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	345184	A. BUILDING _____ B. WING _____	C 01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ELIZABETH CITY	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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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 staff interview and record review the facility failed to develop and initiate a care plan for a resident at nutritional risks for 1 of 5 sampled residents (Resident # 1) whose care plan was reviewed. Findings included: Resident #1 was admitted on 12/3/14 with diagnoses that included protein calorie malnutrition, dysphagia, anorexia and dementia without behaviors.	F 279	1. Resident #1 is no longer in the facility. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the Staff Development Coordinator will perform a one time audit with current resident population to determine residents with nutritional risks. Newly identified residents will have an individualized care plan initiated. Newly identified residents will have an individualized care plan initiated. Newly admitted residents will be assessed on admission for nutritional	2/12/15

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

Electronically Signed | 02/05/2015

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F 279	Continued From page 1 Review of the care plan, with an onset date of 12/3/14, did not identify a nutritional problem for Resident #1. An interview was held with the Minimum Data Set (MDS) Coordinator on 1/14/15 at 3:26 PM. She stated the Dietary Department was responsible for the development of nutritional care plans. The Registered Dietician (RD) was interviewed on 1/14/15 at 5:50 PM. She stated she was responsible for nutritional care plans. She acknowledged care plans should be developed for any resident with a diagnosis of dehydration, anorexia or protein calorie malnutrition. The RD added if the resident is eating well, she does not automatically add a care plan. There was no explanation as to why Resident #1 had no care plan for anorexia or protein calorie malnutrition, dehydration or his weight loss. The Administrator was interviewed on 1/15/15 at 12:35 PM. She stated based on the RD's interview from yesterday, she would have expected more interventions to be added to halt Resident #1's weight loss.	F 279	risks and will be care planned as appropriate. Residents identified with nutritional risks will be discussed in daily Clinical Rounds and the weekly Standards of Care Meeting to monitor performance to ensure ongoing compliance. 3. The Staff Development Coordinator will re-educate the Interdisciplinary Team (IDT) and Licensed Nurses regarding implementation of the resident care plan as it relates to nutritional risk by 2/9/2015. The above in-service will be included in the new employee orientation program for Licensed Nurses and IDT members. 4. The DNS and/or the ADNS will audit 5 residents' care plans for the presence of nutritional risk 2 x weekly x 4 weeks the weekly x 4 and monthly x 3 to ensure resident care plans for nutritional risk are developed and implemented. 5. Data results will be presented by the DNS,reviewed and analyzed by the IDT at the centers monthly Quality Assessment and Performance Improvement meeting for three months with a subsequent plan of correction as needed.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		2/12/15

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F 280	Continued From page 2 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to revise the care plan with new interventions after a resident fall, for 1 of 3 sampled residents (Resident #1) reviewed for falls. Findings included: Resident #1 was admitted on 12/3/14 with diagnoses that included protein calorie malnutrition, dysphagia, anorexia and dementia without behaviors. The resident's care plan, with a date of 12/3/14 indicated he was at a high risk of sustaining falls. The goal indicated Resident #1 would comply with safety measures and would express understanding of personal risk factors. Interventions to attain the goal included administering calcium and vitamin D, anticipating and meeting his needs, keeping him in view and	F 280	1. Resident #1 is no longer in the facility. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the Staff Development Coordinator will perform a one time audit of residents who have sustained a fall in the last 45 days to validate the implementation of new fall interventions. Interventions will be initiated or revised on the resident care plan as needed. Residents who sustained a fall will be reviewed in the daily falls meeting and weekly Standards of Care Meeting to ensure ongoing compliance. 3. The Staff Development Coordinator will re-educate the Interdisciplinary Team (IDT) and Licensed Nurses regarding revision of the resident care plan as it relates to implementing new interventions after a resident fall by 2/9/2015. The	

