

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>155481</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>01/23/2020</b>	
NAME OF PROVIDER OR SUPPLIER <b>ARBOR TRACE HEALTH &amp; LIVING COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3701 HODGIN RD RICHMOND, IN 47374</b>		
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00317356.</p> <p>Complaint IN00317356 - Substantiated. Federal/state deficiencies related to the allegations are cited at F692 and F712.</p> <p>Survey dates: January 21, 22 and 23, 2020</p> <p>Facility number: 000455 Provider number: 155481 AIM number: 100291010</p> <p>Census Bed Type: SNF/NF: 85 SNF: 12 Residential: 28 Total: 125</p> <p>Census Payor Type: Medicare: 17 Medicaid: 70 Other: 10 Total: 97</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on February 4, 2020</p>		F 0000	<p><b>This plan of correction is to serve as Arbor Trace's credible allegation of compliance.</b></p> <p><b>Submission of this plan of correction does not constitute -or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</b></p> <p><b>Arbor Trace respectfully requests a desk review for these deficiencies.</b></p>	
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				

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>resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§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;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.</p> <p>Based on interview and record review, the facility failed to ensure significant weight loss or weight gain of residents were identified, assessed, evaluated and monitored on an on-going basis until determined to no longer be at risk for 2 of 3 residents reviewed for weight concerns. (Resident B and C)</p> <p>Findings include:</p> <p>1. The clinical record of Resident C was reviewed on 1-22-20 at 3:35 p.m. Her diagnoses included, but were limited to, pressure areas to the right and left buttocks, bladder cancer, age-related cognitive decline, dysphagia, atrial fibrillation, history of clostridium difficile upon return from a hospital stay on 10-16-19, and chronic kidney disease.</p> <p>A review of her most recent weights documented in the clinical record of Resident C indicated the</p>	F 0692	<p><b>F692 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)</b></p> <p><b>I. Resident C has been reviewed by the Registered Dietitian. Her dietary recommendations are up to date. Her unavoidable wound statement has been updated to include significant weight loss. Her care plan has been reviewed and updated. Resident B no longer resides in the community.</b></p> <p><b>II. All residents with significant weight loss or weight gain have the potential to be affected by the alleged deficient practice. All residents with significant</b></p>	02/17/2020

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	<p>following weights of 112.3 pounds on 1-19-20, 118.6 pounds on 12-15-19, 122.6 pounds on 10-20-19 and 128.1 pounds on 7-16-19. These weights indicate a significant weight loss of 6.3 pounds, or 5.3% [percent], in the last month, a significant weight loss of 10.3 pounds, or 8.4%, in 3 months and a significant weight loss of 5.8 pounds, or 12.3%, in 6 months.</p> <p>A review of Resident C's care plans indicated a care plan for significant weight loss was not developed until 12-8-19, but she did have care plans developed prior to this date related to nutritional risk, low serum albumin levels and wounds.</p> <p>Review of the clinical record from 10-2-19 until 1-22-20, indicated Resident C experienced a physical and cognitive decline, with a hospitalization in November, 2019, and several falls during this time period. A general dietary department entry, dated 11-18-19, indicated the consistency of her fluids were changed from thin to nectar thick. On 11-22-19 and 11-26-19, an entry from the nursing department documented a new physician's order was received to change the consistency of her fluids back to thin fluids, based upon the results of a swallow study recently conducted.</p> <p>A document dated 12-10-19, and entitled, "Unavoidable Pressure Ulcer Observations and Assessment" identified Resident C's bilateral buttocks pressure areas. It addressed the resident's low serum albumin and hemoglobin levels, but did not specifically identify Resident C's significant weight loss.</p> <p>A second unavoidable wound statement, dated 1-8-20, again identified Resident C's low</p>		<p><b>weight loss or significant weight gain have been reviewed by the Registered Dietitian. Any RD recommendations have been put into place. The IDT meeting is occurring weekly to monitor significant weight loss or significant weight gain. The systemic change includes the RD will attend the IDT meeting at least monthly and make recommendations for significant weight loss or significant weight gain if needed.</b></p> <p><b>III. Education to all nursing staff has been provided to licensed nursing staff regarding the weight policy.</b></p> <p><b>IV. The DON/Designee will review through record review all residents with significant weight loss or significant weight gain to determine they are identified, assessed, evaluated and monitored on an on-going basis until determined to no longer be at risk for weight concerns. This will occur 5 days per week for 1 month and then 4 times monthly thereafter to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.</b></p>	

