STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 2, 3, 4, 7, and 8, 2019 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 7 Medicaid: 54 Other: 2 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 14, 2019	F 0000	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
F 0583 SS=E Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to ensure residents' medical information remained confidential for 1 of 1 medication pass and 4 of 4 residents. (Resident 17, 31, 44, and 57) Findings include: On 01/04/19, beginning at 12:54 p.m., LPN 12 used a medication administration electronic health record to set up and administer Resident 17's medication. When LPN 12 walked away from the medication cart, the computer screen was left up	F 0583	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that	02/07/2019

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	and had the resident's name, photo, and medications on the screen. LPN 12 then prepared Resident 31's medications and left the computer screen on with Resident 31's name, photo, and medications on the screen when she walked into Resident 31's room to administer the medication. LPN 12 next prepared Resident 44's medications and left the computer screen on with Resident 44's name, photo, and medications on the screen when she entered Resident 44's room to administer the medication. LPN 12 prepared and administered Resident 57's medication and left the computer screen on with Resident 57's name, photo, and medications on the screen when she walked away from the medication cart. On 1/4/19 at 1:15 p.m., LPN 12 had closed the computer screen when she went into the next room to administer medications, and when she lifted the computer screen, the resident's picture, name, and medications came back up without having to put in a password. LPN 12 said that she doesn't turn the computer off because she doesn't know how to turn it back on, she was never showed that. On 1/8/19 at 9:10 a.m., the Director of Nurses (DoN) indicated the nurses are expected to treat the computer like they would a paper medication administration book, and close it when they walk away from it. A policy for Medication Administration Preparation and General Guidelines was provided by the DoN. The policy included, but was not		the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. F583 – Personal Privacy/Confidentiality of Records 1.The EMAR computer screen was secured at the time of the alleged deficiency. Nurse was verbally educated regarding securing medical information before leaving the medication cart unattended. 2.Residents with electronic medical record had the potential to be affected by the alleged deficiency. DNS conducted education huddles regarding the need to secure medical information before leaving the medication cart unattended. 3.All staff with access to electronic medical records to be educated by DNS or designee regarding personal privacy and confidentiality of records including but not limited to the computers on the medication carts. 4.DNS or designee to audit facility medication carts to ensure personal privacy is met 5x a week for 4 weeks, 3x a week for 8 weeks and then weekly thereafter for 12 weeks. Audits to be reviewed in QAPI for 6 months or	

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	limited to, "...16)...privacy is maintained at all times for all resident information (e.g., MAR) [by closing the MAR book/covering the MAR sheet or computer screen] when not in use...." 3.1-50(d)		until 100% compliance is achieved. 5.To be completed by February 7, 2019.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility			

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	would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and			

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	(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review the facility failed to provide in writing, to the residents, families and the ombudsman with a notice of the reason why the residents were being transferred to the hospital for 1 of 1 resident reviewed for hospitalization (Resident 57) Findings include: During an interview, on 1/2/19 at 2:57 p.m., Resident 57 indicated he was in the hospital in	F 0623	**F623 – Notice Requirements Before Transfer/Discharge** 1.Resident 57 had transfers added to the log for submission to the Ombudsman. 2.Facility audited residents who were transferred or discharged within the past 30 days were logged and sent to the Ombudsman. 3.ED or designee to educate	02/07/2019

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	November and has been in the hospital for pneumonia. Resident 57's record was reviewed on 1/4/19 at 2:39 p.m. and indicated diagnoses that included, but were not limited to, congestive heart failure, left sided weakness after stroke, diabetes, kidney failure, blood clots in left lower leg, chronic respiratory failure with low oxygen, and chronic obstructive pulmonary disease. A significant change minimum data set, dated 12/9/18, indicated Resident 57 was cognitively intact. Progress notes, dated 1/6/2019 at 6:33 p.m.: "Behavior Charting Describe Behavior/Mood: Resident began asking to be sent to ER, resident states per Dialysis if he is having pain or issues with the port, he was to go to the ER immediately. Resident became loud with staff What was the resident doing prior to or at the time of behavior/mood: Resident was sitting at the Nursing Station no issues, joking with staff no issues was addressed or voiced. Interventions attempted: : Called 911 at resident's request. No signs or symptoms of distress observed. Notified [Name of] NP (Nurse Practitioner) of residents request to be transported to ER and asked for an order to send him to ER, per [NP] order was refused due to resident not having any urgent symptoms yet if the resident wants to call 911 himself now or in the future it is his right. [NP] goes on to say she will be speaking to the Medical Director to suggest resident be transferred to another facility due to the inability to meet the needs he requires and she said please inform resident of this...Resident verbally refused VS (vital signs) and assessment and paperwork needed for hospital. Resident wheels himself to		nursing staff and social services regarding the need to provide, in writing, to the residents, families and the ombudsman with a notice of the reason why the residents were being transferred to the hospital. 4.ED or designee to audit facility transfers and discharges to ensure written notices of transfer or discharge are issued 5x a week for 4 weeks, 3x a week for 8 weeks and then weekly thereafter for 12 weeks. Audits to be reviewed in QAPI for 6 months or until 100% compliance is achieved. 5.To be completed by February 7, 2019.	

