results of the Care Plan audits will be presented to the QA Committee at quarterly meetings to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>	

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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>2.) The clinical record for Resident #76 was reviewed on 1/4/12 at 3:15 p.m.</p> <p>Diagnoses for Resident #76 included, but were not limited to, hypertension, anxiety, dementia, and depression.</p> <p>The clinical record indicated Resident #76 received Verapamil ER (an antihypertensive medication) 240 milligrams (mg) once a day and fosinopril-hydrochlorothiazide (an antihypertensive medication) 20-12.5 mg once a day related to her diagnosis of hypertension. Resident #76 also received clonazepam (an</p>	F0279	<p>It is the facility's intent to review and update care plans at a minimum of quarterly and as resident's condition changes.I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency.Resident # 16's Care Plan was reviewed and updated to reflect diagnosis of dysphagia, current diet, use of Zyprea and medication side effects to be monitored.Resident # 76's Care Plan was reviewed and updated to reflect diagnosis of hypertension and anxiety and medication side effects to be monitored, and BP will be monitored.II. Describe how the facility reviewed all clients in the</p>		02/05/2012		

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	<p>anti-anxiety medication) 1 mg every 12 hours related to her diagnosis of anxiety.</p> <p>The clinical record lacked any comprehensive health care plan (HCP) having been developed related to Resident #76's diagnosis of hypertension requiring the need for an antihypertensive medication and blood pressure monitoring. The clinical record also lacked any HCP having been developed related to her diagnosis of anxiety and monitoring.</p> <p>During an interview with the Director of Nursing (DoN) on 1/5/12 at 4:30 p.m., additional information was requested related to the lack of any comprehensive HCP having been developed regarding the resident's use of antihypertensive and anti-anxiety medications.</p> <p>The facility failed to provide any additional information as of exit on 1/6/12</p> <p>3.) Review of the current facility policy, dated 7/11, titled "Care Plans," provided by the DoN on 1/5/12, at 3:30 p.m., included, but was not limited to, the following:</p>		<p>facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. A 100% Care Plan audit was completed on 1/17/12 by the IDT team to ensure all Care Plans reflect the residents current status. Care Plans were update as appropriate by the team. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. All licensed nursing staff will be in-serviced on 1/31/12, on Care Plan development/revision; which will include all active diagnosis', monitoring of side effects of anti-psychotic medications, current diet, and all identified needs. The DON/designee with the IDT will audit/review all care plans at a minimum of quarterly to ensure active diagnosis, monitoring of side effects of anti-psychotic medications, and all identified needs. This will be an on-going process. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. The DON/designee will present results of Care Plan Audits to the QA Committee during the quarterly meetings to</p>		

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	<p>"GUIDELINES:...</p> <p>...each resident will have a plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care....</p> <p>...PROCEDURE...</p> <p>...2. A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment...</p> <p>...5. For each problem, need or strength a resident-centered goal is developed....</p> <p>...7. All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition...."</p> <p>3.1-35(a)</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive health care plan was</p>		<p>ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>developed with measurable objectives and approaches related to medical diagnoses, medication use, and nursing care needs for 2 of 10 residents reviewed for development of comprehensive health care plans in a stage 2 sample of 35. (Resident #16 and #76)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #16 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, vascular dementia with delusions, personality disorder with narcissistic history, anemia, depression, Parkinson's tremors related to Zyprexa, iron deficiency, and dysphasia.</p> <p>A recapitulation of physician's orders, dated 9/21/11, indicated the resident received a regular diet with thin liquids. Her diet was changed to a mechanical soft diet with nectar thick liquids on 10/21/11 following speech therapy and swallowing studies.</p> <p>The clinical record lacked the development of any comprehensive health care plan related to the resident's diagnosis of dysphagia</p>						

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	<p>(difficulty swallowing) and the need for a mechanical soft diet with nectar thick liquids due to swallowing problems.</p> <p>The clinical record indicated the resident received Zyprexa (an antipsychotic) 5 milligrams daily for vascular dementia with delusions. The clinical record also indicated the resident had tremors related to Zyprexa use.</p> <p>The clinical record lacked any comprehensive health care plan having been developed related to the resident's order for Zyprexa and the monitoring of side effects and/or tremors related to the medication.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 1/5/12 at 2:15 p.m., additional information was requested related to the lack of any comprehensive health care plan having been developed regarding the Zyprexa use and dysphagia diagnosis.</p> <p>The facility failed to provide any additional information as of exit on 1/6/12.</p>			

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F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>2.) Review of the current facility policy, dated 7/11, titled "Care Plans," provided by the DoN on 1/5/12, at 3:30 p.m., included, but was not limited to, the following:</p> <p>"GUIDELINES:...</p> <p>...each resident will have a plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care....</p> <p>...PROCEDURE...</p> <p>...7. All goals and approaches are to be reviewed and revised as appropriate by a team of qualified</p>	F0280	<p>It is the intent of this facility to update weight loss care plans with interventions to prevent further weight loss. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. A meeting was held with Resident #16, her daughter, and resident and daughter stated resident had desired to loose weight. The MD and RD were notified and her Care Plan was updated to reflect her current status. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have</p>	02/05/2012

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	<p>persons after each assessment and upon significant change of condition...."</p> <p>3.1-35(d)(2)(b)</p> <p>Based on record review and interview, the facility failed to ensure resident health care plans were reviewed timely following each Minimum Data Set assessment period and updated as necessary related to changes in</p>		<p>the potential to be affected by the alleged deficient practice. A 100% Care Plan audit was completed on 1/17/12 by the IDT team to ensure all Care Plans reflect the residents current status. Care Plans were updated as appropriate by the team. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. All nursing staff will be in-serviced on 1/31/12, on revising/updating care plans with the appropriate interventions as resident status/desires change. The IDT will audit/revise all care plans for each resident at a minimum of quarterly to ensure their current status is reflected in each care plan. This will be an on-going process. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. The DON/designee will present results of Care Plan Audits to the QA Committee during the quarterly meetings to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>the resident's condition for 1 of 10 residents reviewed for health care plan development in a stage 2 sample of 35. (Resident #16)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #16 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, vascular dementia with delusions, hypertension, coronary artery disease, chronic obstructive pulmonary disease with asthma, anemia, and gastroesophageal reflux disease.</p> <p>The clinical record indicated Resident #16 had a quarterly Minimum Data Set (MDS) assessment completed on 10/14/11.</p> <p>A health care plan (HCP) problem, dated 5/23/10 and last updated on 8/19/11, indicated Resident #16 was at risk for weight loss related to dementia. The goal for this problem was for Resident #16 to have no unplanned weight loss prior to the next review. Approaches for this problem included, but were not limited to, encourage meal consumption per</p>			
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	<p>order, diet per order, monitor consumption, weigh monthly and as needed, notify medical doctor and family as needed, and (3/20/10) provide power food.</p> <p>Monthly weight records for Resident #16 indicated the resident had lost 31 pounds from July 2011 to December 2011.</p> <p>The resident's above noted health care plan had not been updated to identify actual weight loss and new interventions. The health care plan problem had not been reviewed since 8/19/11.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 1/5/12 at 2:15 p.m., additional information was requested related to Resident #16's HCP not being updated to identify a weight loss and all current interventions. Information was also requested related to the lack of any HCP review having been done following the completion of the quarterly 10/14/11 MDS assessment.</p> <p>During an interview on 1/6/12 at 11:20 a.m., the DoN indicated she had been unable to find documentation of Resident #16's HCP having been</p>			
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	reviewed after the 10/14/11 MDS assessment. She indicated a review had now been completed.			
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F0282 SS=E	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>B. 2.) Resident #71's clinical record was reviewed on 1/5/12 at 3:04 p.m. The resident's diagnoses included, but were not limited to, dysphagia, esophagitis, hiatal hernia, cerebral vascular accident, and tracheotomy.</p> <p>The resident's current physician's orders were signed by the physician on 11/25/11. The resident's physician's orders indicated the resident was to have nothing by mouth except nectar thick liquid at the bedside. The resident had a gastrostomy tube [g-tube] for nutritional intake and medications.</p> <p>The physician's medication orders included, but were not limited to, promethazine 25 mg tablet via g-tube as directed as needed for nausea/vomiting. This order was initiated on 7/12/11. The order lacked an indication for the frequency the medication was to be given.</p> <p>The resident also had a physician's order for zolpidem tartrate 5 mg tablet give one half tablet [2.5 mg] orally daily at bedtime for insomnia.</p>	F0282	<p>The intent of the facility is that services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written care plan. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. Resident #16's power pudding was discontinued and replaced with a supplement of choice, medications were reviewed and clarification oreders were obtained as needed. Resident #14 was removed from the third shift get up list and care plan was updated to reflect desire to skip breakfast and sleep in. Resident #33's supplement was added to the Treatment Administration Record to include acceptance and consumption. Resident # 71's medications were reviewed and clarification orders were obtained as necessary. Resident #24's medications were reviewed and clarification orders were obtained as needed. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected</p>		02/05/2012		

