

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155448	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2015
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NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00187801 and IN00188041,</p> <p>Complaint IN00187801- Substantiated. Federal/State deficiencies related to the allegations were cited at F157, F325, and F327.</p> <p>Complaint IN00188041-Substantiated. Federal/State deficiencies related to the allegations were cited at F157, F309, F325, and F327</p> <p>Survey dates: December 2 & 3, 2015</p> <p>Facility number: 000361 Provider number: 155448 AIM number: 100266340</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 11 Medicaid: 58 Other: 09 Total: 78</p> <p>Sample: 5</p>	F 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after January 2, 2016.</p>	

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

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on December 8, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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</p>			

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	<p>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 a resident's Physician and Responsible Party of a change in condition, related to a resident who had a significant weight loss and had a decrease in nutritional and fluid intakes for 1 of 3 residents reviewed for weight loss and hydration, in a total sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 12/02/15 at 1:21 p.m. The diagnoses included, but were not limited to, Lewey Body dementia, Parkinson's disease, and congestive heart failure.</p> <p>An Admission Minimum Data Set</p>	F 0157	<p>F157 – Notify of Changes(Injury/Decline/Room, Etc.,)</p> <p>It is the practice of this provider to promptly notify the resident, consult with resident's physician, resident's legal representative or interested family member when there is a significant change in condition in the resident's physical, mental or psychosocial status in either life threatening conditions, clinical complication, the need to alter treatment, need to transfer or discharge the resident to an acute care facility or change in room or roommate assignment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>·Physician and family</p>	01/02/2016			

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	<p>(MDS) assessment, dated 11/16/15, indicated the resident had short and long term memory problems, had moderately impaired decision making skills, required extensive assistance of two or more staff for bed mobility, transfers, dressing, and required extensive assistance of one staff for eating. The resident's weight was documented as 179 with no significant weight loss.</p> <p>A care plan, dated 11/04/15, indicated the resident was at risk for fluid imbalance due to decreased mobility and diuretic use. The interventions included, "Administer medications as ordered, Document and notify MD (Physician) of signs and symptoms of fluid volume deficit: dry mucous membranes, thirst, weight loss, decreased blood pressure, weak/rapid pulse, change in mental status, decreased urine output, abnormal labs, poor skin turgor, encourage fluids...record intake."</p> <p>A care plan, dated 11/06/15, indicated the resident was a nutritional risk. The interventions included, "...Notify MD/Family of significant weight changes..."</p> <p>A Nutrition Risk Assessment, dated 11/06/15, indicated the estimated calorie needs were 2025-2430 calories per day</p>		<p>/responsible party notification is occurring for all residents experiencing a significant change in condition such as weight loss and decrease in nutritional and fluid intake.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by this finding. · An audit was completed by the Nurse Management Team to ensure physician and family notification related to any resident change in condition including residents with significant weight loss and decreased nutritional and fluids intakes. · The Nurse Management Team will review nursing progress notes daily Monday through Friday (Charge Nurse to review on the weekend) to ensure that any resident change in condition is being appropriately addressed and followed up with as well as to ensure that physicians and families are notified timely. · Weekly Weights and daily Dietary Intake Records will be reviewed by the IDT (Charge Nurse on the weekend) to identify residents with significant weight changes and/or a decrease in nutritional and fluid intakes. Significant changes will be reported to the physician and 		

