

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2013
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an immediate jeopardy. This visit included the investigation of Complaint #IN00126085.</p> <p>Complaint number IN00126085 - Substantiated. Federal/State deficiencies related to allegation are cited at F279, F280 and F327.</p> <p>Survey dates: 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/22, 4/23, 4/24, 2013.</p> <p>Facility number: 000034 Provider number: 155086 AIM number: 100274880</p> <p>Survey Team: Lora Swanson, RN - TC (04 /15, 04/16, 04/17, 04/18, 04/19, 04/22, 04/23, and 04/24, 2013) Julie Wagoner, RN Deb Kammeyer, RN (04 /15, 04/16, 04/17, 04/18, 04/19, 04/22, 04/23, and 04/24, 2013)</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor type: Medicare: 10</p>	F000000		

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>Medicaid: 44 Other: 3 Total: 57</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 4, 2013, by Brenda Meredith, R.N.</p>						

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F000225 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</p>	F000225	F225 483.13(c) (1) (ii)-(iii), (c) (2)	05/24/2013			

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	<p>interview, the facility failed to ensure an allegation of abuse and misappropriation of resident property was reported timely to the Administrator and thoroughly investigated. This affected 1 of 4 residents reviewed who made allegations of abuse. (Resident D)</p> <p>Findings include:</p> <p>1. Interview with alert and oriented, Resident D, on 04/16/13 at 9:30 A.M., indicated CNA #17 was really rude to the resident and her roommate. She indicated CNA #17 had also tried to "steal" a bottle of Pepsi from her roommate. She indicated when he confronted CNA #17 regarding the Pepsi, the CNA became very rude, intrusive to Resident D and her roommate's conversations, and did not treat Resident D with any respect for the rest of the evening. She indicated this had all occurred on the evening of 04/15/13, around the evening meal time. Resident D indicated LPN #8, who was working at the time, was aware of the issue but she had told Resident D.</p> <p>Interview with Resident #18, on 04/18/13 at 12:40 P.M., indicated the resident, on Monday evening, 04/15/13, told the LPN #8 about what</p>		<p>- (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>Woodland Manor is committed to ensuring all allegations of mistreatment are reported timely to the Administrator and the Department and are thoroughly investigated.</p> <p>I. The allegation of misappropriation was reported to the Administrator and was thoroughly investigated. LPN # 18 and ADON were provided with 1:1 education regarding abuse allegation reporting. C.N.A. #17 was provided with 1:1 reeducation on abuse prohibition and customer service. C.N.A. #18 was provided with reeducation on abuse prohibition.</p> <p>II. All interviewable Residents were interviewed to identify any outstanding allegations of mistreatment. All non-interviewable Residents were assessed for signs or symptoms of mistreatment.</p> <p>III. The facility's Abuse Prevention Policy was reviewed and revised to include checklists to guide the facility through the proper actions, investigatory process and reporting process. All staff members will be reeducated on the Abuse Prevention Policy. This education will include but will not be limited to; recognizing abuse allegations, reporting abuse allegations and the investigatory process for</p>	

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	<p>she had said to the CNA #17, what had went on, and told the nurse now she (CNA #17) is "going off." The nurse told the Resident "I'm going to stay out of it because I wasn't there for either side." Resident #18 indicated she though LPN #8 had called LPN #8, the ADON (Assistant Director of Nursing). She indicated the next day after the incident, I think in the afternoon, I talked with the DON (Director of Nursing). I told her the whole story and then told her how CNA#17 kept coming back in our room, interrupting my conversation with my roommate, and how angry she (CNA #17) got. Resident D indicated the Social Service Director, employee #13 had not spoken with her about the issue between herself, her roommate, and CNA #17.</p> <p>Interview with LPN #8, on 04/18/13 at 2:00 P.M., indicated on Monday evening (04/15/13) after supper, Resident D and Resident #57 were in the hallway having a private conversation. CNA #17 came up to LPN #8 and told her "Well they're discussing me." Resident D saw CNA #18 talking to me and she came to me and said, "Well she know what she done" and "She had no business saying what she said to her (Resident #57)." LPN #8 indicated she asked</p>		<p>abuse allegations.</p> <p>IV. In addition to the process noted above, the SSD or her designee will interview Residents using the Resident Interview and Observation Form (CMS-20050) Section G no less often than quarterly during the assessment reference period according to the RAI schedule. Interviews will continue according to RAI schedule until 100% compliance is met for a full quarter. Results will be presented in Quality Assurance Meeting monthly.</p>				

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	<p>Resident D to clarify what did she say and resident stated, "It doesn't matter she knows what she said." LPN #8 indicated "There was something else going on, CNA #17 and Resident D had words back and forth, CNA #17 was arguing with Resident D, so I separated them. CNA #17 was not assigned to that room (Resident D and Resident #57's) but was assigned to deliver hall trays to both units and Resident #57 eats in her room. I think CNA #17 called the DON or the ADON, LPN #18, because the ADON called back and asked me about it. The ADON told me to make sure CNA #17 stayed on unit 1 where they (CNA #17 and Resident D) wouldn't cross paths again. After I spoke with CNA #17, Resident D was following me and was confrontational (verbally) and I advised Resident D to stay out of CNA #17's way so she didn't have to run into her. LPN #8 went on to say, Resident D is sometimes attention seeking if there's nothing being done she tries to be demanding and the "enforcer." I try to use a calm approach, ask what I can do for her, tell her she's "right." LPN #8 denied telling Resident D she did not want to get involved. LPN #8 indicated because she was the charge nurse at the time she was already involved.</p>			

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	<p>LPN #8 indicated she was in the dining room when CNA #18 was evidently observed by Resident #57 getting into the her personal belongings to get a pop (Pepsi) and when resident #57 said "what are you doing in my things," CNA #18 said, "I'm getting the pop you said I could have," and then, when Resident #57 said, "No," CNA #18 left the room without taking the pop.</p> <p>The Director of Nursing was interviewed on 04/18/13 at 10:00 A.M. The DON indicated around 9:30 A.M. on 04/16/13, she found a note from CNA #18 in her mailbox after the morning meeting. She indicated on 04/16/13, at around 11:30 A.M., Resident D came to my office, right before lunch, and said, "I guess you've already heard about me." I told her no not specifically, and she said "I called State on you guys last night." I told her that was her right and she said, "I wanted to give you my side of the story." I asked her to tell me her side of the story. She said the incident with CNA #18 asking Resident #57 for a Pepsi. She said CNA #18 was passing meal trays and later on CNA #18 came back into room to pick up trays, Resident #57 was coming out of the bathroom, and saw CNA #18 bent over and Resident</p>			

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	<p>#57 asked CNA #18 "what are you doing?" And CNA #18 said tying my shoe. Resident D said she was in the room in the corner and CNA #18 did not see her. I reassured her that she had every right to call state. The DON indicated Resident D did not tell her that CNA #18 got angry with her. She indicated that was the extent of the conversation. She indicated she spoke to Resident #57 about 35 minutes later and she basically told me the same story Resident D had told me. I asked Resident #57 if CNA #18 had ended up taking her Pepsi and she indicated "No, she stopped and said she was just tying her shoe."</p> <p>The DON indicated she informed the Administrator about the issue around noon on 04/16/13. She indicated she had already told SSD (Social Service Director), Employee #13 about this and when she went to tell Administrator about the incident, the SSD was already telling her about it.</p> <p>Interview with the ADON, on 04/18/13 at 2:45 P.M., indicated on Monday evening, 04/15/13, CNA #18 called her and left a message on her phone. She indicated she called back and spoke to LPN #8. She indicated LPN #8 told her that Resident D had stated CNA #18 was trying to steal a pop</p>						

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	<p>and that LPN #8 had talked to CNA #18 and they were saying that wasn't true. The ADON indicated she told both LPN #8 and CNA #18 to write up a statement. LPN #8 indicated she would make sure there was minimum interaction between CNA #18 and Resident D. The ADON agreed. The ADON indicated LPN #8 did not indicate the two, CNA #18 and Resident D were arguing. My understanding is it was a misunderstanding about a pop. ADON indicated if a CNA had stolen a resident's pop it would be a form of abuse. ADON did not view this as an abuse allegation because the two staff members via the phone told her this was not true. ADON indicated her responsibility regarding an allegation of abuse involving an employee was to ensure the accused staff member left the building, ensure the resident's safety, and immediately notify the DON and the Administrator. The ADON indicated she was getting conflicting stories about the incident because Resident #57 offers people pop all the time and Resident D's story was conflicting with Resident #57's. She did not elaborate on what information was conflicting about Resident D and Resident #57's stories about the incident.</p>			

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	<p>Review of the investigation report, sent to the ISDH (Indiana State Department of Health) and other state agencies, on 04/16/13 at 3:45 P.M., indicated other alert and oriented residents and other staff were not interviewed regarding the issue or any similar issue. In addition, the LPN #18 did not report the allegation timely. The ADON did not recognize the allegation as potential abuse and did not report the issue to the Administrator immediately.</p> <p>3.1-28(e)</p>				

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F000226 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, the facility failed to implement their policy and procedures to ensure 2 of 3 allegations of rudeness and misappropriation of resident property were reported timely to the Administrator and other state agencies. (Resident D, Resident 57)</p> <p>Findings include:</p> <p>1. Interview with alert and oriented, Resident D, on 04/16/13 at 9:30 A.M., indicated CNA #17 was really rude to the resident and her roommate. She indicated CNA #17 had also tried to "steal" a bottle of Pepsi from her roommate. She indicated when he confronted CNA #17 regarding the Pepsi, the CNA became very rude, intrusive to Resident D and her roommate's conversations, and did not treat Resident D with any respect for the rest of the evening. She indicated this had all occurred on the evening of 04/15/13, around the evening meal time.</p>	F000226	<p>F226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>Woodland Manor is has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.</p> <p>I. Allegations have been reported to the Administrator and have been thoroughly investigated. LPN # 18, ADON, and Employee #21 were provided with 1:1 education regarding abuse allegation reporting. C.N.A. #17, C.N.A. #19 and LPN #22 were provided with 1:1 reeducation on abuse prohibition and customer service. C.N.A.s #18 was provided with reeducation on abuse prohibition.</p> <p>II. All interviewable Residents were interviewed to identify any outstanding allegations of mistreatment. All non-interviewable Residents were assessed for signs or symptoms of mistreatment.</p> <p>III. The facility's Abuse</p>	05/24/2013	

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	<p>Resident D indicated LPN #8, who was working at the time, was aware of the issue but she had told Resident D. Further interview with Resident #18, on 04/18/13 at 12:40 P.M., indicated the resident, on Monday evening, 04/15/13, told the LPN #8 about what she had said to the CNA #17, what had went on, and told the nurse now she (CNA #17) is "going off." The nurse told the Resident "I'm going to stay out of it because I wasn't there for either side."</p> <p>Resident #18 indicated she though LPN #8 had called LPN #8, the ADON (Assistant Director of Nursing). She indicated the next day after the incident, I think in the afternoon, I talked with the DON (Director of Nursing). I told her the whole story and then told her how CNA#17 kept coming back in our room, interrupting my conversation with my roommate, and how angry she (CNA #17) got.</p> <p>Resident D indicated the Social Service Director, employee #13 had not spoken with her about the issue between herself, her roommate, and CNA #17.</p> <p>Interview with LPN #8, on 04/18/13 at 2:00 P.M., indicated on Monday evening (04/15/13) after supper, Resident D and Resident #57 were in</p>		<p>Prevention Policy was reviewed and revised to include checklists to guide the facility through the proper actions, investigatory process and reporting process. All staff members will be reeducated on the Abuse Prevention Policy. This education will include but will not be limited to; recognizing abuse allegations, reporting abuse allegations and the investigatory process for abuse allegations.</p> <p>IV. In addition to the process noted above, the SSD or her designee will interview Residents using the Resident Interview and Observation Form (CMS-20050) Section G no less often than quarterly during the assessment reference period according to the RAI schedule. Interviews will continue according to RAI schedule until 100% compliance is met for a full quarter. The Administrator or designee will interview 5 employees weekly to assure full understanding of abuse recognition and reporting requirements. These interviews will be unannounced and will be conducted on all three shifts. These interviews will continue until 100% compliance is met for a full quarter. Results will be presented in Quality Assurance Meeting monthly.</p>		

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	<p>the hallway having a private conversation. CNA #17 came up to LPN #8 and told her "Well they're discussing me." Resident D saw CNA #18 talking to me and she came to me and said, "Well she know what she done," and "She had no business saying what she said to her (Resident #57)." LPN #8 indicated she asked Resident D to clarify what did she say and resident stated, "It doesn't matter she knows what she said." LPN #8 indicated "There was something else going on, CNA #17 and Resident D had words back and forth, CNA #17 was arguing with Resident D, so I separated them. CNA #17 was not assigned to that room (Resident D and Resident #57's) but was assigned to deliver hall trays to both units and Resident #57 eats in her room. I think CNA #17 called the DON or the ADON, LPN #18, because the ADON called back and asked me about it. The ADON told me to make sure CNA #17 stayed on unit 1 where they (CNA #17 and Resident D) wouldn't cross paths again. After I spoke with CNA #17, Resident D was following me and was confrontational (verbally) and I advised Resident D to stay out of CNA #17's way so she didn't have to run into her. LPN #8 went on to say, Resident D is sometimes attention seeking if there's nothing</p>			

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	<p>being done she tries to be demanding and the "enforcer." I try to use a calm approach, ask what I can do for her, tell her she's "right." LPN #8 denied telling Resident D she did not want to get involved. LPN #8 indicated because she was the charge nurse at the time she was already involved.</p> <p>LPN #8 indicated she was in the dining room when CNA #18 was evidently observed by Resident #57 getting into the her personal belongings to get a pop (Pepsi) and when resident #57 said, "what are you doing in my things, CNA #18 said, "I'm getting the pop you said I could have," and then when Resident #57 said, "No," CNA #18 left the room without taking the pop.</p> <p>During an interview on 04/18/13 at 10:00 A.M., the DON indicated around 9:30 A.M. on 04/16/13, she found a note from CNA #18 in her mailbox after the morning meeting. She indicated on 04/16/13 at around 11:30 A.M., Resident D came to my office, right before lunch, and said "I guess you've already heard about me." I told her no not specifically, and she said "I called State on you guys last night." I told her that was her right and she said, "I wanted to give you my side of the story." I</p>						

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	<p>asked her to tell me her side of the story. She said the incident with CNA #18 asking Resident #57 for a Pepsi. She said CNA #18 was passing meal trays and later on CNA #18 came back into room to pick up trays, Resident #57 was coming out of the bathroom, and saw CNA #18 bent over and Resident #57 asked CNA #18 "what are you doing?" And CNA #18 said "tying my shoe." Resident D said she was in the room in the corner and CNA #18 did not see her. I reassured her that she had every right to call state. The DON indicated Resident D did not tell her that CNA #18 got angry with her. She indicated that was the extent of the conversation. She indicated she spoke to Resident #57 about 35 minutes later and she basically told me the same story Resident D had told me. I asked Resident #57 if CNA #18 had ended up taking her Pepsi and she indicated "No, she stopped and said she was just tying her shoe."</p> <p>The DON indicated she informed the Administrator about the issue around noon on 04/16/13. She indicated she had already told SSD (Social Service Director), Employee #13 about this and when she went to tell Administrator about the incident, the SSD was already telling her about it.</p>			

