

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2012
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NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
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F0000	<p>This visit was for Investigation of Complaints IN00111647 and IN00112883.</p> <p>Complaint IN00111647 Substantiated. Federal/State deficiencies related to the allegations are cited at F279 and F329.</p> <p>Complaint IN00112883 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282, F327 and F514.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: July 25, 26, 27, 2012 and August 1, 2012</p> <p>Facility number: 001127 Provider number: 155771 AIM number: 200247220</p> <p>Survey Team: Mary Jane G. Fischer, RN</p> <p>Census bed type: SNF: 18 NF: 103 SNF/NF: 11 Residential: 154 NCC: 35 Total: 321</p>	F0000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain.	

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>Census payor type: Medicare: 18 Medicaid: 85 Other: 218 Total: 321</p> <p>Sample: 7 Supplemental sample: 1</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 6, 2012 by Bev Faulkner, RN</p>				

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F0157 SS=E	<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 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>A. Based on record review and interview, the facility failed to ensure a resident's physician was notified of a decline in food and fluid consumption, in that when residents food and fluid intake was</p>	F0157	During the complaint survey, the ISDH surveyor identified that the facility was out of compliance with the regulation of F157. Two (2) residents out of seven (7) reviewed were cited. These	08/24/2012			

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	<p>inadequate and resulted in weight loss, the nursing staff failed to notify the physician for possible intervention for 2 of 3 cognitively impaired residents reviewed for hydration needs and physician notification in a sample of 7. [Resident "A" and "G"].</p> <p>B. Based on record review and interview, when a cognitively impaired resident displayed inappropriate actions towards another cognitively impaired resident, the nursing staff failed to report the incident to an interested family member. This deficient practice effected 1 of 3 residents reviewed for behaviors in a sample of 7 and 1 of 1 supplemental sampled residents. [Residents "F" and "H"]</p> <p>Findings include:</p> <p>A.1. The record for Resident "A" was reviewed on 07-26-12 at 8:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, hypertension, dysphasia, depression, diabetes mellitus and gastroesophageal reflux disease. These diagnoses remained current at the time of the record review.</p> <p>The facility weight variance report, dated 07-26-12, indicated the resident's weight on 05-09-12 was 94 lbs., and 88 lbs on 07-12-12. The weight variance report also</p>		<p>residents lacked documentation to indicate that the physician and/or family was notified for a change in condition or a behavior that occurred. It is the policy and procedure of the facility to assess each resident for changes and notify the physician and families/responsible party as indicated. 1) Resident A resides on the end stage dementia unit. Resident is very resistant to eat and drink as her dementia progresses. Although the facility has made many steps/measures to try to prevent weight loss and encourage the intake of fluids it continues to be a challenge as is expected from Resident A's diagnosis. However, nursing staff failed to document thoroughly that the physician was notified frequently of the changes and slow deterioration of Resident A. A) All residents have the potential to be affected by weight loss or insufficient fluid intake. Monitoring of nursing documentation of notifying the physician will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter to ensure each resident's physician is notified of any and all changes or declines with residents in a timely manner. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring that the process for notifying the physician and family/responsible party of any</p>		

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	<p>indicated the resident consumed a puree diet, health shakes three times a day, and staff needed to "encourage clear liquids."</p> <p>Fluid consumption for a resident with a weight of 94 lbs, required 1,281 ml [milliliters] of fluid daily, while a resident with a weight of 88 lbs. required 1200 ml of fluid daily.</p> <p>The resident's current plan of care, dated 07-17-12, indicated the resident had a "deficit r/t [related to] decreased fluid intake." The "measurable goal" indicated the "res. [resident] will maintain moist mucous membranes by staff encouraging res. to consume at least 1500 ml daily." Approaches to this plan of care prompted the nursing staff to "notify the MD [Medical Doctor] as needed."</p> <p>The facility "Meal Consumption" records were reviewed and indicated the following daily fluid consumption [total fluids] for the resident:</p> <p>07-13-12 - 300 c.c. [cubic centimeters] 07-14-12 - 910 c.c. 07-15-12 - 600 c.c. 07-16-12 - 240 c.c. 07-17-12 - 540 c.c. 07-18-12 - 300 c.c. 07-19-12 - 420 c.c. 07-20-12 - 100 c.c. prior to being</p>		<p>changes with a resident is followed. This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. D) Substantial compliance date: August 24, 2012. 2) Resident F resides on the end stage dementia unit. Resident F has to be monitored for normal wandering behaviors due to their diagnosis, and as with any resident with dementia also must be monitored for aggressive behaviors. Resident F has acquired a maternal attachment to another resident on the unit and needs to be closely monitored to ensure Resident F does not impose on the other resident's rights or wishes. However, nursing staff failed to document that the physician and family/responsible party were notified of any behaviors exhibited by Resident F. A) All residents on the end stage dementia unit have the potential to be affected by another resident exhibiting a behavior. Monitoring of nursing documentation of notifying the physician will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter to ensure each</p>				

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	<p>transported to the local area hospital per the family's request.</p> <p>The record, reviewed from 07-13-12 through 07-20-12 indicated the resident refused meal and fluid consumption on the following dates and meals:</p> <p>07-13-12 Breakfast - refused food Lunch - refused food Dinner - refused food and fluids Miscellaneous fluids - refused on night shift</p> <p>07-14-12 Lunch - refused food Dinner - refused food</p> <p>07-15-12 Breakfast - refused food and fluids Dinner - refused food and fluids</p> <p>07-16-12 Breakfast - refused food and fluids Lunch - refused food and fluids Dinner - refused food and fluids</p> <p>07-17-12 Lunch - refused food and fluids Dinner - refused food and fluids Miscellaneous - refused fluids on the evening shift</p> <p>07-18-12 Lunch - refused food and fluids Dinner - refused food and fluids Miscellaneous - refused fluids on the</p>		<p>resident's physician is notified of any and all changes or declines with residents in a timely manner. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring that the process for notifying the physician and family/responsible party of any changes or behaviors with a resident is followed. This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. D) Substantial compliance date: August 24, 2012. Additional Plan of Correction response in regards to correspondence request from ISDH dated August 23, 2012: 1. Resident G was reviewed following the exit of the state surveyor on August 1, 2012. The documented weight loss and risk for hydration from January 9, 2012 - July 9, 2012 was reviewed. An order "to increase 2 cal to 90ml three times a day due to weight loss." which addressed the resident's weight loss was received on May 23, 2012. This order remains in place. The</p>		

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	<p>night shift</p> <p>07-19-12 Breakfast - refused food and fluids Lunch refused food Dinner - refused food and fluids</p> <p>07-20-12 Breakfast - refused food and fluids Lunch - refused food and fluids Dinner - refused food and fluids Miscellaneous - refused fluids on the night shift</p> <p>The record lacked documentation the resident's physician was notified of the resident's decline in the consumption of fluids.</p> <p>Review of the Social Service notations, dated 07-20-12 at 12:30 p.m., indicated the family member voiced concern in regard to the resident's decline in condition. "[Name of family member] ... was shocked to see [resident] decline in a little over three months, ... obvious weight loss." The notation indicated the Unit Manager Licensed Nurse employee #9 "informed that weights are taken monthly which [family member] found to be disturbing." The Unit Manager Licensed Nurse employee #9 "explained that the Unit ASCU [advanced special care unit] is a Unit for individual with advanced</p>		<p>resident's physician has again been made aware of the decrease in fluid and food consumption and the resident's care plan has been updated. Resident G is being monitored for intake. 2. All residents in the comprehensive unit with risk for dehydration, weight loss and any acute medical changes were reviewed and had their care plans updated or initiated as necessary. Their physicians will be made aware of any issues necessary. Date Certain remains August 24, 2012.</p>		