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	the front of the building awaiting EMS (emergency medical services). [Name of] NP called and requested resident have a psych(psychiatric) eval (evaluation) upon admission to (local hospital). Called and spoke with ER Nurse report given, EMS here to transport and report given. Effectiveness of the interventions: Not effective." Progress notes dated 12/26/2018 at 6:55 p.m.: "General Note Note Text: Resident approached the nursing station, complaining of pain to Dialysis port, area is CDI (clean,dry,intact), no redness to area. Demanded to be sent out to the ER if not he was going to rip out the port. Nurse Manager was witnessed to conversation. 911 was called and [Name of] NP was notified of residents demand. Vital signs obtained T99.1 BP 155/88 P84 RR 20 O2Sat 98 on 3L." Progress notes dated 12/26/2018 at 7:04 p.m.: "General Note Note Text: EMS here to transport resident via stretcher to (local hospital) ER, in stable condition, transferred to stretch x 1 assist." Progress notes dated 12/13/2018 at 12:13 a.m.: "Change of Condition Situation: Resident complaining of pain midline upper chest. Resident says the pain was so severe it woke him up Background: Has a history of Cardiac issues Assessment: VS obtained T 98.6, P 143/91, P 78, RR 22, O2 98 % on 3l per NC Response: Notified [Name of] NP, she asked if resident had Nitroglycerine on his med list, resident does not. received verbal order to send to ER for eval and treatment. Called 911 and called ER and spoke to [Name] RN and gave report." Progress notes dated 12/5/2018 at 8:40 p.m.: "Change of Condition Situation: resident called aid in to let her know he was having some left sided numbness. and if we didn't squad him out he was going to call the ambulance himself.			

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	Background: I went into room to assess resident and he stated he had already called the squad, I left room to get equipment for vitals and in that time resident had called another aid in the room and informed them that he was also having some chest pain. Assessment: I let the RN in building know what was going on and he called [Name of]. she stated to send resident to ED. I called squad after obtaining VS, BP 69/50 p 104 temp 98.7 R 18 O2 96 Response: resident was in room, while paperwork was obtained an aide sat with him." Progress notes dated 12/6/2018 at 6:23 a.m. "General Note Note Text: this nurse spoke with [Name] on 4 East at [local] hospital. resident was admitted for observation for chest pain." On 1/08/19 at 12:52 p.m., the Medical Records Director indicated she could not locate the paperwork where the resident and resident representative were notified of the transfer/discharge to the hospital and the bedhold, including the reserve bed payment for the dates of 1/6/19, 12/26/18, 12/13/18, or 12/5/18. A policy for transfers and discharges was provided by the Director of Nurses on 1/8/19 at 2:20 p.m. The policy included, but was not limited to; "...Conditions for Transfers and Discharges...When a resident has a change of medical condition which requires transfer for the medical care and services...Notification of Transfer...This notification will include: Reason for and effective date of transfer, location of transfer, explanation of right to appeal, name, address, and telephone number of ombudsman and other parties/agencies required by the state...The timing of notification will be based on state and federal regulations. The resident and their family will be notified verbally for unplanned acute transfers (the written notice will follow the verbal notification as soon as possible). A copy			

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	of the written notice of transfer is to be included in the resident's records...." 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)D) 3.1-12(a)(9)(F) 3.1-12(a)(9)(G)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which			

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	specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to provide a resident or the resident's representative with a bed hold notice when a resident was transferred to a hospital for 1 of 1 resident reviewed for hospitalization. (Resident 57) Findings include: During an interview, on 1/2/19 at 2:57 p.m., Resident 57 indicated he was in the hospital in November and has been in the hospital for pneumonia. Resident 57's record was reviewed on 1/4/19 at 2:39 p.m. and indicated diagnoses that included, but were not limited to, congestive heart failure, left sided weakness after stroke, diabetes, kidney failure, blood clots in left lower leg, chronic respiratory failure with low oxygen, and chronic obstructive pulmonary disease. A significant change minimum data set, dated 12/9/18, indicated Resident 57 was cognitively intact. Progress notes, dated 1/6/2019 at 6:33 p.m.: "Behavior Charting Describe Behavior/Mood, Resident began asking to be sent to ER, resident states per Dialysis if he is having pain or issues with the port, he was to go to the ER immediately... Called 911 at resident's request. No signs or symptoms of distress observed. Notified [Name of] NP (Nurse Practitioner) of residents request to be transported to ER and asked for an order to send him to ER, per [NP] order was refused due to resident not having any urgent	F 0625	**F625 – Notice of Bed Hold Policy Before/Upon Transfer** 1.Since survey date of 1/8/19, Resident 57 has had no further transfers to the hospital and therefore no bed hold policy has been issued. 2.Since survey date of 1/8/19, no additional residents have had a transfer to the hospital and therefore no bed hold policy has been issued. 3.ED or designee to educate nursing staff and social services regarding the need to provide a resident or the resident's representative with a bed hold notice when a resident is transferred to the hospital. 4.ED or designee to audit facility transfers to ensure written notices of the bed hold policy have been issues to the resident or resident's representative 5x a week for 4 weeks, 3x a week for 8 weeks and then weekly thereafter for 12 weeks. Audits to be reviewed in QAPI for 6 months or until 100% compliance is achieved. 5.To be completed by February 7, 2019.	02/07/2019

