DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	155042		C 01/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIDGE HEALTH INVESTORS LLC	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	This visit was for the Investigation of Complaint IN00084086 and Complaint IN00084156. Complaint IN00084086- Substantiated, Federal/State deficiencies are cited at F279, F282, and F327. Complaint IN00084156- Substantiated, Federal/State deficiencies are cited at F312. Survey dates: January 3 and 4, 2011 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Survey team: Anne Marie Crays, RN add 1/19/11 BN Census bed type: SNF: 21 SNF/NF: 97 Total: 118 app 1/27/11 BN Census payor type: Medicare: 21 Medicaid: 78 Other: 19 Total: 118 Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 5, 2011 by Bev Faulkner, RN		By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request this plan of correction is considered as our allegation of compliance. RECEIVED JAN 13 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carolyn Davis	Administrator	1-12-11

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.

F279 483.20(d), 483.20(k)(1)
COMPREHENSIVE CARE PLANS

It is the practice of Fox Ridge Health Investors to review and revise the resident's comprehensive care plan.

I. The care plans for Resident A have been reviewed and revised. Resident C no longer resides in the facility.

II. Residents with acute short term condition changes have been reviewed and care plans updated as appropriate.

III. The facility policy regarding care planning acute short term change of condition has been reviewed and revised. Licensed nurses have been educated on this change. The facility has implemented a daily clinical interdisciplinary team meeting. Residents who have acute change of condition are reviewed at this time. This review will include a review of the care plan to ensure that appropriate interventions have been implemented.

IV. The DON or her designee is conducting a quality improvement audit of care plans. This audit includes a random review of 5 residents per week to ensure that acute

changes have been addressed. The QI audit is being completed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are being reviewed at the facility QA Committee meeting monthly for additional recommendations where necessary.

COMPLETION DATE: 1-15-2011 gw

F282 483.20(k)(3)(ii)
SERVICES BY QUALIFIED PERSONS PER CARE PLAN

It is the practice of Fox Ridge Health Investors to provide services by qualified persons in accordance with each resident's written plan of care.

I. Resident C no longer resides in the facility.

II. Residents with acute short term condition changes have been reviewed and care plans updated as appropriate. This included a review of fluid intake records and medication administration to ensure the treatment plan is being followed.

III. The facility policy regarding care planning acute short term change of condition has been reviewed and revised. Licensed nurses have been educated on

this change. The facility has implemented a daily clinical interdisciplinary team meeting. Residents who have acute change of condition are reviewed at this time. This review will include a review of the care plan, fluid intake records, BM documentation, and medication administration (where appropriate) to ensure that the treatment plan is being followed.

IV. The DON or her designee is conducting a quality improvement audit of care plans, fluid intake records, BM documentation, and medication administration records. This audit includes a random review of 5 residents per week to ensure that acute changes have been addressed. The QI audit is being completed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are being reviewed at the facility QA Committee meeting monthly for additional recommendations where necessary.

COMPLETION DATE: 1-15-2011
DW

F312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

It is the practice of Fox Ridge Health Investors to ensure that 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.

I. The facility continues to encourage Resident B to allow assistance with ADLs. Refusal of care is being documented.

II. The facility realizes other residents have the potential to be affected.

III. Nursing assistants have been re-educated regarding the importance of providing assistance with ADLs. This re-education also included the importance of appropriately documenting receipt or refusal of that care. Additional systemic changes are being monitored through our QI program as indicated below.

IV. The DON or her designee is completing a quality improvement audit of resident care including bathing and personal hygiene. A random

sample of 5 residents are being reviewed to monitor for provision of services as well as documentation of those services. This QI audit is being completed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are being reviewed at the facility QA Committee meeting monthly for additional recommendations where necessary.

COMPLETION DATE: 1-15-2011
gw

F327 483.25(j) HYDRATION

It is the practice of Fox Ridge Health Investors to provide each resident with sufficient fluid intake to maintain proper hydration and health.