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	<p>Alzheimer's/Dementia. With that comes anticipated weight loss although we do everything we can to prevent such." [Family member] commented "well obviously you have not." The Unit Manager Licensed Nurse employee #9 explained that there are snacks and drinks offered daily in between meals, but that it comes back to getting [name of resident] to do it. "[Resident] often clamps mouth shut or will display physical abuse." [Family member] "moved to the edge of seat and told [name of Unit Manager] that she needed to be very careful on her choice of terminology, and informed her [family member] would call it 'fear.'" [Family member] informed that in regards to [resident] eating and drinking that what ever is being tried is not obviously working." The Unit Manager "informed that we want [resident] and mobile [sic] to assist in preventing further skin breakdown" and "this is possible due to the level of nutrition and hydration. This is also another potential from the natural progressin <sic> of the disease."</p> <p>The record indicated the resident's family member's visited with the resident on 07-20-12 at 4:30 p.m., and "asked signee to call family doctor and get an order to send res. to [name of local area hospital] to be evaluated. Res. family states "we would like [resident] to be on IV</p>						

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	<p>[intravenous fluids] for dehydration."</p> <p>The hospital notation, dated 07-20-12 [nurses notes] indicated, "[Family member] states pt. [patient] last few days more listless and not eating. [Family member] came from [another State] to have [resident] checked out." The "general assessment" indicated the resident "appears frail, behavior is listless" and "level of consciousness is obtunded." The emergency room physician ordered testing to include a basic metabolic profile, complete blood count as well as a urinalysis. In addition, the physician ordered the administration of 1000 ml of 0.9 % of normal saline.</p> <p>The laboratory test, basic metabolic profile, indicated the resident's BUN [blood urea nitrogen - a test to check hydration] was 52 with a normal range of 7 - 18 mg [milligrams] per dl [deciliter], and a complete blood count which indicated the resident's hematocrit was 50 with a normal range of 33 - 45 %. The urinalysis indicated the resident's urine was "cloudy with mucous and bacteria present."</p> <p>The hospital discharge instructions identified the resident with a Urinary Tract Infection and Dehydration."</p>				

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	<p>Interview on 07-27-12 at 1:30 p.m., the Unit Manager Licensed Nurse employee # 9 indicated the resident had "all kinds of things to eat and drink in [resident] room." When further interviewed, the Unit Manager confirmed the resident was unable to request the items and the staff would need "to assist [name of resident]."</p> <p>A. 2. The record for Resident "G" was reviewed on 07-26-12 at 9:10 a.m. Diagnoses included but not limited to senile dementia, macular degeneration, hypertension, and degenerative joint disease. These diagnoses remained current at the time of the record review.</p> <p>The resident's current plan of care, dated 05-22-12, indicated the resident had the "Potential for fluid volume defecit [sic] r/t decreased fluid intake." The "measurable goal" included the resident will "maintain most [sic] mucous membranes by staff encouraging fluid intake of 1500 mg daily times 90 days." An approach to this plan of care included "Notify MD as needed."</p> <p>The facility "Weight Variance report," dated 07-26-12, indicated the resident received a pureed diet with whole milk and Two Cal. [a supplement] 90 ml three times a day. In addition, the resident's weight was recorded at 142.5 lbs in</p>						

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	<p>01-09-12, with a current weight of 130.5 lbs on 07-09-12 - a loss of 12 lbs.</p> <p>The report indicated the resident weighed 130.5 lbs on 07-09-12, which required a fluid intake of 1779 c.c. daily.</p> <p>The "Meal Consumption Record," indicated the following fluid intakes for the resident.</p> <p>07-13-12 - 750 c.c. 07-14-12 - 1220 c.c. 07-15-12 - 1230 c.c. 07-16-12 - 990 c.c. 07-17-12 - 1290 c.c. 07-18-12 - 1210 c.c. 07-19-12 - 660 c.c. 07-20-12 - 1250 c.c.</p> <p>The record indicated the resident consumed the following in regard to meal consumption:</p> <p>07-13-12 - Breakfast 25% Lunch 75 % Dinner 25 %</p> <p>07-15-12 - Lunch 25%</p> <p>07-16-12 - Breakfast 50 % Dinner 25%</p> <p>07-17-12 - Breakfast 50 %</p>						

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	<p>07-18-12 - Lunch 50%</p> <p>07-19-12 Breakfast 25% Dinner 50 %</p> <p>07-20-12 Dinner 25%</p> <p>The record lacked documentation the resident's physician was notified of the resident's decline in food and fluid consumption.</p> <p>A. 3. During interview on 07-26-12 at 9:30 a.m., the Unit Manager Licensed Nurse employee #9 indicated "If fluid consumption falls below 1500 c.c. per day we put the resident on I & O [intake and output]."</p> <p>A. 4. The facility policy titled "Hydration Monitoring," provided by the Director of Nurses, dated as "revised 04-27-05, and reviewed on 07-27-12 at 8:40 a.m., indicated the following:</p> <p>"POLICY [bold type]: It is the policy of the Nursing Department to monitor the resident's fluid balance in accordance with assessed needs or problems. Monitoring shall be performed ongoing to assure needs or problems are identified."</p> <p>"STANDARDS [bold type and</p>						

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	<p>underscored]: If resident does not maintain a daily average of 1500 c.c./day (unless baseline fluid need is lower per weight) when assessed in the weekly summary the resident will be monitored for signs and symptoms of dehydration, fluids will be encouraged and the doctor will be notified as needed."</p> <p>A.5. During the Exit Conference on 08-01-12 at 9:00 a.m., the Director of Nurses verified the intake and output record was a tool used to monitor the resident's food and fluids, and the total amount of fluids was documented on the daily consumption record.</p> <p>A.6. Review of the facility policy on 07-27-12 at 8:40 a.m., and titled "Physician Notification for Change in Condition," dated 06-30-05 and provided by the Director of Nurses, indicated the following:</p> <p>"Overview: These guidelines were developed to ensure that" 1. Medical care problems are communicated to the attending physician in a timely, efficient, and effective manner. 2. All significant changes in resident status are assessed and documented in the medical record. The Immediate (Acute) and Non immediate (subacute) problems listed below are not meant to be all-inclusive.</p>			

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	<p>The charge nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgement requires immediate assessment."</p> <p>Review of a subsequent facility policy also provided on 07-27-12 at 8:40 a.m., by the Director of Nurses, titled "Notification of resident change in condition policy," dated 06-20-97, indicated the following:</p> <p>"Purpose: To establish guidelines for assuring residents, their legal representatives and attending physicians are informed of resident changes in the resident's condition."</p> <p>"Responsibility: Director of Nursing, Licensed Nurses and Social Service Personnel."</p> <p>"Policy: It is the policy of Franklin United Methodist Community to promptly notify the resident, their legal representative(s) and attending physicians of changes in the resident's health condition."</p> <p>B.1. The record for Resident "F" was reviewed on 07-26-12 at 9:40 a.m. Diagnoses included but were not limited to Mild mental retardation, and</p>			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
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	<p>Alzheimer's dementia with behavior disturbances. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had severe cognitive impairment.</p> <p>Review of the Nurses notes, dated 07-01-12 at 4:59 p.m., indicated the following:</p> <p>"Res. [resident] was found with another resident, whom [sic] in a wheelchair, in a resident's room with the door shut and [Resident "F"] was undressing the resident [Resident "H"] in a wheelchair. Signee told res. ["F"] that it was inappropriate and was not suppose [sic] to undress other residents. Res. was yelling at signee and other cna's [certified nurses aides] 'You're not going to take [Resident "H"] from me !' Signee and cna's were attempting to remove both residents from the other residents room and [name of Resident "F"] was grabbing the residents wheelchair yelling '[name of Resident "H"] mine! Were not going anywhere.' Resident ["F"] began grabbing and swinging at staff yelling 'If [resident "H"] dies I'll know who killed [resident] I'm going to call the police on her [in regard to the nursing staff] !' 'Get out of here [resident "H"] is mine, you're not taking [resident "H"] away from me !"</p>			