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	<p>During an interview with the Director of Nursing on 1/5/12 at 2:00 p.m., she indicated the promethazine order needed clarified to indicate the frequency the medication could be given. She indicated the resident's medications were to be given via the g-tube and not be given orally.</p> <p>B.3.) The clinical record for Resident #24 was reviewed on 1/5/12 at 9:20 a.m.</p> <p>Current diagnoses for Resident #24 included, but were not limited to, hypertension, congestive heart failure, and constipation.</p> <p>Resident #24 had a current physician's order for the following: "Milk of Magnesia suspension give 30 milliliters as directed as needed". Milk of Magnesia is a laxative medication. The original date of this order was 8/27/2008.</p> <p>Resident #24 had a current physician's order for the following: "Fleet enema insert 133 milliliters rectally as directed as needed". A Fleet enema is a laxative medication. The original date of this order was 8/27/08.</p>		<p>by the alleged deficient practice. A 100% audit/review was completed to ensure all medication orders had complete administration instructions as required. Clarification orders were obtained as necessary. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. All licensed nursing staff will be in-serviced on proper completion of physician orders and proper review of monthly Physician Rewrites by facility DON on 1/31/12. All licensed nursing staff will be in-serviced by facility DON on proper recording of acceptance and consumption of dietary supplements on 1/31/12. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. All physician orders will be reviewed by the DON/designee during facility Morning Stand-up meeting M-F for proper completion. Results of audits will be presented to QA Committee during quarterly meetings to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>				

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	<p>During an interview with the Director of Nursing (DoN), on 1/5/12 at 4:30 p.m., additional information was requested regarding the Milk of Magnesia and the Fleet enema orders.</p> <p>The facility failed to provide any additional information as of exit on 1/6/12.</p> <p>B4.) Review of the current facility policy, dated 7/11, titled "Completing Rewrites," provided by the DoN on 1/5/12, at 3:30 p.m., included, but was not limited to, the following:</p> <p>"GUIDELINES:...</p> <p>...The pharmacy will provide rewrites, medication/treatment administration records as mutually agreed upon with the facility....</p> <p>...PROCEDURE...</p> <p>...1. The nursing facility is responsible for verifying the accuracy of all data on the rewrites, medication/treatment administration records by the time of inclusion in the resident's health record....</p> <p>...2. Rewrites, medication/treatment administration records will be sent by</p>				

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	<p>the pharmacy to the facility at a pre-determined date near the end of the previous month. The designated nursing personnel will then update and make corrections through the last day of that respective month. Once the orders are validated they will be signed by the nurse...."</p> <p>3.1-35(g)(2)</p> <p>B.1.) The clinical record for Resident #16 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, vascular dementia with delusions, pulmonary disease with asthma, personality disorder with narcissistic history, anemia, depression, gastroesophageal reflux disease, Parkinson's tremors related to Zyprexa, iron deficiency, and dysphasia.</p> <p>A recapitulation of physician's orders, signed by the physician on 11/30/11, included, but was not limited to, the following orders:</p> <p>Loperamide (a medication given for</p>			
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	<p>loose stools) 2 milligrams (mg) 1 capsule orally as directed as needed for diarrhea</p> <p>Milk of Magnesia (MOM)) (a laxative) suspension 30 milliliters (ml) orally as directed prn (as needed) for constipation</p> <p>Saline Mist 0.65% (a medication given for nasal congestion) nose spray- give 1 spray in each nostril as directed as needed for nasal congestion.</p> <p>The clinical record lacked any information or directions from the physician related to how often these "as directed" or "as needed" medications could be given.</p> <p>During an interview with the Administrator and Director of Nursing on 1/5/12 at 2:15 p.m., additional information was requested related to the lack of clarifications obtained for the "as directed" medications noted above.</p> <p>The facility failed to provide any additional information as of exit on 1/6/12.</p> <p>A. 2.) Resident #14's clinical record was reviewed on 1/4/12 at 3:00 p.m.</p>						

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	<p>The resident had a 11/28/11, Quarterly Minimum Data Set assessment. The assessment indicated the resident had short and long term memory problems, was moderately impaired making decisions and had communication problems with not always being able to be understood or able to understand others.</p> <p>The resident had an interdisciplinary care plan review on 12/14/11. The resident had a care plan problem of being at risk for sleep deprivation and sleeps days and stays up at night. Interventions for the problem included, but were not limited to, provide sleeping conditions per resident's request.</p> <p>Resident #14's family member was interviewed on 1/3/12 at 12:56 p.m. During the interview the resident's family member indicated the resident had never been a morning person and had always slept late in the morning. She indicated the resident always skipped breakfast. She indicated she had informed the facility of this during the resident's health care plan conferences and she wanted the facility to continue to let the resident do this. She indicated</p>						

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	<p>the facility was not letting the resident sleep in. She said the resident was gotten up before breakfast every morning.</p> <p>During an interview with the Social Service Director on 1/5/12 at 1:55 p.m., she indicated she was aware of the resident being a late sleeper and had a care plan for the resident to not be gotten up early.</p> <p>During an interview with CNA #3 on 1/6/12 at 9:40 a.m., she indicated the resident was up when she came on duty that morning at 6:00 a.m.</p> <p>During an interview with day shift LPN #2 on 1/6/12 at 9:45 a.m., she indicated Resident #14 was up in her wheelchair, dressed and sitting in the lounge every morning when she comes in to work. LPN #2 provided the "Third Shift Get Up List" for review during the interview and the resident was on the list for third shift to get up in the mornings.</p> <p>A.3.) The clinical record for Resident #33 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Resident #33's current diagnoses included, but were not limited to, heart disease, osteoarthritis,</p>						

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	<p>depression, macular degeneration, chronic obstructive pulmonary disease, dementia, anemia, protein malnutrition, hypertension, ischemic bowel disease and debility.</p> <p>Resident #33 had a healthcare plan, dated 6/22/11, which indicated the resident had a problem listed as, has a potential for weight loss due to tendency to leave 25% or more of each meal, has protein malnutrition and receives a pureed diet. Approaches for this problem included, serve diet as ordered, serve supplements as ordered and notify physician of any concerns.</p> <p>Resident #33's weights were documented as follows,</p> <p>May 8, 2011 - 102.5 June 8, 2011 - 98.4, a loss of 4.1 pounds in 1 month. July 8, 2011 - 91.8, a loss of 6.6 pounds in 1 month August 8, 2011 - 88.4, a 3.4 pounds in 1 month and 14.1 pounds in 3 months</p> <p>Resident #33 had current physician's orders for, a pureed diet and house supplements three times daily as snacks.</p>				

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	<p>The clinical record lacked any information to indicate if the resident consumed the house supplements. The food consumption records had only meal intakes and did not include any supplements.</p> <p>During an Interview with the Director of nursing on 1/5/12 at 10:30 a.m., she indicated supplements and snacks should be documented by the nursing staff on the Medication Administration Record. She further indicated she could not find any documentation of Resident #33's supplement consumption on the Medication Administration Record.</p> <p>During an interview with CNA #1 on 1/6/12 at 9:45 a.m., she indicated the CNAs on the halls pass to the resident's all health shakes, and supplements when they are brought to the nurses station from the kitchen. She indicated the CNAs were to assist the residents with drinking supplements and report to the nurses how much of the supplements the resident took. She indicated the CNAs do not record the amount of supplements the resident drank. She indicated she thought the nurses were to document the amount of intake of supplements "somewhere."</p>			

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	<p>A.) Based on observation, record review, and interview, the facility failed to ensure the nursing staff monitored and documented resident supplements in accordance with their plan of care for 2 of 6 residents (Resident #'s 16 and 33 ) reviewed for nutritional services and failed to follow the plan of care for 1 of 1 resident reviewed who desired to sleep late (Resident #14) in a stage 2 sample of 35.</p> <p>B.) Based on record review and interview, the facility failed to ensure the nursing staff clarified all medication orders to include complete directions for use for 3 of 10 residents reviewed for complete medication orders in a stage 2 sample of 35. (Resident #'s 16, 71, and 24)</p> <p>Findings include:</p> <p>A.1.) The clinical record for Resident #16 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, vascular dementia with delusions, pulmonary disease with asthma, personality disorder with narcissistic history, anemia, depression,</p>						