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	<p>and the estimated fluid needs were 2025-2430 cc per day. The resident's oral nutritional intake was documented as 76-100% of estimated needs and the fluid intake was 1000-1499 cc/day.</p> <p>The Registered Dietician's Note, dated 11/19/15 at 3:59 p.m., indicated the resident's weight on 11/15/15 was 181 and the resident was stable with intakes of 100% for breakfast, 75-100% for lunch, and refused-100% for supper, fluid intake was adequate and the facility would continue to monitor the resident.</p> <p>The Dietary Intake electronic records indicated the following dietary intakes for November 18-25, 2015: 18th- breakfast- 51-75%, lunch- nothing documented, supper-none 19th- breakfast-none, lunch-nothing documented, supper-1-25% 20th- breakfast-1-25%, lunch-75% (hand-written on a paper form provided by the Administrator), supper-none 21st- breakfast-1-25%, lunch-1-25%, supper-1-25% 22nd-breakfast-1-25% (hand written on paper form), lunch-1-25% (hand written on paper form), supper-1-25% 23rd- breakfast-1-25%, lunch-refused (hand written on paper form), supper-none 24th- breakfast-1-25%, lunch-1-25%,</p>		<p>family at the time noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> ·Nursing staff will be in-serviced on Physician/Family Notification and the Resident Change in Condition Policy by the DNS/designee on or before 1/2/16. ·The Nurse Management Team will review nursing progress notes daily Monday through Friday (Charge Nurse to review on the weekend) to ensure that any resident change in condition is being appropriately addressed and followed up with as well as to ensure that physicians and families are notified timely. ·Weekly and Monthly Weights and daily Dietary Intake Records will be reviewed by the IDT (Charge Nurse on the weekend) to identify residents with significant weight changes and/or a decrease in nutritional and fluid intakes. Significant changes will be reported to the physician and family at the time noted. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> ·The DNS/designee will be responsible for completion of the CQI Tool titled, "Change in Condition" which includes 		

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	<p>supper-1-25% 25th- breakfast-nothing documented, lunch-nothing documented, supper-resident in hospital.</p> <p>The electronic Fluid Intake form and documented amounts of fluids with medications indicated the following 24 hour (daily) intake of fluid for November 18-25, 2015: 18th- 1190 cc's 19th- 270 cc's 20th- 510 cc's, a hand written amount of 360 cc's was documented on a paper form (provided by the Administrator) 21st- 480 cc's 22nd- 320 cc's, a hand written amount of 240 cc's was documented on a paper form (provided by the Administrator) 23rd- 360 cc's 24th- 600 cc's 25th- 60 cc' s'</p> <p>The resident's weights were, 10/30/15-182, 11/01/15-179, 11/15/15-181, and 11/22/15-159.</p> <p>The Nurses' Progress Notes, dated 11/19/15 through 11/25/15 indicated the facility had not notified the resident's Physician and Power of Attorney for the decrease in food and fluid intakes and the significant weight loss.</p>		<p>notification to appropriate parties of change in condition such as significant weight loss and decrease fluid and nutritional intake daily until 4 weeks of 100% compliance is achieved and then monthly for at least 6 months.</p> <ul style="list-style-type: none"> · If threshold of 90% is not met, an action plan will be developed. · Findings will be submitted to the CQI Committee for review and follow up. 				

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	<p>The Nutrition at Risk Progress Note, dated 11/30/15 at 1:10 p.m., indicated the team met on 11/25/15 and the resident had a possible 22 pound weight loss in one week. The note indicated the resident was re-weighed and the resident's weight was 159. The note indicated the team had requested another re-weight, but was unable to get due to the resident being transferred to the Emergency Room.</p> <p>During an interview on 12/03/15 at 10:10 a.m., the Administrator indicated the resident had been a risk for dehydration and was eating and drinking up to 11/19/15. The Administrator indicated the resident had not had a change in mental status and the facility was offering the resident food and fluid and the resident did whatever he wanted to do. The Administrator indicated the facility had followed the facility policy and care plan.</p> <p>A facility policy, dated 01/15, titled, "Resident Change of Condition", received from the Administrator as current, indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party...All symptoms and unusual signs will be documented in the medical record</p>			

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F 0309 SS=D Bldg. 00	<p>and communicated to the attending physician promptly...The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when a significant change in the resident's condition is noted..."</p> <p>A facility policy, dated 11/13, titled, "Resident Weight Monitoring", received from the Administrator as current, indicated, "...The physician will be notified of unplanned significant weigh loss/gains..."</p> <p>This Federal Tag relates to Complaints IN00187801 and IN00188041.</p> <p>3.1-5(a)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide necessary care and services, related to not</p>	F 0309	F309 – Provide Care/Services forHighest Well Being It isthe practice of this provider that each resident receive and the	01/02/2016