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	symptoms yet if the resident wants to call 911 himself now or in the future it is his right...Resident wheels himself to the front of the building awaiting EMS. [Name of] NP called and requested resident have a psych(psychiatric) eval (evaluation) upon admission to [local] Hospital. Called and spoke with ER Nurse report given, EMS here to transport and report given." Progress notes dated 12/26/2018 at 6:55 p.m.: "General Note Note Text: Resident approached the nursing station, complaining of pain to Dialysis port, area is CDI (clean,dry,intact), no redness to area. Demanded to be sent out to the ER if not he was going to rip out the port. Nurse Manager was witnessed to conversation. 911 was called and [Name of] NP was notified of residents demand. Vital signs obtained T99.1 BP 155/88 P84 RR 20 O2Sat 98 on 3L." Progress notes dated 12/26/2018 at 7:04 p.m.: "General Note Note Text: EMS here to transport resident via stretcher to Reid ER, in stable condition, transferred to stretch x 1 assist." Progress notes dated 12/13/2018 at 12:13 a.m.: "Change of Condition Situation: Resident complaining of pain midline upper chest. Resident says the pain was so severe it woke him up...received verbal order to send to ER for eval and treatment. Called 911 and called ER and spoke to [Name] RN and gave report." Progress notes dated 12/5/2018 at 8:40 p.m.: "Change of Condition Situation: resident called aid in to let her know he was having some left sided numbness. and if we didn't squad him out he was going to call the ambulance himself...Response: resident was in room, while paperwork was obtained an aide sat with him." Progress notes dated 12/6/2018 at 6:23 a.m.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	"General Note Note Text: this nurse spoke with [Name] on 4 East at [local] hospital. resident was admitted for observation for chest pain." On 1/08/19 at 12:52 p.m., the Medical Records Director indicated she could not locate the paperwork where the resident and resident representative was notified of the transfer/discharge to the hospital and the bedhold, including the reserve bed payment for the dates of 1/6/19, 12/26/18, 12/13/18, or 12/5/18. A policy for transfers and discharges was provided by the Director of Nurses on 1/8/19 at 2:20 p.m. The policy included, but was not limited to; "...Conditions for Transfers and Discharges...When a resident has a change of medical condition which requires transfer for the medical care and services...Notification of Transfer...This notification will include: Reason for and effective date of transfer, location of transfer, explanation of right to appeal, name, address, and telephone number of ombudsman and other parties/agencies required by the state...The timing of notification will be based on state and federal regulations. The resident and their family will be notified verbally for unplanned acute transfers (the written notice will follow the verbal notification as soon as possible). A copy of the written notice of transfer is to be included in the resident's records...." 3.1-12(25)(A) 3.1-12(25)(B)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	01/08/2019

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	(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview the facility failed to develop a care plan for a resident with diabetes, and failed to implement the care plan to notify the physician of a low blood sugar for 2 of 5 residents reviewed for care plans, (Resident 15, and 27). Findings include: 1. Resident 15's record was reviewed on 1/7/19 at 1:46 p.m. His diagnoses included but, were not limited to, diabetes mellitus due to underlying condition with diabetic neuropathy, morbid obesity due to excess calories.	F 0657	**F657 – Care Plan Timing and Revision** 1.Resident 15 had care plan for Diabetes developed. 2.Facility to audit all other residents with a diagnosis of diabetes to ensure a care plan is in place and implemented to notify the physician of blood sugars outside of notification parameters. 3.DNS or designee to educate nursing staff regarding implementing and following the	02/07/2019