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	<p>gastroesophageal reflux disease, Parkinson's tremors related to Zyprexa, iron deficiency, and dysphasia.</p> <p>The clinical record indicated the resident received a mechanical soft diet with nectar thick liquids.</p> <p>A health care plan (HCP) problem, dated 5/23/10 and last updated on 8/19/11, indicated Resident #16 was at risk for weight loss related to dementia. The goal for this problem was for Resident #16 to have no unplanned weight loss prior to the next review. Approaches for this problem included, but were not limited to, encourage meal consumption per order, diet per order, monitor consumption, weigh monthly and as needed, notify medical doctor and family as needed and (3/20/10) provide power food.</p> <p>Monthly weight records for Resident #16 indicated the resident had lost 31 pounds from July 2011 to December 2011.</p> <p>A Registered Dietician (RD) note, dated 10/21/11, indicated a consult had been requested in October 2011 based on the resident's weight loss. She indicated the resident had a</p>			
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	<p>severe weight loss in the last six months. The note indicated the RD recommended a fortified food as a morning snack and with lunch and supper to help stabilize the resident's weight.</p> <p>A RD note, dated 12/9/11, indicated the resident's chart had been reviewed for weight loss. The note indicated the resident had continued to lose weight. The noted indicated the resident currently was receiving power pudding with lunch and supper and a 10 a.m. snack to promote adequate intakes. The note indicated "no dietary intolerance reported by nursing." The note indicated these recommendations would be continued.</p> <p>The resident's printed dietary slip, observed on her tray on 1/5/12 at 12:50 p.m., indicated the resident was to have a mechanical soft diet with nectar thick liquids and was to receive "power pudding" with her lunch and supper. The tray observed contained the power pudding.</p> <p>During an interview on 1/5/12 at 12:50 p.m., Resident #16 indicated she did not eat the pudding in the bowls. She indicated she got it often, but did not like it and had not been eating it.</p>				

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	<p>During an interview with Dietary Assistant #5 on 1/5/12 at 1:55 p.m., she indicated the kitchen did not contain any master list to use when adding supplements and/or special foods to the resident's trays. She indicated those items are put on the tray by looking at the resident's "dietary meal slip."</p> <p>During an observation of the dietary meal slip for Resident #16, done with Dietary Assistant #5 on 1/5/12 at 1:55 p.m., the meal slip indicated the resident was to receive power pudding with lunch and supper.</p> <p>The resident's clinical record lacked any consumption records for the resident's 10 a.m. snack and/or the power pudding being given with lunch and supper.</p> <p>The December 2011 food consumption record for Resident #16 indicated the resident had eaten less than 50% of her meal on 28 of the 93 meals served. A notation on the form stated a substitution would be offered when a resident ate less than 75% of the meal. The form lacked any area to document a substitution being offered when less than 75% of the meal was eaten or the amount of the</p>				

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	<p>substitution consumed.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 1/5/11 at 2:15 p.m., the DoN indicated the facility did not document the offering of food substitutions when the resident ate less than 75% of a meal. She indicated the facility also did not document the amount of power pudding and/or 10 a.m. snack the resident consumed. She indicated the facility had no method in place to document if the interventions recommended by the dietician and identified in the plan of care were being provided.</p>			
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F0323 SS=D	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>3.) Review of the current facility policy, dated 7/11, titled "Risk Assessment for Falls," provided by the DoN on 1/5/12, at 3:30 p.m., included, but was not limited to, the following:</p> <p>"GUIDELINES:</p> <p>It is the intent of the facility that all resident will have a Risk Assessment for Falls performed on admission/readmission, with a significant change in condition, quarterly and annually....</p> <p>...PROCEDURE...</p> <p>...8. Risk Assessments are reviewed on admission, quarterly, and as needed...."</p> <p>3.1-45(a)(2)</p>	F0323	<p>The facility's intent is for interventions to be in place to prevent falls; for care plans to be updated with new interventions as put into place; and for alarms used as interventions to be maintained and functioning.</p> <p>I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. Resident #87 no longer resides in the facility. Resident #33 's Fall Risk Assessment and Care Plan was reviewed and updated. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents with a high risk for falls would have the potential to be affected by the alleged deficient practice. A 100% audit of Fall Risk assessments was completed to ensure completion/accuracy. Care Plans were updated as appropriate. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. All licensed nurses will be in-serviced on proper</p>	02/05/2012	

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	<p>2.) The clinical record for Resident #33 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Resident #33's current diagnoses included, but were not limited to, heart disease, osteoarthritis, depression, macular degeneration, chronic obstructive pulmonary disease, dementia, anemia, protein</p>		<p>completion of Fall Risk Assessments and updating care plans on 1/31/12 by facility DON. The licensed staff will perform alarm checks for all types of alarms at the beginning of each shift to check for placement and operation of the alarms. This will be an on-going process. The IDT will audit/review all Fall Risk Assessments with the Care Plan review to ensure appropriate completion and accuracy. This will be an on-going process. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. The Administrator/designee will monitor for compliance by reviewing Walking Rounds tools in daily Stand-up Meetings (Monday - Friday) Results of the audits will be presented to the QA Committee by the DON/designee during quartley meetings to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>malnutrition, hypertension, ischemic bowel disease and debility.</p> <p>A quarterly Minimum Data Set assessment, dated 11/7/11, indicated the resident required extensive assistance from the staff for all activities of daily living, and had sustained a fall.</p> <p>Resident #33 had a healthcare plan, dated 6/27/11, which indicated the resident had a problem listed as, at risk for falls related to weakness, osteoarthritis, and forgets to ask for assistance from staff. Approaches for this problem included, apply pressure alarms to bed and chair, non skid strips to bedside and encourage resident to ask for assistance to get up.</p> <p>The clinical record indicated a nursing note entry, dated 9/10/11 at 4:45 p.m., which indicated, "called to res [resident] room by CNA where found res sitting on buttock on floor between foot of bed et [and] w/c [wheelchair] by the closet [with] back leaning against footboard...."</p> <p>Review of the post fall investigation report for the above fall indicated the pressure alarm was not in place as indicated in the resident's healthcare</p>						

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	<p>plan.</p> <p>During an interview with the Director of Nursing on 1/5/12 at 2:10 p.m., she indicated she provided 1:1 education with the staff who had transferred the resident to her bed and did not place the pressure alarm on the bed . She indicated the pressure alarm should have been in place to alert the staff the resident had fallen.</p> <p>Based on record review and interview, the facility failed to ensure each resident was assessed for their fall risk and interventions identified to help reduce falls were in place for 2 of 5 residents reviewed who met the criteria for falls in a stage 2 sample of 35. (Resident #87 and #33)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #87 was reviewed on 1/6/12 at 9:00 a.m.</p> <p>Diagnoses for Resident #87 included, but were not limited to, atrial fibrillation, debility, hypertension, and osteoarthritis.</p> <p>The clinical record indicated Resident #87 was admitted to the facility from the hospital on 12/31/11. Transfer</p>						

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	<p>orders indicated the resident was to be up only with assistance.</p> <p>The hospital history and physical indicated the resident had been admitted to the hospital due to weakness and fatigue, had become unable to ambulate by herself, and had slid from her bed to the floor several times at home prior to the hospital admission.</p> <p>An "Interim Care Plan," dated 12/31/11, indicated Resident #87 was at risk for "initial fall". There was a section designated to fill in the resident's fall risk assessment score. This section was blank. Approaches for this problem included, "call light in reach" and to complete a "Fall Risk Assessment."</p> <p>An admission nursing assessment, dated 12/31/11, indicated the resident was "weak" and "transfers with assistance of 3 and the gait belt."</p> <p>A nursing note, dated 12/31/11 at 7:00 p.m., indicated the resident was alert and oriented but confusion was noted at times.</p> <p>A nursing note, dated 1/1/12 at 8 p.m., indicated the resident was alert and oriented with "some noted</p>						

