

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2013
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NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038
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F000000	<p>This visit was for the Investigation of Complaints IN00134886, IN00135253, IN00135398, IN00135420 and IN00135704.</p> <p>Complaint: IN00134886 - Unsubstantiated due to lack of evidence.</p> <p>Complaint: IN00135253 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F441 and F514.</p> <p>Complaint: IN00135398 - Unsubstantiated due to lack of evidence.</p> <p>Complaint: IN00135420 - Unsubstantiated. Allegation did not occur.</p> <p>Complaint: IN00135704 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F441 and F514.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: September 4, 5 & 6, 2013</p> <p>Facility Number: 012466</p>	F000000	<p>F000Please find the attached plan of correction for the complaint survey #IN00134886, #IN00135253, #IN00135398, #IN00135420, and #IN00135704 performed on September 4,5 and 6, 2013. The provider respectfully request that the 2567 plan of correction be considered the letter of credible allegation of compliance and respectfully request a desk review in lieu of a post survey revisit.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Provider Number: 155786 AIM Number: 201014060</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 30 SNF/NF: 117 Total: 147</p> <p>Census Payor Type: Medicare: 30 Medicaid: 101 Other: 16 Total: 147</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on September 12, 2013.</p>				

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview the facility failed to ensure the personal privacy of residents, in that when residents were dependent for care on the nursing staff, the nursing staff failed to ensure residents were covered appropriately for 2 of 2 dependent residents in a sample of 8.</p>	F000164	F1641, What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice Resident E was covered by a sheet/blanket to cover her lower extremities to provide dignity for this resident. Resident F was covered by bath towels, and the privacy curtain was pulled	10/02/2013	

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	<p>(Resident's "E" and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "E" was reviewed on 09-05-13 at 9:25 a.m. Diagnoses included, but were not limited to, Alzheimers disease, hypertension, esophageal reflux, history of urinary tract infection and history of hip fracture with repair. These diagnoses remained current at the time of the record review.</p> <p>During the initial tour of the facility on 09-04-13, at 9:10 a.m., with Licensed Nurse #3 in attendance, indicated the resident was in isolation due to the c-diff (clostridium difficile) infection.</p> <p>A review of the resident's Minimum Data Set assessment, dated 08-06-13 indicated the resident required extensive assistance with dressing.</p> <p>During a observation on 09-05-13 at 8:30 a.m., the resident was observed seated in a wheelchair. At the time of this observation the resident had a sheet placed across the waist area, however the resident's upper thighs and lower legs were exposed.</p> <p>2. The record for Resident "F" was reviewed on 09-05-13 at 8:50 a.m.</p>		<p>while in the shower room to provide dignity for this resident.2, How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be takenAll residents have the potential to be affected.Allnursing assistants and licensed nursing staff were inserved by the Director of Nursing and Social Service Director on 9/12/13 and on 9/18/13 regarding personal privacy of residents while providing care.3, What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Allnursing assistants and licensed nursing staff were inserved by the Director of Nursingand Social Service Director on 9/12/13 and on 9/18/13 regarding personal privacy of residents while providing care.DNS/unit managers will monitor residents dignity utilizing a nurse rounds checklist which includes privacy, daily on each shift to ensure all nursing staff provide privacy with care on a daily basis.Staff not adhering to policy will receive education, disciplinary action up to and including termination.4, How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into placeTo ensure compliance the DNS/Designee is</p>		