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	<p>"07-01-12 6:34 p.m. - Signee spoke with UM [Unit Manager] on call and ADON [Assistant Director of Nurses] regarding all that was stated earlier regarding res. behavior. Signee was informed to attempt to keep residents seperated [sic]. Residents are seperated [sic] at this time."</p> <p>Review of the "Investigation" of the Incident, dated "June 2, 2012" [sic] and signed by a licensed nurse on "07-03-12, [sic]" indicated the following: "Resident ["F"] was witnessed by staff unbuttoning the shirt of ["H"] in room per [name of licensed nurse employee #16]. Residents were separated and neither seemed upset by the incident. A head to toe assessment was completed on both residents. Per interview neither resident was able to repeat what had occurred or showed any indicated of psychosocial harm. Will continue to watch residents to ensure that no side effects occur."</p> <p>During the Exit conference on 08-01-12 at 9:00 a.m., the Director of Nurses indicated an incident report was not completed and verified neither resident family members were notified of the incident.</p> <p>B.2. Review of the facility policy on 07-27-12 at 8:40 a.m., and titled</p>						

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	<p>"Physician Notification for Change in Condition," dated 06-30-05 and provided by the Director of Nurses, indicated the following:</p> <p>"Overview: These guidelines were developed to ensure that" 1. Medical care problems are communicated to the attending physician in a timely, efficient, and effective manner. 2. All significant changes in resident status are assessed and documented in the medical record. The Immediate (Acute) and Non immediate (subacute) problems listed below are not meant to be all-inclusive. The charge nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgement requires immediate assessment."</p> <p>Review of a subsequent facility policy also provided on 07-27-12 at 8:40 a.m., by the Director of Nurses, titled "Notification of resident change in condition policy," dated 06-20-97, indicated the following:</p> <p>"Purpose: To establish guidelines for assuring residents, their legal representatives and attending physicians are informed of resident changes in the resident's condition."</p>				

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	<p>"Responsibility: Director of Nursing, Licensed Nurses and Social Service Personnel."</p> <p>"Policy: It is the policy of Franklin United Methodist Community to promptly notify the resident, their legal representative(s) and attending physicians of changes in the resident's health condition."</p> <p>"Standards: 8. Resident representative(s) notifications and attempts will be made promptly and documented in the nurse's notes."</p> <p>This Federal tag relates to Complaint IN00112883.</p> <p>3.1-5(a)</p>				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview,</p>	F0225	During the complaint survey, the	08/24/2012			

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	<p>when a cognitively impaired resident displayed inappropriate actions towards another cognitively impaired resident, the facility failed to thoroughly investigate the incident and report to the state agency. This involved 1 of 3 residents reviewed for behaviors in a sample of 7 and 1 of 1 supplemental sampled residents. [Residents "F" and "H"].</p> <p>Findings include:</p> <p>The record for Resident "F" was reviewed on 07-26-12 at 9:40 a.m. Diagnoses included but were not limited to Mild mental retardation, and Alzheimer's dementia with behavior disturbances. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had severe cognitive impairment.</p> <p>Review of the Nurses notes, dated 07-01-12 at 4:59 p.m., indicated the following:</p> <p>"Res. [resident] was found with another resident, whom [sic] in a wheelchair, in a resident's room with the door shut and [Resident "F"] was undressing the resident [Resident "H"] in a wheelchair. Signee told res. ["F"] that it was inappropriate and was not suppose to</p>		<p>ISDH surveyor identified that the facility was out of compliance with the regulation of F225. This was identified by the review of one (1) resident out of seven (7) residents reviewed. Resident F displayed a "behavior" that involved yelling at staff regarding another resident, and unbuttoning a couple of the other resident's shirt buttons. This incident was not reported to state agencies. An investigation was completed but not thoroughly documented.</p> <p>1) Resident F exhibited "inappropriate" actions towards another resident in that Resident F was found in another resident's room unbuttoning the other resident's shirt. The nursing staff on this unit was educated and counseled regarding ensuring that an investigation is thoroughly documented and follow up to any incident is also thoroughly documented. Management staff has reviewed the policy and procedure on investigation and reporting any unusual occurrence.</p> <p>A) All residents have the potential to be involved in a situation where another resident displays inappropriate actions towards them. Any incident involving two residents will be thoroughly investigated and reported to the appropriate agencies as indicated. This will be monitored by nursing</p>				

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	<p>undress other residents. Res. was yelling at signee and other cna's [certified nurses aides] 'You're not going to take [Resident "H"] from me !' Signee and cna's were attempting to remove both residents from the other residents room and [name of Resident "F"] was grabbing the resident's wheelchair yelling '[name of Resident "H"] mine! Were not going anywhere.' Resident ["F"] began grabbing and swinging at staff yelling 'If [resident "H"] dies I'll know who killed [resident] I'm going to call the police on her [in regard to the nursing staff] !' 'Get out of here [resident "H"] is mine, you're not taking [resident "H"] away from me!"</p> <p>"07-01-12 6:34 p.m. - Signee spoke with UM [unit manager] on call and ADON [Assistant Director of Nurses] regarding all that was stated earlier regarding res. behavior. Signee was informed to attempt to keep residents seperated [sic]. Residents are seperated [sic] at this time."</p> <p>Interview on 07-27-12 at 1:30 p.m., the Unit Manager licensed nurse employee #9 indicated "the incident between the two residents was not reported because the staff said neither resident's complained."</p> <p>Review of the facility abuse policy on 07-26-12 at 9:00 a.m., provided by the Executive Director indicated the</p>		<p>management staff on any incident that involves a resident behavior.</p> <p>B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process for investigating and reporting any allegations of resident to resident behaviors. This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education.</p> <p>C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation.</p> <p>Substantial compliance date: August 24, 2012.</p>		

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	<p>following:</p> <p>"Abuse Policy - Purpose: To establish guidelines for assuring residents are free of all abusive acts and to establish guidelines for investigating, resolving and reporting abuse."</p> <p>"Responsibility: All Facility Employees."</p> <p>"Standards: 1. Policies and procedures for reporting and recording accidents and incidents are maintained in the Administration and Nursing Policy Manuals."</p> <p>"2. A confidential Accident/Incident Report will be used as a management tool by administration to prevent, when possible, similar occurrences and in needed, for legal defense."</p> <p>"3. Each employee is responsible for reporting to their immediate supervisor each accident/incident occurrence which has or could have resulted in injury to them. The written report shall be initiated and signed by the employee, however, the department head or Unit Manager shall be responsible for a final review, documenting all pertinent observations and information derived from the investigation and signing/dating the Accident/Incident Report upon</p>				

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	<p>completion."</p> <p>The "Investigation" of the Incident, dated "June 2, 2012" [sic] and signed by a licensed nurse on "07-03-12, [sic]" indicated the following: "Resident ["F"] was witnessed by staff unbuttoning the shirt of ["H"] in room per [name of licensed nurse employee #16]. Residents were separated and neither seemed upset by the incident. A head to toe assessment was completed on both residents. Per interview neither resident was able to repeat what had occurred or showed any indicated of psychosocial harm. Will continue to watch residents to ensure that no side effects occur."</p> <p>During the Exit conference on 08-01-12 at 9:00 a.m., the Director of Nurses verified an incident report had not been completed by the nursing staff and the above notation was the extent of an investigation.</p> <p>3.1-28(d)</p>						