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	<p>confusion."</p> <p>A nursing note, dated 1/4/12 at 1:20 a.m., indicated "during rounds, resident on floor, lying on right side...." The note indicated no injuries were noted at that time, but the resident had mental confusion noted a short time later. The physician was contacted and the resident was transferred to the hospital for treatment at 1:55 a.m. A nursing note, dated 1/4/12 at 2:50 a.m., indicated the emergency room physician had called the nursing home and the resident had possibly had a stroke.</p> <p>The clinical record contained a fall risk assessment, dated 1/4/12 (no time included). The fall risk assessment had not been totaled, but the added total for the information on the form indicated the resident had a score of 14. A score of 14 indicated the resident was at high risk for falls. The form contained a section for "history of falls." The form indicated the resident had not fallen within the last 3 months. The form did not indicate the resident had fallen at home prior to being hospitalized. The form indicated a "prevention protocol" should be initiated immediately for residents identified at high risk for</p>						

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	<p><b>falls.</b></p> <p>This indicated the fall risk assessment had not been completed until 4 days after the resident was admitted and the resident had already sustained a fall.</p> <p>During an interview with the Director of Nursing on 1/5/12 at 4:20 p.m., additional information was requested related to the lack of an admission fall risk assessment having been completed and the lack of this information being documented in the interim health care plan for Resident #87. The facility failed to provide any additional information as of exit on 1/6/12.</p>				

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F0325 SS=G	<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>2.) The clinical record for Resident #18 was reviewed on 1/5/12 at 12:30 p.m.</p> <p>Resident #18's current diagnoses included, but were not limited to, type 2 diabetes mellitus, decreased appetite, dementia, chronic pain, status post stent placement, emphysema, coronary heart disease, atria fibrillation, chronic obstructive pulmonary disease, hyperlipidemia, peripheral vascular disease, chronic kidney disease, history of prostate cancer, and hypothyroidism.</p> <p>Resident #18's monthly weights,were as follows,</p> <p>October 8, 2011 - weight was 161.</p> <p>November 8, 2011 - weight was 158.4, a loss of 2.6 pounds in 1 month.</p> <p>December 8, 2011 - weight was 156.3, a loss of 2.1 pounds in one</p>	F0325	<p>It is the intent of this facility to provide appropriate dietary supplements as needed; to monitor acceptance and consumption of these dietary supplements; for dietary cards to be up to date and accurate; and for the MD to be notified of any weight loss. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. A meeting was held with resident #16 and her daughter on 1/19/12. Both the resident and her daughter voiced that the resident had wanted to loose weight. The power pudding was discontinued. Her Care Plan was updated to reflect current status. MD and RD were notified. Resident #18's dietary meal ticket was updated to reflect current supplemental interventions. The care plan was reviewed and updated. Resident #33's physician was notified on 1/4/12 of weight loss. Her supplement was added to her TAR and acceptance and consumption is being recorded. Her Care Plan was reviewed and updated to reflect her current</p>	02/05/2012	

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	<p>month and 4.7 pounds in 3 months.</p> <p>The clinical record indicated Resident #18 had a laboratory test completed on 12/14/11 which indicated a total serum protein level of 5.7 which was noted to be "low." The laboratory test indicated the normal range for serum protein was 6.0 - 8.5.</p> <p>Nursing notes indicated Resident #18's physician was called on 12/14/11 and was notified of the resident's weight loss noted above and the low serum protein levels. The nursing notes indicated a new order was received.</p> <p>A telephone order, dated 12/16/11, indicated the resident was to receive protein supplements three times daily.</p> <p>During an interview with the Interim Dietary Manager on 1/4/12 at 2:10 p.m., she indicated Resident #18 did not receive any supplements. The resident's dietary meal ticket, which the dietary staff used to know what type of diet the resident was to receive, lacked any information related to the resident having a physician's order for protein supplements three times daily. The Dietary Manager indicated if the resident received any type of</p>		<p>status. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of Dietician recommendations was completed by DON to ensure all recommendations have been addressed. Any recommendation found to have not been followed was addressed. Dietary meal tickets and Care Plans were updated as appropriate. A 100% audit will be completed to ensure no other resident has had a weight loss. Interventions will be put into place as needed. MD/RD will be notified as needed. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. On 1/20/12 all Dietary Staff were in-serviced by Dieitian on updating of dietary meal tickets. On 1/31/12 all licensed nurses will in-serviced by facility DON on proper recording of acceptance and consumption of supplements. The IDT will be educated/in-sreviced to facility QA policy adn QA tools by Nursing Consultant in regards to the Persons at Risk (PAR)</p>		

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	<p>supplement it would be noted on the meal ticket.</p> <p>During an interview with the Director of Nursing on 1/5/12 at 1:30 p.m., she indicated the nursing staff had sent the kitchen a communication form on 12/16/11 to indicate the diet changes related to the physician order for protein supplements three times a day. She provided a copy of the communication form which was sent to the kitchen sent to the kitchen. The communication form was signed by the previous dietary manager on 12/16/11. The Director of Nursing indicated she did not know why the kitchen staff were not made aware of the changes to Resident #18's diet. This resulted in Resident #18 not receiving the protein supplements three times daily as ordered by the physician for a total of 18 days.</p> <p>An interview with CNA #1 on 1/6/12 at 9:45 a.m., she indicated CNAs on the halls pass all health shakes, and supplements when brought from the kitchen, and give to residents. She indicated the CNAs were to assist the residents with drinking supplements and report to the nurses how much of the supplements the resident took. She indicated the CNAs do not record the amount of supplements the</p>		<p>program and notification of the MD and Dietary Consultant of any significant weight loss. The Dietary Manager/designee will initiate a Master Diet List including supplements, fortified foods, and any other dietary interventions as put into place. To be updated at daily Stand Up Meeting (M-F) with review of MD orders and all RD visits. This will be an on-going process. The DON/designee and Dietary Manager/designee will audit/review all weights monthly to identify any resident who has a weight loss/gain. The MD will be notified of any significant weight loss. The Dietary Consultant will be notified via telephone (significant weight loss) and/or upon her next visit of any resident identified. The appropriate dietary interventions will be put into place, including weekly weights and addition to the PAR program. The care plan will be updated accordingly. This will be on on-going process. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. DON/designee and Dietary Manager/designee will perform a monthly audit of all weights to identify any resident with a weight loss/gain. The Dietary Manager/designee will report any significant changes to the Dietary Consultant. Results of the monthly weight loss/gain will be presented to the QA</p>		

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	<p>resident received. She indicated she thought the nurses documented the supplements "somewhere."</p> <p>3.) The clinical record for Resident #33 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Resident #33's current diagnoses included, but were not limited to, heart disease, osteoarthritis, depression, macular degeneration, chronic obstructive pulmonary disease, dementia, anemia, protein malnutrition, hypertension, ischemic bowel disease and debility.</p> <p>Resident #33 had a healthcare plan, dated 6/22/11, which indicated the resident had a problem listed as, has a potential for weight loss due to tendency to leave 25% or more of each meal, has protein malnutrition and receives a pureed diet. approaches for this problem included, serve diet as ordered, serve supplements as ordered and notify physician of any concerns.</p> <p>Resident #33 had current physician's orders for, a pureed diet and house supplements three times daily as snacks.</p>		Committee Quarterly to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.		

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	<p>Resident #33's weights were documented as follows,</p> <p>May 8, 2011 - 102.5 June 8, 2011 - 98.4, a loss of 4.1 pounds in 1 month. July 8, 2011 - 91.8, a loss of 6.6 pounds in 1 month August 8, 2011 - 88.4, a 3.4 pounds in 1 month and 14.1 pounds in 3 months</p> <p>A physician's order, dated 9/30/11, for Remeron an appetite stimulant 7.5 milligrams 1 tablet daily was noted on the clinical record.</p> <p>A 10/7/11 Registered Dietician progress note indicated the following, chart review for weight loss, resident averages 25-50% intakes, receives house supplements three times daily, severe weight loss noted, resident started on appetite stimulant to promote intakes, will continue to monitor.</p> <p>During an interview with the Director of Nursing on 1/5/12 at 10:30 a.m., she indicated she could find no information to indicated the physician was notified of the significant weight loss until 9/30/11.</p>						

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	<p>The meal consumption records for October, November, December, 2011 indicated Resident #33 had consumed between 25 and 100% of her daily meals. The food consumption records lacked any information related to how much of the supplements the resident consumed.</p> <p>During an Interview with the Director of Nursing on 1/5/12 at 10:30 a.m., she indicated supplements, snacks when ordered for weight loss should be documented on the MAR (Medication Administration Record). She indicated she did not find any documentation on Resident #33's MAR of house shakes being documented as consumed. She also indicated the physician should be notified of weight loss of 5 lbs in a month, and should be documented on the weight form in the clinical record. She indicated she could not find in the clinical record where the physician had been notified of the resident having lost on the weight form for Resident #33.</p> <p>3.1-46(a)(1)</p>				