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	<p>Interview with the ADON, on 04/18/13 at 2:45 P.M., indicated on Monday evening, 04/15/13, CNA #18 called her and left a message on her phone. She indicated she called back and spoke to LPN #8. She indicated LPN #8 told her that Resident D had stated CNA #18 was trying to steal a pop and that LPN #8 had talked to CNA #18 and they were saying that wasn't true. The ADON indicated she told both LPN #8 and CNA #18 to write up a statement. LPN #8 indicated she would make sure there was minimum interaction between CNA #18 and Resident D. The ADON agreed. The ADON indicated LPN #8 did not indicate the two, CNA #18 and Resident D were arguing. My understanding is it was a misunderstanding about a pop. ADON indicated if a CNA had stolen a resident's pop it would be a form of abuse. ADON did not view this as an abuse allegation because the two staff members via the phone told her this was not true.</p> <p>ADON indicated her responsibility regarding an allegation of abuse involving an employee was to ensure the accused staff member left the building, ensure the resident's safety, and immediately notify the DON and</p>			

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	<p>the Administrator. The ADON indicated she was getting conflicting stories about the incident because Resident #57 offers people pop all the time and Resident D's story was conflicting with Resident #57's. She did not elaborate on what information was conflicting about Resident D and Resident #57's stories about the incident.</p> <p>Review of the investigation report, sent to the ISDH (Indiana State Department of Health) and other state agencies, on 04/16/13 at 3:45 P.M., indicated other alert and oriented residents and other staff were no interviewed regarding the issue or any similar issue. In addition, the LPN #18 did not report the allegation timely. The ADON did not recognize the allegation as potential abuse and did not report the issue to the Administrator immediately.</p> <p>2. Review of an investigation of an allegation of staff to resident physical and verbal abuse indicated a housekeeper, Employee #21, left a note for the Director of Nursing, on 11/14/12, which indicated she had witnessed CNA #19 swearing at two residents on the dementia unit and physically yanking the arm of one of the residents on the evening of</p>			

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	<p>11/13/12. In addition, Employee #21 had witnessed LPN #22 on the same evening, in a resident's room watching the resident's television. LPN #22 refused to leave the resident's room or stop watching her television and told the resident who had requested she leave her room that she could do anything she wanted because she was the nurse. Staff were reinserved on 11/14/12 regarding the policy to report abuse immediately to their supervisor and the Administrator.</p> <p>3. Interview, on 04/19/13 at 11:30 A.M., with the Administrator, who had been working in the facility less than a week, indicated she had already revised the policy to include instructions for staff to report any allegation of abuse immediately to the Administrator. All staff were inserviced on the revised Abuse policy and procedure on 04/19/30 at an all staff inservice meeting conducted at 2:00 P.M.</p> <p>3.1-28(a)</p>			

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F000246 SS=A	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review, and interviews, the facility failed to ensure residents who preferred a bath tub for bathing were given the option of a tub bath. This affected 1 resident who indicated they disliked taking showers but had no other option in a sample of 35 residents interviewed regarding choices. (Resident #57)</p> <p>Finding includes;</p> <p>1. During an interview, with Resident #57, conducted on 04/16/13 at 2:43 P.M., Resident #57 indicated "They (the facility) only have showers and I hate it, I liked to take baths at home."</p> <p>Observation of the shower room on 100 unit, on 04/18/13 at 9:20 A.M., with LPN #8, confirmed there was only one shower stall and a large storage type room in the shower rooms. LPN #8 indicated the two other shower rooms in the facility were set up the same and there was</p>	F000246	<p>F246 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>Woodland Manor assures each resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>I. Resident #57 was reassessed for bathing preferences.</p> <p>II. Those residents who prefer tub bathing were identified through review of MDS and will be assessed for ability to bathe via tub safely.</p> <p>III. Maintenance will inspect and service available tub in facility. Those residents choosing to tub bathe and being assessed as safe to do so will be provided with tub baths. Tub bathing will be identified on C.N.A. assignment sheets and in care plan.</p> <p>IV. In addition to the</p>	05/24/2013	

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	<p>no usable tub in any of the three shower rooms.</p> <p>Interview with the Social Service Director, on 04/22/13 at 10:42 A.M. indicated the "preferences" questions/assessment are included in the Activity MDS (Minimum Data Set) assessment section. She indicated "it was somewhat important" for the resident to choose her own bathing options, on the admission MDS assessment, completed on 10/22/12, for Resident #57.</p> <p>A care plan, initiated on 10/28/12, indicated Resident #57 preferred "showers" but the pretyped plan did not give a bath tub as a bathing option on the care plan only showers or complete bed baths.</p> <p>3.1-3(v)(1)</p>		<p>process noted above, the DON or designee will monitor bathing practices during daily walking rounds to assure compliance. Results will be presented in Quality Assurance Meeting monthly.</p>		

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interviews, the facility failed to ensure a comprehensive, accurate assessment of nutritional needs was completed to ensure nutritional</p>	F000272	<p>F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>Woodland Manor does conduct initial and periodic</p>	05/24/2013	

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	<p>parameters were maintained 1 of 4 residents reviewed for nutrition. (Resident #76) In addition, the facility failed to ensure the bladder contingency of 1 of 3 residents reviewed for urinary incontinence was completed. (Resident # 26)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #76 was reviewed on 04/24/13 at 9:20 A.M. Resident #76 was admitted to the facility on 03/01/13, from an acute care facility with diagnoses, including but not limited to, recent traumatic amputation of bilateral legs, lack of coordination, symbolic dysfunction, HTN (hypertension), CHF (congestive heart failure), PVD (peripheral vascular disease), urinary obstruction, and depressive disorder. The resident's weight on admission was 112 pounds.</p> <p>The Admission Nursing Assessment, completed on 03/01/13, indicated the resident had scrotal edema and bilateral surgical incisions on his leg stumps. There were no pressure ulcers or other impaired skin issues identified. The initial skin risk assessment, completed on 03/01/13, indicated the resident was at high risk</p>		<p>comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity.</p> <p>I. A comprehensive nutritional assessment including but not limited to R#76's caloric and nutritional needs has been completed by registered dietician. A urinary assessment was completed by a licensed nurse for R#26 and a corrected MDS was completed and submitted.</p> <p>II. Nutritional assessments were reviewed for all residents to assure caloric and nutritional needs had been identified. MDS assessments were reviewed for every resident to identify currently coded continence. Current MDS scores were compared to current documentation by direct care staff to identify any discrepancies.</p> <p>III. The facility's Interdisciplinary Meeting Policy was reviewed and found to be appropriate. A new nutritional assessment form was drafted and approved by QA. A new CDM communication worksheet was drafted and approved. All nursing staff, dietary staff, nursing managers, social services director and registered dietician will be educated on IDT meeting policy. The CDM and registered dietician will be educated on the new nutritional assessment form and on the new communication</p>				

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	<p>for impaired skin issues.</p> <p>The initial Nutrition Assessment form, completed on 03/02/13, by the FSS (Food Service Supervisor), Employee #11, indicated the resident's caloric needs were figured using the resident's height after his bilateral amputations. The total caloric needs were estimated to be 1028 calories per day and his estimated fluid needs were 1530 cc of fluid per day. The resident's estimated protein needs were 51 grams per day.</p> <p>On 03/04/13, the resident developed a shearing wound to his buttocks/coccyx area.</p> <p>On 03/08/13, the resident's weight was down to 108 pounds, a 4 pounds weight loss in one week. The resident then refused to be weighed so arm circumference measurement ensued from 03/20/13 - 03/29/13.</p> <p>The initial care plan regarding nutritional needs, initiated on 03/08/13, indicated the problem of the resident refusing to eat at least one of the meals on three different days. The interventions were to encourage his family members to bring in favorite food items from home or restaurants, explain the importance of eating, offer</p>		<p>form. A policy entitled Continenence Assessment was drafted and approved by QA. A form entitled Bowel and Bladder Monitoring record was drafted and approved QA. All nursing staff and MDS Coordinator will be educated on the Continenence Assessment policy and Bowel and Bladder monitoring record.</p> <p>IV. In addition to the process noted above, the DON or designee will attend Nutrition at Risk meetings bi-weekly to assure proper nutritional assessments are completed. The MDS Coordinator will review the Bowel and Bladder Monitoring record during the assessment reference period for each resident according to the RAI schedule and will code MDS assessments in accordance with continence documentation. The DON or designee will audit 5 MDS assessments per month until audit results are 100% compliant for one full quarter. Results will be presented in Quality Assurance Meeting monthly.</p>		

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	<p>alternatives, invite him to food-related activities, monitor/document circumstances surrounding mealtimes/refusals to eat. Attempt to determine cause, praise all of his progress or efforts, weights according to facility policy, inform doctor and family of weight loss according to policy.</p> <p>There was an additional nutritional care plan, initiated on 03/11/13, regarding the resident's significant weight loss and poor appetite. The interventions indicated the following: "feeding tube placement. Resident will receive majority of nutrition at this time from peg tube (with an initiation date of 03/22/13), encourage him to partake of food related events in facility, receive a regular diet per physician order, be on the skin and nutrition at risk program per facility policy."</p> <p>Review of the March 2013, Food Consumption record for Resident #76 indicated he was refusing and/or taking just bites of most of his meals.</p> <p>Nursing notes, dated 03/06/13, indicated the physician was notified of the resident's poor appetite due to the family's concern. There were no new orders received at the time. In</p>			

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	<p>addition, nursing notes indicated the resident had been having loose stools. On 03/08/13, the resident also was documented to have a temperature of 99.9 degrees Fahrenheit.</p> <p>On 03/09/13, the physician was notified of the resident's poor appetite. The physician order the medication, Megace to be given as an appetite stimulant.</p> <p>On 03/10/12, the physician ordered the laboratory test, albumin and prealbumin, to be done due to the residents new wounds. The lab test results, completed on 03/12/13, indicated both levels were lower than normal for Resident #76.</p> <p>The resident was not reassessed regarding his nutritional needs despite the development of a large shearing pressure ulcer, continued weight loss, loose stools, elevated temperature, and low albumin and prealbumin levels. Physician orders, dated 03/15/13, indicated an order for med pass 120 cc three times a day as a nutritional supplement.</p> <p>On 03/18/13, the Consultant Dietician, Employee #16, recommended the resident receive a</p>			

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	<p>regular diet and med pass supplement 120 cc three times a day until the gastrostomy tube was placed. Once the gastrostomy feeding tube was placed he recommended Jevity 60 ml per hour continuously with 120 cc water flush q 4 hours, and an iron tablet be started due to the wound and the resident's low hemoglobin. The resident's low hemoglobin level of 9.9 had been present on admission to the facility on 03/01/13. The dietician did not reassess the resident's total nutritional needs on the 03/18/13, handwritten note of recommendations.</p> <p>On 03/19/13, Prostat was ordered to be given twice a day for a protein supplement.</p> <p>On 03/22/13, an iron supplement, which was recommended by the dietician on 03/18/13, was ordered.</p> <p>On 03/29/13, the resident's weight was obtained and noted to be 95.8 pounds.</p> <p>On 03/29/13, the Registered Dietician documented a progress note and recommended a vitamin, zinc supplement, Vitamin C supplement, and Prostat for additional protein be</p>			

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	<p>started due to the resident's wound. The dietician still did not indicate how many calories, fluids, and protein the recommended Jevity was to provide, nor did he evaluate the caloric and nutritional needs of the resident. He did document recent laboratory test results and the resident's current condition on the progress note.</p> <p>On 04/12/13, the resident's tube feeding was increased from Jevity 60 ml/hr (milliliters per hour) to Jevity 75 ml/hr due to the resident's wound and weight loss.</p> <p>Interview with the CDM (Certified Dietary Manager), on 04/24/13 at 11:15 A.M. indicated the Dietician visited the facility about every 2 weeks and often came in the early mornings and left before conversing with the CDM regarding any specific resident concerns or facility dietary needs. She indicated 03/29/13, was the first time the dietician assessed Resident #76's nutritional needs, after the gtube was placed. She indicated when the resident was first admitted, the family was trying to bring in fresh fruits and fast foods to try and get the resident to eat.</p> <p>2. The clinical record of resident #26 was reviewed on 4-23-13 at 1:40 p.m.</p>				

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	<p>The resident's diagnoses included, but were not limited to: abnormal gait, colostomy, anxiety disorder, and Alzheimer's disease.</p> <p>A Careplan, dated 5-9-12 with a revision date of 10-16-12, indicated a restorative program for scheduled toileting. Goal documented that resident will be cued to toilet every 2-3 hours to help remain continent of bladder and have fewer episodes. The interventions included but were not limited to: direct resident to bathroom before meals, upon arising and at night. There was no other Careplan that addressed incontinence.</p> <p>On 4-23-13 at 1:50 p.m., a review of the nursing notes, dated 2/1, 2/7, 2/21, 3/1, 3/4, 3/13 and 3/20, 2013, indicated resident was "continent of bladder."</p> <p>A review of the "ADL [activities of daily living] Grid", indicated the resident was continent.</p> <p>A review of a form titled "Restorative Care Plan and Charting" for January, February and March of 2013, indicated the resident was receiving restorative services for a scheduled toilet plan. The problems listed were</p>			

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	<p>"... incontinent of bladder, unable to find the bathroom and is unaware of toileting needs due to cognitive loss. Staff assistance required...."</p> <p>An interview with the restorative CNA #4, on 4-23-13 at 2:20 p.m., indicated that the plan didn't make much sense to her as it stated to assist the resident to the bathroom every 2-3 hours while awake with a plan to assist resident to bathroom upon arising, before meals and before bedtime.</p> <p>An interview with the MDS (Minimum Data Set Assessment) coordinator, on 4-23-13 at 2:30 p.m., indicated that she had just started 2 weeks ago and had realized there was a problem with the incontinence plan, a lack of a bladder pattern assessment, and a possibility of inaccurate MDS reporting, She was unable to explain why the MDS assessment indicated the resident was incontinent when the nursing staff was documenting that the resident was continent. She indicated she would have her consultant review the MDS assessments completed for 2013.</p> <p>On 4-24-13 a review of the MDS assessment, dated 2-28-13, (90 day scheduled assessment) indicated the</p>				

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	<p>resident was frequently incontinent of urine and was involved in a toileting program to manage the resident's urinary incontinence. Another MDS assessment, dated 3-30-13, (Quarterly review assessment) indicated the resident was always incontinent of urine and was not currently on a toileting program.</p> <p>3.1-31(a)</p>			