I. Resident C no longer resides in the facility.

II. Residents with acute short term condition changes have been reviewed and care plans updated as appropriate. This included a review of fluid intake records, BM documentation, and medication administration to ensure the treatment plan is being followed.

III. The facility policy regarding care planning acute short term change of condition has been reviewed and revised. Licensed nurses have been educated on this change. The facility has implemented a daily clinical interdisciplinary team meeting. Residents who have acute change of condition are reviewed at this time. This review will include a review of the care plan, fluid intake records, BM documentation, and medication administration (where appropriate) to ensure that the treatment plan is being followed.

IV. The DON or her designee is conducting a quality improvement audit of care plans, fluid intake records, BM documentation, and medication administration records. This audit includes a random review of 5 residents per week to ensure that acute changes have been addressed. The QI audit is being completed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are being reviewed at the facility QA Committee meeting monthly for additional recommendations where necessary.

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents who were being treated for urinary tract infections, an upper respiratory infection, increased loose stools and decreased fluid intake, had plans of care developed, for 2 of 3 residents reviewed for care plans, in a sample of 3. Resident A, Resident C Findings include: 1. In interview on 1/3/11 at 9:30 A.M., LPN # 1 indicated Resident A was currently on an antibiotic for an upper respiratory infection. LPN #	F 279		

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F 279	Continued From page 2 1 indicated Resident A was confused at times. Resident A was observed lying in bed at the time. The clinical record of Resident A was reviewed on 1/3/11 at 10:00 A.M. A Minimum Data Set [MDS] assessment, dated 7/24/10, indicated Resident A had a short-term and long-term memory problem, was moderately impaired in cognitive skills for daily decision-making, required extensive assistance with eating, and was totally dependent on one staff for hygiene and bathing. The clinical record indicated the resident had a urostomy and colostomy. Nurse's Notes included the following notations: 9/11/10 at 1:00 P.M.: "...Atb [antibiotic] cont [continues] for UTI [urinary tract infection] et [and] penile drng [drainage]. Urine cloudy yellow...." 9/13/10 [untimed]: "ATB continues for UTI - urine remains cloudy...Fluids encouraged...." 10/13/10 at 7:40 A.M.: "Res [resident] in bed - unable to follow commands well. Unable to swallow his meds...Speech garbled, unable to understand anything res said...0800: ...transport to ER...1300 [1:00 P.M.] Res admitted to [hospital room] [with] dx [diagnosis] sepsis et [and] acute kidney injury." A hospital history and physical, dated 10/13/10, indicated, "...It was noticed by his daughters that he was starting to become somewhat confused several days ago to one week and he got progressively more confused...It looks like he has a urinary tract infection...." A Plan of Care regarding the urinary tract	F 279		

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F 279	Continued From page 3 infection was not observed in the clinical record. Nurse's Notes continued: 10/21/10 at 7:00 P.M.: "Resident readmitted to facility - alert [with] confusion...On IV ATB one dose daily...." 10/23/10 at 10:30 A.M.: "...Cont on IV Rocephin for UTI...." 10/26/10 at 2:00 P.M.: "IV Rocephin continues for UTI...." A Plan of Care regarding the UTI was not observed in the clinical record. Nurse's Notes, dated 12/28/10 at 2:00 P.M., indicated, "Noted nasal congestion et occ [sic] non prod [productive] cough...[Physician] notified [with] N.O. [new orders]...." A Physician's order, dated 12/28/10, indicated, "Levaquin 500 mg [an antibiotic]...daily x 7 days URI [upper respiratory infection]." A Plan of Care regarding the URI was not observed in the clinical record. On 1/4/11 at 2:05 P.M., during an interview with the Director of Nursing [DN], she indicated the UTI and URI may have been acute problems, and therefore not listed on a care plan. 2. The closed clinical record of Resident C was reviewed on 1/3/11 at 12:40 P.M. The resident was admitted to the facility on 10/8/10 with diagnoses including, but not limited to, pneumonia, congestive heart failure, and	F 279		