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	<p>Based on observation, interview, and record review, the facility failed to ensure resident weight loss was identified promptly, referred to the Registered Dietician promptly, and all interventions were put into place, documented, and assessed which resulted in a significant loss of weight for 3 of 6 residents reviewed for nutritional services in a stage 2 sample of 35. (Resident #16, #33 , and #18 )</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #16 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, vascular dementia with delusions, hypertension, coronary artery disease, chronic obstructive pulmonary disease with asthma, personality disorder with narcissistic history, arthritis, insomnia, anemia, depression, gastroesophageal reflux disease, Parkinson's tremors related to Zyprexa, iron deficiency, and dysphasia.</p> <p>A 10/14/11 quarterly Minimum Data Set (MDS) assessment indicated Resident #16 had no cognitive</p>		<p>It is the intent of this facility to provide appropriate dietary supplements as needed; to monitor acceptance and consumption of these dietary supplements; for dietary cards to be up to date and accurate; and for the MD to be notified of any weight loss. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. A meeting was held with resident #16 and her daughter on 1/19/12. Both the resident and her daughter voiced that the resident had wanted to loose weight. The power pudding was discontinued. Her Care Plan was updated to reflect current status. MD and RD were notified. Resident #18's dietary meal ticket was updated to reflect current supplemental interventions. The care plan was reviewed and updated. Resident #33's physician was notified on 1/4/12 of weight loss. Her supplement was added to her TAR and acceptance and consumption is being recorded. Her Care Plan was reviewed and updated to reflect her current status. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the</p>	02/05/2012	

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	<p>impairment and had no problems making herself understood or understanding others.</p> <p>A recapitulation of physician's orders, dated 9/21/11, indicated the resident received a regular diet with thin liquids. The clinical record indicated the resident received 2 units of blood at the hospital on 9/23/11 due to a low hemoglobin level. The resident had endoscopy and colonoscopy testing done due to anemia from chronic blood loss. Iron supplementation was given and further testing and/or follow-up continues. Her diet was changed to a mechanical soft with nectar thick liquids on 10/21/11 following speech therapy and swallowing studies.</p> <p>A health care plan (HCP) problem, dated 5/23/10 and last updated on 8/19/11, indicated Resident #16 was at risk for weight loss related to dementia. The goal for this problem was for Resident #16 to have no unplanned weight loss prior to the next review. Approaches for this problem included, but were not limited to, encourage meal consumption per order, diet per order, monitor consumption, weigh monthly and as needed, notify medical doctor and family as needed, and (3/20/10)</p>		<p>alleged deficient practice. A 100% audit of Dietician recommendations was completed by DON to ensure all recommendations have been addressed. Any recommendation found to have not been followed was addressed. Dietary meal tickets and Care Plans were updated as appropriate. A 100% audit will be completed to ensure no other resident has had a weight loss. Interventions will be put into place as needed. MD/RD will be notified as needed. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. On 1/20/12 all Dietary Staff were in-serviced by Dieitian on updating of dietary meal tickets. On 1/31/12 all licensed nurses will in-serviced by facility DON on proper recording of acceptance and consumption of supplements. The IDT will be educated/in-sreviced to facility QA policy adn QA tools by Nursing Consultant in regards to the Persons at Risk (PAR) program and notification of the MD and Dietary Consultant of any significant weight loss. The Dietary Manager/designee will initiate a Master Diet List including supplements, fortified foods, and any other dietary interventions as put into place. To be updated at daily Stand Up Meeting (M-F) with review of</p>				

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	<p>provide power food.</p> <p>Monthly weight records for Resident #16 indicated the following: January 2011- 200 pounds March 2011 - 201 pounds May and June 2011- refused to be weighed July 2011- 178 pounds (no repeat or follow-up weight documented) August 2011 - 164.4 pounds (no repeat or follow-up weight documented) September 2011 - 160.8 pounds October 2011 - 160.2 pounds November 2011 - 150 pounds (no repeat or follow-up weight documented) December 2011 - 147 pounds January 2012 - 147.9 pounds</p> <p>This indicated Resident #16 had lost 53 pounds from January to December 2011. This indicated the resident had lost 31 pounds from July 2011 to December 2011.</p> <p>The resident's above noted health care plan had not been updated to identify actual weight loss and new interventions. The health care plan problem had not been reviewed since 8/19/11.</p> <p>A Registered Dietician (RD) note,</p>		<p>MD orders and all RD visits. This will be an on-going process. The DON/designee and Dietary Manager/designee will audit/review all weights monthly to identify any resident who has a weight loss/gain. The MD will be notified of any significant weight loss. The Dietary Consultant will be notified via telephone (significant weight loss) and/or upon her next visit of any resident identified. The appropriate dietary interventions will be put into place, including weekly weights and addition to the PAR program. The care plan will be updated accordingly. This will be on on-going process. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. DON/designee and Dietary Manager/designee will perform a monthly audit of all weights to identify any resident with a weight loss/gain. The Dietary Manager/designee will report any significant changes to the Dietary Consultant. Results of the monthly weight loss/gain will be presented to the QA Committee Quarterly to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>dated 10/21/11, indicated no RD consult had been requested in July 2011. The note indicated a consult had been requested in October 2011 based on the resident's weight loss. She indicated the resident had a severe weight loss in the last six months. She indicated the resident had recently had a diet change to a mechanical soft diet and nectar thick liquids. She indicated the resident had recently had a endoscopy and colonoscopy completed. She recommended a fortified food as a morning snack and with lunch and supper to help stabilize the resident's weight.</p> <p>A RD note, dated 12/9/11, indicated the resident's chart had been reviewed for weight loss. The note indicated the resident had continued to lose weight. The noted indicated the resident currently was receiving power pudding with lunch and supper and a 10 a.m. snack to promote adequate intakes. The note indicated "no dietary intolerance reported by nursing." The note indicated the previous recommendations would be continued. The note also included new recommendations noted below:</p> <p>fortified food with all meals (except eggs as resident dislikes)</p>				

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	<p>whole milk with each meal weekly weight times four consider starting an appetite stimulant to help stabilize her weight</p> <p>The clinical record lacked any order for an appetite stimulant for Resident #16.</p> <p>The resident's printed dietary slip, observed on her tray on 1/5/12 at 12:50 p.m., indicated the resident was to have a mechanical soft diet with nectar thick liquids and was to receive "power pudding" with her lunch and supper. The dietary slip lacked any information related to the resident receiving whole milk with each meal and fortified foods with all meals except eggs as recommended above. The tray observed contained the power pudding, but did not have any milk or fortified food noted on the tray. The resident was eating a sandwich with ground meat, a salad, and a pie type dessert.</p> <p>During an interview on 1/5/12 at 12:50 p.m., Resident #16 indicated she did not eat the pudding in the bowls. She indicated she got it often, but did not like it and had not been eating it. She was unaware of receiving any "fortified foods." She indicated her appetite was poor.</p>			
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	<p>During an interview with Dietary Assistant #5 on 1/5/12 at 1:55 p.m., she indicated the kitchen did not contain any master list to use when adding supplements and/or special foods to the resident's trays. She indicated those items are put on the tray by looking at the resident's "dietary meal slip."</p> <p>During an observation of the dietary meal slip for Resident #16, done with Dietary Assistant #5 on 1/5/12 at 1:55 p.m., the meal slip indicated the resident was to receive power pudding with lunch and supper. The meal slip had not been updated following the RD recommendations made on 12/9/11 and lacked any information related to whole milk and/or fortified food being required with each meal.</p> <p>The resident's clinical record lacked any consumption records for the resident's 10 a.m. snack and/or the power pudding being given with lunch and supper.</p> <p>The December 2011 food consumption record for Resident #16 indicated the resident had eaten less than 50% of her meal on 28 of the 93 meals served. A notation on the form</p>			
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	<p>stated a substitution would be offered when a resident ate less than 75% of the meal. The form lacked any area to document a substitution being offered when less than 75% of the meal was eaten or the amount of the substitution consumed.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 1/5/11 at 2:15 p.m., the DoN indicated the facility did not document the offering of food substitutions when the resident ate less than 75% of a meal. She indicated the facility also did not document the amount of power pudding and/or 10 a.m. snack the resident consumed. She indicated the facility had no method in place to document if the interventions recommended by the dietician were being provided. Additional information was requested as noted below:</p> <p>a.) the lack of her HCP having been updated to identify a weight loss and current interventions</p> <p>b.) the lack of documentation of food supplements and/or the resident's acceptance and consumption of the supplements</p>				