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F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interviews, the facility failed to ensure there was plans to address the monitoring of medical and/or behavioral symptoms for which psychotropic, hypnotic, and/or antianxiety medication was given for 5 of 10 residents reviewed for unnecessary medication use. (Resident C, D, 5, 29, and 57) In addition, the facility failed to develop a care plan to address a resident's hydration needs. (Resident # A)</p> <p>Findings include:</p>	F000279	<p>F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>Woodland Manor does 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>I. Resident D, #5, #29, #57 and C were reassessed for medical symptoms, behaviors and mood conditions, and care</p>	05/24/2013	

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	<p>1. The clinical record for Resident D was reviewed on 04/18/13 at 11:00 A.M. Resident D was admitted to the facility on 02/17/11 and readmitted on 05/21/12.</p> <p>Resident D had diagnoses, including but not limited to, cerebral palsy, chronic back pain, s/p (status post) hysterectomy, hip surgery x (times) 6, bilateral ankle surgeries, cholecystectomy, HTN (hypertension), depression, personality disorder, bipolar disorder, post traumatic stress syndrome, recurrent UTI's (urinary tract infections), and hyperlipidemia.</p> <p>The physician orders for Resident D, current through April 2013, indicated the resident was to take the following medications: Zalephone 5 mg (milligrams) two tablets at bedtime (a hypnotic medication to induce sleep), Clonazepam 1 mg at bedtime (an antianxiety medication), Abilify 20 mg once a day (an antipsychotic medication), and Cymbalta 60 mg once a day (an antidepressant).</p> <p>The behavior plans, located in a blue binder on the nursing unit, indicated the following behavior plan for Resident D: "[Resident's name] is of a younger age with a diagnosis of Depression, Bipolar d/o [disorder],</p>		<p>plans were revised. Resident A was reassessed for hydration risk and care plan was updated.</p> <p>II. All residents receiving psychoactive medications were identified through review of physician's orders. All residents at risk for dehydration were identified through the review of dehydration risk assessments. Care plans for all identified Residents were reviewed and updated to reflect each Resident's current needs.</p> <p>III. A new Care Plan – Interdisciplinary Team policy was drafted and approved through QA. Licensed nurses, MDS/Care Plan Coordinator, Nurse managers, SSD and CDM will be educated on new policy. New Psychoactive Medications policy was drafted and approved through QA. All nursing staff, MDS/Care Plan Coordinator, Nurse managers and SSD will be educated on new policy. A new Acute Hydration at Risk policy was drafted and approved through QA. All nursing staff, MDS/Care Plan Coordinator, Nurse managers and dietary staff will be educated on new policy.</p> <p>IV. In addition to the process noted above, the SSD will conduct an audit of all psychoactive medications to identify diagnosis for use, medical symptoms, behaviors and mood, behavior tracking in place and care plan reflective of resident's needs initially and then monthly</p>				

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	<p>personality d/o, Chronic back pain, and post traumatic stress syndrome. She has made negative statements such as "I feel very depressed and I don't think I want to live anymore." The goal for the plan was for the resident to "accept staff and family assistance and continue to voice concerns to others." The preventative interventions included the following: "Encourage [resident's name] to voice her feelings while staff conveys an attitude of caring and concern at all times, observe for anything that would cause [Resident's name] to become upset and alter situation, encourage to participate in activities of her interest: music, movies, painting, etc, be positive with [Resident's name], smile and speak in friendly manner, administer medications as ordered, encourage to call family/friends." The management techniques included the following: "Approach [Resident's name] in calm, unhurried manner, speaking in a soft and gently voice when making negative statements, listen intently to [Resident's name] concerns, provide comfort measures if appropriate, encourage [Resident's name] to participate in activities of her interest, remind [Resident's name] of positive things in life when making negative statements, place on visual checks per facility policy, encourage</p>		<p>through the Behavior Management Meeting. The DON or designee will monitor hydration care plans weekly through the Hydration at Risk Committee. Results will be presented in Quality Assurance Meeting monthly.</p>				

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	<p>to call family/friends, inform family and physician when making negative statements, inform [acute psychiatric facility name] as needed for mental health evaluation."</p> <p>There were 3 behaviors documented on the Behavior Tracking Log in the behavior book. On 02/28/13, staff documented resident was rude to staff, on 04/12/13 staff documented the resident was "cussing" at staff, and on 04/15/13 the resident was documented as having been "attention seeking."</p> <p>Interview with Social Service Director, employee #13, on 04/19/13 at 10:43 A.M. indicated based on the care plan in the behavior book which talked about all of the resident's diagnosis and did mention depression and the behavior of making negative statements, there was no way for staff to tell which medical symptoms for which medications they needed to be monitoring. When asked how staff would know which medical symptoms they needed to be monitoring for the resident she indicated "I guess they wouldn't. "</p> <p>Review of the all health care plans for Resident D, current through 06/06/13, included plans to monitor the resident</p>				

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	<p>for side effects of the hypnotic medications, antianxiety medications, antidepressant medications, and antipsychotic medications, and a plan to monitor the resident's mood issues evidenced by trouble sleeping, feeling tired/having little energy, overeating, and feeling bad about herself. There was no plan to address the resident's insomnia. There was no plan which indicated what medical symptoms the resident's exhibited which supported the use of the antipsychotic and antianxiety medications.</p> <p>The Social Service Director provided copies of Psychiatric review forms, dated 03/01/13, which indicated they had reviewed the resident and documented her mood, and the psychiatric diagnosis for which they saw the resident, however, there was no specific documentation of medical symptoms for which the facility should be monitoring Resident D.</p> <p>2. The clinical record for Resident #5 was reviewed on 04/23/13 at 2:45 P.M. Resident #5 had diagnosis, including but not limited to, prostate cancer, hypertension, coronary artery disease, congestive heart failure, arthralgia, osteoarthritis, depression, joint pain, and stiffness.</p>			

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	<p>Review of the April 2013, physician rewrites of the orders for medications for Resident #5 included an order for the resident to receive the antidepressant medication, Mirtazapine 15 mg at bedtime for insomnia.</p> <p>Review of the health care plans for Resident #5, current through April 2013, included a plan to observe the resident for adverse side effects of the antidepressant medication. A plan to address the resident's behaviors of "pounding on the wall wanting help instead of using his call light" and "being verbally abusive and physically towards other [sic]..." and "refusing care or to change his wet pants..." There was no plan to monitor and address the resident's insomnia and/or depression issues.</p> <p>On 4/23/13 at 2:17 P.M., review of the blue behavior book , located at the nursing station, indicated there was no behavior tracking forms for Resident #5.</p> <p>During an interview, on 04/23/13 at 2:20 P.M., CNA #14, a second shift aide, indicated she was not sure what types of behaviors she was supposed to document for Resident #5. She looked at her assignment sheet for</p>			

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	<p>Resident #5 and could not find any special instructions regarding behavior monitoring for the resident.</p> <p>3. The clinical record for Resident #29 was reviewed on 04/24/13 at 11:30 A.M. Resident #29 was admitted to the facility on 01/25/12, with diagnoses, including but not limited to, hypothyroidism, depression, hypertension, heart disease, esophageal reflux, osteoporosis, aphasia, late effects of CVA (cerebral vascular accident), hx (history) of gastric outlet obstruction, senile dementia, CAD (coronary artery disease), s/p (status post) rt (right) ankle fracture with closed reduction, afib (atrial fibrillation), and hyperlipidemia.</p> <p>The physician orders for Resident #29, current through April 2013, included orders for the medications, Mirtazapine 15 mg at bedtime for insomnia, Lorazepam 5 mg 1/2 tablet twice a day for anxiety, and Lexapro 10 mg a day for depression.</p> <p>Review of the behavior book, located at the nursing station, indicated the following plan for Resident #29: "[(Resident 29's name) has diagnosis of Dementia with expressive Aphasia and anxiety. She has demonstrated</p>						

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	<p>being verbally and physically [sic] abusive behaviors towards others by calling/yelling out and hitting staff." Interventions to the plan included: " Administer her medications as ordered while observing for side effects of medications, analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, approach [Resident's name] in a calm manner and ask her to stop this type of behavior and inquire as why she is activity this way, assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body position, pain etc, bring to the MDR (main dining room) just before the meal is ready to be served, establish a good rapport with [resident's name] and explain in simple terms what care you are wanting to provide. Give [Resident's name] as many choices as possible about car and activities. Have another qualified staff member provide the care trying to be provided. If she does not calm down, inform her you are going to stop and come back later when she is calm."</p> <p>During an Interview on 04/24/13 at 2:35 P.M., LPN #15 indicated the resident did not exhibit any behavior issues but was very regimented and</p>			
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	<p>desired to get up only for meals and immediately wanted to go back to bed. The nurse indicated even when the resident was able to transfer and ambulate per self she was like this.</p> <p>There was no plan to address the resident's depression or insomnia issues, only to monitor the resident for adverse side effects due to the medications.</p> <p>4. The clinical record for Resident #57 was reviewed on 04/19/13 at 2:00 P.M. Resident #57 was admitted to the facility on 10/16/12, with diagnoses, including but not limited to, COPD (chronic obstructive pulmonary disease), GERD (gastric esophageal disease), major depression- recurrent/severe, and anxiety.</p> <p>Review of the current, April 3013, physician orders for medication, included orders for the following medications, Seroquel xr 50 mg at bedtime (an antipsychotic medication), Paxil 40 mg every morning (an antidepressant), Zyprexa 5 mg bid (twice a day) for agitation (an antipsychotic), Lorazepam .25 mg twice a day for anxiety (an antianxiety medication), Buspirone 10 mg tid (three times a day) for anxiety (an</p>				

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	<p>antianxiety medication), Lithium Carbonate 150 mg three times a day for mood (a medication approved to treat mania), Neurontin 100 mg qid (four times a day) for mood (a medication usually ordered to treat neuralgic pain), and Klonopin 5 mg qid for anxiety (an antianxiety medication).</p> <p>On 01/30/13, the physician had given orders to increase the Buspirone to 10 mg tid and on 03/14/13, the physician gave orders for Ativan (Lorazepam) to be gvien .25 mg q (every) 6 hours prn (as needed) for anxiety. On 03/22/13, the physician gave orders to discontinue the Ativan .25 mg q 6 hours prn and change the order to Ativan .25 mg bid routinely. The fax to the physician indicated the nursing staff had requested the medication change from the physician because of the residents "repeated use" of the Ativan.</p> <p>Observation of the blue behavior book, located on the nursing unit, on 04/24/13 at 2:00 P.M., confirmed there were no behavior monitoring forms located in the binder.</p> <p>Review of the health care plans for Resident #57, current through 04/10/13, indicated there was a plan</p>				

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	<p>to address the resident's mood issues as exhibited by "feeling down, depressed, or hopeless. Feeling tired or having little energy, feeling bad about themselves, trouble concentrating on things, moving or speaking so slowly that other notice, and thoughts of being better off dead. Interventions to the plan included: "Administer medications as ordered while observing for the effectiveness an side effects, encourage family visits, encourage to participate in activity of her interest, encourage to verbalize feelings during care and 1 on 1 conversation every day while conveying an attitude of caring and concern at all times, provide validation of feelings when warranted, refer or a psych [psychiatric] consult as needed." There were 3 other care plans related to the multiple psychoactive medications the resident took, but the plans focused on observing the resident for adverse side effects due to the medication use.</p> <p>Social Service Director (SSD) was queried, on 04/23/13 at 1:40 P.M., as to what medical symptoms required the use of each of the medications for the resident, she provided documentation from the inpatient psychiatric facility, dated 01/30/13,</p>			

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	<p>which indicated the resident required Paxil for "depression and anxiety", Seroquel for "Mood psychosis", Lithium for "Mood", Zyprexa for "agitation", Gabepentin for "mood", and Clonazepam - not identified.</p> <p>There was no quantitative documentation regarding any mood or behavior issues exhibited by the resident. During the survey process, on 04/15/13 - 04/18/13 and 04/22/13 - 04/23/13, Resident #57 was observed to spend most of the daytime hours in her darkened room, lying on her bed asleep. She was only noted to get up to go to the bathroom, receive a shower, ask the nurse about medication, and take herself to the designated smoking place outside the facility.</p> <p>A History and Physical from the acute Psychiatric hospital, completed on 10/16/12, indicated the resident had been admitted to the acute care psychiatric facility, was asking for multiple antidepressants and anxiolytics, needed encouragement to come out of her room, had ongoing passive thoughts of death, was pessimistic, was afraid to be alone, had increase anxiety and tremulous, had reduced sleep, passive suicidal thoughts, and</p>				

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	<p>exhibited depression.</p> <p>Interview with Social Services Director, employee #13, on 04/23/13 at 1:40 P.M. indicated resident #57 should have a mood care plan. She indicated the resident came to the facility on the psychoactive medications. The SSD did not provide any specific behavior tracking documentation for Resident #57 to support the use of all of the resident's multiple psychotropic, antianxiety, and antidepressant type medications. She was not aware of any specific medical symptoms of mania or agitation exhibited by the resident which would warrant the use of the Lithium or the Zyprexa. The Social Service director, employee #13, could only provide the documentation from the acute psychiatric facility.</p> <p>5. The clinical record for Resident C was reviewed on 04/18/13 at 10:15 A.M. Resident C was admitted on 02/05/2008 with diagnosis, including but not limited to, Alzheimer's disease, incontinence, hypertension, depressed disorder, hx (history of) fx (fractured) radius, chronic hepatitis, osteoporosis, autoimmune disease, adjustment disorder with depressed mood. Review of the history and physical assessment from an acute</p>						

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	<p>care facility, completed on 2008, indicated the resident had a history of severe physical abuse and had incurred a traumatic brain injury in the past.</p> <p>The physician's orders for Resident C, current through April 2013, included orders for the following medications: Lexapro 10 mg qd (daily) (an antidepressant), Remeron 15 mg at bedtime (an antidepressant), and Seroquel 100 mg twice a day (an antipsychotic).</p> <p>Review of the health care plans for Resident C, current through 05/2013, included a plan to observe the resident for side effects of the antidepressant medications and the antipsychotic medications, but there was no plan to monitor the resident for the medical symptoms which warranted the use of any of the psychotropic medications.</p> <p>Interview with SSD on 04/23/13 at 1:25 P.M. indicated the Seroquel was for Resident C's Dementia with behaviors. When asked what behaviors, the SSD said, "A long time ago resident was combative with care and cursing/hitting others. " The SSD said Resident C had not been having any recent behaviors so she</p>				