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	Review of physicians recapitulation orders dated 1/3/19, indicated humalog inject as per sliding scale: if 0-60 < 61, notify MD; 61-150=0 u, 151-200=1 u, 201-250=2 u, 251-300=3 u, 301-350=4 u, 351-399=5 u, 400+ >399, notify MD, subcutaneously before meals and at bed time related to diabetes mellitus, lantus inject 50 u subcutaneously at bedtime related to diabetes mellitus. No care plan found for insulin use/diabetes. On 1/7/19, at 2:14 p.m., interview with the Director of Nursing indicated she could not find a care plan for insulin use/diabetes. 2. On 1/4/19, at 12:35 p.m., Resident 27's record was reviewed. Her diagnoses included but, were not limited to, type 2 diabetes mellitus without complications, long term (current) use of insulin. Review of the physicians recapitulation orders indicated Levemir FlexPen Solution Pen-injector 100 unit/ml Inject 5 unit subcutaneously at bedtime related to type 2 diabetes mellitus without complications, blood glucose test strip (glucose blood)1 drop in vitro in the morning for diabetes related to type 2 diabetes mellitus without complications, Call MD if <60 or>400 Documentation of a blood sugar reading dated 11/26/18 at 5:35 a.m., indicated a blood sugar of 54. Nursing progress notes dated 11/26/18, indicated no documentation of physician notification for a low blood sugar of 54. Review of Resident 27's care plan indicated an		care plan intervention of notifying the physician of a blood sugars outside of notification parameters. ED or designee to educate MDS staff regarding the need to develop a care plan for residents with a diabetes diagnosis. 4.DNS or designee to audit blood sugars to ensure physician notification of a blood sugar outside of notification parameters is completed 5x a week for 4 weeks, 3x a week for 8 weeks and then weekly thereafter for 12 weeks. ED or designee to audit all new admissions with a diagnosis of diabetes to ensure a care plan is developed 2x a week for 4 weeks, weekly for 8 weeks and then 2x a month thereafter for 12 weeks. Audits to be reviewed in QAPI for 6 months or until 100% compliance is achieved. 5.To be completed by February 7, 2019.	

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	Alteration in Blood Glucose due to: Insulin Dependent Diabetes Mellitus, Goals: Patient will experience minimal signs and symptoms associated with hyperglycemia/hypoglycemia through next review period, Interventions: Administer medications as ordered [NS], Consults as ordered by Physician (podiatry, nephrology, nutritional, ophthalmology) [NS,DS,SS], Diabetes Foot Screen upon admission and quarterly [NS], Labs per Physician order and PRN for change in condition/manifestation of clinical signs or symptoms [NS], Observe for high blood sugar symptoms - increased thirst, increased hunger, increased urinary output [NS,DS,SS,ACT], Observe for low blood sugar symptoms - flushed face, sweating, change in usual mental status, lethargy, irritability, fruity breath odor, coma, nervousness, trembling, difficulty concentrating, lightheadedness [NS,DS,SS,ACT], Report abnormal results per Physician parameters/guideline [NS,DS,SS,ACT], Report to Nursing/Physician any signs and symptoms of advanced hypoglycemia - confusion, lethargy, loss of concentration, poor coordination, drowsiness, general weakness, sudden altered mood and behavior, tachycardia, vision changes, seizures and coma [NS,DS,SS,ACT] On 1/7/19 at 2:37 p.m., an interview with the Director of Nursing indicated she could not find documentation that the physician was notified of the low blood sugar. The "Interdisciplinary Care Plan Policy" was provided by the Director of Nursing on 1/8/19 at 10:39 a.m., included the following: "Policy Statement: The Interdisciplinary care plan (ICP) team, will participate in the development of a comprehensive care plan for each resident. Purpose: The Interdisciplinary care plan is			

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	implemented to guide the Living Center in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident and to promote the participation of the resident, family, or legal representative in planning care." 3.1-35(c)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) 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 assist with nail care and failed to assist a dependent resident out of bed for 2 of 2 residents reviewed for Activities Of Daily Living (ADL) assistance (Resident 22 and resident 20). Findings include: 1.) During an observation on 1/02/19 at 10:57 a.m., Resident 22's fingernails were long with dark substance underneath them. The resident was laying in bed awake. During an observation on 1/03/19 at 10:11 a.m., Resident 22's fingernails long with a lot of dark debris underneath them. The resident was laying in bed awake. During observation on 1/03/19 at 2:37 p.m., Resident 22 was laying in bed, his fingernails were long with dark debris underneath them.	F 0677	**F677 – ADL Care Provided for Dependent Residents** 1.Facility provided nail care to Resident 20 & 22. 2.Facility assessed all other residents to ensure nail care is completed. 3.DNS or designee to educate nursing staff regarding ADL Care including but not limited to nail care and dependent resident assistance. 4.DNS or designee to audit a minimum of 5 residents for proper nail care 5x a week for 4 weeks, 3x a week for 8 weeks and then weekly thereafter for 12 weeks. DNS or designee to audit a minimum of 2 dependent residents bed mobility 5x a week for 4 weeks, 3x a week for 8 weeks and then weekly thereafter for 12	02/07/2019