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	<p>c.) the lack of documentation of replacements offered when the resident consumed less than 75% of a meal</p> <p>During an interview on 1/6/12 at 10:30 a.m., the DoN indicated she had consulted with the physician on 12/14/11 regarding Resident #16's weight loss and the dietary recommendations made on 12/9/11. She indicated the physician declined to order an appetite stimulant at that time, but had approved of the other recommendations. Additional information was requested as to why those recommendations had not been added to the resident's dietary slip and had not been initiated by the dietary department.</p> <p>The facility failed to provide any additional information as of exit on 1/6/12.</p>			
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F0329 SS=D	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>2.) Review of the current facility policy, dated 1/05, titled "ANTIPSYCHOTIC DRUGS," provided by the DoN on 1/6/12, at 1:00 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE:</p> <p>To support the cooperative efforts of the physician, pharmacist, and nursing staff. To establish specific goals and objectives for the safe use of antipsychotic medications....</p> <p>...If drug therapy with an</p>	F0329	<p>The facility's intent is to provide appropriate use of psychotropic medications and to monitor for side effects. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. Resident #16 has a Side Effect Monitoring Sheet added to her MAR for monitoring of possible side effects of Zyprexa. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. Any resident</p>	02/05/2012			

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	<p>antipsychotic drug is indicated, the agent initiated should be effective, with the fewest potential side effects, and lowest dose for that resident.</p> <p>Consistent monitoring will be done to assess the risk/benefit relationship of psychotropic drug therapy including the appropriateness of drug selection, dosage, and evaluation of adverse drug reactions....</p> <p>...MONITORING FOR SIDE EFFECT</p> <p>The assessment of side effects will be performed on a daily basis. The appearance of side effects (both movement and non-movement) will be noted by an "X" in the appropriate box of the antipsychotic monthly flow record according to date and shift, the initials must be accompanied by full signature and title. Total amount of side effects should be noted for each category per month.</p> <p>The initial presence of any of these symptoms should be brought to the attention of the physician as well as any increase in severity...."</p> <p>...PROCEDURE...</p> <p>...2. A comprehensive care plan must be developed within 7 days after completion of the comprehensive</p>		<p>receiving a psychotropic medication has the potential to be affected by the alleged deficient practice. A 100% audit was completed to identify all residents receiving psychotropic medications. Side Effect Monitoring Sheets were added to those residents MARs to record side effects observed. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. On 1/31/12 all licensed nurses will be in-serviced psychotropic medications and proper use of Side Effect Monitoring Sheets by the facility DON. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. The SSD/designee will audit/monitor the behavior management program for appropriate monitoring and documentation of side effects of all psychotropic medications at a minimum of quarterly with the care plan review along with the IDT. This will be an on-going process. This audit will be presented to the QA Committee at the Quarterly meetings to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>assessment....</p> <p>...5. For each problem, need or strength a resident-centered goal is developed....</p> <p>...7. All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition...."</p> <p>3.1-48(a)(3)</p> <p>Based on record review and interview, the facility failed to ensure side effect monitoring was completed for a resident receiving Zyprexa who had a diagnosis of tremors related to Zyprexa use for 1 of 10 residents reviewed for unnecessary medications in a stage 2 sample of 35. (Resident #16)</p> <p>Findings include:</p>				

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	<p>1.) The clinical record for Resident #16 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, vascular dementia with delusions, personality disorder with narcissistic history, anemia, depression, Parkinson's tremors related to Zyprexa, iron deficiency, and dysphasia.</p> <p>The clinical record indicated the resident received Zyprexa (an antipsychotic) 5 milligrams daily for vascular dementia with delusions. The clinical record also indicated the resident had tremors related to Zyprexa use. The initial date of the Zyprexa order was 8/17/11.</p> <p>The clinical record lacked any documentation of side effect monitoring in regards to Zyprexa use.</p> <p>During an interview with the Social Services Director on 1/5/12 at 9:50 a.m., she indicated psychotropic medication side effect monitoring was done "by exception only." She indicated the notation of side effects would be documented in the nursing notes. No side effect monitoring sheet was in use. She indicated the</p>			
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	<p>side effects to be monitored should be on the resident's health care plan.</p> <p>The clinical record lacked any comprehensive health care plan having been developed related to the resident's order for Zyprexa and the monitoring of side effects and/or tremors related to the medication. The clinical record lacked any description of the side effects to be monitored in regards to the administration of Zyprexa.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 1/5/12 at 2:15 p.m., additional information was requested related to the lack of side effects for which the resident was to be monitored being identified in the clinical record related to Zyprexa use.</p> <p>The facility failed to provide any additional information as of exit on 1/6/12.</p>			

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F0364 SS=E	<p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>A. 6.) During a kitchen observation of the lunch meal on 1/4/12 at 11:30 a.m., temperatures of the lunch food items on the steam table were checked by Dietary Staff #1. The temperature of the turkey meat was 93 degrees Fahrenheit. The dressing temperature was 82 degrees Fahrenheit. Dietary Staff #1 indicated the turkey and dressing were at the proper temperature when she put them on the steam table. Dietary Staff #1 then noted that the steam table knob was not tuned on. The steam table knob was in the "off" position. Dietary Staff #1 then turned on the steam table and indicated they would get the turkey and dressing back up to the proper temperatures and then place on the steam table. Dietary Staff #1 indicated she thought the steam table was on when she placed the turkey and the dressing items on the steam table.</p> <p>B. 1.) During an observation of the puree process on 1/4/12 at 11:00 a.m., with Dietary Cook #1, the cook was preparing to puree the dressing for the lunch meal. The cook indicated the recipe indicated to use</p>	F0364	<p>Each resident receives and the facility provides food prepared in a form designed to meet the individual needs. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. Resident #16's likes/dislikes were reviewed with the resident. Temperatures of trays will be monitored. Appropriate substitutions will be reviewed with this resident. Resident #19's likes/dislikes will be reviewed with resident and appropriate seasonings to taste. Temperatures of trays will be monitored. Resident #37's likes/dislikes will be reviewed and appropriate seasonings to taste. Resident #24's temperatures will be monitored. Resident #59's likes/dislikes will be reviewed and appropriate seasonings to taste.</p> <p>II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. III. Describe the steps or systemic changes the facility has made or</p>	02/05/2012			

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	<p>chicken broth instead of water for the puree process. She indicated this would make the pureed foods taste better. The cook obtained a 3 quart pitcher of hot water. She then obtained a jar of concentrated chicken broth paste. The cook took 1 teaspoon of the concentrated chicken broth paste and stirred the paste into the 3 quarts of hot water. The water had only a tinge of yellow color noted in the pitcher. The cook was instructed to stop the puree process. When queried related to the amount of chicken broth paste that was to be added to the water she indicated she was told by the previous Dietary Manager to add 1 teaspoon of the paste to the water. The cook indicated that she always added 1 teaspoon of paste to the 3 quarts of water to make the chicken broth when she pureed the food. The cook then read the label on the jar of chicken broth concentrated paste and the instructions indicated to add 1 teaspoon of the paste to 1 cup of hot water to make the chicken broth. The cook indicated she would need 12 teaspoons of the concentrated chicken broth added to the 3 quart pitcher to make the chicken broth correctly according to the label. The dietary cook then discarded the contents in the pitcher with the 3</p>		<p>will make to ensure that the alleged deficient practice does not recur, including any in-services. On 1/20/12 all dietary staff were in-serviced by Dietician on proper food temperatures, proper food preparation, food palatability, proper preparation of pureed foods. The Dietary Manager/designee will take the temperature of all foods prior to meal service and the last tray set up to ensure appropriate temperature is maintained. this will be an on-going process. The Administrator/designee will take the food temperatures at a minimum of weekly for one meal to ensure appropriate temperature is sustained during meal service. The Administrator or other Department Head will taste a sample tray of all items served daily for compliance with palm of correction for appropriate temperature, consistency and seasoning of food. A log will be maintained of the person who sampled the tray and their comments in regards to temperature, consistency and appropriate seasonings. This will be an on-going process. Dietary Manager/designee will interview a minum of 5 residents per day M-F following meal service randomly between all three meals for taste/temperature. This will be an on-going process. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient</p>	
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	<p>quarts of water and the 1 teaspoon of concentrated chicken broth paste. She then began the process again of making the chicken broth for the puree process. The dietary cook added 12 teaspoons of the concentrated chicken broth paste to the 3 quarts of hot water. The water in the pitcher now had a bright dark yellow color. The dietary cook indicated "that does look a lot better."</p> <p>3.1-21(a)(1) 3.1-21(a)(2)</p> <p>A.) Based on observation, record review, and interview, the facility failed to ensure food was served at the proper temperature and palatable for 5 of 15 residents interviewed for food palatability in a stage 2 sample of 35. (Resident #'s 16, 37, 19, 59, and 24)</p> <p>B) .Based on observation, interview and record review the facility failed to ensure dietary staff followed recipes</p>		<p>practice will not recur. The Dietary Manager/designee will review audit results in daily stand up meeting (M-F) with IDT team. The Dietary Manager/designee will present findings of audits to QA Committee during quarterly meeting. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>				