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	<p>did not have any plan for behavior monitoring.</p> <p>Review of the Behavior Monitoring book, located at the nurses station, indicated there was no plan for Resident C in the book.</p> <p>No Behavior Monitoring in MAR for April 2013 only signed off for nurses to document and side effects in the nurses notes</p> <p>During an interview, on 04/22/13 at 11:20 A.M., LPN #9 indicated she did not know the behavior for which Resident C was given the psychiatric medications because she (Resident C) was transferred from the dementia unit and was already receiving the medication when she was transferred. She indicated she had not observed any behaviors from Resident C, nor had staff informed her of any behavior issues with Resident C.</p> <p>6. The clinical record of Resident #A was reviewed on 4-24-13 at 10:16 am. MDS (Minimum Data Set) Assessment, dated 3-24-13, indicated the residents risk score was again reported at a 6.</p> <p>A review of the resident's weights indicated at admission the resident weighed 138.2 pounds and on 4-1-13,</p>			

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	<p>he weighed 238.2 pounds.</p> <p>Review of the "Nutrition Assessment Form," dated 12-25-12, completed by the dietary manager, indicated the resident required 1890 ml (milliliters) of fluids per day. A "Nutritional Services Progress Note" completed by the dietician, dated 1-7-13, indicated the resident had a potential for alteration in nutrition/hydration with a goal that Resident #A would have no signs or symptoms of dehydration. The estimated daily needs fluids was 1.6-2.0 liters of fluid and 1200-1600 calories a day. The report also indicated the resident was able to feed himself after receiving some setup assistance and direction.</p> <p>On 4-24-13 at 3:40 p.m. a review of a Careplan dated 4-1-13 for nutrition indicated, resident was slightly above his IBW (ideal body weight) at this time. Interventions included but were not limited to: make changes when necessary on tray card, receives regular diet, on skin and nutrition program per facility policy, and monitor weight and labs. Another Careplan for constipation was reviewed and did not include an intervention to offer fluids to resident.</p> <p>Review of the "Food Consumption"</p>				

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	<p>form for February, March and April 2013, indicated the resident wasn't receiving the estimated 1.6 to 2.0 liters (1600 to 2000 ml) of fluid per day as recommended by the dietician.</p> <p>Fluid intake recorded at meal times for February, March and April were: 2-1-13 the recorded fluid intake was 1580 ml. 2-15-13 the recorded fluid intake was 1380 ml. 2-28-13 the recorded fluid intake was 1320 ml. 3-10-13 the recorded fluid intake was 1320 ml. 3-20-13 the recorded fluid intake was 1080 ml. 3-30-13 the recorded fluid intake was 1560 ml. 4-10-13 the recorded fluid intake was 1100 ml. 4-30-13 the recorded fluid intake was 1200 ml.</p> <p>During an interview on 4-24-13 at 11:10 a.m., CNA #6 indicated the resident was sometimes able to feed himself. The staff help to get him started then they let him try. CNA #6 indicated,"Sometimes he feeds himself and sometimes he don't." CNA #6 also indicated the staff refilled water pitchers at the beginning of each shift and water was offered to</p>			

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	<p>the resident when he was in his room. She also indicated she was not aware of documenting fluids given between meals.</p> <p>On 4-24-13 at 11:05 am an observation of resident's water pitcher indicated it was empty and had the lid on it with no straw. The water pitcher was located on a drawer behind a chair. The resident was observed wandering within a secure unit.</p> <p>During an interview on 4-24-13 at 3:30 p.m., CNA's # 7 and #3 indicated they pass fresh water at the beginning of their shift and offer resident's water throughout their shift. They were not aware they should document fluids given to resident's between meals.</p> <p>On 4-24-13 at 3:35 p.m., an observation of resident's water pitcher indicated it was empty. Resident #A was observed wandering up and down the hallway.</p> <p>On 4-24-13 at 3:50 p.m., a review of a policy, dated 7-2012, titled "Hydration & Snack Carts" indicated "...residents will be offered fluids between meals...documentation of fluid and snack consumption will be completed...."</p>			

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	<p>This Federal tag relates to Complaint IN000126085.</p> <p>3.1-35(b)(1)</p>			
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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interviews, the facility failed to ensure 2 of 2 resident representatives were invited to care plan meetings. (Resident #52 and G) In addition, the facility failed to revise a hydration plan when a resident's condition changed for 1 of 3 residents reviewed for hydration needs. (Resident B)</p> <p>Findings include:</p> <p>1. During an interview with the family of Resident #52, conducted on 04/17/13 at 9:57 A.M., the family member indicated the resident's</p>	F000280	<p>F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>Woodland Manor does recognize and upholds the resident's right resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>I. Responsible parties for Resident #52 and G were called and provided with current care planning information. Resident B was reassessed for hydration needs and care plan</p>	05/24/2013	

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	<p>power of attorney lived out of state. He indicated he lived locally and visited the resident several times a week. He indicated the facility contacted him if there was any change of condition with the resident. When queried as to whether he or his sister, who was the resident's power of attorney, were invited to care plan conferences, he indicated he had not been invited to any conference and his sister had not notified him of any such conference.</p> <p>Interview with the Social Service Director, on 04/22/13 at 11:20 A.M., indicated she normally telephoned families to invite them to care plan meetings and she did not document that she had done this. She indicated she had emailed Resident #52's son regarding a care plan meeting. She indicated the son never showed up.</p> <p>Review of the email did confirm Resident #52's son was invited to the November care plan meeting and a time convenient for him was requested. He provided the time but the care plan meeting was held 3 days prior to the time set up with the son. There was no documentation of an invitation to the care plan meeting conference for Resident #52 for the February 2013 care plan meeting.</p>		<p>was updated. Resident B's responsible party was called and updated with care plan changes. Communication with responsible parties was documented in each Resident's clinical record.</p> <p>II. A listing of all Residents, responsible parties and addresses was reviewed to identify those who will be notified of future care plan meetings. All residents' dehydration risk assessments were reviewed and care plans updated to reflect hydration needs. All changes in care planning were communicated verbally to the Resident/and or responsible party and this communication documented in each Resident's clinical record.</p> <p>III. A new Care Plan – Interdisciplinary Team policy was drafted and approved through QA. Licensed nurses, MDS/Care Plan Coordinator, Nurse managers, SSD and CDM will be educated on new policy. A new Acute Hydration at Risk policy was drafted and approved through QA. All nursing staff, MDS/Care Plan Coordinator, Nurse managers and dietary staff will be educated on new policy.</p> <p>IV. In addition to the process noted above, the Administrator or designee will review 2 charts weekly to assure documentation is present in each Resident's clinical record that Resident and/or responsible party had been invited to scheduled</p>				

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	<p>2. During an interview on 4-16-13 at 11:17 a.m., Resident #G's daughter indicated she had never been asked to attend a Careplan meeting for the resident. The daughter expressed an interest in attending a Careplan but wasn't sure what a Careplan was and that she could attend.</p> <p>On 4-24-13 at 11:00 a.m. a review of the Care Plan Conference, dated 9-11-12, indicated the family was not present. Previous Care Plan Conference Records, dated 3-12-12 & 12-27-11, indicated that no family member had been present for the conference.</p> <p>On 4-24-13 at 11:05 a.m., a review of the Careplan, dated 12-21-12, and revised on 1-9-13, indicated "...Involve family in discussion regarding care."</p>		<p>care plan conference. These audits will continue until 100% compliance has been achieved for one full quarter. The DON or designee will review documentation during Hydration at Risk meetings weekly to assure Resident and/or resident's responsible party are notified of changes in hydration care plans. Results will be presented in Quality Assurance Meeting monthly.</p>				

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	<p>Interview with CNA #6 on 4-24-13 at 11:10 a.m. indicated the resident's daughter visited the resident at least every other week. Most of the time she would come for the noon meal and visit with the resident in the dining room.</p> <p>Interview on 4-24-13 with Director of Nursing (DON) and Social Service Director at 11:25 a.m. indicated a message had been left on the daughter's phone regarding attending a Careplan meeting but she didn't return the call. The Social Service Director indicated she had no record of an attempt to contact the daughter. The DON and Social Service Director indicated there was no Policy or Procedure regarding the Careplan meetings at this time.</p> <p>3. The clinical record for Resident "B" was reviewed on 4/18/13 at 9:30 A.M. An initial care plan for Resident "B" for dehydration risk, dated 01/24/13, indicated the plan to address hydration needs was to determine likes and dislikes, labs as ordered, assist as needed and encourage fluids.</p> <p>Review of the dietician Care Plan, dated 02/04/13, indicated "... alteration in nutrition with potential for</p>				

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	<p>alteration in hydration. Approaches: regular diet with pureed consistency, honey thickened liquids, extensive to total assistance with eating and dysphasia therapy...."</p> <p>Review of the Care Plan Conference, dated 2/5/13, indicated dietary: see dietary progress note. Resident/Family: not in attendance. Care Plan meeting is scheduled with family 2/19/13.</p> <p>Review of the food consumption sheets for resident "B," from 01/25/13 -02/16/13, indicated the resident's meal fluid intake was below the 2610 ml (milliliters) requirement assessed by the facility's dietary manager on 01/25/13. Review of the dietician nutritional services progress note, dated 02/02/13, indicated estimated daily needs 1.8-2.1 liters (1800-2100 ml) fluid.</p> <p>Review of the specific fluid intake amounts for Resident "B," from 01/25/13-02/16/13, indicated the resident's daily fluid intake averaged approximately 950 cc (cubic centimeters) per day. However, from 02/12/13 five days prior to his transfer to the acute care facility on 02/16/13 indicated the following total cc's of fluid per day: 02/12/13- 720,</p>			

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	<p>02/13/13- 600, 02/14/13- 900, 02/15/13-60 plus sips, 02/16/13 sips.</p> <p>There was no plan to address the resident's chronic less than required intake of fluids from 01/25/13-02/16/13. There was no indication the facility reviewed and revised the care plan when fluid intake declined.</p> <p>This Federal tag relates to Complaint #IN000126085.</p> <p>3.1-35(d)(2)(B)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interviews, the facility failed to follow the care plan regarding self feeding interventions for 1 of 3 residents reviewed for hydration and nutrition needs. (Resident #C) In addition, the facility failed to follow the care plan regarding assisting a resident with routine oral care for 1 of 3 residents reviewed for activity's of daily living needs. (Resident #G)</p> <p>Finding includes:</p> <p>1. Resident C was observed on 04/18/13 at 9:13 A.M. in her room in her wheelchair. Resident C's pitcher of water, with no ice, was located on the overbed table in her room. There was no straw and no cup noted in and/or beside the pitcher. Resident C did not respond verbally when greeted and was not noted to attempt to propel her own wheelchair.</p> <p>The clinical record for Resident C was reviewed on 04/18/13 at 10:15 A.M. Resident C was admitted on 02/05/2008 with diagnosis, including</p>	F000282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>Woodland Manor does assure the services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.</p> <p>I. Resident C's feeding needs were reassessed and care plan was updated. Resident G is being provided with oral care according to care plan.</p> <p>II. All Residents requiring finger foods were identified through the review of physician's orders. All Residents requiring assistance with oral care were identified through MDS review.</p> <p>III. C.N.A. assignment sheets were updated to reflect current feeding assistance and oral hygiene assistance needs for all Residents. All C.N.A.s will be provided with a copy of updated assignment sheets and educated on updates. All C.N.A.s will be educated on assisting a Resident to eat and Oral Care.</p> <p>IV. In addition to the process noted above, the DON or</p>	05/24/2013			

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	<p>but not limited to, Alzheimer's disease, incontinence, hypertension, depressed disorder, hx (history) fx (fracture) radius, chronic hepatitis, osteoporosis, autoimmune disease, adjustment disorder with depressed mood. Review of the history and physical assessment from an acute care facility, dated 05/05/08, indicated the resident had a history of severe physical abuse and had incurred a traumatic brain injury in the past.</p> <p>On 04/18/13 at 12:28 P.M., Resident C was observed in the dining room feeding herself noodles with her fingers. She also had a finely cut up fish fillet on her plate. A CNA gave her cookies to eat and she also had pears in a bowl. LPN #10, seated at the table, indicated Resident C generally fed herself with her fingers or staff would assist her to eat (feed her). There was milk served in a carton, and water served to the resident with a lidded cup.</p> <p>On 04/19/13 at 12:22 P.M., Resident C was observed feeding herself carrots (finger sized). She also had potato wedges and diced chicken. She was not scooted up to the table and had to reach to get to her food. Her water was in a lidded cup but her milk was still in a carton. A nursing</p>		<p>designee will audit oral hygiene for 5 Residents weekly on the day and evening shift. These audits will be unannounced and will continue until 100% compliance has been achieved for one full quarter. The DON or designee will monitor meals daily for two weeks and then weekly for the provision of proper feeding assistance. This audit will continue until 100% compliance is achieved for one full quarter. Results will be presented in Quality Assurance Meeting monthly.</p>	

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	<p>staff member pulled Resident C back away further from the table and indicated they were going to feed her.</p> <p>On 04/20/13 at 12:09 P.M., Resident C was served her lunch tray and immediately started feeding herself with her fingers. Resident C was served diced chicken, dumpling noodles, and California blend vegetables. LPN #9 buttered her roll for her. The resident had water in a plastic cup with a lid, but her milk was left in a carton with a small straw.</p> <p>The current diet orders for Resident C, located on the April physician order rewrites were for the following: " regular, finger foods as available, offer chocolate milk from dietary at bedtime, use sippy cups during meals to increase self feeding for liquid intake."</p> <p>Interview with the Occupational Therapist and the Administrator, on 04/24/13 at 3:30 P.M. indicated they were trying to figure out how to "make" a table to better meet the self feeding needs of Resident C. The Occupational Therapist, employee #12, indicated she was going to pick the resident back up for therapy for self feeding needs.</p> <p>2. An interview on 4-16-13 at 11:06</p>				

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	<p>a.m. with Resident #G's daughter, indicated the resident's teeth were not being brush. The daughter was concerned because the resident had her own teeth and didn't want her mother's teeth to get bad. She indicated the resident may need assistance or cueing to completed the task. The daughter had asked the staff to make sure the resident's teeth were brush, but she doesn't believe that was happening. The resident's daughter was made aware that a dental exam was coming up soon but couldn't recall when.</p> <p>The clinical record for Resident #G was reviewed on 4-23-13 at 2:00 p.m. The resident's diagnoses included, but were not limit to: hypertension, severe dementia with delusions, and aortic stenosis.</p> <p>The Careplan, dated 12-12-11 and revised on 12-11-12, indicated the resident had a care plane for self care deficit due to cognitive impairments. The goal included "...res [resident] will participate in daily ADL's [activities of daily living] to maintain personal hygiene...." The interventions included but were not limited to:..." assist/cue to brush teeth, hair, shave, nail care, explain procedures/using simple terms, and praise res</p>			