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, when a cognitively impaired resident displayed inappropriate actions towards another cognitively impaired resident, the facility failed to report the incident to the State Agency in accordance with their policy. This deficient practice effected 1 of 3 resident's reviewed for behaviors in a sample of 7 and 1 of 1 supplemental sampled residents. [Residents "F" and "H"].</p> <p>Findings include:</p> <p>The record for Resident "F" was reviewed on 07-26-12 at 9:40 a.m. Diagnoses included but were not limited to Mild mental retardation, and Alzheimer dementia with behavior disturbances. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had severe cognitive impairment.</p> <p>Review of the Nurses notes, dated 07-01-12 at 4:59 p.m., indicated the</p>	F0226	<p>During the complaint survey, the ISDH surveyor identified that the facility was out of compliance with the regulation of F226. This was identified by the review of one (1) resident out of seven (7) residents reviewed. Resident F displayed a "behavior" that involved yelling at staff regarding another resident, and unbuttoning a couple of the other resident's shirt buttons. This incident was not reported to state agencies. An investigation was completed but not thoroughly documented.A) All residents have the potential to be involved in a situation where another resident displays inappropriate actions towards them. Any incident involving two residents will be thoroughly investigated and reported to the appropriate agencies as indicated. This will be monitored by nursing management staff on any incident that involves a resident behavior. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process for investigating and reporting any allegations of resident to resident behaviors. This in-servicing will</p>	08/24/2012	

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	<p>following:</p> <p>"Res. [resident] was found with another resident, whom [sic] in a wheelchair, in a resident's room with the door shut and [Resident "F"] was undressing the resident [Resident "H"] in a wheelchair. Signee told res. ["F"] that it was inappropriate and was not suppose to undress other residents. Res. was yelling at signee and other cna's [certified nurses aides] 'You're not going to take [Resident "H"] from me!' Signee and cna's were attempting to remove both residents from the other residents room and [name of Resident "F"] was grabbing the resident's wheelchair yelling '[name of Resident "H"] mine! Were not going anywhere.' Resident ["F"] began grabbing and swinging at staff yelling 'If [resident "H"] dies I'll know who killed [resident] I'm going to call the police on her [in regard to the nursing staff]!' 'Get out of here [resident "H"] is mine, you're not taking [resident "H"] away from me!"</p> <p>"07-01-12 6:34 p.m. - Signee spoke with UM [Unit Manager] on call and ADON [Assistant Director of Nurses] regarding all that was stated earlier regarding res. behavior. Signee was informed to attempt to keep residents seperated [sic]. Residents are seperated [sic] at this time."</p>		<p>be completed by August 24, 2012. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. Substantial compliance date: August 24, 2012.</p>				

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	<p>Interview on 07-27-12 at 1:30 p.m., the Unit Manager licensed nurse employee #9 indicated "the incident between the two residents was not reported because the staff said neither residents complained."</p> <p>Review of the "Investigation" of the Incident, dated "June 2, 2012" [sic] and signed by a licensed nurse on "07-03-12, [sic]" indicated the following: "Resident ["F"] was witnessed by staff unbuttoning the shirt of ["H"] in room per [name of licensed nurse employee #16]. Residents were separated and neither seemed upset by the incident. A head to toe assessment was completed on both residents. Per interview neither resident was able to repeat what had occurred or showed any indicated of psychosocial harm. Will continue to watch residents to ensure that no side effects occur."</p> <p>During the Exit conference on 08-01-12 at 9:00 a.m., the Director of Nurses indicated an incident report was not completed and verified the State Agency was not notified of the incident.</p> <p>Review of the facility abuse policy on 07-26-12 at 9:00 a.m., provided by the Executive Director indicated the following: "Abuse Policy - Purpose: To establish</p>				

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	<p>guidelines for assuring residents are free of all abusive acts and to establish guidelines for investigating, resolving and reporting abuse."</p> <p>"Responsibility: All Facility Employees."</p> <p>"Standards: 22. Facility must contact the ISDH by telephone, voice mail for incidents during business hocus, fax or via e-mail within 24 hours upon a determining a situation exists (or existed) that is reportable under these guidelines."</p> <p>3.1-28(a)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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>Based on record review and interview, the facility failed to develop a plan of care for constipation for a resident with a recent hospitalization and diagnosis of severe constipation for 1 of 3 residents reviewed for bowel elimination in a sample of 7. [Resident "B"].</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 07-25-12 at 12:30 p.m. Diagnoses included but were not limited to fractured femur, senile intermittent depressive disorder, dementia, hypertension and a</p>	F0279	During the complaint survey, the ISDH surveyor identified that the facility was out of compliance with the regulation of F279. This was identified by the review of one (1) resident out of seven (7) residents. This one resident lacked documentation to indicate that a care plan was initiated for constipation upon the return of that resident from the hospital with a new diagnosis of constipation. It is the policy and procedure of the facility to ensure each resident's care plan is current and accurate and that care plans are initiated with a new condition or diagnoses.	08/24/2012	

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	<p>history of pelvic fracture. These diagnoses remained current at the time of the record review.</p> <p>The local area hospital record, dated 07-03-12, indicated the resident "comes to the emergency room screaming and grabbing [self] complaining and has pain all over. [Resident] is holding abdomen upon admission."</p> <p>The record indicated the resident's medications information was provided by the facility to the local area hospital. Medications included but were not limited to:</p> <p>Zoloft [an antidepressant] 50 mg [milligrams] every day, Soma [a muscle relaxer] 350 mg every 6 hours, Hydrocodone [a narcotic pain medication] 0 mg 2 tablets every 4 hours, Simvastatin [a cardiac medication] 20 mg every day, Namenda [a medication for Alzheimer disease] 5 mg every day, Furosemide [a diuretic medication] 20 mg every day, and Omeprazole [an antiulcer medication] 40 mg twice a day.</p> <p>"Abdomen: Soft without masses, tenderness or evidence of hernia. "</p> <p>"[Resident] has a fair amount of stool in colon, cannot exclude [illegible word]</p>		<p>1) Resident B returned from the hospital with a new diagnosis of constipation. The facility was employing measures based on the medication administration record to prevent further constipation, although documentation of an actual care plan regarding constipation was not documented. The nursing staff on this unit was educated and counseled regarding initiating acute care plans and the nursing management staff was re-educated on ensuring that care plans for newly acquired conditions or diagnoses were initiated in a timely manner following a hospitalization or an emergency room visit.</p> <p>A) All residents have the potential to be affected by not having a care plan initiated with a new condition or diagnoses after a hospitalization or emergency room visit. Audits of any resident with a hospitalization or an emergency room visit will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter to ensure that a necessary care plan is initiated timely and appropriately.</p> <p>B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process for initiating care plans for residents with a new diagnosis or change in condition</p>		

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	<p>constipation contributes to current state."</p> <p>The hospital "preliminary report," of the Abdomen and Pelvis, dated 07-03-12, indicated 4. Moderate amount of stool: correlate for constipation."</p> <p>The Physician Progress note, dated 07-05-12, indicated the resident had "several BM's [bowel movements]."</p> <p>The hospital "Discharge Summary, dated 07-05-12, indicated the following:</p> <p>"Diagnoses" severe constipation with confusion and pain due to that." "Hospital course - CT scan showed a large amount of stool in the colon. Treatment of this with some laxatives has yielded significant benefits. [Resident] is much better today, saying [resident] is in no pain. Abdomen is soft and nontender. [Resident] is behaving much better by my evaluation, as well as from the nursing staff's evaluation. It appears that all of the potent narcotics [resident] has been receiving is likely contributing to problem here. We will have [resident] on Tramadol only for pain and stop all other potent narcotics. [Resident] probably does not need the anxiolytics, and could probably make matters worse at this point, so we will have that off for the time being and see how [resident] does.</p>		<p>following a hospitalization or an emergency room visit. This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education.</p> <p>C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation.</p> <p>D) Substantial compliance date: August 24, 2012.</p>		