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	<p>correctly for pureed foods to enhance the food flavor for 1 of 1 observations of the puree process and for 1 of 1 dietary staff observed completing the puree process. This had the potential to affect 6 residents who had physicians orders for a pureed diet.</p> <p>Findings include:</p> <p>A. 1.) The clinical record for Resident #16 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, vascular dementia with delusions, hypertension, coronary artery disease, chronic obstructive pulmonary disease with asthma ,iron deficiency, and gastroesophageal reflux disease.</p> <p>Resident #16 had a 10/14/11 Quarterly Minimum Data Set (MDS) assessment which indicated the resident had no cognitive impairment and had no problems making herself understood or understanding others.</p> <p>Resident #16 had a 10/19/11 order for a mechanical soft diet with nectar thick liquids.</p> <p>During an interview on 1/3/12 at 11:30</p>			
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	<p>a.m., Resident #16 indicated the following concerning resident meals:</p> <p>"The food is terrible. For supper you don't get enough to fill you up. 1/2 bowl of soup which is mostly broth and sandwiches." She indicated the potatoes and carrots were not always cooked through. She indicated her meals were cold at least several times a week. " If you ask for a substitution, you get applesauce and cottage cheese, not another meal...."</p> <p>A. 2.) The clinical record for Resident #19 was reviewed on 1/6/12 at 10:15 a.m.</p> <p>Diagnoses for resident #19 included, but were not limited to, hypertension, congestive heart failure, and gastroesophageal reflux disease.</p> <p>An annual MDS, dated 11/17/11, indicated Resident #19 had minimal cognitive impairment and had no problems being understood or understanding others.</p> <p>During an interview on 1/4/12 at 9:45 a.m., Resident #19 indicated the following concerning resident meals:</p> <p>"Not seasoned at all." She indicated</p>						

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	<p>she loved Zucchini, but is was always "mushy" and "not good." "Food is over or under cooked." "Not always hot-effects the taste." "Bacon not fried enough."</p> <p>A. 3.) The clinical record for Resident #59 was reviewed on 1/6/11 at 10:00 a.m.</p> <p>Diagnoses for Resident #59 included, but were not limited to, anemia and gastroesophageal reflux disease.</p> <p>A quarterly MDS, dated 10/15/11, indicated Resident #59 had no cognitive impairment and had not problems being understood or understanding others.</p> <p>During an interview on 1/3/12 at 10:55 a.m., Resident #59 indicated the following concerning resident meals:</p> <p>"Fried eggs are like rubber." "Food not seasoned enough."</p> <p>A. 4.) The clinical record for Resident #37 was reviewed on 1/6/12 at 10:30 a.m.</p> <p>Diagnoses for Resident #37 included, but were not limited to, macrocytic anemia, chronic renal failure, and</p>				

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	<p>hypertension.</p> <p>A quarterly MDS, dated 10/21/11, indicated Resident #37 had minimal cognitive impairment and had no problems being understood or understanding others.</p> <p>During an interview on 1/3/12 at 2:23 p.m., Resident #37 indicated the following concerning resident meals:</p> <p>"Not as good as when she first was admitted several years ago." "Food not flavored like it should be, it's just thrown together."</p> <p>A. 5.) The clinical record for Resident #24 was reviewed on 1/5/12 at 9:20 a.m.</p> <p>Current diagnoses for Resident #24 included, but were not limited to, hypertension, congestive heart failure, and constipation.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/18/11, indicated Resident #24 was moderately impaired but able to understand others and able to make self understood.</p> <p>During an interview with Resident #24 on 1/3/12 at 4:00 p.m., she</p>				

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	indicated the food is cold by the time she is served. Resident indicated she eats in the dining room.			
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F0371 SS=E	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review and interview, the facility failed to ensure the kitchen was maintained in a clean sanitary manner for 1 of 1 kitchens in the facility. This had the potential to affect 63 residents who received meals prepared in the kitchen.</p> <p>Findings include:</p> <p>During the initial walk through tour of the kitchen on 1/3/12 at 9:15 a.m., with the Administrator the following concerns were identified:</p> <p>A. The handwashing sink bowl was covered with a dark grime substance over the entire bowl of the sink. A metal kitchen scrapper was observed on the top of the sink behind the hot water faucet. A used chemical strip test paper was on top of the sink behind the cold water faucet. At the time of the observation, the Administrator indicated the sink needed to be cleaned.</p> <p>B. The lid to the trash can next to the handwashing sink was covered with a</p>	F0371	<p>The facility's intent is the trash can lids will be clean, the oven will be clean, the walk-in refrigerator will be clean, the storage rack will be clean, and the fans will be clean. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. No resident was found to be directly affected by the alleged deficient practice. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. Cleaning of the kitchen was immediately initiated and the kitchen was deep cleaned on 1/3/12, including but not limited to; the trash can lid next to the hand washing sink, the top of the oven, the walk in refrigerator, the bottom of the plastic storage rack containing clean plate cover lids. The stand-up fan in the dishroom was removed from the kitchen. III. Describe the steps or systemic changes the facility has made or will make to ensure that the</p>	02/05/2012	

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	<p>dark grime substance.</p> <p>C. The top of the oven had a dark brown, sticky substance over the entire oven top. Crumbs of dried food were observed on top of the oven.</p> <p>D. The walk in refrigerator had onion peels on the shelves and on the floor.</p> <p>E. A large stand-up fan in the dishroom had an accumulation of dust build up on the fan cover. The fan was on and blowing air on the clean pots and pans. The fan had strings of dust blowing from the fan.</p> <p>F. The bottom of a white plastic storage rack containing clean plate cover lids was covered with an accumulation of dried food particles.</p> <p>Review of the kitchen's, "Weekly Cleaning Schedule" for December 2011 indicated the following,</p> <p>A. Tuesday - All utility carts were to be sprayed down and cleaned using a power sprayer, and all garbage cans and lids were to be sprayed down, cleaned and sanitized.</p> <p>B. Wednesday - Clean conventional ovens inside and out</p>		<p>alleged deficient practice does not recur, including any in-services. The dietary staff were in-serviced by the Dietician on 1/20/12 on proper kitchen sanitation and completion of the posted cleaning schedules. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. The facility Administrator will complete a kitchen sanitation inspection not less than weekly, including completion of the posted cleaning schedule. Any issues identified will immediately be assigned to a staff member for completion with follow-up observation by the facility Administrator to ensure compliance. The consultant Dietician will continue to complete a monthly sanitation check monthly during one of her visits to the facility. Results of both audits will be presented to the QA Committee by the facility Administrator at the quarterly meetings to ensure compliance. This will be an on-going process. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>C. Thursday - Clean and sanitize sinks and wipe down all shelves and rack of the walk - in refrigerator</p> <p>D. Saturday - Clean and sanitize all utility carts with power sprayer</p> <p>The December 2011 weekly cleaning schedule had initials of the staff which indicated the following cleaning had been completed for the month, the utility carts were not cleaned at any time, the shelves of the walk - in refrigerator were cleaned 2 times, the conventional oven was cleaned 2 times, the sinks were not cleaned at any time, the garbage can lids were not cleaned at any time and the fan was not listed on the cleaning schedule .</p> <p>During an interview with the Administrator on 1/3/12 at 9:15 a.m., he indicated he would have the kitchen staff clean and correct the concerns noted above as soon as possible.</p> <p>3.1-21(i)(2)</p>				