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	<p>[resident] for participation...."</p> <p>A review of an untitled form (dental report) indicated the resident's last dental exam was on 4-4-13. The dentist's report indicated, "... heavy tarter, heavy plaque, poor OH [oral health]."</p> <p>Observations of the resident's teeth on 4-18-13 at 10:13 a.m., 4-19-13 at 11:12 a.m., 4-22-13 at 2:30 p.m. and 4-23-13 at 3:30 p.m., indicated the teeth had debris between them, food particles and had a slimy film.</p> <p>During an interview on 4-23-13 at 2:15 p.m., CNA #4 indicated the resident's teeth were brushed every morning and that the tooth brush was kept in the shower room in a cabinet. The CNA #4 was observed going to the shower room and opening a cabinet. CNA #4 opened a drawer inside the cabinet and indicated the drawer contained the resident's tooth brush and tooth paste. The drawer had a full tube of toothpaste but no tooth brush. The CNA #4 had no explanation to where to toothbrush could be located.</p> <p>IDuring an interview on 4-24-13 at 2:30 p.m., CNA #6 indicated the resident's teeth would have been</p>				

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	<p>brushed by the night staff as she was already up and dressed when CNA #6 came on shift. CNA #6 was asked to show writer where the tooth brush was located. CNA #6 was observed going into the shower room and opening a cabinet and pulling open a drawer. CNA #6 pulled from the drawer a new tooth brush, enclosed in plastic from the drawer and indicated that the tooth brush hadn't been used yet.</p> <p>3.1-35(g)(2)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to provide oral care for 1 of 3 residents reviewed for oral care in a sample of 30 residents. (Resident #G)</p> <p>Finding includes:</p> <p>During an interview on 4-16-13 at 11:06 a.m., Resident #G's daughter, indicated the resident's teeth were not being brush. The daughter was concerned because the resident had her own teeth and didn't want her mother's teeth to get bad. She indicated the resident may need assistance or cueing to completed the task. The daughter had asked the staff to make sure the resident's teeth were brush, but she doesn't believe that was happening. The resident's daughter was made aware that a dental exam was coming up soon but couldn't recall when.</p> <p>The clinical record for Resident #G was reviewed on on 4-23-13 at 2:00 p.m. The resident's diagnoses</p>	F000312	<p>F312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>Woodland Manor does assure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>I. Resident G is being provided with oral care according to care plan.</p> <p>II. All Residents requiring assistance with oral care were identified through MDS review.</p> <p>III. C.N.A. assignment sheets were updated to reflect oral hygiene assistance needs for all Residents. All C.N.A.s will be provided with a copy of updated assignment sheets and educated on updates. All C.N.A.s will be educated on provision of Oral Care.</p> <p>IV. In addition to the process noted above, the DON or designee will audit oral hygiene for 5 Residents weekly on the day and evening shift. These audits will be unannounced and will</p>	05/24/2013			

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	<p>included, but were not limit to: hypertension, severe dementia with delusions, and aortic stenosis.</p> <p>A review of the chart indicated the resident's last dental exam was on 4-4-13. The dentist's report indicated ..." heavy tarter, heavy plaque, poor OH [oral health]."</p> <p>Observations of the resident's teeth on 4-18-13 at 10:13 a.m., 4-19-13 at 11:12 a.m., 4-22-13 at 2:30 p.m. and 4-23-13 at 3:30 p.m., indicated the teeth had debris between them, food particles and had a slimy film.</p> <p>During an interview on 4-23-13 at 2:15 p.m., CNA #4 indicated the resident's teeth were brushed every morning and that the tooth brush was kept in the shower room in a cabinet. The CNA was observed going to the shower room and opening a cabinet. CNA #4 opened a drawer inside the cabinet and indicated the drawer contained the resident's tooth brush and tooth paste. The drawer had a full tube of toothpaste but no tooth brush. The CNA #4 had no explanation to where to toothbrush could be located.</p> <p>IDuring an interview on 4-24-13 at 2:30 p.m., CNA #6 indicated the resident's teeth would have been</p>		continue until 100% compliance has been achieved for one full quarter. Results will be presented in Quality Assurance Meeting monthly.				

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	<p>brushed by the night staff as she was already up and dressed when CNA #6 came on shift. CNA #6 was asked to show writer where the tooth brush was located. CNA #6 was observed going into the shower room and opening a cabinet and pulling open a drawer. CNA #6 pulled from the drawer a new tooth brush, enclosed in plastic from the drawer and indicated that the tooth brush hadn't been used yet.</p> <p>3.1-38(a)(3)(C)</p>			

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interviews, the facility failed to ensure interventions were implemented timely to prevent pressure ulcer development for a resident at risk for 1 of 2 residents reviewed for pressure ulcers. This resulted in the resident developing an unstageable pressure ulcer. (Resident #76)</p> <p>Finding includes:</p> <p>The pressure ulcer for Resident #76 was observed, on 04/24/13 at 9:45 A.M. The resident was observed lying in his bed. The resident was noted to be thin, had a gastrostomy tube feeding running, was dressed in a hospital gown and was noted to be lying on his left side on an alternating air mattress. The resident was noted to have a large, butterfly shaped open</p>	F000314	<p>F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Woodland Manor does assure based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>I. Resident #76 is receiving care according to care plan and wound is showing signs of healing.</p> <p>II. A skin sweep was conducted to identify all current areas of skin breakdown. Braden</p>	05/24/2013			

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	<p>area that extended to both the right and left side of his upper buttocks and lower coccyx area. There was visible tunneling noted up into the coccyx area on the right side of his ulcer. The wound bed was noted to be beefy red with moist serosanguinous exudate. LPN #10, who was performing the dressing change on the wound for Resident #76, indicated the wound had developed at the facility. She was noted to clean the wound with normal saline, then lightly pack and cover the wound with gauze dampened with normal saline, and then the gauze was covered with a Mepilex dressing.</p> <p>The clinical record for Resident #76 was reviewed on 04/24/13 at 9:20 A.M. Resident #76 was admitted to the facility on 03/01/13, from an acute care facility with diagnoses, including but not limited to, recent traumatic amputation of bilateral legs, lack of coordination, symbolic dysfunction, HTN (hypertension), CHF (congestive heart failure), PVD (peripheral vascular disease), urinary obstruction, and depressive disorder. The resident's weight on admission was 112 pounds.</p> <p>The Admission nursing assessment, completed on 03/01/13, indicated the</p>		<p>risk assessments were reviewed for all Residents to identify those at high risk.</p> <p>III. A Prevention of Pressure Ulcer policy was reviewed and approved through QA. An IDT Meeting policy was reviewed and approved through QA. A Pressure Ulcer Treatment and Evaluation Policy was reviewed and approved through QA. All nursing staff will be educated on new policies as well as the prevention, identification, treatment and documentation of pressure ulcers.</p> <p>IV. In addition to the process noted above, the DON or designee will visualize all wounds weekly and review weekly wound assessment documentation, RD documentation and wound care plans weekly at Nutrition at Risk meetings. Results will be presented in Quality Assurance Meeting monthly.</p>		

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	<p>resident had scrotal edema and bilateral surgical incisions on his leg stumps. There were no pressure ulcers or other impaired skin issues identified. The initial skin risk assessment, completed on 03/01/13, indicated the resident was at high risk for impaired skin issues. The assessment indicated the resident was totally incontinent of his bladder and bowels, and required 2 person staff assistance for transfers.</p> <p>The initial Nutrition Assessment form, completed on 03/02/13, by the FSS (Food Service Supervisor), Employee #11, indicated the resident's caloric needs were figured using the resident's height after his bilateral amputations. The total caloric needs were estimated to be 1028 calories per day and his estimated fluid needs were 1530 cc of fluid per day.</p> <p>The initial care plan related to impaired skin, initiated on 03/01/13, indicated the resident had an alteration in skin integrity related to the surgical incision on his right and left stump. The interventions on the plan, on 03/01/13, were "skin issues will be measured weekly noting size, color, drainage [sic] and odor," and "resident on pressure reduction mattress." On 03/04/13, "shearing</p>						

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	<p>right and left buttocks" was added to the problem list on the care plan and "wedge cushion to assist with TAP [turning and repositioning]" was added.</p> <p>Nursing notes and Weekly Wound Documentation Records, dated 03/04/13, indicated a 5.9 by .9 cm nonpressure shearing wound was noted on the resident's left buttocks. The physician was notified and no orders were received regarding the wound. The Wound record indicated the wound was cleansed with wound cleanser and a house barrier cream was applied.</p> <p>On 03/08/13, the resident's weight was down to 108 pounds, a 4 pounds weight loss in one week. The resident then refused to be weighed so arm circumference measurement ensued from 03/20/13 - 03/29/13.</p> <p>The initial care plan regarding nutritional needs, initiated on 03/08/13, indicated the problem of the resident refusing to eat at least one of the meals on three different days. The interventions were to encourage his family members to bring in favorite food items from home or restaurants, explain the importance of eating, offer alternatives, invite him to food-related</p>			

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	<p>activities, monitor/document circumstances surrounding mealtimes/refusals to eat. Attempt to determine cause, praise all of his progress or efforts, weights according to facility policy, inform doctor and family of weight loss according to policy. There was an additional nutritional care plan, initiated on 03/11/13, regarding the resident's significant weight loss and poor appetite. The interventions indicated the following: "feeding tube placement. Resident will receive majority of nutrition at this time from peg tube (with an initiation date of 03/22/13), encourage him to partake of food related events in facility, receive a regular diet per physician order, be on the skin and nutrition at risk program per facility policy."</p> <p>Review of the March 2013, Food Consumption record for Resident #76 indicated he was refusing and/or taking just bites of most of his meals.</p> <p>Nursing notes, dated 03/06/13, indicated the physician was notified of the resident's poor appetite due to the family's concern. There were no new orders received at the time. In addition, nursing notes indicated the resident had been having loose stools. The resident also was</p>						

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	<p>documented to have a temperature of 99.9 degrees on 03/08/13.</p> <p>On 03/09/13, the resident's blood pressure was noted to be low and the physician was notified of the low blood pressure and the resident's poor appetite. The physician order the medication, Megace to be given as an appetite stimulant. On 03/10/12, the physician ordered the laboratory test, albumin and prealbumin, to be done due to the residents new wounds. The lab test results, completed on 03/12/13 for Resident #76, indicated the resident's albumin level was low at 3.0 g/dl. The normal range for an albumin level was 3.5 - 5.2 g/dl. The resident's prealbumin level was low at 6.1 mg/dl. The normal prealbumin level was 20 - 40 mg/dl.</p> <p>The next weekly Wound Documentation flow record, completed on 03/11/13, indicated the resident was now assessed to have an unstageable 12 by 8 centimeter wound on his coccyx/buttock area. The wound was assessed to have a small amount of purulent drainage and was covered with both slough and necrotic tissue. A low air loss mattress was implemented and a Metrogel foam treatments, and oral</p>			

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	<p>antibiotics were ordered. Also on 03/11/13, an order was received for the resident to see a physician for pressure ulcer treatment. The specialist ordered an antibiotic and a new treatment for pressure area.</p> <p>Physician orders, dated 03/15/13, indicated an order for med pass 120 cc (cubic centimeters) three times a day as a nutritional supplement.</p> <p>On 03/18/13, the Consultant Dietician, Employee #16, recommended the resident receive a regular diet and med pass supplement 120 cc three times a day until the gastrostomy tube was placed. Once the gastrostomy feeding tube was placed he recommended Jevity 60 ml (milliliters) per hour continuously with 120 cc water flush q (every) 4 hours, and an iron tablet be started due to the wound and the resident's low hemoglobin. The resident's low hemoglobin level of 9.9 had been present on admission to the facility on 03/01/13. The dietician did not reassess the resident's total nutritional needs on the 03/18/13 handwritten note of recommendations.</p> <p>On 03/19/13, Prostat was ordered to</p>			

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	<p>be given twice a day for a protein supplement.</p> <p>On 03/22/13, an iron supplement, which was recommended by the dietician on 03/18/13, was ordered.</p> <p>On 03/29/13, the resident's weight was obtained and noted to be 95.8 pounds.</p> <p>On 03/29/13, the Registered Dietician documented a progress note and recommended a vitamin, zinc supplement, Vitamin C supplement, and Prostat for additional protein be started due to the resident's wound. The dietician still did not indicate how many calories, fluids, and protein the recommended Jevity was to provide, nor did he evaluate the caloric and nutritional needs of the resident. He did document recent laboratory test results and the resident's current condition on the progress note.</p> <p>On 04/12/13, the resident's tube feeding was increased from Jevity 60 ml/hr to Jevity 75 ml/hr due to the resident's wound and weight loss.</p> <p>Interview with the CDM (Certified Dietary Manager), on 04/24/13 at 11:15 A.M. indicated the Dietician visited the facility about every 2</p>			

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	<p>weeks and often came in the early mornings and left before conversing with the CDM regarding any specific resident concerns or facility dietary needs. She indicated 03/29/13 was the first time the dietician assessed Resident #76's nutritional needs, after the gtube was placed. She indicated when the resident was first admitted, the family was trying to bring in fresh fruits and fast foods to try and get the resident to eat.</p> <p>3.1- 40(a)(1)</p>			

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F000325 SS=G	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review and interviews, the facility failed to ensure interventions were implemented timely to ensure nutritional parameters were maintained 1 of 4 residents reviewed for nutrition. This resulted in a significant weight loss and development of an unstageable pressure ulcer. (Resident #76)</p> <p>Finding includes:</p> <p>The clinical record for Resident #76 was reviewed on 04/24/13 at 9:20 A.M. Resident #76 was admitted to the facility on 03/01/13, from an acute care facility with diagnoses, including but not limited to, recent traumatic amputation of bilateral legs, lack of coordination, symbolic dysfunction, hypertension, congestive heart failure, peripheral vascular disease, urinary obstruction, and depressive</p>	F000325	<p>F325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Woodland Manor does assure 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 protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>I. Resident #76 is receiving care according to care plan and wound is showing signs of healing. A comprehensive nutritional assessment including but not limited to R#76's caloric and nutritional needs has been completed by registered dietician.</p> <p>II. A skin sweep was conducted to identify all current</p>	05/24/2013	

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	<p>disorder. The resident's weight on admission was 112 pounds.</p> <p>The Admission nursing assessment, completed on 03/01/13, indicated the resident had scrotal edema and bilateral surgical incisions on his leg stumps. There were no pressure ulcers or other impaired skin issues identified. The initial skin risk assessment, completed on 03/01/13, indicated the resident was at high risk for impaired skin issues. The assessment indicated the resident was totally incontinent of his bladder and bowels, and required 2 person staff assistance for transfers.</p> <p>The initial Nutrition Assessment form, completed on 03/02/13 by the FSS, Employee #11, indicated the resident's caloric needs were figured using the resident's height after his bilateral amputations. The total caloric needs were estimated to be 1028 calories per day and his estimated fluid needs were 1530 cc (cubic centimeters) of fluid per day. The resident's estimated protein needs were 51 grams per day.</p> <p>On 03/04/13, the resident developed a shearing wound to his buttocks/coccyx area.</p>		<p>areas of skin breakdown. Braden risk assessments were reviewed for all Residents to identify those at high risk. All Residents' weights were reviewed to identify those with significant weight loss.</p> <p>III. A Prevention of Pressure Ulcer policy was reviewed and approved through QA. An IDT Meeting policy was reviewed and approved through QA. A Pressure Ulcer Treatment and Evaluation Policy was reviewed and approved through QA. All nursing staff will be educated on new policies as well as the prevention, identification, treatment and documentation of pressure ulcers. A new nutritional assessment form was drafted and approved through QA. A new CDM communication worksheet was drafted and approved through QA. All nursing staff, dietary staff, nursing managers, social services director and registered dietician will be educated on IDT meeting policy. The CDM and registered dietician will be educated on the new nutritional assessment form and on the new communication form.</p> <p>IV. In addition to the process noted above, the DON or designee will attend Nutrition at Risk meetings weekly to assure proper nutritional assessments are completed. The DON or designee will visualize all wounds weekly and review weekly wound assessment documentation, RD</p>		

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	<p>On 03/08/13, the resident's weight was down to 108 pounds, a 4 pounds weight loss in one week. The resident then refused to be weighed so arm circumference measurement ensued from 03/20/13 - 03/29/13.</p> <p>The initial care plan regarding nutritional needs, initiated on 03/08/13, indicated the problem of the resident refusing to eat at least one of the meals on three different days. The interventions were to encourage his family members to bring in favorite food items from home or restaurants, explain the importance of eating, offer alternatives, invite him to food-related activities, monitor/document circumstances surrounding mealtimes/refusals to eat. Attempt to determine cause, praise all of his progress or efforts, weights according to facility policy, inform doctor and family of weight loss according to policy.</p> <p>There was an additional nutritional care plan, initiated on 03/11/13, regarding the resident's significant weight loss and poor appetite. The interventions indicated the following: "feeding tube placement. Resident will receive majority of nutrition at this time from peg tube (with an initiation date of 03/22/13), encourage him to</p>		documentation and wound care plans weekly at Nutrition at Risk meetings. Results will be presented in Quality Assurance Meeting monthly.		