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	During observation on 1/04/19 at 11:40 a.m., Resident 22 was laying in bed his fingernails were long with dark substance underneath them. During an interview with CNA 8 on 1/4/19 at 3:02 p.m., CNA 8 indicated she had never assisted Resident 22 out of bed and had only seen him up one time and that was on a holiday when his family came. During an interview with CNA 9 on 1/4/19 at 3:05 p.m., CNA 9 indicated Resident 22 did not get out of bed and he was "bed bound". Review of the record of Resident 22 on 01/04/19 at 1:40 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, hypertension, convulsions, anemia, major depression disorder, aphasia, joint pain and right hand contracture , hemiplegia and hemiparesis affecting the right dominant side and Cerebral Vascular Accident (CVA) (stroke). The Minimum Data Set (MDS) for Resident 22, dated 10/24/18, indicated the resident was severely impaired for daily decision making and had no rejection of care. The resident transferred once or twice with the assistance of two people and required extensive assistance of two people for personal hygiene. The resident had functional limitation in his range of motion on one side of his upper extremity and lower extremity. The plan of care for Resident 22, dated 6/12/18, indicated the resident was dependent on staff for ADL's related to right sided hemiplegia due to CVA. The interventions included, but were not limited to, use mechanical lift for transfers of two staff.		weeks. Audits to be reviewed QAPI for 6 months or until 100% compliance is achieved. 5.To be completed by February 7, 2019.	

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	During an interview the Director Of Nursing (DON) on 1/7/19 at 3:52 p.m., indicated she was unsure why the facility staff had not been assisting Resident 22 out of bed, but she had seen the resident out of bed on 1/5/19. 2.) During an observation on 1/02/19 at 11:15 a.m., Resident 20's fingernails were long on both hands with some black debris underneath them. During an observation on 1/03/19 10:11 a.m., Resident 20's fingernails with long on both hands with some debris underneath them. The resident's right hand was contracted with no splint device in place. During observation on 1/03/19 at 2:35 p.m., Resident 20's fingernails on both hands were long with some debris underneath them. During observation on 1/04/19 at 11:38 a.m., Resident 20's fingernails were long on both hands with some dark debris underneath them. During an interview with CNA 8 on 1/4/19 at 3:02 p.m., indicated it was the nurses responsibility to clean and cut Resident 22 and Resident 20's fingernails because both residents were diabetic. During an interview with CNA 9 on 1/4/19 at 3:05 p.m., indicated it was the nurses responsibility to cut and clean Resident 22 and Resident 20's fingernails as both residents were diabetic. Review of the record of Resident 20 on 1/03/19 at 1:37 p.m., cerebral infarction, hemiplegia and hemiparesis, diabetes, Cererbrovascular Vascular Accident (CVA) (stroke), chronic viral hepatitis, pain chronic ischemic heart disease, adult failure to thrive, feeding difficulty, hyperlipidemia,			

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	aphasia and hypertension. The Minimum Data Set (MDS) assessment for Resident 20, dated 12/12/18, indicated the resident was moderately impaired for daily decision making. The resident had no behaviors of rejection of care. The resident required extensive assistance with personal hygiene. The plan of care for Resident 20, dated 5/25/18, indicated the resident had alteration in Activities of Daily Living (ADL) related to hemiplegia right extremities due to CVA and required extensive to total assistance with ADL's. The bath policy provided by the Director Of Nursing on 1/7/19 at 1:50 p.m., indicated the purpose was to cleanse, refresh, and soothe the resident. Care of fingernails are a part of the bath. "Fingernails and toenails of diabetic residents are cut by the licensed nurse or podiatrist. 3.1-38(a)(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to			