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F 279	Continued From page 4 dementia. A Physician's order, dated 10/26/10, indicated, "Cefazolin [antibiotic] 250 mg IM q [every] 8 [hours] x 7 days for UTI [urinary tract infection]." A Plan of Care regarding the UTI was not observed in the clinical record. The resident was transferred to the hospital on 12/11/10 and returned the same day with the diagnosis of "UTI." A Plan of Care regarding the UTI was not observed in the clinical record. Nurse's Notes included the following notations: 12/17/10 at 2:00 A.M.: "...confused to place et [and] time...Continues on Levaquin [an antibiotic] for UTI...." 12/17/10 at 6:00 P.M.: "Remains confused. Total care [with] all ADL's [activities of daily living]. Had loose stools x 2...." 12/19/10 at 1:30 P.M.: "Res [resident] had ls [loose] stool x 2...Incontinent of B/B [bowel and bladder]...(name of physician) aware of ls stool [with] N.O. [new order]...." 12/23/10 at 1:30 P.M.: "Res very lethargic @ this x - had [no] ls stool until staff went to get res [up]...CNA reports had to feed res lunch she was unable to feed herself - notified [physician] of [change] in condition [with] N.O. to send to ER...." 12/23/10 at 5:00 P.M.: "[Hospital] phoned et res admitted [with] DHD [dehydration]."	F 279		

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F 279	Continued From page 5 A "BM Monitoring" form, dated December 2010, indicated the following stools: 12/16, 2 medium loose; 12/17, 5 extra large loose and 2 medium loose; 12/18, 2 medium loose and 1 medium watery; 12/19, 2 medium loose, 1 medium watery, and 1 extra large watery; 12/20, 3 large loose +; 12/21, 3 large loose; 12/22, 2 large loose, 1 medium loose, 3 extra large loose. Resident C's intake and output record, dated December 2010, indicated the following 24 hour fluid intake: 12/16, 480 cc; 12/17, 1440 cc; 12/18, 1980 cc; 12/19, 1630 cc; 12/20, 600 cc; 12/21, 600 cc; 12/22, 1840 cc. A Plan of Care, dated 12/19/10, indicated a problem of "Fluid Volume Deficit related to Inadequate fluid intake, Diarrhea Intermittent, 12-19-10 Flagyl as ordered, Immodium as ordered, 12-21-10 Lomotil as ordered. Clear liquid diet as needed, Increase [water] intake, 12-19-10 Imodium adm. - loose stools stopped. 12-23-10 Despite efforts to [increase] fluids (which pt [patient] had been taking in) admitted to [hospital] - Dx [diagnosis] dehydration...." The Interventions included, "Monitor for poor skin turgor, concentrated urine, dry skin...diarrhea, lethargy...Monitor fluid intake and output every shift. Encourage fluids as ordered 12-19 Res fed...." A Plan of Care regarding hydration status or diarrhea was not observed in the clinical record prior to 12/19/10. The hospital clinical record of Resident C was reviewed on 1/4/11 at 9:45 A.M. An Emergency	F 279		

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F 279	Continued From page 6 Room Nurse's Note, dated 12/23/10 at 2:45 P.M., indicated, "...diarrhea x 1 week. Has had [increased] lethargy. Upon arrival incontinent of BM...not oriented. Skin turgor poor...." An Emergency Room Note, dated 12/23/10, indicated, "...she had a history of diarrhea...the diarrhea has gotten a lot worse, and the patient has become more lethargic...Laboratory: ...BUN and creatinine are 61 and 2.14 [abnormal results, indicative of dehydration] respectively...Assessment: Diarrhea with acute kidney injury...." On 1/4/11 at 12:45 P.M., during an interview with the Director of Nursing [DN], she indicated dietary would be the staff responsible to develop a care plan regarding the resident's fluid needs. This federal tag relates to Complaint IN00084086. 3.1-35(a)	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident who was having frequent loose stools and was being treated for urinary tract infections, received adequate hydration and medications ordered for diarrhea, resulting in hospitalization for dehydration, for 1 of	F 282		