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F 280	Continued From page 3 providing a safe environment. The Admission Minimum Data Set (MDS), dated 12/10/14, coded Resident #1 with short and long term memory impairment. Review of progress notes for 12/30/14 at 12:57 PM, indicated Resident #1 was found on the floor, lying on his back, beside his bed. He was assisted back to bed. No interventions or revision to the care plan were made. On 1/1/15 at 5:34 AM, progress notes indicated Resident #1 was found on the floor by the side of the bed. Review of the progress note and the 1/1/15 post fall review revealed the care plan was not revised to reflect new interventions for the prevention of falls. Progress notes dated 1/3/15 at 3:54 PM indicated Resident #1 was found in his room with his feet on the bed and his torso in the floor. The resident was placed in a geri chair. Review of the notes and the care plan failed to reveal new interventions had been placed to prevent the reoccurrence of falls. On 1/7/15, one day after Resident #1's readmission, the care plan was revised to add bolsters. The MDS nurse was interviewed on 1/14/15 at 3:26 PM. She stated it was the responsibility of the Assistant Director of Nursing (ADON) to revise the fall care plans after the interdisciplinary team (IDT) had determined an appropriate intervention. The MDS nurse confirmed the bolsters were not added to Resident #1's care plan until 1/7/15. She acknowledged the goal	F 280	above in-service will be included in the new employee orientation program for Licensed Nurses. 4. The DNS and/or the ADNS will audit 5 residents' care plans for the presence of new fall interventions 5 x weekly x 4 weeks then 2 x weekly x 4 then weekly x 4 and monthly x 3 to ensure that residents' care plans have been updated to reflect new fall interventions after a resident fall. 5. Data results will be presented by the DNS,reviewed and analyzed at the centers monthly Quality Assessment and Performance Improvement meeting by the IDT for three months with a subsequent plan of corrections as needed.	

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F 280	Continued From page 4 indicated on the care plan was not realistic for Resident #1 since he was cognitively impaired. The ADON was interviewed on 1/15/15 at 11:31 AM. She stated she was responsible for the fall program and care planning interventions after determination of appropriate interventions by the IDT team. The ADON stated she had not updated the care plan for Resident #1 until 1/7/15. She confirmed the revision occurred after Resident #1's third fall because she was doing supervisory work on the floor.	F 280		
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 observation, staff interviews and record review, the facility failed to provide oral care, failed to offer to shave a resident with facial hair and failed to provide nail care to 1 of 2 sampled residents (Resident #5) that was observed receiving morning care. Findings included: Resident #5 was readmitted to the facility on 5/21/13 with diagnoses that included kidney disease, stroke with hemiplegia, diabetes, hypertension and chronic obstructive pulmonary disease.	F 312	1. Resident #5 received oral hygiene and nail care. Resident #5 refused to be shaved. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the Staff Development Coordinator will perform a one time audit with current resident population to validate that oral hygiene, nail care and shaving is evident. 3. The Staff Development Coordinator will re-educate the Nursing Assistants to the centers policy and procedures	2/12/15