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	<p>Overall, it appears that probably now that [resident] bowels are improving, if [resident] stays on a good bowel regimen, hopefully the pain and confusion will not be as bad and things will be a lot better managed."</p> <p>The Resident was discharged from the local area hospital with physician orders for Colace [a stool softener] 100 mg twice a day and Miralax 17 grams in liquid daily."</p> <p>The record lacked a plan of care to meet the elimination needs of the residents.</p> <p>During the Exit conference on 08-01-12 at 9:00 a.m., the Director of Nurses indicated she was unaware the resident had a discharge diagnosis which included severe constipation and during review of the resident's record verified a plan of care had not been developed for the resident.</p> <p>This Federal tag relates to Complaint IN00111647.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>				

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F0282 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 record review and interview, the facility failed to follow resident's plan of care, in that when residents were identified with suboptimal nutritional needs in regard to fluid intake, the nursing staff failed to follow the resident's current plan of care for 2 of 3 residents care plans reviewed for hydration needs in a sample of 7. [Resident "A" and "G"]</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 07-26-12 at 8:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, hypertension, dysphasia, depression, diabetes mellitus and gastroesophageal reflux disease. These diagnoses remained current at the time of the record review.</p> <p>The facility weight variance report, dated 07-26-12, indicated the resident's weight on 05-09-12 was 94 lbs., and 88 lbs on 07-12-12, the weight variance report also indicated the resident consumed a puree diet, health shakes three times a day, and staff needed to "encourage clear liquids."</p>	F0282	<p>During the complaint survey, the ISDH surveyor identified that the facility was out of compliance with the regulation of F282. This was identified by the review of two (2) residents out of seven (7) residents reviewed. These residents lacked documentation to indicate that the physician was notified of Resident A and Resident G not maintaining a fluid intake of 1500 cc or more as indicated by the care plan for hydration for both of these residents. It is the policy and procedure of the facility to ensure that each resident's care plan is followed as documented. Although nursing staff had been notifying the physician of any and all resident's statuses the clinical record lacked documentation to support this. 1) Resident A and Resident G both had documented that they did not consume 1500 cc or above of fluids daily as was recommended in each of their care plans for hydration for the week prior to the complaint investigation. No documentation was available in the clinical record to indicate the physician was notified of either Resident A or Resident G's lack of fluid intake as indicated on the care plan.</p>	08/24/2012			

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	<p>Fluid consumption for a resident with a weight of 94 lbs, required 1,281 ml [milliliters] of fluid daily, while a resident with a weight of 88 lbs. required 1200 ml of fluid daily.</p> <p>The resident's current plan of care, dated 07-17-12, indicated the resident had a "deficit r/t [related to] decreased fluid intake." The "measurable goal" indicated the "res. [resident] will maintain moist mucous membranes by staff encouraging res. to consume at least 1500 ml daily." Approaches to this plan of care prompted the nursing staff to "notify the MD [Medical Doctor] as needed."</p> <p>The facility "Meal Consumption" records were reviewed and indicated the following daily fluid consumption [total fluids] for the resident:</p> <p>07-13-12 - 300 c.c. [cubic centimeters] 07-14-12 - 910 c.c. 07-15-12 - 600 c.c. 07-16-12 - 240 c.c. 07-17-12 - 540 c.c. 07-18-12 - 300 c.c. 07-19-12 - 420 c.c. 07-20-12 - 100 c.c. prior to being transported to the local area hospital per the family's request.</p>		<p>The nursing staff on this unit was educated and counseled regarding following each resident's care plan for hydration and notifying the physician as indicated on the care plan. A) All residents with a care plan for hydration have the potential to be affected by the physician not being notified of lack of fluid intake. Monitoring of nursing documentation of notifying the physician of any residents with a hydration care plan that does not maintain their fluid intake goals will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter to ensure each resident's physician is notified of any and all changes or declines with residents in a timely manner. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process for physician notification and for ensuring each resident's plan of care is followed for residents with care plans for hydration. This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. D) Substantial compliance date:</p>		

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	<p>The record, reviewed from 07-13-12 through 07-20-12, indicated the resident refused meal and fluid consumption on the following dates and meals:</p> <p>07-13-12 Dinner - refused fluids Miscellaneous fluids - refused on night shift</p> <p>07-15-12 Breakfast - refused fluids Dinner - refused fluids</p> <p>07-16-12 Breakfast - refused fluids Lunch - refused fluids Dinner - refused fluids</p> <p>07-17-12 Lunch - refused fluids Dinner - refused fluids Miscellaneous - refused fluids on the evening shift</p> <p>07-18-12 Lunch - refused fluids Dinner - refused fluids Miscellaneous - refused fluids on the night shift</p> <p>07-19-12 Breakfast - refused fluids Dinner - refused fluids</p> <p>07-20-12 Breakfast - refused fluids Lunch - refused fluids Dinner - refused fluids Miscellaneous - refused fluids on the night shift</p>		August 24, 2012.				

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	<p>The record indicated the resident's family member's visited with the resident on 07-20-12 at 4:30 p.m., and "asked signee to call family doctor and get an order to send res. to [name of local area hospital] to be evaluated. Res. family states "we would like [resident] to be on IV [intravenous fluids] for dehydration."</p> <p>The hospital notation, dated 07-20-12 [nurses notes], indicated, "[Family member] states pt. [patient] last few days more listless and not eating. [Family member] came from [another State] to have [resident] checked out." The "general assessment" indicated the resident "appears frail, behavior is listless" and "level of consciousness is obtunded." The emergency room physician ordered testing to include a basic metabolic profile, complete blood count as well as a urinalysis. In addition, the physician ordered the administration of 1000 ml of 0.9 % of normal saline.</p> <p>Review of Nurses Notes, dated 07-21-12, after the resident returned from the hospital visit indicated, "[Family member] states has some concerns [family member] would like to discuss. [Family members] have contacted hospice to come out and admit resident this afternoon. [Family member] states per</p>			

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	<p>family request, may do necessary labs and catheterize for U/A's [urinalysis]as needed" ... "may treat infections and dehydration per family request. and also states hospice stated they will able [sic] to send resident out to ER [emergency room] for fluids as needed d/t [due to] dehydration for comfort measures. Signee reminded [family member] that "sedation" during visit of past 24 hours could be related to dehydration and it may take resident more that just a day to "be back up to par."</p> <p>Interview on 07-27-12 at 1:30 p.m., the Unit Manager Licensed Nurse employee #9 indicated the resident had "all kinds of things to eat and drink in [resident] room." When further interviewed the Unit Manager Licensed Nurse confirmed the resident was unable to request the items and the staff wound need to "assist [name of resident]."</p> <p>The record lacked documentation the resident's physician was notified of the resident's decline in the consumption of fluids as an intervention noted in the resident's plan of care.</p> <p>2. The record for Resident "G" was reviewed on 07-26-12 at 9:10 a.m. Diagnoses included but not limited to senile dementia, macular degeneration,</p>						

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	<p>hypertension, and degenerative joint disease. These diagnoses remained current at the time of the record review.</p> <p>The resident's current plan of care, dated 05-22-12, indicated the resident had the "Potential for fluid volume defecit [sic] r/t decreased fluid intake." The "measurable goal" included the resident will "maintain most [sic] mucous membranes by staff encouraging fluid intake of 1500 mg daily times 90 days." An approach to this plan of care included "Notify MD as needed."</p> <p>The facility "Weight Variance report," dated 07-26-12, indicated the resident received a pureed diet with whole milk and Two Cal. [a supplement] 90 ml three times a day. In addition, the resident's weight was recorded at 142.5 lbs in 01-09-12, with a current weight of 130.5 lbs on 07-09-12 - a loss of 12 lbs.</p> <p>The report indicated the resident weighed 130.5 lbs on 07-09-12, which required a fluid intake of 1779 c.c. daily.</p> <p>The "Meal Consumption Record," indicated the following fluid intakes for the resident.</p> <p>07-13-12 - 750 c.c. 07-14-12 - 1220 c.c. 07-15-12 - 1230 c.c.</p>						