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	<p>Diagnoses included, but were not limited to, hypertension, cerebral vascular accident and Alzheimers dementia. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set assessment, dated 07-11-113 indicated the resident required extensive assistance with bathing.</p> <p>During an observation on 09-05-13 at 8:30 a.m., the door to the shower room was closed. Hollering could be heard coming from the shower room. Upon entrance to this shower room, the resident was observed seated in a shower chair, naked, and without a bath blanket on to provide dignity, while the CNA was waiting for the water to get warm. When interviewed, the CNA indicated the resident always hollers when she gets in here, "but her daughter wanted her to have a shower today." During this observation, the resident indicated "I'm cold." The Licensed Nurse #4 provided towels to comfort the resident and indicated to the CNA that she should have provided covering for the resident. In addition the CNA failed to provide privacy to this resident by pulling the privacy curtain while in the shower room.</p>		<p>responsible for completing CQI monitoring for dignity , weekly X4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance.5, Date of compliance 10/2/13.</p>		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on on record review the facility failed to ensure the nursing staff followed the plan of care, in that when residents were identified with the potential for fluid imbalance, the nursing staff failed to ensure the documentation of the resident's hydration for 2 of 3 residents reviewed for hydration and ensure a resident's plan of care was communicated to the nursing staff and followed for 1 of 3 resident's reviewed for hip precautions in a sample of 8. (Residents "B", "F" and "H").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 09-04-13 at 11:42 a.m. Diagnoses included, but were not limited to, senile dementia - Alzheimers, hypertension, depressive disorder and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>The resident had a plan of care, dated 10-10-12 which indicated the</p>	F000282	F2821, What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceResident B, omissions for fluid intakes were corrected in matrix system and are documented on all shifts.Resident F, omissions for fluid intakes were corrected in matrix system and are documented on all shifts.Resident H, proper hip precaution education and instructions were given to the nursing staff on 9/12/13 and 9/18/13 by the therapy department. The nursing assistants will have a communication binder to help provide general care with residents affected with hip precautions. 2, How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be takenAll residents have the potential to be affected .All nursing assistants and licensed nurses were inserviced on 9/12/13 and 9/18/13 on matrix care documentation regarding fluid intakes and generalrestrictions regarding hip precautions with the residents	10/02/2013	

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	<p>resident was at "risk for fluid imbalance related to history of chronic kidney disease, history of chronic renal insufficiencies, multiple medications and needs assistance with foods/fluids." An intervention included "observe fluid intake."</p> <p>A subsequent plan of care, dated 10-10-12, indicated the "resident presents with potential for nutritional risk related to requires a therapeutic diet related to diagnosis of diabetes and resident is noncompliant with diet due to wanting ice cream at meal, but family wishes to continue the therapeutic diet." An approach to this plan of care included "Monitor food / fluid intake at meals."</p> <p>A review of the dietary nutrition risk assessment, originally dated 02-21-13 indicated the resident required an estimated fluid need daily of 1525 - 1830 ml (milliliters) (25 - 30 ml/kg (milliliters per kilogram).</p> <p>The resident recently returned to the facility from a hospitalization. A review of the matrix fluid intake report indicated the following omissions in regard to the resident's fluid intake on 08-30-13 for dinner, 08-31-13 for breakfast and lunch, 09-01-13 for breakfast and lunch, 09-02-13 for</p>		<p>who are admitted with hip fractures to ensure the plan of care is being followed. Audit of all residents charts who are care planned to have fluid intake monitored was completed by DNS/designee to ensure fluid intake is monitored and documented per plan of care. All residents who have hip precautions are care planned and care sheets reviewed to ensure specific care instruction were provided to nursing staff. 3, What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur. All nursing assistants and licensed nurses were inserviced on 9/12/13 and 9/18/13 on matrix care documentation regarding fluid intakes and general restrictions regarding hip precautions for residents who are admitted with hip fractures to ensure the plan of care is being followed. DNS/Unit managers will monitor the matrix documentation regarding fluid intake daily to ensure the hydration of the resident is being documented. DNS/Designee will ensure plan of care regarding hip precautions is communicated with instructions by the therapy department to the nursing staff during daily clinical meeting and is included in the plan of care and in the communication binder. Any staff not adhering to policy will receive education, disciplinary</p>		

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	<p>breakfast and lunch, 09-03-13 for breakfast and lunch, and 09-04-13 for breakfast.</p> <p>2. The record for Resident "F" was reviewed on 09-05-13 at 8:50 a.m. Diagnoses included, but were not limited to, hypertension, cerebral vascular accident and Alzheimers dementia. These diagnoses remained current at the time of the record review.</p> <p>The resident had a plan of care which identified the resident with "Dehydration / Fluid Maintenance - at risk for fluid imbalance due to: dementia, routine diuretics and needs assistance with food / fluids." Interventions to this plan of care included: "Record intake."</p> <p>The dietician's Nutrition Risk Assessment, dated 09-06-13 indicated the resident's "estimated fluid needs were 1248 - 1352 (24 - 26 ml/kg [milliliters per kilogram] decreased related to CHF [congestive heart failure]; min [minimum] 1500 ml per day per policy."</p> <p>Review of the Matrix for fluids lacked complete documentation of fluids on 08-01-13 for breakfast and dinner, 08-02-13 for lunch, 08-04-13 for</p>		<p>action up to and including termination⁴, How the corrective action will be monitor to ensure the deficient practice will not recur i.e. what quality assurance program will be put into placeTo ensure compliance the DNS/Unit manager is responsible for completing the food and fluid CQI tool. And the care plan CQI tool weekly X4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance.⁵, Date of compliance 10/2/13.</p>				