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	<p>albumin level and specified the resident had a "terminal diagnosis." This statement did not specifically address Resident C's significant weight loss.</p> <p>On 12-26-19, the Registered Dietician documented a weight loss of 11.8% in the last 34 days and a weight loss of 17.5% in 56 days, with the a low albumin level and the current dietary measures in place for Resident C, as well as recommendations to potentially enhance her nutritional status. This was the only entry located in the clinical record from the Registered Dietician in over 2 months.</p> <p>In an interview with the Administrator on 1-22-20 at 4:30 p.m., she indicated in late summer and through the fall of 2019, there had been some issues with the Director of Nursing (DON) position in which an interim DON had been in place until the current DON was hired in December, 2019. "There were some issues that did not get addressed as timely as they probably should have been. As far as I know, all weight issues, losses or gains, were followed up on."</p> <p>In an interview on 1-23-20 at 11:10 a.m., with DON, she relayed, "When I started here the first week of December, 2019, I found several areas that needed attention. Apparently, no one had been tracking weights closely." She shared she plans to be able to "track any changes more closely and take any weight concerns to our IDT [interdisciplinary team's] Clinically At Risk Review to look at more closely....I could not really find any recent IDT notes for the time before I came that addressed any weight concerns for...[Resident C]."</p> <p>2. The clinical record of Resident B was</p>		<b>COMPLIANCE DATE: February 17, 2020</b>	

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	<p>reviewed on 1-21-20 at 2:10 p.m. Her diagnoses included, but were not limited to, Alzheimer's disease, age-related cognitive decline, unspecified vitamin deficiency and vitamin D deficiency, GERD (gastroesophageal reflux disease), functional dyspepsia, depression, a history of a right femur fracture, and a history of urinary tract infections. It indicated she was admitted to the facility in 2016 and remained a resident of the facility until discharged to an area hospital on 1-2-20.</p> <p>A review of Resident B's most recent weights documented the following weights of 180.0 pounds on 12-11-19, 177.3 pounds on 11-11-19, no weight documented for October, 2019, 173.5 pounds on 9-3-19, 168.9 pounds on 8-6-19, 168.4 pounds on 7-2-19, and 162.0 pounds on 6-3-19. These weights indicate a weight gain of 18 pounds, or 11.1 percent (%) in 6 months.</p> <p>A review of Resident B's care plans revealed a care plan was developed on 6-14-19, for "Resident has experienced significant weight gain," with the goal identified as, "Resident will have no further significant weight gain thru [sic] next review."</p> <p>A review of Registered Dietician (RD) documentation indicated the RD had reviewed Resident B on 12-26-18 and identified "beneficial" significant weight gain of 11.1% in 33 days, 23.3% in 91 days and 19.2% in 166 days. An RD note, dated 1-24-19, indicated Resident B continued with the "beneficial weight gain" of 6.2% in 32 days, 18.5% in 88 days and 23.3% in 88 days. The next RD note, dated 6-12-19, delineated Resident B continued with significant weight gain of 7.3% in 28 days, 13.3% in 90 days and 20.2% in 167 days. No</p>			

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	<p>other RD notes were located in the clinical record, according to records printed on 1-23-20 by the Administrator.</p> <p>A review of Resident B's clinical progress notes included a note dated, 10-16-19, from the Social Services staff. This note alluded to the resident's weight gain, without specifically stating so. This note specified, "It was brought to the attention of the writer by the resident's aid [sic] that her clothes are getting tight on her and she needs some new ones brought in by family."</p> <p>In an interview with the Administrator on 1-22-20 at 4:30 p.m., she indicated in late summer and through the fall of 2019, there had been some issues with the Director of Nursing (DON) position in which an interim DON had been in place until the current DON was hired in December, 2019. "There were some issues that did not get addressed as timely as they probably should have been. As far as I know, all weight issues, losses or gains, were followed up on."</p> <p>In an interview on 1-23-20 at 11:10 a.m., with DON, she relayed, "When I started here the first week of December, 2019, I found several areas that needed attention. Apparently, no one had been tracking weights closely." She shared she plans to be able to "track any changes more closely and take any weight concerns to our IDT [interdisciplinary team's] Clinically At Risk Review to look at more closely....I could not really find any recent IDT notes for the time before I came that addressed any weight concerns for...[Resident B]."</p> <p>On 1-23-20 at 4:45 p.m., the DON provided a copy of policy entitled, "CarDon Weight Management Policy." This policy was identified</p>			