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	<p>07-16-12 - 990 c.c. 07-17-12 - 1290 c.c. 07-18-12 - 1210 c.c. 07-19-12 - 660 c.c. 07-20-12 - 1250 c.c.</p> <p>During the Exit Conference on 08-01-12 at 9:00 a.m., the Director of Nurses verified the intake and output record was a tool used to monitor the resident's food and fluids, and the total amount of fluids was documented on the daily consumption record.</p> <p>This Federal tag relates to Complaint IN00112883.</p> <p>3.1-35(g)(2)</p>			

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F0327 SS=G	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview, the facility failed to ensure residents received adequate hydration needs, in that when cognitively impaired residents were identified with suboptimal nutritional needs, the nursing staff failed to provide adequate fluid intake which resulted in one resident's transportation to a local area hospital to be evaluated and treated which included intravenous therapy for 2 of 3 cognitively impaired residents reviewed for hydration needs in a sample of 7. [Resident's "A" and "G"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 07-26-12 at 8:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, hypertension, dysphasia, depression, diabetes mellitus and gastroesophageal reflux disease. These diagnoses remained current at the time of the record review.</p> <p>The facility weight variance report, dated 07-26-12, indicated the resident's weight on 05-09-12 was 94 lbs., and 88 lbs on 07-12-12, the weight variance report also</p>	F0327	<p>During the complaint survey, the ISDH surveyor identified that the facility was out of compliance with the regulation of F327. This was identified by the review of two (2) residents out of seven (7) residents. These residents lacked documentation to indicate that each was monitored and assessed to ensure their hydration needs were being addressed. It is the policy and procedure of the facility to ensure that each resident receives proper hydration. 1) Resident A resides on the end stage dementia unit. It was identified and care planned that the resident was extremely resistant to care and that they were at risk for insufficient fluid intake. Although staff was aware, encouraging fluid consumption, and monitoring the resident's consumption and fluid intake, documentation was lacking to indicate the physician was notified about Resident A's lower than required fluid intake. The nursing staff on this unit was educated and counseled regarding following the policy and procedure on physician notification. A) All residents have the potential to be affected by insufficient fluid intake. Audits of the Meal</p>	08/24/2012	

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	<p>indicated the resident consumed a puree diet, health shakes three times a day, and staff needed to "encourage clear liquids."</p> <p>Fluid consumption for a resident with a weight of 94 lbs, required 1,281 ml [milliliters] of fluid daily, while a resident with a weight of 88 lbs. required 1200 ml of fluid daily.</p> <p>The resident's current plan of care, dated 07-17-12, indicated the resident had a "deficit r/t [related to] decreased fluid intake." The "measurable goal" indicated the "res. [resident] will maintain moist mucous membranes by staff encouraging res. to consume at least 1500 ml daily." Approaches to this plan of care prompted the nursing staff to "notify the MD [Medical Doctor] as needed."</p> <p>The facility "Meal Consumption" records were reviewed and indicated the following daily fluid consumption [total fluids] for the resident:</p> <p>07-13-12 - 300 c.c. [cubic centimeters] 07-14-12 - 910 c.c. 07-15-12 - 600 c.c. 07-16-12 - 240 c.c. 07-17-12 - 540 c.c. 07-18-12 - 300 c.c. 07-19-12 - 420 c.c. 07-20-12 - 100 c.c. prior to being</p>		<p>Consumption Sheet will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter to ensure that any resident with inadequate fluid consumption is being properly assessed, monitored, and that the family and physician are being notified. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the policy and procedure for hydration and physician notification is being followed. This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. D) The facility policy and procedure for hydration was re-assessed and in future will include notifying the physician of any resident who is below their recommended fluid requirements after a three day period. The facility is also adding a Dehydration Risk Assessment to the assessment process. This assessment will be completed on admission and with any full MDS assessment. E) Substantial compliance date: August 24, 2012. 2) Resident G's documentation in the clinical record indicated they were not</p>		

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	<p>transported to the local area hospital per the family's request.</p> <p>The record, reviewed from 07-13-12 through 07-20-12, indicated the resident refused fluid consumption on the following dates:</p> <p>07-13-12 Dinner - refused fluids Miscellaneous fluids - refused on night shift</p> <p>07-15-12 Breakfast - refused fluids Dinner - refused fluids</p> <p>07-16-12 Breakfast - refused fluids Lunch - refused fluids Dinner - refused fluids</p> <p>07-17-12 Lunch - refused fluids Dinner - refused fluids Miscellaneous - refused fluids on the evening shift</p> <p>07-18-12 Lunch - refused fluids Dinner - refused fluids Miscellaneous - refused fluids on the night shift</p> <p>07-19-12 Breakfast - refused fluids Dinner - refused fluids</p> <p>07-20-12 Breakfast - refused fluids Lunch - refused fluids</p>		<p>receiving the recommended daily fluid requirements. Although staff was aware, encouraging fluid consumption, and monitoring the resident's consumption and fluid intake, documentation was lacking to indicate the physician was notified about Resident G's lower than required fluid intake. The nursing staff on this unit was educated and counseled regarding following the policy and procedure on physician notification. A) All residents have the potential to be affected by insufficient fluid intake. Audits of the Meal Consumption Sheet will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter to ensure that any resident with inadequate fluid consumption is being properly assessed, monitored, and that the family and physician are being notified. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring that the policy and procedure for hydration and physician notification is being followed. This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data</p>		

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	<p>Dinner - refused fluids Miscellaneous - refused fluids on the night shift</p> <p>The record lacked documentation the resident's physician was notified of the resident's decline in the consumption of fluids.</p> <p>The record indicated the resident's family member's visited with the resident on 07-20-12 at 4:30 p.m., and "asked signee to call family doctor and get an order to send res. to [name of local area hospital] to be evaluated. Res. family states "we would like [resident] to be on IV [intravenous fluids] for dehydration."</p> <p>The hospital notation, dated 07-20-12 [nurses notes], indicated, "[Family member] states pt. [patient] last few days more listless and not eating. [Family member] came from [another State] to have [resident] checked out." The "general assessment" indicated the resident "appears frail, behavior is listless" and "level of consciousness is obtunded." The emergency room physician ordered testing to include a basic metabolic profile, complete blood count as well as a urinalysis. In addition, the physician ordered the administration of 1000 ml of 0.9 % of normal saline.</p>		<p>presentation. D) The facility policy and procedure for hydration was re-assessed and in future will include notifying the physician of any resident who is below their recommended fluid requirements after a three day period. The facility is also adding a Dehydration Risk Assessment to the assessment process. This assessment will be completed on admission and with any full MDS assessment. E) Substantial compliance date: August 24, 2012.</p>				

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	<p>The laboratory test, basic metabolic profile, indicated the resident's BUN [blood urea nitrogen - a test to check hydration] was 52 with a normal range of 7 - 18 mg [milligrams] per dl [deciliter], and a complete blood count which indicated the resident's hematocrit was 50 with a normal range of 33 - 45 %. The urinalysis indicated the resident's urine was "cloudy with mucous and bacteria present."</p> <p>The hospital discharge instructions identified the resident with a Urinary Tract Infection and Dehydration."</p> <p>Review of the Social Service notations, dated 07-20-12 at 12:30 p.m., indicated the family member voiced concern in regard to the resident's decline in condition. "[Name of family member] ... was shocked to see [resident] decline in a little over three months, ... obvious weight loss." The notation indicated the Unit Manager Licensed Nurse employee #9 "informed that weights are taken monthly which [family member] found to be disturbing." The Unit Manager Licensed Nurse employee #9 "explained that the Unit ASCU [advanced special care unit] is a Unit for individual with advanced Alzheimers/Dementia. With that comes anticipated weight loss although we do everything we can to prevent such."</p>						