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	promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to provide a pressure relieving cushion to a resident's wheelchair and failed to keep the resident's medication treatment in a secure place to prevent the resident from self treatment of an acquired pressure ulcer for 1 of 2 residents reviewed for pressure ulcers. (Resident 49). Finding include: 1.) During an interview and observation on 1/02/19 at 11:55 a.m., Resident 49 indicated he had a pressure ulcer on his "bottom" and was unsure how long he has had it but it had been awhile. The resident was observed in a wheelchair sitting on a pillow. The resident indicated the pressure ulcer was painful and that he was sitting on two pillows to help cushion the wheelchair. The resident was continuously repositioning himself back and forth in the wheelchair during the interview. During an observation on 1/3/19 at 10:35 a.m., Resident 49 was sitting in his room in a wheelchair on a pillow, there was no pressure relieving cushion in the wheelchair. During an observation on 1/4/19 at 9:46 a.m., Resident 49 was sitting in his wheelchair on a pillow, there was no pressure relieving cushion in the wheelchair. The resident indicated he applied the medication treatment to his pressure ulcer himself most of the time. The resident indicated the medication treatment was in his bathroom. A tube of calmoseptine ointment was observed sitting on the back of the resident's toilet. The medication treatment was dated 12/4/18 and labeled with the resident's name. CNA 11	F 0686	**F686 – Treatment/Services to Prevent/Heal Pressure Ulcer** 1.Facility provided a pressure relieving cushion to Resident 49's wheelchair. Facility removed Resident 49's medication treatment from the resident and store in a secure place. 2.Facility audited all other residents that have an intervention of a pressure relieving cushion to ensure they are in place. Facility audited all other resident rooms to ensure all medication treatments are properly stored. 3.DNS or designee to educate nursing staff regarding proper storage of medications and treatments. DNS or designee to educate nursing staff regarding care plan interventions including but not limited to pressure relieving cushions. 4.DNS or designee to audit a minimum of 2 residents with an intervention of a pressure relieving cushion 2x a week for 4 weeks, weekly for 8 weeks and 2x a month thereafter for 12 weeks. DNS or designee to audit a minimum of 5 resident rooms to ensure medications and treatments are properly stored 5x a week for 4 weeks, 3x a week for 8 weeks and weekly thereafter for 12 weeks. Audits to be reviewed in QAPI for 6 months or until 100%	02/07/2019

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	indicated she was unsure why the resident's medication treatment was in his bathroom but she would give it to the nurse. During an interview on 1/4/19 at 9:53 a.m., RN 4 indicated he did not know why Resident 49's calmoseptine ointment was in the resident's bathroom. During an observation and interview on 1/4/19 at 10:49 a.m., RN 4 applied calmoseptine ointment to Resident 49's rectal area, the area was red. The resident had a 1 centimeter round open area on the left buttock. RN 4 was unaware the resident had a pressure ulcer and was going to call the physician for a treatment. Resident 49 had a pillow in his wheelchair and no pressure relieving cushion. During an observation on 1/7/19 at 9:10 a.m., Resident 49 was sitting in his room in a wheelchair on a pillow no pressure ulcer cushion in wheelchair. The Calmoseptine ointment dated 12/4/18 and labeled with resident's name was sitting with the lid open on the back of the resident's toilet. LPN 5 indicated she did not know if the resident required a pressure relieving cushion in his wheelchair. During an interview with LPN 5 on 1/7/19 at 9:15 a.m., indicated she did not see an order for the pressure relieving cushion to Resident 49's wheelchair. Review of the record of Resident 49 on 1/7/19 at 3:15 p.m., indicated the resident's diagnoses included, but were not limited to, end stage renal disease, Alzheimer's disease, anxiety disorder, muscle weakness, congestive heart failure, dementia and diabetes.		compliance is achieved. 5.To be completed by February 7, 2019.	

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The Significant Change Minimum Data Set (MDS) for Resident 49, dated 12/1/18, indicated the resident was cognitively intact for daily decision making. The resident was at risk to develop a pressure ulcer and had a pressure reducing device in his chair. The resident used a wheelchair as a mobility device.

The plan of care for Resident 49, dated 12/13/18, indicated the resident was at risk to develop a pressure ulcer due to assistance with Activities Of Daily Living (ADL), incontinence, diabetes and refusal to lay down in bed most of the time. The interventions included, but were not limited to , provide a pressure reducing wheelchair cushion.

The physician order for Resident 49, dated 12/19/18 at 10:57 a.m., indicated the resident was ordered calmoseptine ointment (menthol zinc oxide) to be applied to bilateral inner buttocks topically every day and evening shift for redness.

The wound evaluation for Resident 49, dated 1/4/19 at 2:23 p.m., indicated the resident had a stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed) on the left buttock acquired in the facility. The pressure ulcer measured 0.8 centimeters (cm) by 0.8 cm by 0.1 cm. The treatment was hydrogel once daily and cover with a bandage.

During an interview with Director Of Nursing (DON) on 1/7/19 at 9:55 a.m., indicated it was communicated to staff about pressure relieving cushions in the electronic health record. The DON indicated it was not the facilities normal practice to leave medication treatments in the residents bathroom. The DON indicated it was the

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	responsibility of the nurse to ensure medication treatment was not left in Resident 49's bathroom. During an interview with the DON on 1/7/19 at 3:51 p.m., indicated she was unsure what happened to Resident 49's pressure relieving wheelchair cushion and she had placed a new one in his chair today. The DON indicated it was the responsibility of the CNA's to ensure pressure relieving devices were in place. The skin integrity guideline policy provided by the DON on 1/7/19 at 1:25 p.m., indicated the purpose was to provide a comprehensive approach for monitoring skin conditions, decrease pressure ulcers and to promote healing of wounds. The residents utilizing wheelchair as primary mode of transportation will have a pressure redistribution device in place as indicated by the plan of care. 3.1-40			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility			