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	<p>investigating for potential causes of skin tears for 3 of 4 residents reviewed for skin tears, in a total sample of 5. (Residents #B, #E, and #F)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 12/02/15 at 1:21 p.m. The diagnoses included, but were not limited to, Lewey Body dementia, Parkinson's disease, and congestive heart failure.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 11/16/15, indicated the resident had short and long term memory problems, had moderately impaired decision making skills, required extensive assistance of two or more staff for bed mobility, transfers, dressing, and required extensive assistance of one staff for eating.</p> <p>An Event Note, dated 11/12/15 at 8:44 p.m., indicated a skin tear was found on the resident's right forearm, which measured 9 by 0.1 centimeters (cm), had scant bleeding and the Physician and Responsible Party were notified.</p> <p>A Nurses' Progress Note, dated 11/12/15 at 7:30 p.m., indicated the Nurse had been called into the resident's room, and the CNA who was providing care had</p>		<p>facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> · Assessments, investigations and identification of root cause are occurring for all residents with skin impairments such as skin tears. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · All residents are at risk to be affected by this finding. · Weekly Skin Assessments will be completed on all residents as well as skin inspections during routine bathing and shower care. · Any new skin issues noted such as skin tears will be promptly investigated by the IDT and followed up with per policy and to determine possible cause. · Once root cause has been identified, necessary prevention interventions will be added to the care plan as appropriate. · New Skin Events will be reviewed daily during clinical meetings to ensure all skin areas 		

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	<p>found a skin tear on the resident's right forearm, which was 9 cm by 0.1 cm. The note indicated the resident did not know how the skin tear occurred.</p> <p>During an interview on 12/03/15 at 3:40 p.m., LPN #2 indicated the CNA had informed her she had found the skin tear. LPN #2 indicated the skin was easy to piece together. She indicated the resident was already in bed and the CNA had been there providing incontinent care. She indicated the resident had not been combative with care. She indicated she checked the side of the bed and table and nothing was sharp.</p> <p>During an interview on 12/03/15 at 3:45 p.m., the Administrator indicated the cause of the skin tear had not been investigated. He indicated the CNA was in the room, the Nurse had indicated it was a fresh skin tear, and the resident stated he didn't know how it happened. He indicated there was no one else to talk to.</p> <p>During an interview on 12/03/15 at 3:54 p.m., the Administrator indicated they investigate injuries of unknown origin by the State Reportable Guidelines or if the injury is suspicious. He indicated the Interdisciplinary Team (IDT) investigation note was not completed.</p>		<p>are investigated by the IDT and followed up with per policy to determine possible cause.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> ·Nursing staff will be in-serviced on the Skin Management Policy by the DNS/designee on or before 1/2/16. ·Weekly Skin Assessments will be completed on all residents as well as skin inspections during routine bathing and shower care. ·Any new skin issues noted such as skin tears will be promptly investigated by the IDT and followed up with per policy to determine possible cause. ·Once root cause has been identified, necessary prevention interventions will be added to the care plan as appropriate. ·New Skin Events will be reviewed daily during clinical meetings to ensure all skin areas are investigated by the IDT and followed up with per policy to determine possible cause. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> ·The DNS/designee will be responsible for completion of the CQI Tool titled, "Skin Tears" which includes investigation and identification of root cause of 		

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	<p>During an interview on 12/03/15 at 4:06 p.m., the Administrator indicated a weekly summary completed indicated the skin tear was not there the shift prior to the skin tear occurring and the Nurse worked a double shift, so she knew it wasn't there prior. He indicated the Nurse and the CNA said they did not know how it happened.</p> <p>2. Resident #E's record was reviewed on 12/03/15 at 4 p.m. The resident's diagnoses included, but were not limited to, dementia and neurogenic bladder.</p> <p>The Quarterly MDS assessment, dated 09/03/15, indicated the resident's cognition was moderately impaired, required extensive assistance of two for bed mobility, dressing, toileting, bathing, and was dependent on two staff for transfers.</p> <p>A New Skin Event, dated 10/09/15 at 2:11 p.m., indicated the resident had a skin tear to the left outer leg, which measured 2 cm by 0.5 cm.</p> <p>A Nurses' Progress Note, dated 10/09/15 at 2:12 p.m., indicated a small amount of bleeding was seen down by the resident's outer left ankle and upon assessment of the area a small skin tear was found.</p>		<p>skin alterations such as skin tears daily until 4 weeks of 100% compliance is achieved and then monthly for at least 6 months.</p> <ul style="list-style-type: none"> · If threshold of 90% is not met, an action plan will be developed. · Findings will be submitted to the CQI Committee for review and follow up. 	