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	<p>[Family member] commented "well obviously you have not." The Unit Manager Licensed Nurse employee #9 explained that there are snacks and drinks offered daily in between meals, but that it comes back to getting [name of resident] to do it. "[Resident] often clamps mouth shut or will display physical abuse." [Family member] "moved to the edge of seat and told [name of Unit Manager] that she needed to be very careful on her choice of terminology, and informed her [family member] would call it 'fear.'" [Family member] informed that in regards to [resident] eating and drinking that what ever is being tried is not obviously working." The Unit Manager "informed that we want [resident] and mobile [sic] to assist in preventing further skin breakdown" and "this is possible due to the level of nutrition and hydration. This is also another potential from the natural progressin [sic] of the disease."</p> <p>Review of Nurses Notes, dated 07-21-12, after the resident returned from the hospital visit indicated, "[Family member] states has some concerns [family member] would like to discuss. [Family members] have contacted hospice to come out and admit resident this afternoon. [Family member] states per family request, may do necessary labs and catheterize for U/A's [urinalysis]as</p>			

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	<p>needed" ... "may treat infections and dehydration per family request. and also states hospice stated they will able [sic] to send resident out to ER [emergency room] for fluids as needed d/t [due to] dehydration for comfort measures. Signee reminded [family member] that "sedation" during visit of past 24 hours could be related to dehydration and it may take resident more that just a day to "be back up to par."</p> <p>Interview on 07-27-12 at 1:30 p.m., the Unit Manager Licensed Nurse employee #9 indicated the resident had "all kinds of things to eat and drink in [resident] room." When further interviewed the Unit Manager Licensed Nurse confirmed the resident was unable to request the items and the staff would need to "assist [name of resident]."</p> <p>2. The record for Resident "G" was reviewed on 07-26-12 at 9:10 a.m. Diagnoses included but not limited to senile dementia, macular degeneration, hypertension, and degenerative joint disease. These diagnoses remained current at the time of the record review.</p> <p>The resident's current plan of care, dated 05-22-12, indicated the resident had the "Potential for fluid volume defecit [sic] r/t</p>						

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	<p>decreased fluid intake." The "measurable goal" included the resident will "maintain most [sic] mucous membranes by staff encouraging fluid intake of 1500 mg daily times 90 days." An approach to this plan of care included "Notify MD as needed."</p> <p>The facility "Weight Variance report," dated 07-26-12, indicated the resident received a pureed diet with whole milk and Two Cal. [a supplement] 90 ml three times a day.</p> <p>The report indicated the resident weighed 130.5 lbs on 07-09-12, which required a fluid intake of 1779 c.c. daily.</p> <p>The "Meal Consumption Record," indicated the following fluid intakes for the resident.</p> <p>07-13-12 - 750 c.c. 07-14-12 - 1220 c.c. 07-15-12 - 1230 c.c. 07-16-12 - 990 c.c. 07-17-12 - 1290 c.c. 07-18-12 - 1210 c.c. 07-19-12 - 660 c.c. 07-20-12 - 1250 c.c.</p> <p>3. The facility policy titled "Hydration Monitoring," provided by the Director of Nurses, dated as "revised 04-27-05, and reviewed on 07-27-12 at 8:40 a.m.,</p>			

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	<p>indicated the following:</p> <p>"POLICY [bold type]: It is the policy of the Nursing Department to monitor the resident's fluid balance in accordance with assessed needs or problems. Monitoring shall be performed ongoing to assure needs or problems are identified."</p> <p>"STANDARDS [bold type and underscored]: If resident does not maintain a daily average of 1500 c.c./day (unless baseline fluid need is lower per weight) when assessed in the weekly summary the resident will be monitored for signs and symptoms of dehydration, fluids will be encouraged and the doctor will be notified as needed."</p> <p>During the Exit Conference on 08-01-12 at 9:00 a.m., the Director of Nurses verified the intake and output record was a tool used to monitor the resident's food and fluids, and the total amount of fluids was documented on the daily consumption record.</p> <p>This Federal tag relates to Complaint IN00112883.</p> <p>3.1-46(b)</p>						

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F0329 SS=G	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <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>Based on record review and interview, the facility failed to monitor a resident for adverse affects (constipation) when a resident had physician orders for multiple medications with constipation implicated as an adverse consequence. This resulted in the resident being transported to the local area hospital for evaluation, intervention and treatment for 1 of 3 residents sampled for elimination needs in a sample of 7. [Resident "B"].</p> <p>Findings include:</p>	F0329	During the complaint survey, the ISDH surveyor identified that the facility was out of compliance with the regulation of F329. This was identified by the review of one (1) resident out of seven (7) residents. This one resident lacked documentation to indicate that the facility was monitoring for adverse consequences to medication usage specifically narcotics. It is the policy and procedure of the facility to ensure each resident receives medication and treatments per physician's orders and that an	08/24/2012			

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	<p>1. The record for Resident "B" was reviewed on 07-25-12 at 12:30 p.m. Diagnoses included but were not limited to fractured femur, senile intermittent depressive disorder, dementia, hypertension and a history of pelvic fracture. These diagnoses remained current at the time of the record review.</p> <p>The local area hospital record, dated 07-03-12, indicated the resident "comes to the emergency room screaming and grabbing [self] complaining and has pain all over. [Resident] is holding abdomen upon admission."</p> <p>The record indicated the resident's medications information was provided by the facility to the local area hospital. Medications included but were not limited to the following:</p> <p>Zoloft [an antidepressant] 50 mg [milligrams] every day; Soma [a muscle relaxer] 350 mg every 6 hours; Hydrocodone [a narcotic pain medication] 10 mg, 2 tablets every 4 hours; Simvastatin [a cardiac medication] 20 mg every day; Namenda [a medication for Alzheimer disease] 5 mg every day; Furosemide [a diuretic medication] 20 mg every day, and Omeprazole [an antiulcer medication] 40 mg twice a day.</p>		<p>assessment for any adverse reactions is documented in the medical record. 1) Resident B was documented as having a bowel movement routinely between the dates of review (June 27, 2012 - July 3, 2012). However, per the policy and procedure, when Resident B was sent to the emergency department for abdominal pain, no assessment of the abdomen was completed to indicate an adverse consequence. A) All residents have the potential to be affected by not having a documented assessment in the clinical record. Audits of the nurses' notes with any resident having new onset pain or symptoms to ensure an assessment is documented will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter to ensure residents with complaints of any symptoms are assessed and that it is documented in the medical record. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process for assessing and documenting that assessment for residents with any complaints of a new onset of pain, symptom, etc.... This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be</p>				

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	<p>"Abdomen: Soft without masses, tenderness or evidence of hernia. "</p> <p>"[Resident] has a fair amount of stool in colon, cannot exclude [illegible word] constipation contributes to current state."</p> <p>The hospital "preliminary report," of the Abdomen and Pelvis, dated 07-03-12, indicated 4. Moderate amount of stool: correlate for constipation."</p> <p>The Physician Progress note, dated 07-05-12, indicated the resident had "several BM's [bowel movements]."</p> <p>The hospital "Discharge Summary dated 07-05-12, indicated the following:</p> <p>"Diagnoses" severe constipation with confusion and pain due to that." "Hospital course CT scan showed a large amount of stool in the colon. Treatment of this with some laxatives has yielded significant benefits. [Resident] is much better today, saying [resident] is in no pain. Abdomen is soft and nontender. [Resident] is behaving much better by my evaluation, as well as from the nursing staff's evaluation. It appears that all of the potent narcotics [resident] has been receiving is likely contributing to problem here. We will have [resident] on</p>		<p>reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. D) Substantial compliance date: August 24, 2012. Additional Plan of Correction response in regards to correspondence request from ISDH dated August 23, 2012: All residents in the comprehensive unit with risk for dehydration, weight loss and any acute medical changes were reviewed and had their care plans updated or initiated as necessary. Their physicians will be made aware of any issues necessary. Date Certain remains August 24, 2012.</p>	