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	<p>breakfast and lunch, 08-05-13 for breakfast and lunch, 08-06-13 for breakfast, 08-07-13 for lunch, 08-09-13 for dinner, 08-11-13 for dinner, 08-14-13 for lunch, 08-15-13 for lunch, 08-18-13 for dinner, 08-19-13 for dinner, 08-20-13 for breakfast and lunch, 08-21-13 for lunch, 08-23-13 for breakfast and lunch, 08-24-13 for lunch, 08-25-13 for dinner, 08-26-13 for breakfast and lunch, 08-29-13 for dinner, 08-30-13 for breakfast and lunch, 08-31-13 for breakfast and lunch, 09-01-13 for breakfast and lunch, 09-02-13 for breakfast and lunch, 09-03-13 for breakfast, and on 09-04-13 for breakfast and lunch.</p> <p>3. The record for Resident "H" was reviewed on 09-05-13 at 12:50 p.m. Diagnoses included, but were not limited to, fractured right hip with open reduction and internal fixation, Alzheimers dementia, depression, back pain and anemia. These diagnoses remained current at the time of the record review.</p> <p>The resident record included notation from the local area hospital which indicated the resident required "fall precaution, hip flexion precautions and spinal precautions."</p>						

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	<p>At the time of the Initial Tour of the facility on 09-04-13 at 8:20 a.m., with Licensed Nurse #5 in attendance, identified Resident "H" with a right hip fracture. The resident was observed seated in bed.</p> <p>During an interview on 09-05-13 at 12:15 p.m., the Physical Therapy Assistant #10 indicated the resident "has hip flexion precautions." When further interviewed what specific precautions this included, the Physical Therapy Assistant indicated the resident, when seated or getting out of bed, could not flex "any more than 90 degrees." The Physical Therapy Assistant further indicated "Anyone with a fractured hip the CNA's (certified nurses aides) get education on hip precautions. We don't want any type of rotation."</p> <p>During an interview on 09-06-13 at 9:15 a.m., the Physical Therapist #11 indicated "with [name of Resident "H"] we don't want any adduction [moving toward center] and when he is sitting in the wheelchair or bed, we don't want him to flex forward, and only want him to sit at 90 degrees." When interviewed who receives these specific instruction, the therapist indicated "we tell the nurse in charge." When further interviewed if</p>						

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	<p>specific education, or documentation of the education that was provided to the nursing staff, the therapist indicated, "no that's probably something we should be doing. We generally tell the nurse and we expect her to give the information to the aides and the next shift."</p> <p>A review of the Physical Therapy Plan of Care with a "start of care date 08-27-13," indicated the resident "was found down at ALF [assisted living facility] and was found to sustained a right femur fracture. Pt [patient] underwent ORIF [open reduction and internal fixation]. Also had previous fall where he broke 4 bones in his foot 5 weeks ago. Medical History related to diagnosis/condition: s/p [status post] right displaced intertrochanteric and subtrochanteric proximal femur fx. [fracture] with ORIF, dementia, Alzheimers, depression. Precautions - hip flex precautions."</p> <p>The facility Initial Assessment, dated 08-27-13, indicated the functional deficits included bed mobility, supine - sit, weight bearing status right LE [lower extremity], transfers sit - stand, transfers, stand - sit, balance, static standing, and balance - fall risk." The resident's "current level" was assessed at "Bed mobility - maximum</p>						

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	<p>assistance times 2 (76 - 99 % assist with 2 people), weight bearing as tolerated, transfers sit - stand maximum assistance times 2 (76 - 99 % with 2 people), transfers - minimal assistance (20 % assist), Balance, static standing - Pt static (requires handhold support and moderate assistance to maintain position, and a high fall risk."</p> <p>During an interview on 09-06-13 at 9:45 a.m. Licensed Nurse #5 indicated she was unaware of any limitations for Resident "H."</p> <p>A subsequent interview on 09-06-03 at 10:25 a.m., CNA (certified nurses aide) #15 indicated she was unaware of anything specific for Resident "H." "We know some things like not to cross their legs and elevate their feet to keep the swelling down."</p> <p>Interview on 09-06-13 at 10:50 a.m., CNA #16, indicated Resident "H" was her "patient today and I know not to get him out of bed on the badder leg or out of the wheelchair on the badder leg. I don't know anything about precautions with bending forward."</p> <p>This Federal tag relates to Complaint IN00135253 and Complaint IN00135704.</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review the facility failed to ensure</p>	F000441	F 4411, What corrective action(S) will be accomplished for	10/02/2013			