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	receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review the facility failed to provide a splint device on contracted hand and failed to provide Passive Range Of Motion (PROM) for 1 of 3 residents reviewed for range of motion/ positioning devices (Resident 22). Finding include: 1.) During an observation on 1/02/19 at 10:54 a.m., Resident 22 was laying in bed, his right hand was contracted and he had no splint device in place. During an observation on 1/03/19 at 10:11 a.m., Resident 22 was laying in bed, his right hand was contracted and he had no splint device in place. During an observation on 1/03/19 at 2:37 p.m., Resident 22 was laying in bed, his right hand was contracted and he had no splint device in place. During an observation on 1/04/19 at 11:40 a.m., Resident 22 was laying in bed, his right hand was contracted and he had no splint device in place. During an interview with CNA 8 on 1/4/19 at 3:02 p.m., the aides do not apply Resident 22's splint and do his range of motion. Resident 22 was on a restorative program and the restorative aide places his splint device and range of motion. During an interview with CNA 9 on 1/4/19 at 3:05 p.m., indicated Resident 22's splint device and range of motion program was completed and documented by the restorative aide.	F 0688	**F688 – Increase/Prevent Decrease in ROM/Mobility** 1.Resident 22 received PROM and provided a splint device. 2.Facility reviewed all other residents with contractures and a physician's order of a splint device to ensure they are available and in place. Facility reviewed all other residents with a physician's order for PROM to ensure program in place and completed. 3.DNS or designee to educate nursing staff regarding restorative programming and care plan interventions including but not limited to contracture management and PROM programming. 4.DNS or designee to audit restorative programming regarding contracture management and PROM 2x a week for 4 weeks, weekly for 8 weeks and 2x a month thereafter for 12 weeks. Audits to be reviewed in QAPI for 6 months or until 100% compliance is achieved. 5.To be completed by February 7, 2019.	02/07/2019

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	155157	A. BUILDING 00 B. WING	01/08/2019

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During an interview with the Restorative Nursing Aide (RNA) on 1/4/19 at 3:10 p.m., indicated Resident 22 was no longer on a restorative program for range of motion or splint device placement. The RNA indicated the resident had not been treated by restorative for a couple months and the CNA's should be providing his range of motion and splint device placement.

During an interview with the Restorative Nurse on 1/7/19 at 10:44 a.m., indicated Resident 22 was discharged from his restorative program because he was maintaining his range of motion, he had no skin issues and no problems with pain. The Restorative Nurse was unsure why nursing was not completing his range of motion or splint placement.

During an observation on 1/07/19 at 11:11 a.m., Resident 22 was laying in bed with no splint device in place in his contracted right hand.

During an observation on 1/07/19 at 2:43 p.m., Resident 22 was sitting in an specialized wheelchair, the resident's right hand contracture did not have a splint device in place.

Interview with the Director Of Nursing (DON) on 1/7/19 at 3:52 p.m., indicated Resident 22 was not receiving range of motion services or splint device placement because nursing thought restorative doing it and restorative thought nursing was doing.

Review of the record of Resident 22 on 01/04/19 01:40 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, hypertension, convulsions, anemia, major depression disorder, aphasia, joint pain and right

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	hand contracture , hemiplegia and hemiparesis affecting the right dominant side and Cerebral Vascular Accident (CVA) (stroke). The Minimum Data Set (MDS) for Resident 22, dated 10/24/18, indicated the resident was severely impaired for daily decision making and had no rejection of care. The resident transferred once or twice with the assistance of two people and required extensive assistance of two people for personal hygiene. The resident had functional limitation in his range of motion on one side of his upper extremity and lower extremity. The plan of care for Resident 22, dated 6/12/18, indicated the resident was at risk for a decline in joint mobility due to CVA. The interventions included, but were not limited to, place soft hand splint daily for at least six hours a day and Passive Range Of Motion (PROM) to upper and lower extremities to prevent further contracture's and improve circulation with morning and evening care. The Occupational Therapy discharge summary for Resident 22, dated 8/2/18, indicated the resident was being treated for a right hand contracture. The resident was treated with range of motion and right hand splint. The resident would be followed and treated by Restorative nursing. Review of the most recent restorative program documentation for Resident 22, dated October 2018, indicated the resident was receiving PROM of the right upper extremity and splint to the right hand to prevent further contracture's. The resident last treatment date by Restorative nursing was 10/14/18. The Restorative guideline policy provided by the			