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	<p>as the current policy utilized by the facility and had an effective date of March, 2015. This policy indicated, "This policy is meant to provide guidance on obtaining weights and addressing significant weight changes...Significant weight change is defined as: 5% loss/gain in 30 days, 7.5% loss/gain in 90 days, 10% loss/gain in 180 days. Significant weight changes will be reviewed by the IDT by the 10th day of each month to ensure timely interventions are implemented to prevent further unwanted loss/gain. Significant weight loss/gain protocol (for weekly admission weights and routine monthly weight monitoring and any other weight change the IDT determines to be at risk) [includes the following steps]:</p> <ul style="list-style-type: none"> <li>-Family/physician/RD notification will be documented in the medical record.</li> <li>-The RD will be notified to assess/review the resident for recommendations on his/her next visit.</li> <li>-IDT will meet weekly on residents with significant weight changes to evaluate the current interventions and makes changes as necessary to stabilize the resident and attain the care plan goal.</li> <li>-Document meeting in the medical record.</li> <li>-Weekly weight monitoring.</li> <li>-Residents who attain their care plan goal and are stable will be reviewed by the IDT weekly x2 weeks and if the resident is stable, monthly weight monitoring after that.</li> <li>-Initiate or update care plan to include planned weight changes, expected weight changes, risks affecting weight changes, medications affecting weight changes, individual goal determined by the IDT/MD/RD/Family/Resident, RD consult and recommendations, weekly weight results, resident and family preferences being honored, resident compliance, intake records for food and fluids, supplements, nurse aide communication</li> </ul>				

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F 0712 SS=D Bldg. 00	<p>matches the care plan interventions when applicable, and utilization of the '5 Whys' for root cause analysis..."</p> <p>This Federal tag relates to Complaint IN00317356.</p> <p>3.1-46(a)(1)</p> <p>483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.</p> <p>§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.</p> <p>§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.</p> <p>Based on interview and record review, the facility failed to ensure the attending physician conducted resident visits at least every 60 days for 1 of 4 residents reviewed for timely physician visits. (Resident B)</p>	F 0712	<p><b>F712 Physician Visits-Frequency/Timeliness/Alt NPP</b> <b>CFR(s):483.30©(1)-(4)</b></p> <p><b>I. Resident B no longer resides in the facility.</b></p>	02/17/2020

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	<p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 1-21-20 at 2:10 p.m. Her diagnoses included, but were not limited to, Alzheimer's disease, age-related cognitive decline and a history of urinary tract infections. It indicated she was admitted to the facility in 2016 and remained a resident of the facility until discharged to an area hospital on 1-2-20.</p> <p>Review of the most recent visits conducted by the attending physician documented visits on 8-27-19 and 12-17-19. In an interview with the Director of Nursing on 1-23-20 at 8:55 a.m., she indicated the facility could not locate any other doctor visit notes in Resident B's clinical record for that time frame. She added the facility had spoken with the attending physician's off and no additional visits could be identified for Resident B for that time frame.</p> <p>This Federal tag relates to Complaint IN00317356.</p> <p>3.1-22(d)(1)</p>		<p><b>II. All residents have the potential to be affected by the alleged deficient practice. All residents have been reviewed to determine their physician visits are current per regulation. Any residents identified not to be in compliance have been examined by their physician.</b></p> <p><b>III. Education to all licensed nurses regarding timely physician visits. The systemic change includes the DON/Designee will monitor weekly residents due for a physician visit and notify the MD of the visit being due.</b></p> <p><b>IV. The DON/Designee will review through record review to determine physician visits are in compliance. This will occur 5 days per week for 5 random residents for 1 month and then 4 times monthly thereafter to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.</b></p> <p><b>COMPLIANCE DATE: February 17, 2020</b></p>	