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F 282	Continued From page 7 3 residents reviewed for hydration, in a sample of 3. Resident C Findings include: The closed clinical record of Resident C was reviewed on 1/3/11 at 12:40 P.M. The resident was admitted to the facility on 10/8/10 with diagnoses including, but not limited to, Pneumonia, Congestive Heart Failure, and Dementia. An Admission Nursing Assessment, dated 10/8/10, indicated the resident was cognitively impaired with poor decision making skills, was incontinent of bowel and bladder, and was independent with eating. The resident was hospitalized from 10/12/10 to 10/16/10 with the diagnosis of "GI bleed." A "Nutrition Risk Assessment," dated 10/18/10, indicated the recommended total fluid intake was "2154 cc" daily. A Physician's order, dated 10/26/10, indicated, "Cefazolin [antibiotic] 250 mg IM q [every] 8 [hours] x 7 days for UTI [urinary tract infection]." The resident was transferred to the hospital on 12/11/10 and returned the same day with the diagnosis of "UTI." Nurse's Notes included the following notations: 12/17/10 at 2:00 A.M.: "...confused to place et [and] time...Continues on Levaquin [an antibiotic] for UTI...."	F 282		

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F 282	Continued From page 8 12/17/10 at 6:00 P.M.: "Remains confused. Total care [with] all ADL's [activities of daily living]. Had loose stools x 2...." 12/19/10 at 1:30 P.M.: "Res [resident] had ls [loose] stool x 2...Incontinent of B/B [bowel and bladder]...(name of physician) aware of ls stool [with] N.O. [new order]...." A Physician's order, dated 12/19/10, indicated, "Imodium [anti-diarrheal] [one] q [every] 3 hrs prn [as needed] loose stools. Flagyl 250 mg...[three times daily] x 7d for GI distress." A Physician's order, dated 12/21/10, indicated, "Lomotil [anti-diarrheal] give [two] tabs...q 4 [hours] prn [as needed for diarrhea." Nurse's Notes continued: 12/23/10 at 10:00 A.M.: "...has had [no] loose stools today yet...fluids enc [encouraged] et taken in water well [sic]. Incont of B/B...Chem 8 [lab] reported to [physician] [with] N.O." A Physician's order, dated 12/23/10, indicated, "Chem 8 results...D/C [discontinue] Bumex, hold Lasix, [Potassium] x 5 days...Chem 8 on Mon 12-27-10." 12/23/10 at 1:30 P.M.: "Res very lethargic @ this x - had [no] ls stool until staff went to get res [up]...CNA reports had to feed res lunch she was unable to feed herself - notified [physician] of [change] in condition [with] N.O. to send to ER...." 12/23/10 at 5:00 P.M.: "[Hospital] phoned et res admitted [with] DHD [dehydration]."	F 282		