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F0428 SS=D	<p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>3.) The clinical record for Resident #24 was reviewed on 1/5/12 at 9:20 a.m.</p> <p>Current diagnoses for Resident #24 included, but were not limited to, hypertension, congestive heart failure, and constipation.</p> <p>Resident #24 had a current physician's order for the following: "Milk of Magnesia suspension give 30 milliliters as directed as needed". Milk of Magnesia is a laxative medication. The original date of this order was 8/27/2008.</p> <p>Resident #24 had a current physician's order for the following: "Fleet enema insert 133 milliliters rectally as directed as needed." A Fleet enema is a laxative medication. The original date of this order was 8/27/08.</p> <p>A pharmacist "Consultation Report" indicated the pharmacist reviewed Resident #24's clinical record on</p>	F0428	<p>It is the intent of this facility for the pharmacy to provide services to identify issues/concerns with MD orders. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. Resident #16's physician's orders were reviewed and clarification orders were obtained as needed. Resident #71's physician orders were reviewed and clarification orders were obtained as needed. Resident #24's physician orders were reviewed and clarification orders were obtained as needed.</p> <p>II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all physician orders will be completed by 2/5/12 to ensure all orders are complete. Any orders found to be incomplete will be clarified with physician to be complete. III. Describe the steps or systemic changes the facility</p>		02/05/2012		

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	<p>12/6/11, 11/21/11 and 10/7/11. The report lacked any information related to the clarification of the Milk of Magnesia and the Fleet enema orders.</p> <p>During an interview with the Director of Nursing (DoN), on 1/5/12 at 4:30 p.m., additional information was requested regarding the Milk of Magnesia and the Fleet enema orders.</p> <p>The facility failed to provide any additional information as of exit on 1/6/12.</p> <p>3.1-25(b) 3.1-25(i)</p> <p>2.) Resident #71's clinical record was reviewed on 1/5/12 at 3:04 p.m. The resident's diagnoses included, but were not limited to, dysphagia, esophagitis, hiatal hernia, cerebral vascular accident, and tracheotomy.</p> <p>The resident's current physician's orders were signed by the physician on 11/25/11. The resident's physician's orders indicated the</p>		<p>has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. All licensed nurses will be in-serviced on completion of physician orders and monthly checking of physician rewrites on 1/31/12. Medical Records/designee will audit/review all rewrites for complete/accurate medication orders. This will be an on-going process. The consultant pharmacist, was re-educated by her supervisor at PRN Pharmacy on monthly physician order reviews. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. Results of the audits will be presented by Medical Records/designee to QA Committee during quarterly meetings to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>resident was to have nothing by mouth except nectar thick liquid at the bedside. The resident had a gastrostomy tube [g-tube] for nutritional intake and medications.</p> <p>The physician's medication orders included, but were not limited to, promethazine 25 mg tablet via g-tube as directed as needed for nausea/vomiting. This order was initiated on 7/12/11. The order lacked an indication for the frequency the medication was to be given.</p> <p>The resident also had a physician's order for zolpidem tartrate 5 mg tablet give one half tablet [2.5 mg] orally daily at bedtime for insomnia.</p> <p>The current signed physician's orders were reviewed and signed by the Consultant Pharmacist on 11/21/11.</p> <p>During an interview with the Director of Nursing on 1/5/12 at 2:00 p.m., she indicated the promethazine order needed clarified to indicate the frequency the medication could be given. She indicated the resident's medications were to be given via the g-tube and not be given orally. She indicated the resident had not had any pharmacy recommendations related to these medications needing</p>			
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	<p>to be clarified.</p> <p>Based on record review and interview, the facility failed to ensure the pharmacist identified medication orders that contained incomplete directions for 3 of 10 residents reviewed for complete medication orders in a Stage 2 Sample of 35. (Resident #'s 16, 71, and 24)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #16 was reviewed on 1/4/12 at 3:00 p.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, vascular dementia with delusions, pulmonary disease with asthma, personality disorder with narcissistic history, anemia, depression, gastroesophageal reflux disease, Parkinson's tremors related to Zyprexa, iron deficiency, and dysphasia.</p> <p>A recapitulation of physician's orders, signed by the physician on 11/30/11, included, but was not limited to, the following orders:</p> <p>Loperamide (a medication given for</p>						

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	<p>loose stools) 2 milligrams (mg) 1 capsule orally as directed as needed for diarrhea.</p> <p>Milk of Magnesia (MOM)) (a laxative) suspension 30 milliliters (ml) orally as directed prn (as needed) for constipation</p> <p>Saline Mist 0.65% (a medication given for nasal congestion) nose spray- give 1 spray in each nostril as directed as needed for nasal congestion.</p> <p>The clinical record lacked any information or directions from the physician related to how often these "as directed" medications could be given.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 12/6/11 and no recommendations were made to clarify the above noted incomplete physician's orders.</p> <p>During an interview with the Administrator and Director of Nursing on 1/5/12 at 2:15 p.m., additional information was requested related to the lack of clarifications obtained for the "as directed" medications noted above following a pharmacy review on</p>						

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	12/6/11.  The facility failed to provide any additional information as of exit on 1/6/12.				

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F0514 SS=D	<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>2.) The clinical record for Resident #24 was reviewed on 1/5/12 at 9:20 a.m.</p> <p>Current diagnoses for Resident #24 included, but were not limited to, hypertension, left-sided paralysis, congestive heart failure, and constipation.</p> <p>Resident #24 had a current physician's order for the following: "Calf exercises daily at bedtime." The original date of this order was 11/30/2008.</p> <p>Review of the October Treatment Administration Record (TAR) for Resident #24 lacked documentation of calf exercises daily at bedtime for 26 out of 31 days.</p> <p>Review of the November TAR for Resident #24 lacked any documentation of calf exercises daily</p>	F0514	<p>The facility's intent to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. I. Describe what the facility did to correct the alleged deficient practice for each client cited in the alleged deficiency. Resident #18's orders were clarified to discontinue house supplements. Resident #24's orders were received for a therapy screen to determine if resident is able to independently perform leg exercises. Care plan will be updated to reflect the results of this screen. II. Describe how the facility reviewed all clients in the facility that could be affected by the alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged deficient practice.</p>	02/05/2012			

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	<p>at bedtime.</p> <p>During an interview with Resident #24 on 1/6/12, at 9:00 a.m., she indicated she performs leg exercises daily.</p> <p>During an interview with the Director of Nursing (DoN), on 1/6/12 at 9:10 a.m., additional information was requested regarding the documentation of the calf exercises daily at bedtime.</p> <p>The facility failed to provide any additional information as of exit on 1/6/12.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p> <p>Based on record review and interview the facility failed to ensure physician's orders were accurate and</p>		<p>A 100% audit of all physician orders will be completed by 2/5/12 to ensure orders are complete and accurate. III. Describe the steps or systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur, including any in-services. All licensed nurses will in-serviced on 1/31/12 on proper completion of physician orders, complete administration instructions for each medication, and auditing monthly physician rewrites for accuracy. Medical Records/designee will audit/review all physician rewrites monthly for complete and accurate administration of medication instructions. This will be an on-going audit. The DON/designee will audit/review all new admissions for complete/accurate instructions for administering medications. This will be an on-going audit. IV. Describe how the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. Results of the audits will be presented to the QA Committee during quarterly QA Meetings to ensure compliance. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>documented as having been completed for 2 of 15 residents reviewed for physician's orders in a stage 2 sample of 35. (Resident #'s 18 and 24)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #18 was reviewed on 1/5/12 at 12:30 p.m.</p> <p>Resident #18's current diagnoses included, but were not limited to, type 2 diabetes mellitus, decreased appetite, dementia, chronic pain, status post stent placement, emphysema, coronary heart disease, atria fibrillation, chronic obstructive pulmonary disease, hyperlipidemia, peripheral vascular disease, chronic kidney disease, history of prostate cancer, and hypothyroidism.</p> <p>The January 2012 recapitulation of physician's orders indicated the following dietary orders,</p> <p>A. carbohydrate controlled diet (original order date was 7/6/11)</p> <p>B. house supplements 4 times daily (original order date was 7/13/11)</p> <p>c. protein supplements 3 times daily</p>				

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	<p>(original order date was 12/16/11)</p> <p>A dietary progress note, dated 10/5/11, indicated the resident's weight had increased and weights appeared to be stable and she recommended to discontinue the house supplements 4 times daily.</p> <p>A physician's order, dated 10/5/11, was noted in the clinical record to discontinue house supplements 4 times daily for Resident #18.</p> <p>The recapitulation of physician's orders for November, December 2011 and January 2012 continued to have the house supplements listed on the orders.</p> <p>During an interview with the Director of Nursing on 1/5/12 at 3:15 p.m., she indicated the order for the house supplements should have been removed from the physician's orders. She further indicated she did not know why the order remained on the recapitulation of orders.</p>				