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	<p>During an interview on 12/04/15 at 4:18 p.m., LPN #3 indicated there had not been an investigation for the cause of the skin tear. The Administrator indicated the areas are only investigated for the cause if they are over 10 cm.</p> <p>3. Resident #F's record was reviewed on 12/03/15 at 4:22 p.m. The resident's diagnoses included, but were not limited to, dementia and osteoarthritis.</p> <p>A Quarterly MDS assessment, dated 11/12/15, indicated the resident had long and short term memory problems, severely impaired cognition, required extensive assistance of two staff for bed mobility, transfers, toileting, and bathing, and extensive assistance of one for dressing and hygiene.</p> <p>A New Skin Event form, dated 11/20/15 at 4:28 p.m., indicated a skin tear was found on the resident's third left knuckle, which measured 0.5 cm by less than 0.1 cm.</p> <p>A New Skin Event form, dated 11/20/15 at 5:02 p.m., indicated a skin tear was found on the resident's fourth left knuckle, which measured 0.5 cm by less than 0.1 cm.</p>			

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F 0325 SS=D Bldg. 00	<p>A Nurses' Progress Note, dated 11/20/15 at 4:52 p.m., indicated the staff had alerted the Nurse about the resident's skin tears on the left hand.</p> <p>During an interview on 12/03/15 at 4:30 p.m., the Administrator indicated the skin tears had not been investigated for a cause.</p> <p>A facility policy, dated 02/15, titled, "Skin Management Program", received from the Administrator as current, indicated, "...When a new alteration in skin integrity is identified such as a bruise, skin tear, abrasion, rashes..IDT (Interdisciplinary Team) note to identify root cause and initiate preventative interventions if applicable..."</p> <p>This Federal Tag relates to Complaint IN00188041.</p> <p>3.1-37(a)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and</p>				

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	<p>protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure a resident maintained an acceptable nutritional status, related to a potential significant weight loss when a resident's dietary intake had decreased, for 1 of 3 residents reviewed for weight loss in a total sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 12/02/15 at 1:21 p.m. The diagnoses included, but were not limited to, Lewey Body dementia, Parkinson's disease, and congestive heart failure.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 11/16/15, indicated the resident had short and long term memory problems, had moderately impaired decision making skills, required extensive assistance of one staff for eating. The resident's weight was documented as 179 with no significant weight loss.</p> <p>A care plan, dated 11/06/15, indicated, "nutritional risk". The interventions included, monitor food and fluid intakes</p>	F 0325	<p>F325 – Maintain Nutrition Status Unless Unavoidable</p> <p>It is the practice of this provider that based on a resident's comprehensive assessment, the facility will ensure that a resident maintains acceptable parameters of nutritional status and receives a therapeutic diet when there is a nutritional problem.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> · Acceptable nutritional status is being maintained for residents identified with a potential significant weight loss or decreased dietary intake. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by this finding. · An audit was completed by the Nurse Management Team to identify any resident with a significant weight change and/or a decreased nutritional and/or fluid intake. · Weekly and Monthly Weights and daily Dietary Intake Records will be reviewed by the IDT 	01/02/2016