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F 282	Continued From page 9 A "BM Monitoring" form, dated December 2010, indicated the following stools: 12/16, 2 medium loose; 12/17, 5 extra large loose and 2 medium loose; 12/18, 2 medium loose and 1 medium watery; 12/19, 2 medium loose, 1 medium watery, and 1 extra large watery; 12/20, 3 large loose +; 12/21, 3 large loose; 12/22, 2 large loose, 1 medium loose, 3 extra large loose. The resident's Medication Administration Record indicated she received Imodium three times: on 12/19, 12/20, and 12/23. The resident received Lomotil one time on 12/23/10 [untimed]. Resident C's intake and output record, dated December 2010, indicated the following 24 hour fluid intake: 12/16, 480 cc; 12/17, 1440 cc; 12/18, 1980 cc; 12/19, 1630 cc; 12/20, 600 cc; 12/21, 600 cc; 12/22, 1840 cc. The hospital clinical record of Resident C was reviewed on 1/4/11 at 9:45 A.M. An Emergency Room Nurse's Note, dated 12/23/10 at 2:45 P.M., indicated, "...diarrhea x 1 week. Has had [increased] lethargy. Upon arrival incontinent of BM...not oriented. Skin turgor poor...." An Emergency Room Note, dated 12/23/10, indicated, "...she had a history of diarrhea...the diarrhea has gotten a lot worse, and the patient has become more lethargic...Laboratory: ...BUN and creatinine are 61 and 2.14 [abnormal results, indicative of dehydration] respectively...Assessment: Diarrhea with acute kidney injury...." On 1/4/11 at 12:30 P.M., during an interview with	F 282		

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F 282	Continued From page 10 LPN # 1, she indicated she was the normal day shift nurse taking care of Resident C. LPN # 1 indicated the resident did not have any loose stools for her, but had heard she did for other staff. On 1/4/11 at 12:45 P.M., during an interview with the Director of Nursing [DN], she indicated nursing would be unaware of the required fluid intake recommended by the dietician unless a diet communication would be sent to nursing. The DON indicated she did not know why nursing would not have given the resident the medication ordered for diarrhea, but that the facility had recently changed the way BMs were documented. This federal tag relates to Complaint IN00084086. 3.1-35(g)(2)	F 282		
F 312 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident who required assistance with activities of daily living [ADL's] received personal hygiene care, for 1 of 2 residents reviewed for ADL assistance in a sample of 3. Resident B Findings include:	F 312		

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	155042		C 01/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIDGE HEALTH INVESTORS LLC	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

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F 312	Continued From page 11 The clinical record of Resident B was reviewed on 1/3/11 at 11:35 A.M. Diagnoses included, but were not limited to, aspiration pneumonia, chronic obstructive pulmonary disease, and congestive heart failure. A Minimum Data Set [MDS] assessment, dated 12/10/10, indicated Resident B required extensive assistance of one staff for dressing and hygiene/bathing, and was occasionally incontinent of bowel and bladder. A Care Area Assessment [CAA] Summary, dated 12/10/10, indicated, "ADL [activities of daily living] Functional/Rehab, Resident has had a recent hospitalization. He has increased weakness and decrease in strength and endurance...He also has had some incont [sic] bowel and bladder episodes. Only walking a few steps and requires assist of 2 staff members to transfer sit to stand...." A care plan, dated 12/10/10, indicated a problem of "Self Care Deficit: all ADL's Bathing, grooming and hygiene Related to: Muscle Weakness." The Interventions included: "Check and change incontinence pad q [every] 2 hrs and provide peri care at that time...Assist with ADL's - bathing, grooming, hygiene, and dressing...." The clinical record indicated the resident was transferred to the hospital on 12/30/10 at 3:30 A.M. On 1/4/11 at 9:30 A.M., the hospital clinical record of Resident B was reviewed. An emergency room nurses note, dated 12/30/10 at 4:10 A.M., indicated, "...Pt. [patient] hygiene poor [with] wet	F 312		

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F 312	Continued From page 12 attends. Shirt et [and] sweats smelling strong of urine et ammonia...Skin inspection reveals very red perineum...." An Emergency Room Note, dated 12/30/10, indicated, "...When he arrived here to the hospital he was elderly, older than his stated age, somewhat disheveled male...." On 1/4/11 at 11:30 A.M., the Unit Manager provided "ADL Daily Documentation," dated December 2010. The form indicated Resident B received a bed bath on 12/28/10, and a partial bath on 12/30/10 "10-6" shift. The form indicated the resident received at least a "partial" bath daily. Documentation of the resident refusing a bath of shower was not observed on the ADL form. On 1/4/11 at 12:45 P.M., the Director of Nursing indicated Resident B refused ADL care frequently, but it was not indicated on the resident's ADL sheet. This federal tag relates to Complaint IN00084156.	F 312		
F 327 SS=G	3.1-38(a)3 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident who was having frequent loose stools and was being treated for	F 327		