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	<p>partake of food related events in facility, receive a regular diet per physician order, be on the skin and nutrition at risk program per facility policy."</p> <p>Review of the March 2013, Food Consumption record for Resident #76 indicated he was refusing and/or taking just bites of most of his meals.</p> <p>Nursing notes, dated 03/06/13, indicated the physician was notified of the resident's poor appetite due to the family's concern. There were no new orders received at the time. In addition, nursing notes indicated the resident had been having loose stools. The resident also was documented to have a temperature of 99.9 degrees Fahrenheit, on 03/08/13.</p> <p>On 03/09/13, the resident's blood pressure was noted to be low and the physician was notified of the low blood pressure and the resident's poor appetite. The physician order the medication, Megace to be given as an appetite stimulant.</p> <p>On 03/10/12, the physician ordered the laboratory test, albumin and prealbumin, to be done due to the residents new wounds. The lab test</p>			

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	<p>results, completed on 03/12/13, for Resident #76, indicated the resident's albumin level was low at 3.0 g/dl. The normal range for an albumin level was 3.5 - 5.2 g/dl. The resident's prealbumin level was low at 6.1 mg/dl. The normal prealbumin level was 20 - 40 mg/dl.</p> <p>The resident was not reassessed regarding his nutritional needs despite the development of a large shearing pressure ulcer, continued weight loss, loose stools and elevated temperature, or low albumin and prealbumin levels. Physician orders, dated 03/15/13, indicated an order for med pass 120 cc three times a day as a nutritional supplement.</p> <p>On 03/18/13, the Consultant Dietician, Employee #16, recommended the resident receive a regular diet and med pass supplement 120 cc three times a day until the gastrostomy tube was placed. Once the gastrostomy feeding tube was placed he recommended Jevity 60 ml (milliliters) per hour continuously with 120 cc water flush q 4 hours, and an iron tablet be started due to the wound and the resident's low hemoglobin. The resident's low hemoglobin level of 9.9 had been present on admission</p>			

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	<p>to the facility on 03/01/13. The dietician did not reassess the resident's total nutritional needs on the 03/18/13, handwritten note of recommendations.</p> <p>On 03/19/13, Prostat was ordered to be given twice a day for a protein supplement.</p> <p>On 03/22/13, the iron supplement, which was recommended by the dietician on 03/18/13, was ordered.</p> <p>On 03/29/13, the resident's weight was obtained and noted to be 95.8 pounds.</p> <p>On 03/29/13, the Registered Dietician documented a progress note and recommended a vitamin, zinc supplement, Vitamin C supplement, and Prostat for additional protein be started due to the resident's wound. The dietician still did not indicate how many calories, fluids, and protein the recommended Jevity was to provide, nor did he evaluate the caloric and nutritional needs of the resident. He did document recent laboratory test results and the resident's current condition on the progress note.</p> <p>On 04/12/13, the resident's tube feeding was increased from Jevity 60</p>			

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	<p>ml/hr to Jevity 75 ml/hr due to the resident's wound and weight loss.</p> <p>Interview with the CDM (Certified Dietary Manager), on 04/24/13 at 11:15 A.M., indicated the Dietician visited the facility about every 2 weeks and often came in the early mornings and left before conversing with the CDM regarding any specific resident concerns or facility dietary needs. She indicated 03/29/13, was the first time the dietician assessed Resident #76's nutritional needs, after the gtube was placed. She indicated when the resident was first admitted, the family was trying to bring in fresh fruits and fast foods to try and get the resident to eat.</p> <p>Interview with the CDM, on 04/24/13 at 4:20 P.M., indicated there was no facility policy regarding completing nutritional assessments and implementing interventions. She indicated she just utilized the forms and completed them herself when a resident was admitted.</p> <p>3.1-46(a)(1)</p>				

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F000327 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 observation, interview and record review, the facility failed to ensure 2 of 3 residents reviewed for hydration needs in a sample of 3 was provided fluids and/or interventions to maintain proper hydration. This resulted in the residents blood urea nitrogen, creatinine and sodium levels becoming critical and the need to transfer the resident to an acute care center. (Resident A and B)</p> <p>Findings include:</p> <p>1. During an interview on 4/18/13 at 10:00 A.M., Resident B ' s son indicated his father was not offered fluids during the 4 days he stayed with his father.</p> <p>During an interview on 4/19/13 at 10:15 A.M., Resident B ' s wife indicated she asked the nurse on duty when he stopped eating and drinking is he could have an IV (intravenous fluids). The nurse ' s indicated they do not do those things here. She further indicated when he went to the hospital on 2/16/13, she was told by the doctors that he was severely</p>	F000327	<p>F327 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>Woodland Manor does provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>I. Resident B no longer resides at the facility. Resident A was reassessed for hydration risk and care plan was updated.</p> <p>II. All residents at risk for dehydration were identified through the review of dehydration risk assessments. Care plans for all identified Residents were reviewed and updated to reflect each Resident's current needs.</p> <p>III. A new Care Plan – Interdisciplinary Team policy was drafted and approved through QA. Licensed nurses, MDS/Care Plan Coordinator, Nurse managers, SSD and CDM will be educated on new policy. A new Acute Hydration at Risk policy was drafted and approved through QA. All nursing staff, MDS/Care Plan Coordinator, Nurse managers and dietary staff will be educated on new policy. The Hydration and Snack Cart policy was revised and approved</p>	05/24/2013

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	<p>dehydrated and malnourished.</p> <p>The closed clinical record for resident "B" was reviewed on 4/18/13 at 8:48 A.M. The resident was admitted to the facility on 01/24/13 with diagnosis included but was not limited to "...congestive heart failure, cerebral artery occlusion with infarct, diabetes type II, urinary tract infection, hypertension, dementia and seizures...."</p> <p>Review of a blood chemistry laboratory test, completed on 1/29/13, indicated the residents BUN (blood urea nitrogen) level was elevated at 32 mg/dl. The normal range for a BUN was 8-23 mg/dl. The residents creatinine level was elevated at 1.76 mg/dl. The normal range for a blood creatinine level was 0.7-1.50 mg/dl. The residents sodium level was elevated at 149 mEq/L. The normal range for a sodium blood level was 134-145 mEq/L. The residents chloride level was slightly elevated at 109 mEq/L. The normal range for a chloride blood level was 96-108 mEq/L. The resident's potassium level was within the normal range.</p> <p>Review of the admission nursing assessment, dated 1/24/13, indicated nutrition: total dependence,</p>		<p>through QA. All nursing and dietary staff will be educated on revised policy. All licensed nursing staff will be educated on the prevention, identification and treatment of dehydration.</p> <p>IV. In addition to the process noted above, the DON or designee will review 24 hour report sheets daily to identify changes in condition which may lead to or represent new onset dehydration. The DON or designee will review acute hydration at risk care plans weekly through the Hydration at Risk Committee to assure proper interventions are in place. Results will be presented in Quality Assurance Meeting monthly.</p>				

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	<p>swallowing problem, thickened liquids (type) honey. Dehydration risk assessment: score of 17, a score or 10 or more places the resident at risk for dehydration. Braden pressure ulcer risk assessment: score 13, a score of 13-14 represents moderate risk.</p> <p>A nurse note, dated 2/10/13 at 3:30 P.M., indicated the following: " Resting in bed with eyes closed. Opens eyes when name called. Skin feels warm to touch. LCTA [lungs clear to auscultation]. [physician's name] called R/T [related to] increased temp [temperature] with n.o. [new orders] rec'd [received] for UA [urinalysis] with C&S [culture and sensitivity]. [daughter's name] called and notified of order rec'd. T [temperature] 99.5."</p> <p>A nurse note, dated 2/13/13 at 9:00 A.M., indicated the following: "n.o. obtained for Cipro 500 mg [milligrams] QD [daily] X [for] 10 days, Dx [diagnosis] UTI [urinary tract infection]."</p> <p>A nurse note, dated 2/13/13 at 1:00 P.M., indicated the following: "vs [vital signs] T [temperature] 99.1, p [pulse] 62, R [respirations] 18, Bp [blood pressure] 152/90, biox 90% on RA</p>			

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	<p>[room air]. Res [resident] skin w/d [warm and dry] to touch BS [blood sugar] elevated. Md [medical doctor] aware. No s/s [signs and symptoms] of hyperglycemia. Res continues to decline, family aware. Md aware."</p> <p>A nurse note, dated 2/14/13, untimed, indicated the following: "Res continues to decline. Md, family aware. T 99.8. Fed by family took 100 cc (cubic centimeters) of flds (fluids)."</p> <p>A nurse note, dated 2/14/13 at 1545 (3:45 P.M.), indicated " Biox 88%. Applied O2 [oxygen] @ [at] 2L [liters]/min [minute] per NC [nasal cannula]. Doctor, pharmacy, and POA [power of attorney] notified."</p> <p>A nurse note, dated 2/16/13 at 9:00 A.M., indicated "Attempted to feed resident breakfast, pockets food, coughing c [with] moist/coarse lung sounds...Updated resident's wife; verbalized understanding but continues to question why doctor did not start IV [intravenous], explained to her that resident is able to take fluids in, skin is moist/warm."</p> <p>A nurse note, dated 2/16/13 at 1910 (7:10 P.M.), indicated "Son observed by staff attempting to force res to swallow thickened liquids. Res</p>			

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	<p>coughing/choking. Son states to res "you've just got a cold Dad, you need to drink this."</p> <p>A nurse note, dated 2/16/13 at 2015 (8:15 P.M.), Son has decided to send res to ER [emergency room] c [with] the intention of res receiving an IV. Res wife agrees c [with] transfer. Md notified and order received for transfer to ER."</p> <p>Review of the hospital admission history and physical assessment, dated 02/16/13, indicated the resident presented to the emergency room with a BUN of 102 mg/dl, a creatinine level of 4.03 mg/dl and a sodium level of 175mEq/L. The resident was diagnosed with severe dehydration secondary to decreased p.o. [oral] intake, severe malnutrition and hypernatremia.</p> <p>Review of the hospital consultation, dated 02/22/13, indicated the resident was found to be profoundly dehydrated with severe hypernatremia and acute renal failure.</p> <p>Review of the food consumption sheets for resident "B", from 01/25/13 -02/16/13, indicated the resident's meal fluid intake was below the 2610 ml (milliliters) requirement assessed</p>			

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	<p>by the facility's dietary manager on 01/25/13. Review of the dietician nutritional services progress note, dated 02/02/13, indicated estimated daily needs 1.8-2.1 liters (1800-2100 ml) fluid.</p> <p>Review of the five day scheduled assessment MDS (minimum data set) assessment for Resident "B", completed on 01/31/13, indicated the resident was moderately cognitively impaired, required extensive assistance for eating, total dependence for toileting needs, and was incontinent of both bowel and bladder.</p> <p>An initial care plan for dehydration risk, dated 01/24/13, indicated the plan to address hydration needs was to determine likes and dislikes, labs as ordered, assist as needed and encourage fluids.</p> <p>Review of the dietician Care Plan, dated 02/04/13, indicated "... alteration in nutrition with potential for alteration in hydration. Approaches: regular diet with pureed consistency, honey thickened liquids, extensive to total assistance with eating and dysphasia therapy..."</p> <p>Review of the specific fluid intake</p>			

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	<p>amounts for Resident "B", from 01/25/13-02/16/13, indicated the resident's daily fluid intake averaged approximately 950 cc (cubic centimeters) per day. However, from 02/12/13 five days prior to his transfer to the acute care facility on 02/16/13 indicated the following total cc's of fluid per day: 02/12/13- 720 cc's, 02/13/13- 600 cc's, 02/14/13- 900 cc's, 02/15/13-60 cc's plus sips, 02/16/13 sips. There was no plan to address the resident's chronic less than required intake of fluids from 01/25/13-02/16/13.</p> <p>Review of the current "Hydration & Snack Carts," policy dated 7/2012, indicated "To ensure that residents will be offered fluids between meals...Documentation of fluid and snack consumption will be completed...Identify resident and explain need for adequate fluid intake...Explain benefits of the procedure to the resident...Encourage family and friends to assist resident with fluid intake when possible...."</p> <p>2. The clinical record of Resident #A was reviewed on 4-24-13 at 10:16 a.m. The resident's diagnoses included, but were not limited to: Alzheimer's disease, major depression, cognitive decline,</p>			

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	<p>seizures disorder, and urinary disturbance.</p> <p>Review of the "Nutrition Assessment Form" dated 12-25-12, completed by the dietary manager, indicated the resident required 1890 ml (milliliters) of fluids per day. A "Nutritional Services Progress Note" completed by the dietician dated 1-7-13, indicated the resident had a potential for alteration in nutrition/hydration with a goal that Resident #A would have no signs or symptoms of dehydration. The estimated daily needs fluids was 1.6-2.0 liters(1600-2000 ml) of fluid and 1200-1600 calories a day. The report also indicated the resident was able to feed himself after receiving some setup assistance and direction.</p> <p>Review of the "Food Consumption" form for February, March and April indicated the resident wasn't receiving the estimated 1.6 to 2.0 liters (1600 to 2000 ml) of fluid per day as recommended by the dietician.</p> <p>Fluid intake recorded at meal times for February, March and April were: 2-1-13 the recorded fluid intake was 1580 ml. 2-15-13 the recorded fluid intake was 1380 ml. 2-28-13 the recorded fluid intake was</p>				