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	<p>at meals and, monitor weight.</p> <p>The Physician's Admission Orders, dated 10/30/15, included, regular diet with super cereal with breakfast, 240 cc (cubic centimeters) of mighty milk with every meal, document in cc's all fluids taken with meds (medications), Lasix (diuretic) 20 mg (milligrams) once a day, and Losartan (anti-hypertensive) 25 mg once a day.</p> <p>A Nutrition Risk Assessment, dated 11/06/15, indicated the resident's usual body weight was 165-180, Body Mass Index was 27.2 over the weight range, was overweight, the estimated calorie needs were 2025-2430 calories per day and the estimated fluid needs were 2025-2430 cc per day. The resident's oral nutritional intake was documented as 76-100% of estimated need and the fluid intake was 1000-1499 cc/day.</p> <p>The Registered Dietician's Note, dated 11/19/15 at 3:59 p.m., indicated to see the full assessment for complete information. The note indicated the resident received therapeutic items to maintain his weight, on 11/09/15 his BUN (kidney function test) was high, on 11/15/15 his weight was 181 and the resident was stable with intakes of 100% for breakfast, 75-100% for lunch, and</p>		<p>(Charge Nurse on the weekend) to identify residents with significant weightchanges and/or a decrease in nutritional and fluid intakes.</p> <ul style="list-style-type: none"> Residentspecific interventions as deemed appropriate by the IDT will be promptlyinitiated to maintain an acceptable nutritional status of each identifiedresident. Ongoing evaluation related tothe effectiveness of these interventions will be reviewed by the IDT duringdaily clinical meetings and weekly nutritional meetings. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficientpractice does not recur:</p> <ul style="list-style-type: none"> Nursingstaff will be in-serviced on the Weight Management Policy and Food and FluidIntake Monitoring by the DNS/designee on or before 1/2/16. Weeklyand Monthly Weights and daily Dietary Intake Records will be reviewed by theIDT (Charge Nurse on the weekend) to identify residents with significant weightchanges and/or a decrease in nutritional and fluid intakes. Residentspecific interventions as deemed appropriate by the IDT will be promptlyinitiated to maintain an acceptable nutritional status of each identifiedresident. Ongoing evaluation related tothe effectiveness of these 				

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	<p>refused-100% for supper, fluid intake was adequate and the resident would be continued to be monitored.</p> <p>The Dietary Intake electronic records indicated the following dietary intakes for November 18-25, 2015: 18th- breakfast- 51-75%, lunch- nothing documented, supper-none 19th- breakfast-none, lunch-nothing documented, supper-1-25% 20th- breakfast-1-25%, lunch-75% (hand-written on a paper form provided by the Administrator), supper-none 21st- breakfast-1-25%, lunch-1-25%, supper-1-25% 22nd-breakfast-1-25% (hand written on paper form), lunch-1-25% (hand written on paper form), supper-1-25% 23rd- breakfast-1-25%, lunch-refused (hand written on paper form), supper-none 24th- breakfast-1-25%, lunch-1-25%, supper-1-25% 25th- breakfast-nothing documented, lunch-nothing documented, supper-resident in hospital.</p> <p>The resident's weights were, 10/30/15-182, 11/01/15-179, 11/15/15-181, and 11/22/15-159.</p> <p>The Nurses' Progress Notes, dated 11/19/15 through 11/25/15 had not</p>		<p>interventions will be reviewed by the IDT duringdaily clinical meetings and weekly nutritional meetings.</p> <ul style="list-style-type: none"> ·Directcare staff will be alerted to these resident specific interventions and anyidentified resident will have their daily nutritional and fluid intakesmonitored closely by the IDT. <p>How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place:</p> <ul style="list-style-type: none"> ·TheDNS/designee will be responsible for completion of the CQI Tool titled, "Weight/NAR" and "Food and Fluid Documentation" daily until 4 weeks of 100%compliance is achieved and then monthly for at least 6 months. ·Ifthreshold of 90% is not met, an action plan will be developed. ·Findingswill be submitted to the CQI Committee for review and follow up. 	

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	<p>indicated the staff attempted to encourage the resident to eat and drink and had not assessed the cause for the decrease of food and fluid intake. The notes also did not indicated the resident's Physician and Power of Attorney had been notified of the changes in the oral intake.</p> <p>The Nutrition at Risk Progress Note, dated 11/30/15 at 1:10 p.m., indicated the team met on 11/25/15 and the resident had a possible 22 pound weight loss in one week. The note indicated the resident was re-weighed and the resident's weight was 159. The note indicated the team had requested another re-weight, but was unable to get due to the resident being transferred to the Emergency Room.</p> <p>The Hospital Information Record, indicated the resident's admission weight on 11/25/15 was 170 pounds. There was another weight of 157 pounds and 6.4 ounces listed on the form with no date documented.</p> <p>A facility investigation, dated 11/30/15, indicated the facility verified with the hospital the resident's information form had two weights, one was 170 pounds on admission (11/25/15) and a weight of 156 pounds being his current weight at the hospital on 11/30/15.</p>			