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	<p>Tramadol only for pain and stop all other potent narcotics. [Resident] probably does not need the anxiolytics, and could probably make matters worse at this point, so we will have that off for the time being and see how [resident] does. Overall, it appears that probably now that [resident] bowels are improving, if [resident] stays on a good bowel regimen, hopefully the pain and confusion will not be as bad and things will be a lot better managed."</p> <p>The Resident was discharged from the local area hospital with physician orders for Colace [a stool softener] 100 mg twice a day and Miralax 17 grams in liquid daily."</p> <p>3. The facility "Elimination Procedure," dated 03-29-05 and reviewed on 07-27-12 at 8:40 a.m., and provided by the Director of Nurses indicated the following:</p> <p>"Purpose: To assure residents have regular elimination of the bowel preventing problems related to constipation."</p> <p>"Policy: 4. Resident's with no BM [bowel movement] or small BM in past 3 days will receive the following: a. Initiate BM tracking using appropriate form, b. Assess bowel sounds &</p>			

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	<p>abdomen, c. 120 c.c. prune juice with supper, d. PRN [as needed] laxative if available, e. Document findings & interventions in the nurses notes."</p> <p>4. The Resident's bowel movement record were requested and provided on 08-01-12 at 9:00 a.m. The record, dated 06-27-12 thru 07-04-12, indicated the resident had three soft medium bowel movements on 06-27-12, three soft medium bowel movements on 06-28-12, one soft medium bowel movement on 06-29-12, a small soft bowel movement on 06-30-12, one soft large bowel movement on 07-01-12, and one soft medium bowel movement on 07-03-12.</p> <p>5. The nurses notes, dated 07-03-12 [no time documented], indicated "woke up at 6:30 crying. Family heard [resident] over the phone et [and] care [sic] in to see [resident}. Family wanted [resident] evaluated et treated because [resident] was not responding to them, [resident] just kept crying. Notified doctor of family concerns et received order to send to [name of local area hospital]."</p> <p>6. The facility policy reviewed on 07-27-12 at 8:40 a.m., titled "Assessment," and dated 05-20-05, indicated, PURPOSE: To gather comprehensive</p>			

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	<p>information as a basis for identifying resident problems/needs and developing or revising an individual plan of care."</p> <p>"STANDARDS: 1. Assessment process should include: a. observations, b. interview, c. palpation, d. auscultation and e. documentation."</p> <p>The nurses notes lacked documentation of a full assessment of the resident prior to the transport of the resident to the local area hospital for evaluation and treatment.</p> <p>During the Exit conference on 08-01-12 at 9:00 a.m., the Director of Nurses indicated the documentation of the resident's bowel movement, "I know [resident] had diarrhea stool during this period."</p> <p>This Federal tag relates to Complaint IN00111647.</p> <p>3.1-48(a)(5)</p>				

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F0514 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 record review and interview, the facility failed to ensure complete and accurate clinical records for 3 of 7 sampled residents. [Residents "A", "G" and "E"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 07-26-12 at 8:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, hypertension, dysphasia, depression, diabetes mellitus and gastroesophageal reflux disease. These diagnoses remained current at the time of the record review.</p> <p>The resident's weight variance report indicated the resident weighed 94 lbs on 05-09-12 which required 1,281 ml</p>	F0514	<p>During the complaint survey, the ISDH surveyor identified that the facility was out of compliance with the regulation of F514. This was identified by the review of three (3) residents out of seven (7) residents. It is the policy and procedure of the facility to ensure that accurate and complete documentation is available in the medical record. 1) Resident A, Resident G, and Resident E all lacked documentation of their fluid "total" intake for the day being completed as was indicated to be completed on the "Meal Consumption Form" in that the total fluid consumption for the twenty-four hour period was not documented. A) All residents have the potential to be affected by having their meal consumption form incompletely filled out and documented on. Monthly audits of the Fluid Consumption Form</p>	08/24/2012			

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	<p>[milliliters] of fluid daily, and a weight documented on 07-12-12 indicated the resident weighed 88 lbs which required 1,200 ml of fluid daily.</p> <p>The resident had an "Intake and Output Record" established. The record included fluid totals per shift but lacked documentation of "total intake" over a 24 hour period on the following dates:</p> <p>April 26, 28, 30 and 31, 2012.</p> <p>May 2, 3, 4, 6, 7, 12, 13, 14, 16, 17, 19, 23, 25, 26, 27, 29, 30 and 31, 2012</p> <p>June 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 25, 26, 27, 28, 29, 30 and 31, 2012.</p> <p>July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20,21, 22, 23, 24, and 25.</p> <p>2. The record for Resident "G" was reviewed on 07-26-12 at 9:10 a.m. Diagnoses included but not limited to senile dementia, macular degeneration, hypertension, and degenerative joint disease. These diagnoses remained current at the time of the record review.</p> <p>The weight variance report indicated the resident weighed 130.5 lbs on 07-09-12, which required a fluid intake of 1779 c.c.</p>		<p>will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter to ensure that the forms are accurately and thoroughly completed and documented. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process for completing the Meal Consumption Form. This in-servicing will be completed by August 24, 2012. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. D) Substantial compliance date: August 24, 2012.</p>				

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	<p>daily.</p> <p>The record included fluid totals per shift but lacked documentation of "total intake" over a 24 hour period on the following dates:</p> <p>April 2, 6, 8, 9, 10, 11, 14, 15, 16, 20, 21, 22, 23, and 30, 2012.</p> <p>May 2, 3, 4,6, 7, 12, 13, 14, 16, 17, 19, 23, 25, 27, 29, and 30, 2012.</p> <p>June 1, 2, 3,4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, and 29, 2012.</p> <p>July 1, 2, 3, 4, 7, 8, 9, 11, 12, 21, 22, 23, 24, 25, and 27, 2012.</p> <p>The fluid totals for each shift differed on the following dates in comparison to the "total fluids" on the meal consumption record:</p> <p>July 13, 2012 indicated the resident consumed 1050 c.c.; July 14, 2012 indicated the resident consumed 1250 c.c.; July 16, 2012 indicated the resident consumed 1410 c.c.; July 17, 2012 the resident consumed 1170 c.c., July 18, 2012 the resident consumed 1080 c.c.; July 19, 2012 the resident consumed 840 c.c., and July 20, 2012 the resident</p>						

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	<p>consumed 1350 c.c.,</p> <p>The "Meal Consumption Record," indicated the following fluid intakes for the resident.</p> <p>July 13, 2012 - 750 c.c. July 14, 2012 - 1220 c.c. July 15, 2012 - 1230 c.c. July 16, 2012 - 990 c.c. July 17, 2012 - 1290 c.c. July 18, 2012 - 1210 c.c. July 19, 2012 - 660 c.c. July 20, 2012 - 1250 c.c.</p> <p>The record lacked verified and accurate documentation the resident's fluid consumption.</p> <p>3. The record for Resident "E" was reviewed on 07-26-12 at 10:10 a.m. Diagnoses included but were not limited to cerebral vascular accident, hemiplegia, atrial fibrillation and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The record included fluid totals per shift but lacked documentation of "total intake" over a 24 hour period on the following dates:</p> <p>May 2, 3, 4, 6, 7, 12, 13, 14, 16, 17, 19, 21, 23, 25, 26, 27, 29, 30 and 31, 2012.</p>				

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	<p>June 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 24, 25, 26, 27, 28, 29, and 30, 2012</p> <p>During the Exit Conference on 08-01-12 at 9:00 a.m., the Director of Nurses verified the intake and output record was a tool used to monitor the resident's food and fluids, and the total amount of fluids was documented on the daily consumption record.</p> <p>This Federal tag relates to Complaint IN00112883.</p> <p>3.1-50(1) 3.1-50(2)</p>				