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	<p>infection control measures, in that when a resident was identified with Clostridium Difficile infection, and was in isolation for the infection, the nursing staff failed to ensure proper bagging of soiled linens for 1 of 3 resident's reviewed for infection control in a sample of 8. (Resident "E").</p> <p>Findings include:</p> <p>The record for Resident "E" was reviewed on 09-05-13 at 9:25 a.m. Diagnoses included, but were not limited to, Alzheimers disease, hypertension, esophageal reflux, history of urinary tract infection and history of hip fracture with repair. These diagnoses remained current at the time of the record review.</p> <p>During the initial tour of the facility on 09-04-13, at 9:10 a.m., with Licensed Nurse #3 in attendance, indicated the resident was in isolation due to the c-diff (clostridium difficile) infection. During this observation a sign had been observed on the door to the resident's room, which instructed staff / visitors to report to the nurse prior to entering the resident's room. At the time of the observation the resident was seated in a wheelchair. A three drawer storage unit was observed in</p>		<p>those residents found to have been affected by deficient practices. Resident E linens were bagged separately and placed in designated container identified for Clostridium difficile. 2, How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected All nursing assistants and licensed nursing staff were inserviced by the DNS/SDC on 9/12/13 and 9/18/13 regarding infection control. To help prevent the development and transmission of disease and infection. All residents in isolation rooms were reviewed to ensure proper bagging of linen was completed by DNS/Designee. 3, What measure will be put into place or what systemic changes will be made to ensure that deficient practice does not recur. All nursing assistants and licensed nursing staff were inserviced by the DNS/SDC on 9/12/13 and 9/18/13 regarding residents in isolation with Clostridium Difficile infection, utilize proper bagging of soiled linens to prevent spread of infection. A nursing rounds checklist which includes bagging of linens will be utilized by the DNS/Designee each shift to ensure proper linen handling is being followed. Nursing staff not adhering to policy will receive education, disciplinary action up</p>		

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	<p>the resident's room, as well as large containers to place soiled / contaminated linen.</p> <p>During a observation on 09-05-13 at 8:30 a.m., the resident was observed seated in a wheelchair. Adjacent to the resident were linens and gowns, unbagged, on the chair and additional linen was observed on the floor.</p> <p>A review of the facility policy on 09-05-13 at 12:00 p.m., titled "Clostridium Difficile (bold type and underscored), and dated as "reviewed 04-2013," indicated the following:</p> <p>"POLICY [bold type]: The facility shall utilize proper infection control and prevention when dealing with resident(s) with Clostridium difficile."</p> <p>"PURPOSE [bold type]: To prevent the spread of infections caused by the Clostridium difficile bacteria."</p> <p>"PROCEDURE [bold type]: "8. LINEN / LAUNDRY a. Linen should be handled according to universal precautions. b. Resident's personal laundry will be bagged separately and placed in a designated container identified for c-diff. [clostridium difficile]."</p>		<p>to and including termination.4, How the corrective action will be monitor to ensure the deficient practice will not recur i.e. what quality assurance program will be put in placeTo ensure compliance the DNS/Designee is responsible for completeing CQI infection controltool weekly X 4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance.5, Date of compliance 10/2/13</p>		

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	<p>This Federal tag relates to Complaint IN00135253 and Complaint IN00135704.</p> <p>3.1-19(1)</p>				

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on on record review the facility failed to ensure complete clinical records, in that when residents required documentation of the risk of fluid imbalance and fluid needs, the nursing staff failed to provide complete documentation of resident hydration intake for 2 of 3 residents reviewed for hydration in a sample of 8. (Residents "B" and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 09-04-13 at 11:42 a.m. Diagnoses included, but were not limited to, senile dementia - Alzheimers, hypertension, depressive disorder and diabetes mellitus. These diagnoses remained current at the time of the record review.</p>	F000514	F 5141, What corrective action(S) will be accomplished for those residents found to have been affected by deficient practices. Resident B and F omissions for resident fluid intakes corrected in Matrix system 2, How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected All nursing assistants and licensed nurses were inserviced on 9/12/13 and 9/18/13 on matrix care documentation regarding fluid intakes .Audit of all residents charts who are care planned to have fluid intake monitored was completed by DNS/designee to ensure fluid intake is monitored and documented per plan of care. 3, What measure will be put into place or what systemic	10/02/2013			