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	<p>During an interview on 12/03/15 at 10:10 a.m., The Administrator indicated the resident's oral intake had decreased starting 11/19/15. The Administrator indicated the facility only totals the daily intake if the resident was on a fluid restriction and the Nurses' only document by exception. The Administrator indicated he was not sure if the weight loss was correct. The DoN (Director of Nursing) indicated the resident had been agitated when the other two attempts at weighing the resident were completed and the Physician would have been notified after the weight was verified the third time.</p> <p>During an interview on 12/03/15 at 1:43 p.m., RN #1 indicated the Nurses' did not look at the weekly weights when they were done. RN #1 indicated the Management Team would alert the Nurses' if there was a significant loss or gain.</p> <p>A facility policy, dated 11/13, titled, "Resident Weight Monitoring", received from the Administrator as current, indicated, "...The interdisciplinary team (IDT) will be alerted to residents who have weight or nutritional concerns..."</p> <p>This Federal Tag relates to Complaints</p>			

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F 0327 SS=D Bldg. 00	<p>IN00187801 and IN00188041.</p> <p>3.1-46(a)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview, the facility failed to ensure a resident received adequate fluids orally and assessments were completed to ensure a resident did not exhibit signs of possible dehydration for 1 of 3 residents reviewed for hydration in a total sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 12/02/15 at 1:21 p.m. The diagnoses included, but were not limited to, Lewey Body dementia, Parkinson's disease, and congestive heart failure.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 11/16/15, indicated the resident had short and long term memory problems, had moderately impaired decision making skills, required</p>	F 0327	<p>F327 – Sufficient Fluid to Maintain Hydration It is the practice of this provider to provide each resident with sufficient fluid intake to maintain proper hydration and health. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All resident fluid intakes are being properly monitored to maintain proper hydration and health. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by this finding. · An audit of all residents' average daily fluid intake was completed by the Nurse Management Team. A hydration assessment was completed on any resident 	01/02/2016	

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	<p>extensive assistance of two or more staff for bed mobility, transfers, dressing, and required extensive assistance of one staff for eating. The resident's weight was documented as 179 with no significant weight loss.</p> <p>A care plan, dated 11/04/15, indicated the resident was at risk for fluid imbalance due to decreased mobility and diuretic use. The interventions included, "Administer medications as ordered, Document and notify MD (Physician) of signs and symptoms of fluid volume deficit: dry mucous membranes, thirst, weight loss, decreased blood pressure, weak/rapid pulse, change in mental status, decreased urine output, abnormal labs, poor skin turgor, encourage fluids...record intake."</p> <p>The Physician's Admission Orders, dated 10/30/15, included, regular diet with super cereal with breakfast, 240 cc (cubic centimeters) of mighty milk with every meal, document in cc's all fluids taken with meds (medications), Lasix (diuretic) 20 mg (milligrams) once a day, and Losartan (anti-hypertensive) 25 mg once a day.</p> <p>A Nutrition Risk Assessment, dated 11/06/15, indicated the resident's usual body weight was 165-180, Body Mass</p>		<p>identified with a decrease in average daily fluidintake.</p> <ul style="list-style-type: none"> ·Weeklyand Monthly Weights and daily Dietary Intake Records will be reviewed by theIDT (Nursing Supervisor on the weekend) to identify residents with significantweight changes and/or a decrease in nutritional and fluid intakes. ·Residentspecific interventions as deemed appropriate by the IDT will be promptlyinitiated to maintain an acceptable hydration status of each identifiedresident. Ongoing evaluation related tothe effectiveness of these interventions will be reviewed by the IDT duringdaily clinical meetings and weekly nutritional meetings. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficientpractice does not recur:</p> <ul style="list-style-type: none"> ·Nursingstaff will be in-serviced on the Hydration Policy and Food and Fluid IntakeMonitoring by the DNS/designee on or before 1/2/16. ·Nurseswill also be re-educated on monitoring for signs and symptoms of dehydrationsuch as dry mucous membranes, thirst, weight loss, poor skin turgor. ·Weeklyand Monthly Weights and daily Dietary Intake Records will be reviewed by theIDT (Charge Nurse on the weekend) to identify residents with 		