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	Director Of Nursing (DON) on 1/7/19 at 1:25 p.m., indicated Restorative care included nursing interventions that assist or promote the resident's ability to maintain or improve his or her maximum functional status. The splint application and removal policy provided by the DON on 1/7/18 at 1:25 p.m., indicated the facility would ensure all residents who have an order for a splint, would be provided. A splint is a flexible appliance for fixation of displaced or movable parts; an appliance for preventing movement of a joint or preventing a contracture. 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide a resident who had numerous falls their call light and wheelchair dycem, for 1 of 1 resident reviewed for falls. (Resident 34) Findings include: Resident 34's record was reviewed on 1/3/19 at 1:54 p.m. His diagnoses included but were not limited to, Alzheimer's disease, dementia with	F 0689	**F689 – Free of Accident Hazards/Supervision/Devices** 1.Resident 34 provided dycem for their wheelchair and placed call light within reach. 2.Facility reviewed all other residents with a care plan intervention of wheelchair dycem to ensure it is in place and call light was within reach.	02/07/2019

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	behavioral disturbance, insomnia, and glaucoma. His Significant Change Minimum Data Set assessment dated 11/9/18, indicated he was usually understood and he sometimes understood others. He required extensive assistance of 2 persons for bed mobility and transfer. Post Fall Analysis/Plan's for Resident 34 indicated he had attempted to transfer himself and had slid out of bed, slid out of his wheelchair, or fell off the toilet, on 7/8/18, 7/10/18, 7/23/18, 7/26/18, 8/1/18, 8/17/18, 9/8/18, 9/13/18, 10/26/18, 10/27/18, 10/31/18, 11/4/18 11/9/18, 11/30/18, 12/8/18, 12/9/18, and 12/28/18. A plan of care for Resident 34 initiated 10/20/16, and revised on 12/10/18, indicated he was at risk for falls related to poor safety awareness, incontinence, and required extensive to total assistance with transfers. Interventions to prevent falls included his call light would be within reach and dycem would be in his wheelchair seat. On 1/4/19 at 8:51 a.m., Resident 34 was observed lying in bed. His call light was clipped to his privacy curtain out of his reach. His wheelchair had been parked in his room and no dycem was in the wheelchair seat. At 8:55 a.m., RN 4 moved the call light from the privacy curtain to Resident 34's blanket. On 1/7/19 at 9:50 a.m., Resident 34 was observed lying in bed. His wheelchair had been parked in his room and no dycem was in the wheelchair seat. CNA 2 indicated Resident 34 had no dycem in his wheelchair seat. 3.1-45(a)(2)		3.DNS or designee to educate nursing staff regarding resident call lights being placed within reach and care plan interventions including but not limited to wheelchair dycem. 4.DNS or designee to audit a minimum of 5 residents call light placement 5x a week for 4 weeks, 3x a week for 8 weeks and weekly thereafter for 12 weeks. DNS or designee to audit dycem care plan intervention for a minimum of 2 residents 2x a week for 4 weeks, weekly for 8 weeks and 2x a month thereafter for 12 weeks. Audits to be reviewed in QAPI for 6 months or until 100% compliance is achieved. 5.To be completed by February 7, 2019.	

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to provide a resident her physician ordered house supplement shake on her meal tray for 1 of 2 resident reviewed for nutrition. (Resident 42) Findings include: Resident 42's record was reviewed on 1/4/19. Her diagnoses included but were not limited to, schizoaffective disorder and abnormal weight loss. Her Significant Change Minimum Data Set assessment dated 11/23/18, indicated she was moderately impaired in her cognitive daily decision making skills. She had weight loss and had not been on a prescribed weight loss regimen.	F 0692	**F692 – Nutrition/Hydration Status Maintenance** 1.Resident 42 was provided a supplement per physician's order. 2.Facility reviewed all other residents to ensure physician orders for nutrition/hydration supplements are accurate on the dietary tray card system. 3.DNS or designee to educate nursing and dietary staff regarding following physician orders including but not limited to nutrition/hydration supplements. 4.DDS or designee to audit a	02/07/2019

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	A Nutrition Assessment for Resident 42 dated 8/8/18, indicated Mighty Shakes had been recommended with lunch and dinner for decreased appetite and continual weight loss. A physician's order for Resident 42 dated 8/10/18, indicated a House Supplement everyday and evening shift to be administered with lunch and dinner. On 1/4/19 at 12:23 p.m., Resident 42 was observed seated on the side of her bed eating lunch that had been set up by staff on her bedside table. She hadn't had a Mighty Shake. On 1/4/19 at 12:52 p.m., the Dietary Manager indicated if a health shake had been ordered with meals it would go out on the resident's meal tray. At 1:06 p.m., she indicated Resident 42 had been ordered a Mighty Shake with lunch and supper. It had not been documented on her meal ticket, so she would not have been getting it on her meal tray. 3.1-46(a)		minimum of 2 facility meal trays 5x a week for 4 weeks, 3x a week for 8 weeks then weekly thereafter for 12 weeks. Audits to be reviewed in QAPI for 6 months or until 100% compliance is achieved. 5.To be completed by February 7, 2019.	