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F 327	Continued From page 13 urinary tract infections, received adequate hydration, resulting in hospitalization for dehydration, for 1 of 3 residents reviewed for hydration, in a sample of 3. Resident C Findings include: The closed clinical record of Resident C was reviewed on 1/3/11 at 12:40 P.M. The resident was admitted to the facility on 10/8/10 with diagnoses including, but not limited to, pneumonia, congestive heart failure, and dementia. An Admission Nursing Assessment, dated 10/8/10, indicated the resident was cognitively impaired with poor decision making skills, was incontinent of bowel and bladder, and was independent with eating. The resident was hospitalized from 10/12/10 to 10/16/10 with the diagnosis of "GI bleed." A "Nutrition Risk Assessment," dated 10/18/10, indicated the recommended total fluid intake was "2154 cc" daily. A Physician's order, dated 10/26/10, indicated, "Cefazolin [antibiotic] 250 mg IM q [every] 8 [hours] x 7 days for UTI [urinary tract infection]." The resident was transferred to the hospital on 12/11/10 and returned the same day with the diagnosis of "UTI." Nurse's Notes included the following notations: 12/17/10 at 2:00 A.M.: "...confused to place et [and] time...Continues on Levaquin [an antibiotic]	F 327		

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F 327	Continued From page 14 for UTI...." 12/17/10 at 6:00 P.M.: "Remains confused. Total care [with] all ADL's [activities of daily living]. Had loose stools x 2...." 12/19/10 at 1:30 P.M.: "Res [resident] had ls [loose] stool x 2...Incontinent of B/B [bowel and bladder]... (name of physician) aware of ls stool [with] N.O. [new order]...." A Physician's order, dated 12/19/10, indicated, "Imodium [anti-diarrheal] [one] q [every] 3 hrs prn [as needed] loose stools. Flagyl 250 mg...[three times daily] x 7d for GI distress." A Physician's order, dated 12/21/10, indicated, "Lomotil [anti-diarrheal] give [two] tabs...q 4 [hours] prn [as needed for diarrhea." Nurse's Notes continued: 12/23/10 at 10:00 A.M.: "...has had [no] loose stools today yet...fluids enc [encouraged] et taken in water well [sic]. Incont of B/B...Chem 8 [lab] reported to [physician] [with] N.O." A Physician's order, dated 12/23/10, indicated, "Chem 8 results...D/C [discontinue] Bumex, hold Lasix, [Potassium] x 5 days...Chem 8 on Mon 12-27-10." 12/23/10 at 1:30 P.M.: "Res very lethargic @ this x - had [no] ls stool until staff went to get res [up]...CNA reports had to feed res lunch she was unable to feed herself - notified [physician] of [change] in condition [with] N.O. to send to ER...." 12/23/10 at 5:00 P.M.: "[Hospital] phoned et res	F 327		