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	<p>Index was 27.2 over the weight range, was overweight, the estimated calorie needs were 2025-2430 calories per day and the estimated fluid needs were 2025-2430 cc per day. The resident's oral nutritional intake was documented as 76-100% of estimated needs and the fluid intake was 1000-1499 cc/day.</p> <p>The electronic Fluid Intake form and documented amounts of fluids with medications indicated the following 24 hour (daily) intake of fluid for November 18-25, 2015: 18th- 1190 cc's 19th- 270 cc's 20th- 510 cc's, a hand written amount of 360 cc's was documented on a paper form (provided by the Administrator) 21st- 480 cc's 22nd- 320 cc's, a hand written amount of 240 cc's was documented on a paper form.(provided by the Administrator) 23rd- 360 cc's 24th- 600 cc's 25th- 60 cc' s'</p> <p>The Registered Dietician's Note, dated 11/19/15 at 3:59 p.m., indicated to see the full assessment for complete information. The note indicated the resident received therapeutic items to maintain his weight, on 11/09/15 his BUN (kidney function test) was high, on</p>		<p>significant weightchanges and/or a decrease in nutritional and fluid intakes.</p> <ul style="list-style-type: none"> ·Directcare staff will be alerted to these resident specific interventions and anyidentified resident will have their daily nutritional and fluid intakesmonitored closely by the IDT. ·Residentspecific interventions as deemed appropriate by the IDT will be promptlyinitiated to maintain an acceptable hydration status of each identifiedresident. Ongoing evaluation related tothe effectiveness of these interventions will be reviewed by the IDT duringdaily clinical meetings and weekly nutritional meetings. ·AverageDaily Fluid Intake Records will be monitored by the IDT to ensure residents areconsuming the determined estimated fluid needs daily. <p>How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place:</p> <ul style="list-style-type: none"> ·TheDNS/designee will be responsible for completion of the CQI Tool titled, "Hydration" and "Food and Fluid Documentation" daily until 4 weeks of 100%compliance is achieved and then monthly for at least 6 months. ·Ifthreshold of 90% is not met, an action plan will be developed. ·Findingswill be submitted to 				

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	<p>11/15/15 his weight was 181 and the resident was stable with intakes of 100% for breakfast, 75-100% for lunch, and refused-100% for supper, fluid intake was adequate and the resident would be continued to be monitored.</p> <p>A blood chemistry test, dated 11/09/15, indicated the resident's BUN was 27 (normal 8-23), creatinine (kidney function) was 1.2 (normal 0.7-1.2), sodium was 139 (normal 136-145), and potassium was 4.8 (3.5-5.3).</p> <p>The resident's weights were, 10/30/15-182, 11/01/15-179, 11/15/15-181, and 11/22/15-159.</p> <p>A Weekly Summary, dated 11/19/15 at 3:44 a.m., indicated the resident's skin was warm and dry and was non-tenting. The vital signs were, temperature 98.2, pulse 78/minute, respirations 18/minute, and blood pressure was 144/58.</p> <p>A Shower Report, dated 11/20/15, indicated, "No new issues..."</p> <p>There had been no assessment of the resident's hydration status, weight loss, vital signs after 11/19/15 through 11/25/15, when the resident's fluid intake had decreased.</p>		the CQI Committee for review and follow up.	

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	<p>The Nurses' Progress Notes, dated 11/19/15 through 11/25/15 had not indicated the staff attempted to encourage the resident to eat and drink and had not assessed the cause for the decrease of food and fluid intake. The notes also did not indicated the resident's Physician and Power of Attorney had been notified of the changes in the oral intake.</p> <p>The Nutrition at Risk Progress Note, dated 11/30/15 at 1:10 p.m., indicated the team met on 11/25/15 and the resident had a possible 22 pound weight loss in one week and the weight remained at 159 the second re-weight. The note indicated the team had requested a third re-weight, but was unable to get due to the resident being transferred to the Emergency Room.</p> <p>A Physician's Communication Tool, dated 11/25/15 at 12 p.m., indicated the resident's temperature was 98.6, pulse-94, blood pressure- 110/60, and respirations-20, and the skin was warm and dry. The "problem seems to be" was marked as undetermined and a Progress Note indicated the family was in the building an wanted the resident sent to the hospital for an evaluation, an order to transfer was obtained.</p> <p>The Emergency Room Physician's</p>			