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	<p>1320 ml. 3-10-13 the recorded fluid intake was 1320 ml. 3-20-13 the recorded fluid intake was 1080 ml. 3-30-13 the recorded fluid intake was 1560 ml. 4-10-13 the recorded fluid intake was 1100 ml. 4-30-13 the recorded fluid intake was 1200 ml.</p> <p>During an interview on 4-24-13 at 11:10 a.m., CNA #6 indicated the resident was sometimes able to feed himself. The staff help to get him started then they let him try. CNA stated, "Sometimes he feeds himself and sometimes he don't." CNA #6 also indicated the staff refilled water pitchers at the beginning of each shift and water was offered to the resident when he was in his room. She also indicated she was not aware of documenting fluids given between meals.</p> <p>On 4-24-13 at 11:05 a.m., an observation of resident's water pitcher indicated it was empty and had the lid on it with no straw. The water pitcher was located on a drawer behind a chair.</p> <p>During an interview on 4-24-13 at</p>				

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	<p>3:30 p.m., CNA's # 7 and #3 indicated they pass fresh water at the beginning of their shift and offer resident's water throughout their shift. They were not aware they should document fluids given to resident's between meals.</p> <p>During an observation on 4-24-13 at 3:35 p.m., resident's water pitcher indicated it was empty. Resident #A was observed wandering up and down the hallway.</p> <p>On 4-24-13 at 3:40 p.m. a review of a Careplan dated 4-1-13 for nutrition indicated, resident was slightly above his IBW (ideal body weight) at this time. Interventions included but were not limited to: make changes when necessary on tray card, receives regular diet, on skin and nutrition program per facility policy, and monitor weight and labs. Another Careplan for constipation was reviewed and did not include an intervention to offer fluids to resident.</p> <p>This Federal tag relates to Complaint #IN00126085.</p> <p>3.1-35(b)(1)</p>						

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F000329 SS=D	<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 observation, record review and interviews, the facility failed to ensure there was adequate monitoring of medical and/or behavioral symptoms for which psychotropic, hypnotic, and/or antianxiety medication was given for 6 of 10 residents reviewed for unnecessary medication use. (Resident C, D, 5, 29, 56, and 57)</p> <p>Findings include:</p>	F000329	<p>F329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Woodland Manor does assure each resident's drug regimen must be free from unnecessary drugs.</p> <p>I. Resident C, D, #5, #29, #56, and #57 were reassessed for medical symptoms, behaviors and mood conditions, and care plans and behavior tracking sheets were revised.</p>	05/24/2013			

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	<p>1. The clinical record for Resident D was reviewed on 04/18/13 at 11:00 A.M. Resident D was admitted to the facility on 02/17/11 and readmitted on 05/21/12.</p> <p>Resident D had diagnoses, including but not limited to, cerebral palsy, chronic back pain, s/p (status post) hysterectomy, hip surgery x (times)6, bilateral ankle surgeries, cholecystectomy, HTN (hypertension), depression, personality disorder, bipolar disorder, post traumatic stress syndrome, recurrent UTI's (urinary tract infections), and hyperlipidemia</p> <p>The current physician orders for Resident D, current through April 2013, indicated the resident was to take the following medications: Zalephone 5 mg (milligrams) two tablets at bedtime (a hypnotic medication to induce sleep), Clonazepam 1 mg at bedtime (an antianxiety medication), Abilify 20 mg once a day (an antipsychotic medication), and Cymbalta 60 mg once a day (an antidepressant).</p> <p>The behavior plans, located in a blue binder on the nursing unit, indicated the following behavior plan for Resident D: "[Resident's name] is of a younger age with a diagnosis of Depression, Bipolar d/o [disorder],</p>		<p>II. All residents receiving psychoactive medications were identified through review of physician's orders. Care plans and behavior tracking sheets for all identified Residents were reviewed and updated to reflect each Resident's current needs.</p> <p>III. A new Care Plan – Interdisciplinary Team policy was drafted and approved through QA. Licensed nurses, MDS/Care Plan Coordinator, Nurse managers, SSD and CDM will be educated on new policy. New Psychoactive Medications policy was drafted and approved through QA. All nursing staff, MDS/Care Plan Coordinator, Nurse managers and SSD will be educated on new policy. All nursing staff and social services will be educated on the provision of psychoactive medications, appropriate use, behavior tracking, qualitative and quantitative documentation and gradual dose reductions.</p> <p>IV. In addition to the process noted above, the SSD will conduct an audit of all psychoactive medications to identify diagnosis for use, date of most recent gradual dose reduction, medical symptoms, behaviors and mood, behavior tracking in place and care plan reflective of resident's needs initially and then monthly through the Behavior Management Meeting. The DON or designee</p>				

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	<p>personality d/o, Chronic back pain, and post traumatic stress syndrome. She has made negative statements such as "I feel very depressed and I don't think I want to live anymore." The goal for the plan was for the resident to "accept staff and family assistance and continue to voice concerns to others." The preventative interventions included the following: "Encourage [resident's name] to voice her feelings while staff conveys an attitude of caring and concern at all times, observe for anything that would cause [Resident's name] to become upset and alter situation, encourage to participate in activities of her interest: music, movies, painting, etc, be positive with [Resident's name], smile and speak in friendly manner, administer medications as ordered, encourage to call family/friends." The management techniques included the following: "Approach [resident's name] in calm, unhurried manner, speaking in a soft and gently voice when making negative statements, listen intently to [Resident's name] concerns, provide comfort measures if appropriate, encourage [Resident's name] to participate in activities of her interest, remind [Resident's name] of positive things in life when making negative statements, place on visual checks per facility policy, encourage</p>		<p>will monitor pharmacy recommendations to assure gradual dose reductions are completed or that appropriate documentation is in place when dose reduction is declined. Results will be presented in Quality Assurance Meeting monthly.</p>				

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	<p>to call family/friends, inform family and physician when making negative statements, inform [acute psychiatric facility] as needed for mental health evaluation."</p> <p>There were 3 behaviors documented on the Behavior Tracking Log in the behavior book. On 02/28/13, staff documented resident was rude to staff, on 04/12/13 staff documented the resident was "cussing" at staff, and on 04/15/13 the resident was documented as having been "attention seeking."</p> <p>Interview with Social Service Director (SSD), employee #13, on 04/19/13 at 10:43 A.M., indicated based on the care plan in the behavior book which talked about all of the resident's diagnosis and did mention depression and the behavior of making negative statements, there was no way for staff to tell which medical symptoms for which medications they needed to be monitoring. When asked how staff would know which medical symptoms they needed to be monitoring for the resident she indicated "I guess they wouldn't."</p> <p>Review of the all of the health care plans for Resident D, current through 06/06/13, included plans to monitor</p>				

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	<p>the resident for side effects of the hypnotic medications, antianxiety medications, antidepressant medications, and antipsychotic medications, and a plan to monitor the resident's mood issues evidenced by trouble sleeping, feeling tired/having little energy, overeating, and feeling bad about herself. There was no plan to address the resident's insomnia. There was no plan which indicated what medical symptoms the resident's exhibited which supported the use of the antipsychotic and antianxiety medications.</p> <p>The Social Service Director provided copies of Psychiatric review forms, dated 03/01/13, which indicated they had reviewed the resident and documented her mood, and the psychiatric diagnosis for which they saw the resident, however, there again was no specific documentation of medical symptoms for which the facility should be monitoring Resident D.</p> <p>2. The clinical record for Resident #5 was reviewed on 04/23/13 at 2:45 P.M. Resident #5 had diagnosis, including but not limited to, prostate cancer, hypertension, coronary artery disease, congestive heart failure, arthralgia, osteoarthritis, depression,</p>			

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	<p>joint pain, and stiffness.</p> <p>Review of the April physician rewrites of the orders for medications for Resident #5 included an order for the resident to receive the antidepressant medication, Mirtazapine 15 mg at bedtime for insomnia.</p> <p>Review of the health care plans for Resident #5, current through April 2013, included a plan to observe the resident for adverse side effects of the antidepressant medication. A plan to address the resident's behaviors of "pounding on the wall wanting help instead of using his call light" and "being verbally abusive and physically towards other [sic]..." and "refusing care or to change his wet pants..." There was no plan to monitor and address the resident's insomnia and/or depression issues.</p> <p>Review on 04/23/13 at 2:17 P.M., of the blue behavior book , located at the nursing station, indicated there was no behavior tracking forms for Resident #5.</p> <p>Interview, on 04/23/13 at 2:20 P.M., with CNA #14, a second shift aide, indicated she was not sure what types of behaviors she was supposed to document for Resident #5. She</p>				

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	<p>looked at her assignment sheet for Resident #5 and could not find any special instructions regarding behavior monitoring for the resident.</p> <p>3. The clinical record for Resident #29 was reviewed on 04/24/13 at 11:30 A.M. Resident #29 was admitted to the facility on 01/25/12, with diagnoses, including but not limited to, hypothyroidism, depression, hypertension, heart disease, esophageal reflux, osteoporosis, aphasia, late effects of CVA (cerebral vascular accident), hx (history) of gastric outlet obstruction, senile dementia, CAD (coronary artery disease), s/p (status post) rt (right) ankle fracture with closed reduction, afib (atrial fibrillation), and hyperlipidemia.</p> <p>The current physician orders for Resident #29, current through April 2013, included orders for the medications, Mirtazapine 15 mg at bedtime for insomnia, Lorazepam 5 mg 1/2 tablet twice a day for anxiety, and Lexapro 10 mg a day for depression.</p> <p>Review of the behavior book, located at the nursing station, indicated the following plan for Resident #29: "[Resident 29's name] has diagnosis</p>						

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	<p>of Dementia with expressive Aphasia and anxiety. She has demonstrated being verbally and physically [sic] abusive behaviors towards others by calling/yelling out and hitting staff" Interventions to the plan included: " Administer her medications as ordered while observing for side effects of medications, analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, approach [Resident's name] in a calm manner and ask her to stop this type of behavior and inquire as why she is activity this way, assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body position, pain etc, bring to the MDR [main dining room]just before the meal is ready to be served, establish a good rapport with [resident's name] and explain in simple terms what care you are wanting to provide. Give [Resident's name] as many choices as possible about car and activities. Have another qualified staff member provide the care trying to be provided. If she does not calm down, inform her you are going to stop and come back later when she is calm."</p> <p>Interview with LPN #15, on 04/24/13 at 2:35 P.M., indicated the resident</p>						

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	<p>did not exhibit any behavior issues but was very regimented and desired to get up only for meals and immediately wanted to go back to bed. The nurse indicated even when the resident was able to transfer and ambulate per self she was like this.</p> <p>There was no plan to address the resident's depression or insomnia issues, only to monitor the resident for adverse side effects due to the medications.</p> <p>4. The clinical record for Resident #57 was reviewed on 04/19/13 at 2:00 P.M. Resident #57 was admitted to the facility on 10/16/12, with diagnoses, including but not limited to, COPD (chronic obstructive pulmonary disease), GERD (gastric esophageal disease), major depression- recurrent/severe, and anxiety.</p> <p>Review of the physician orders for medication, included orders for the following medications, Seroquel xr 50 mg at bedtime (an antipsychotic medication), Paxil 40 mg every morning (an antidepressant), Zyprexa 5 mg bid for agitation (an antipsychotic), Lorazepam .25 mg twice a day for anxiety (an antianxiety medication), Buspirone 10 mg tid</p>			

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	<p>(three times a day)for anxiety (an antianxiety medication), Lithium Carbonate 150 mg three times a day for mood (a medication approved to treat mania), Neurontin 100 mg qid (four times a day) for mood (a medication usually ordered to treat neuralgic pain), and Klonopin 5 mg qid for anxiety (an antianxiety medication).</p> <p>On 01/30/13, the physician had given orders to increase the Buspirone to 10 mg tid and on 03/14/13, the physician gave orders for Ativan (Lorazepam) to be given .25 mg q 6 hours prn (as needed) for anxiety. On 03/22/13, the physician gave orders to discontinue the Ativan .25 mg q 6 hours prn and change the order to Ativan .25 mg bid routinely. The fax to the physician indicated the nursing staff had requested the medication change from the physician because of the residents "repeated use" of the Ativan.</p> <p>Observation of the blue behavior book, located on the nursing unit, on 04/24/13 at 2:00 P.M., confirmed there were no behavior monitoring forms located in the binder.</p> <p>Review of the health care plans for Resident #57, current through</p>				

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	<p>04/10/13, indicated there was a plan to address the resident's mood issues as exhibited by "feeling down, depressed, or hopeless. Feeling tired or having little energy, feeling bad about themselves, trouble concentrating on things, moving or speaking so slowly that other notice, and thoughts of being better off dead." Interventions to the plan included: "Administer medications as ordered while observing for the effectiveness an side effects, encourage family visits, encourage to participate in activity of her interest, encourage to verbalize feelings during care and 1 on 1 conversation every day while conveying an attitude of caring and concern at all times, provide validation of feelings when warranted, refer or a psych consult as needed." There were 3 other care plans related to the multiple psychoactive medications the resident took, but the plans focused on observing the resident for adverse side effects due to the medication use.</p> <p>The Social Service Director provided documentation from the inpatient psychiatric facility , dated 01/30/13, which indicated the resident required Paxil for "depression and anxiety", Seroquel for "Mood psychosis",</p>				

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	<p>Lithium for "Mood", Zyprexa for "agitation", Gabepentin for "mood", and Clonazepam - not identified.</p> <p>There was no quantitative documentation regarding any mood or behavior issues exhibited by the resident. During the survey process, on 04/15/13 - 04/18/13 and 04/22/13 - 04/23/13, Resident #57 was observed to spend most of the daytime hours in her darkened room, lying on her bed asleep. She was only noted to get up to go to the bathroom, receive a shower, ask the nurse about medication, and take herself to the designated smoking place outside the facility.</p> <p>A History and Physical from the acute Psychiatric hospital, completed on 10/16/12, indicated the resident had been admitted to the acute care psychiatric facility, was asking for multiple antidepressants and anxiolytics, needed encouragement to come out of her room, had ongoing passive thoughts of death, was pessimistic, was afraid to be alone, had increase anxiety and tremulous, had reduced sleep, passive suicidal thoughts, and exhibited depression.</p> <p>Interview with Social Services Director, employee #13, on 04/23/13</p>				