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	<p>The resident had a plan of care, dated 10-10-12 which indicated the resident was at "risk for fluid imbalance related to history of chronic kidney disease, history of chronic renal insufficiencies, multiple medications and needs assistance with foods/fluids." An intervention included "observe fluid intake."</p> <p>A subsequent plan of care, dated 10-10-12 indicated the "resident presents with potential for nutritional risk related to requires a therapeutic diet related to diagnosis of diabetes and resident is noncompliant with diet due to wanting ice cream at meal, but family wishes to continue the therapeutic diet." An approach to this plan of care included "Monitor food / fluid intake at meals."</p> <p>A review of the dietary nutrition risk assessment, originally dated 02-21-13 indicated the resident required an estimated fluid need daily of 1525 - 1830 ml [milliliters] (25 - 30 ml/kg [milliliters per kilogram]).</p> <p>The resident recently returned to the facility from a hospitalization. A review of the matrix fluid intake report indicated the following omissions in regard to the resident's fluid intake on</p>		<p>changes will be made to ensure that deficient practice does not recur. All nursing assistants and licensed nurses were inserviced on 9/12/13 and 9/18/13 on matrix care documentation regarding fluid intakes. DNS/Unit managers will monitor the matrix documentation regarding fluid intake daily to ensure the hydration of the resident is being documented. Staff not adhering to policy will receive education, disciplinary action up to and including termination 4, How the corrective action will be monitor to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place To ensure compliance the DNS/Unit manager is responsible for completing the food and fluid CQI tool weekly X4, bi weekly X1 month and quarterly thereafter until compliance is maintained for 2 consecutive quarters. The result of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance. 5, Date of compliance 10/2/13</p>		

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	<p>08-30-13 for dinner, 08-31-13 for breakfast and lunch, 09-01-13 for breakfast and lunch, 09-02-13 for breakfast and lunch, 09-03-13 for breakfast and lunch, and 09-04-13 for breakfast.</p> <p>2. The record for Resident "F" was reviewed on 09-05-13 at 8:50 a.m. Diagnoses included, but were not limited to, hypertension, cerebral vascular accident and Alzheimers dementia. These diagnoses remained current at the time of the record review.</p> <p>The resident had a plan of care which identified the resident with "Dehydration / Fluid Maintenance - at risk for fluid imbalance due to: dementia, routine diuretics and needs assistance with food / fluids." Interventions to this plan of care included: "Record intake."</p> <p>The dietician's Nutrition Risk Assessment, dated 09-06-13 indicated the resident's "estimated fluid needs were "1248 - 1352 (24 - 26 ml/kg [milliliters per kilogram] decreased related to CHF [congestive heart failure]; min [minimum] 1500 ml per day per policy."</p> <p>Review of the Matrix for fluids lacked</p>						

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	<p>complete documentation of fluids on 08-01-13 for breakfast and dinner, 08-02-13 for lunch, 08-04-13 for breakfast and lunch, 08-05-13 for breakfast and lunch, 08-06-13 for breakfast, 08-07-13 for lunch, 08-09-13 for dinner, 08-11-13 for dinner, 08-14-13 for lunch, 08-15-13 for lunch, 08-18-13 for dinner, 08-19-13 for dinner, 08-20-13 for breakfast and lunch, 08-21-13 for lunch, 08-23-13 for breakfast and lunch, 08-24-13 for lunch, 08-25-13 for dinner, 08-26-13 for breakfast and lunch, 08-29-13 for dinner, 08-30-13 for breakfast and lunch, 08-31-13 for breakfast and lunch, 09-01-13 for breakfast and lunch, 09-02-13 for breakfast and lunch, 09-03-13 for breakfast, and on 09-04-13 for breakfast and lunch.</p> <p>This Federal tag relates to Complaint IN00135253 and Complaint IN00135704.</p> <p>3.1-50(a)(1)</p>				