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F 327	Continued From page 15 admitted [with] DHD [dehydration]." A "BM Monitoring" form, dated December 2010, indicated the following stools: 12/16, 2 medium loose; 12/17, 5 extra large loose and 2 medium loose; 12/18, 2 medium loose and 1 medium watery; 12/19, 2 medium loose, 1 medium watery, and 1 extra large watery; 12/20, 3 large loose +; 12/21, 3 large loose; 12/22, 2 large loose, 1 medium loose, 3 extra large loose. The resident's Medication Administration Record indicated she received Imodium three times: on 12/19, 12/20, and 12/23. The resident received Lomotil one time on 12/23/10 [untimed]. Resident C's intake and output record, dated December 2010, indicated the following 24 hour fluid intake: 12/16, 480 cc; 12/17, 1440 cc; 12/18, 1980 cc; 12/19, 1630 cc; 12/20, 600 cc; 12/21, 600 cc; 12/22, 1840 cc. A Plan of Care, dated 12/19/10, indicated a problem of "Fluid Volume Deficit related to Inadequate fluid intake, Diarrhea Intermittent, 12-19-10 Flagyl as ordered, Imodium as ordered, 12-21-10 Lomotil as ordered. Clear liquid diet as needed, Increase [water] intake, 12-19-10 Imodium adm. - loose stools stopped. 12-23-10 Despite efforts to [increase] fluids (which pt [patient] had been taking in) admitted to [hospital] - Dx [diagnosis] dehydration...." The Interventions included, "Monitor for poor skin turgor, concentrated urine, dry skin...diarrhea, lethargy...Monitor fluid intake and output every shift. Encourage fluids as ordered 12-19 Res fed...."	F 327		

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F 327	Continued From page 16 A Plan of Care regarding hydration status was not observed in the clinical record prior to 12/19/10. The hospital clinical record of Resident C was reviewed on 1/4/11 at 9:45 A.M. An Emergency Room Nurse's Note, dated 12/23/10 at 2:45 P.M., indicated, "...diarrhea x 1 week. Has had [increased] lethargy. Upon arrival incontinent of BM...not oriented. Skin turgor poor...." An Emergency Room Note, dated 12/23/10, indicated, "...she had a history of diarrhea...the diarrhea has gotten a lot worse, and the patient has become more lethargic...Laboratory: ...BUN and creatinine are 61 and 2.14 [abnormal results, indicative of dehydration] respectively...Assessment: Diarrhea with acute kidney injury...." On 1/4/11 at 12:30 P.M., during an interview with LPN # 1, she indicated she was the normal day shift nurse taking care of Resident C. LPN # 1 indicated the resident did not have any loose stools for her, but had heard she did for other staff. On 1/4/11 at 12:45 P.M., during an interview with the Director of Nursing [DN], she indicated nursing would be unaware of the required fluid intake recommended by the dietician unless a diet communication would be sent to nursing. The DN indicated she did not know why nursing would not have given the resident the medication ordered for diarrhea, but that the facility had recently changed the way BMs were documented. This federal tag relates to Complaint IN00084086.	F 327		

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F 327	Continued From page 17 3.1-46(b)	F 327		

16

January 19, 2011

Indiana State Department of Health
Attention: Brenda Meredith, RN
Public Health Nurse Supervisor
2 North Meridian Street
Indianapolis, Indiana 46204

Dear Brenda Meredith,

Please accept this addendum to our plan of correction for our survey dated January 4, 2011:

F327 "Please explain how the dietitian and nursing will communicate fluid needs for acute situation."
Response: The Food Service Manager or her designee is part of the daily clinical interdisciplinary team meeting. Fluid needs will be communicated at that time. The facility's RD will follow up during facility visits every two weeks.

All Tags Other than paper audits, will there be any audits with observations to insure interventions are being completed."
Response:
F279 During the random reviews of 5 residents per week (as stated in the plan of correction), this review includes a visual observation of those residents.
F282 During the random reviews of 5 residents per week (as stated in the plan of correction), this review includes a visual observation of those residents.
F312 Residents are being observed to insure assistance with personal hygiene is being provided. As stated in the plan of correction, monitor for provision of services is intended to mean a visual observation of that resident.
F327 During the random reviews of 5 residents per week (as stated in the plan of correction), this review includes a visual observation of those residents.

app 1/27/11 BM

Thank you for accepting this addendum and please do not hesitate to contact me if further clarification is needed.

Sincerely,

Carolyn Davis

Carolyn Davis, Administrator
Fox Ridge Health Investors
1-812-882-1783
Vincennes, In.