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	<p>at 1:40 P.M. indicated resident #57 should have a mood care plan. She indicated the resident came to the facility on the psychoactive medications. The SSD did not provide any specific behavior tracking documentation for Resident #57 to support the use of all of the resident's multiply psychotropic, antianxiety, and antidepressant type medications. She was not aware of any specific medical symptoms of mania or agitation exhibited by the resident which would warrant the use of the Lithium or the Zyprexa. The Social Service director, employee #13, could only provide the documentation from the acute psychiatric facility.</p> <p>5. The clinical record for Resident C was reviewed on 04/18/13 at 10:15 A.M. Resident C was admitted on 02/05/2008 with diagnosis, including but not limited to, Alzheimer's disease, incontinence, hypertension, depressed disorder, hx fx radius, chronic hepatitis, osteoporosis, autoimmune disease, adjustment disorder with depressed mood. Review of the history and physical assessment from an acute care facility, completed on 2008, indicated the resident had a history of severe physical abuse and had incurred a traumatic brain injury in the past.</p>				

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	<p>The physician's orders for Resident C, current through April 2013, included orders for the following medications: Lexapro 10 mg qd (an antidepressant), Remeron 15 mg at bedtime (an antidepressant), and Seroquel 100 mg twice a day (an antipsychotic).</p> <p>Review of the health care plans for Resident C, current through 05/2013, included a plan to observe the resident for side effects of the antidepressant medications and the antipsychotic medications, but there was no plan to monitor the resident for the medical symptoms which warranted the use of any of the psychotropic medications.</p> <p>Interview with SSD, on 04/23/13 at 1:25 P.M., indicated the Seroquel was for Resident C's Dementia with behaviors. When asked what behaviors, the SSD said, "A long time ago resident was combative with care and cursing/hitting others. " The SSD said Resident C had not been having any recent behaviors so she did not have any plan for behavior monitoring.</p> <p>Review of the Behavior Monitoring book, located at the nurses station,</p>			

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	<p>indicated there was no plan for Resident C in the book.</p> <p>No Behavior Monitoring in MAR for April 2013 only signed off for nurses to document and side effects in the nurses notes</p> <p>Interview with LPN #9, on 04/22/13 at 11:20 A.M., indicated she did not know the behavior for which Resident C was given the psychiatric medications because she (Resident C) was transferred from the dementia unit and was already receiving the medication when she was transferred. She indicated she had not observed any behaviors from Resident C, nor had staff informed her of any behavior issues with Resident C.</p> <p>6. The clinical record of Resident #56 was reviewed on 4-18-13 at 6:30 p.m. The resident's diagnoses included, but were not limited to: dementia with behavioral disturbances, depression, organic paranoid psychosis, hypertension, history of right hip fracture, Alzheimer's disease, and dysphasia.</p> <p>An observation of the resident in her room was made on 4-22-13 at 2:42 p.m. The resident was sitting in a wheelchair with the bedside table in</p>			

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	<p>front of her. The resident was tearing paper. The resident's affect was flat and she was nonverbal.</p> <p>On 4-22-13 at 6:45 p.m., the Careplan was reviewed and indicated the resident takes an antidepressant (celexa) and has potential for side effects related to the use of the medication. Interventions included but were not limited to: administer medications and observe for side effects such as dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash and excessive weight gain. Complete fall risk and AIMS (Abnormal Involuntary Movement Scale) assessment per facility protocol, evaluate for dose reduction per regulations, and refer to psychiatrist, consult as needed.</p> <p>On 4-22-13 at 2:05 p.m. the monthly pharmacist reviews per Consultant pharmacist were reviewed. On 6/2/12 a request for a gradual dose reduction (GDR) note was reviewed and indicated a request was made to the physician to change present celexa dose of 10 mg daily "... to 10 mg every other day for 2 weeks, then dc (discontinue). And to change Zyprexa 10 mg HS (at bedtime) to zyprexa to 5 mg every HS...." The</p>			

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	<p>physician's response was "... disagree, no change...." On 8-30-12 the pharmacist attempted a decrease of the aspirin dose from 325 mg. to 81 mg due to bleed risk. The physician agree and an order was written to decrease the aspirin dose to 81 mg a day, however when the nurse notified the family they indicated they wanted no changes made to the resident's medications. The nurse contacted the physician who reordered the medication the previous dose of aspirin of 325 mg daily on 9-5-12. On 12-20-12 another attempt was made by the pharmacist for a GDR (Gradual Dose Reduction) requesting that zyprexa be reduced to 7.5 mg before bed. The GDR indicated the "... resident had not seen a psychiatrist, there were no nursing notes, physician notes, or social service progress notes that indicated she had any behavioral issues nor any delusions/hallucinations...she is cognitively declined...." The physician agreed with the reduction of zyprexa to 7.5 mg at bedtime. The order for reduction was discontinued on 1-4-13 by the physician due to "...family requests no med [medication] reductions at this time as res. [resident] is stable...."</p>						

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	<p>On 4-22-13 at 2:10 p.m. a review of the latest Social Service Progress Note, dated 1-21-13, indicated the family declined a GDR for zyprexa on 1-4-13.</p> <p>An interview on 4-22-13 at 2:15 p.m. with the Director of Nursing (DON) indicated the family requested that the zyprexa not be reduced, to keep the medications the same.</p> <p>An interview with the Social Service Director on 4-23-13 at 3:15 p.m. indicated the resident hadn't been having behaviors and therefore there were no behaviors documented on the resident. The Social Service Director further indicated that the resident wasn't receiving psychiatric services because she had been on hospice. The services were not restarted after the resident was removed from hospice services. The last psychiatric consult was dated 5-31-11.</p> <p>Interview with Administrator and Social Service Director on 4-23-13 at 5:05 p.m., indicated the daughter had power of attorney and made the decisions to not have any medication changes recommended by the pharmacist and ordered by the physician. The Social Service</p>				

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	<p>Director indicated the family had received no education in regards to them refusing to follow the recommendations of the physician. The Administrator indicated the family shouldn't be making decisions that keep the resident from reaching her full potential.</p> <p>3.1-48(a)(6)</p>				

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to provide actual hours worked for registered nurses (RN), licensed practical nurses (LPN), and certified nurse aides (CNA) with a posted census for 4 of 8 days during</p>	F000356	F356 483.30(e) POSTED NURSE STAFFING INFORMATION Woodland Manor does post nurse staffing data daily at the beginning of each shift.	05/24/2013			

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	<p>the survey process. This had the potential to affect 57 of 57 residents in the facility.</p> <p>Finding includes:</p> <p>On 4-19-13 at 12:45 p.m., an observation was made of the daily nursing staffing posted on a form titled "Woodland Manor Daily Staff," in the front hallway outside of the social service director's office. The resident census was not posted nor the actual hours worked by the RN, LPN, or CNA as required by the regulations.</p> <p>On 4-22-13 at 8:40 a.m., an observation was made of the daily nursing staffing on a form titled "Woodland Manor Daily Staff." The resident census was not posted nor the actual hours worked by the RN, LPN or CNA as required by the regulations.</p> <p>On 4-23-13 at 10:40 a.m., an observation was made of the daily nursing staffing. The resident census was not posted nor the actual hours worked by the RN, LPN or CNA as required by the regulations.</p> <p>During an interview on 4-23-13 at 3:40 p.m., the Administrator indicated</p>		<p>I. Daily Nurse Staffing poster was revised to include daily census, total hours and actual hours worked for RN, LPN and C.N.A. This form is posted daily at the beginning of each shift.</p> <p>II. All have the potential to be affected.</p> <p>III. A new daily staffing poster was revised and implemented. Nurses were educated on the completion and posting of the form.</p> <p>IV. In addition to the process noted above, the Administrator will monitor the completion and posting of the daily staffing poster daily during walking rounds. This monitoring will continue until 100% compliance is achieved for one full quarter. Results will be presented in Quality Assurance Meeting monthly.</p>		

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	<p>that she was aware that the form titled "Woodland Manor Daily Staff" did not include the total number and actual hours worked by the RN's, LPN's and CNA's. It also did not include a resident census for the day.</p> <p>On 4-24-13 at 2:55 p.m., an observation was made of the daily nursing staffing. The resident census was not posted nor the actual hours worked by the RN, LPN, or CNA as required by the regulations.</p> <p>3.1-13(a)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interviews, the facility failed to ensure there was an air gap in the ice machine, located in the kitchen. This potentially affected 55 of 57 residents who had the potential to consumed ice and liquids in the facility.</p> <p>Finding includes:</p> <p>During the kitchen tour, conducted on 04/15/13 at 9:55 A.M. , there were two drainage hoses coming from the ice machine. There was a clear hose, from the ice machine which went underneath the adjacent kitchen cabinet and was directed into a receptacle in the floor drain, however, the clear hose was touching the side of the receptacle, the bottom of the kitchen cabinet, and there was no air gap. The soft gray colored hose, which also ran from the ice machine, was stuck in a very small hole in the floor also located underneath the adjacent kitchen cabinet. There was</p>	F000371	<p>F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>Woodland Manor does (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.</p> <p>I. The ice machine was affixed so air gap would be present. II. All residents who consume ice with fluids were identified through physician order review. III. The ice machine was affixed so air gap would be present. IV. In addition to the process noted above, the Maintenance director or designee will visualize ice machine during daily walking rounds to assure continued compliance. Results will be presented in Quality Assurance Meeting monthly.</p>	05/24/2013			

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	<p>no gap and the circumference of the gray hose fit snugly into the hole in the floor.</p> <p>During an interview, on 04/15/13 at 9:55 A.M., the Food Service Supervisor, Employee #11, indicated there was no basement underneath the kitchen and there was no air gap noted for the ice machine located in the kitchen.</p> <p>3.1-21(i)(2)</p>				

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F000441 SS=K	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD,	04/24/2013			

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	<p>clean and disinfect the blood glucose machine (device used to check blood sugar) used for multiple residents. This affected 2 of 8 residents who used the blood glucose machine (Resident #32 and #72) The facility also failed to have an effective system to prevent the spread of blood borne pathogens from the use of the blood glucose machine potentially affecting 8 of 8 residents in the facility who had their sugars tested in the facility. (Resident #100, #32, #65, #52, #16, #11, #72, and #15).</p> <p>This immediate jeopardy that began on 4-19-13 at 7:51 a.m. when RN #1 was observed to obtain a blood sugar test from Resident #32 without cleaning the blood glucose machine before or after use. The Administer and Director of Nursing (DON) were notified of the immediate jeopardy on 4-19-13 at 3:17 p.m.</p> <p>Findings included:</p> <p>On 4-19-13 at 7:51 a.m., RN #1 was observed getting a blood glucose machine (a device to check blood sugar) from her cart. RN #1 did not clean the blood glucose machine prior to obtaining a blood sugar reading on Resident #32. RN #1 was observed to clean the resident's finger with</p>		<p>LINENS Woodland Manor has established and does maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. I. Residents #32, 72, 100, 65, 52, 16, 11 and 15 were assessed and show no signs or symptoms of blood borne disease. II. All residents receiving finger stick blood glucose monitoring were identified by review of physician's orders and Medication Administration Records. All identified residents were assessed for signs and symptoms of blood borne pathogenic disease processes with none identified. III. a. A policy entitled "INFECTION CONTROL – BLOOD GLUCOSE MACHINE" was reviewed and adopted on 4/19/2013. b. All licensed nurses and QMAs (Qualified Medication Assistants) will receive education regarding the proper disinfection of blood glucometers to prevent disease transmission. This education will begin with staff currently working on 4/19/2013 and will continue until all licensed nurses and QMAs have received education. No licensed nurse or QMA will be permitted to work until he/she has received education. c. Approved disinfectant wipes were delivered to the facility on 04/19/2013 and</p>				

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	<p>alcohol, prick the finger and obtain a drop of blood for use with the blood glucose machine. RN #1 then put the blood glucose machine back into the medication cart without cleaning it. A small drop on blood was observed on the front of the blood glucose machine. RN #1 indicated she was finished doing her blood sugars for the morning.</p> <p>On 4-19-13 at 9:45 a.m., RN #1 was asked if the blood glucose machine was cleaned and she indicated she had not clean it. She pulled the blood glucose machine out of the medication cart and the drop of blood was observed to still be on the blood glucose machine. The RN #1 then cleaned the blood glucose machine with a Clorox Disinfecting Wipe.</p> <p>On 4-19-13 at 10:50 a.m., a policy titled "Infection Control-Blood Glucose Machine," provided by the DON and deemed as current, indicated on #3 "...Be sure to clean and disinfect the blood glucose machine environmental surface with Clorox-Wipes before and after testing the resident's blood."</p> <p>On 4-19-13 at 11:16 a.m., LPN #2 was observed with a blood glucose machine on her cart and indicated she was gathering her materials to</p>		<p>made readily available to licensed nurses and QMAs. d. MSDS sheets for approved disinfectant wipes were delivered to the facility on 4/19/2013 and placed in appropriate binders accessible to all staff. IV. a. DON or designee will document return demonstration proficiency in glucometer disinfection initially following education to validate proper education and practice of glucometer disinfection for all licensed nurses and QMAs. b. DON or designee will audit glucometer disinfection daily for 14 days, then weekly for four weeks, then monthly for 2 months and quarterly thereafter. These audits will be conducted on all shifts and will be unannounced. i. If it is identified during the audit process that the nurse fails to correctly disinfect the glucometer, immediate reeducation will occur and the facility's progressive disciplinary process will be followed. c. The DON or designee will report to QA weekly for 6 weeks, monthly for 2 months and quarterly thereafter.</p>				

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	<p>obtain an blood sugar reading on Resident # 72. LPN #2 obtained a blood sugar on the resident and returned the blood glucose machine to the cart without cleaning it. When interviewed regarding the protocol for cleaning the blood glucose machine for the facility, LPN #2 indicated she did not cleanse the machine before or after use on the resident as the policy directed.</p> <p>On 4-19-13 at 12:50 p.m., the DON indicated there were no residents in the facility with a diagnosis of Hepatitis C and 8 residents were presently receiving blood glucose testing, (Resident #100, #32, #65, #52, #16, #11, #72, and #15). She further indicated there had not been any in-services in regards to cleaning and disinfecting the blood glucose machine for the nurses.</p> <p>On 4-19-13 at 12:52 P.M., review of the clinical record for #36 indicated a diagnosis of chronic hepatitis. This resident did not receive blood sugar testing.</p> <p>On 4-19-13 at 1:20 p.m., review of the label for the Clorox Disinfecting Wipes revealed the Clorox wipes used by the facility were not effective in disinfecting blood borne pathogens.</p>						

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	<p>During a phone interview, a representative from Clorox confirmed the Clorox Disinfecting Wipes were not effective in killing a blood borne disease (a disease that can be spread through contamination by blood) such as human Immunodeficiency virus (HIV) or Hepatitis virus.</p> <p>The immediate jeopardy, that began on 04/19/13 at 7:51 a.m., was removed, on 4-20-13 at 12:30 p.m., when the facility was noted to have obtained an effective disinfectant, updated their policy and procedure for cleaning blood glucose machine and updated their system for cleaning the blood glucose machines, and inserviced the nursing staff regarding the updated policy and procedures for cleaning the blood glucose machines, and observation confirmed nursing staff were following the correct procedures for cleaning blood glucose machines. The immediate jeopardy was removed, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>3.1-18(a)</p>						

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