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	<p>History and Physical, indicated the family informed them the resident had not been eating or drinking for four days, the blood pressure was 93/54, heart rate was 104, respirations was 23, and the temperature was 101.6. The Physical Exam indicated the resident was not in distress, had dry mucous membranes, poor oral intake, and was febrile with tachycardia (increased heart rate). The note indicated blood tests would be complete to check for dehydration and infection and the Emergency Room would hydrate the resident. The Blood Chemistry test indicated a BUN of 96, creatinine of 4.33, glomerial filtration rate (kidney function) 13 (normal above 60), sodium of 160, and potassium of 5.3.</p> <p>An Emergency Note, dated 11/25/15 at 2:26 p.m., indicated the resident was rechecked and was improving with IV (intravenous) fluid.</p> <p>An Emergency Note, dated 11/25/15 at 2:54 p.m., indicated the laboratory tests indicated infection and acute kidney injury, and would continue to hydrate and admit the resident to the hospital. The admission diagnoses included, but were not limited to, septic shock and acute kidney injury.</p> <p>A hospital Physician's Consult, dated</p>						

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	<p>11/26/15, indicated the resident was brought to the hospital with a change in mental status and decreased oral intake, was diagnosed with urinary tract infection, sepsis, renal failure, and hypernatremia (high sodium). The assessment also indicated the resident was dehydrated.</p> <p>During an interview on 12/03/15 at 10:10 a.m., the Director of Nursing (DoN) indicated an assessment for hydration had been included with the weekly summary, dated 11/19/15. The Administrator indicated the skin had been assessed on the Shower Skin Assessment form on 11/20/15. The Administrator indicated the resident had been a risk for dehydration and was eating and drinking up to 11/19/15. The Administrator indicated the facility only totals the daily intake if the resident was on a fluid restriction and the Nurses' only document by exception. The Administrator indicated the resident had not had a change in mental status and the facility was offering the resident food and fluid and the resident did whatever he wanted to do. The Administrator indicated the staff were following the residents care plan and there were no changes in the residents vital signs, thirst, etc. The Administrator indicated he was not sure if the weight loss was correct. The DoN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155448	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2015
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NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 710 MICHIGAN ST LOWELL, IN 46356
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	<p>indicated the resident had not been lethargic and continued with behaviors of combativeness and the Physician would have been notified after the weight was verified. The Administrator indicated there had been no documented assessment, and if the Nurses' would have seen a decrease in urinary output, they would have documented an assessment.</p> <p>During an interview on 12/03/15 at 1:43 p.m., RN #1 indicated if a resident was not eating or drinking the staff would try to offer alternates and if the resident had a decrease in food and fluids for more than a few days, she would notify the Physician, and assess the resident for a possible reason for the decrease.</p> <p>During an interview on 12/03/15 at 1:51 p.m., LPN #2 indicated if a resident was not eating or drinking the staff would try to offer alternates and if the decrease in food and fluid intake lasted more than a few days, she would notify the Physician, monitor for dehydration, monitor the resident's vital signs, skin turgor, and document the assessment in the Medical Record.</p> <p>A facility policy, dated 01/15, titled, "Hydration Management", received from the Administrator as current, indicated,</p>			

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	<p>"...Any resident with identified risk factors will be assessed by the IDT (Interdisciplinary Team) and documentation will be placed in the EMR (Electronic Medical Records) IDT hydration review observation to include, but not limited to: a. Resident's risk factors for dehydration...c. Physical assessment including mucous membranes, skin turgor...Hydration interventions...fluid intake will be planned to include at least 480 ml (milliliters)/meal...Nursing staff is responsible for documenting fluid intake at mealtime in EMR...24 hour fluid totals will only be calculated for those residents on fluid restriction or as ordered by physician."</p> <p>This Federal Tag relates to Complaints IN00187801 and IN00188041.</p> <p>3.1-46(b)</p>			