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F 312	Continued From page 5 The most current Minimum Data Set (MDS), a quarterly dated 10/21/14, indicated Resident #5 was significantly cognitively impaired and required extensive or total assistance with activities of daily living. On 1/14/15 at 9:13 AM, an observation was made of Nursing Assistant (NA) #5 providing morning care for Resident #5. The resident was observed with a growth of facial hair and black matter under his nails. At 9:44 AM, the NA had completed the resident's bath and exited the room. She stated she had completed the resident's morning care. The NA had not offered any oral care. She had not cleaned the black matter from his nails and had not offered to shave the resident. An interview was held with NA #5 on 1/14/15 at 12:18 PM. She acknowledged she had not offered oral care. The NA stated she did not notice if the resident needed to be shaved and had not noticed if his nails required cleaning. She stated she was expected to shave residents daily unless the resident preferred otherwise. The NA added nails should be cleaned when they were dirty and oral care should be offered daily. NA #5 stated she usually completed all those tasks during morning care, but that morning, it had slipped her mind. At 12:30 PM on 1/14/15, NA #5 reported she had asked the resident if he wanted to be shaven and he declined. She stated his nails were dirty and she would clean those immediately. The NA reported oral care had been completed. On 1/15/15 at 1:05 PM, the Director of Nursing (DON) stated oral care should be completed or	F 312	regarding activities of daily living with an emphasis on oral hygiene, nail care and shaving by 2/9/2015. This information will be included in the new employee orientation program for Nursing Assistants. 4. The DNS, ADNS, and/or the SDC will interview 5 interviewable residents and observe 5 dependent residents on various shifts and halls to include weekends 5 times a week for 4 weeks, 2 x weekly x 4, weekly x 4, then monthly x 3 to ensure that residents are offered and receiving oral hygiene, shaving, and nail care daily and as needed. 5. Data results will be presented by the DNS and/or ADNS, reviewed and analyzed by the IDT at the centers monthly Quality Assessment and Performance Improvement meeting for three months with a subsequent plan of correction as needed.	

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F 312	Continued From page 6 offered to residents during morning care. Shaving and nail care should be provided as needed.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and review of facility policy, the facility failed to implement new fall interventions after falls and failed to assure effective interventions were placed for 1 of 3 sampled residents (Resident # 1) reviewed for falls. Findings included: The facility policy, titled " Fall Response and Management " , with a release date of 5/12/14, indicated the rationale of post fall assessments was to attempt to determine the cause of the fall and implement individualized patient interventions to reduce the risk of a fall reoccurrence. Resident # 1 was admitted on 12/3/14 with diagnoses that included malnutrition, unspecified debility, difficulty walking, generalized muscle weakness and dementia without behaviors.	F 323	1. Resident #1 is no longer in the facility. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the Staff Development Coordinator will perform a one time audit with/on the current resident population plan of care for falls to validate the effectiveness of fall interventions. Ineffective interventions related to falls will be clarified and updated as needed. Fall interventions will be initiated and implemented for residents identified without fall interventions. 3. The SDC will re-educate the Interdisciplinary Team (IDT) and Licensed Nurses regarding the evaluation of the effectiveness of fall interventions after implementation by 2/9/2015. The above in-service will be included in the new employee orientation program for	2/12/15

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F 323	Continued From page 7 A 12/3/14 Patient Nursing Evaluation indicated Resident # 1 was unable to move around the bed without assistance. The evaluation identified the resident had a history of falls. Resident 1 ' s gait was described as weak and he was coded as either over estimating or forgetting his limitations. There were no functional limitations in range of motion of the upper or lower extremities identified. Resident # 1 was assessed as a high risk for falls. Resident # 1 ' s care plan, initiated on 12/3/14 identified him as a high risk for falls. Goals were: resident will comply with safety measures and will express understanding of personal risk factors. Interventions included administer calcium and vitamin D, anticipate and meet resident ' s needs, keep in view, and safe environment. Progress notes for 12/9/14 at 4:10 PM indicated the resident was observed trying to get out of bed without assistance. The nurse documented staff re-directed Resident # 1. An Admission Minimum Data Set (MDS), dated 12/10/14, identified the resident with long and short term memory impairment and severely impaired cognitive skills for daily decision making. Resident # 1 was coded as dependent on staff for completion of activities of daily living. Previous falls were unable to be determined. There had been no falls since admission. A Physical Therapy Discharge Summary, dated 12/23/14, indicated treatment had started on 12/4/14 and ended on 12/23/14. The therapist documented the resident was non-verbal and did not follow verbal or tactile commands. Resident # 1 was identified as a high fall risk. Discharge	F 323	Licensed nurses and IDT members. Residents who sustained a fall will be reviewed in the daily falls meeting and weekly Standards of Care Meeting to ensure interventions are implemented and sustained. The DNS and/or ADNS will updated the resident care plan and validate the intervention has been implemented. Validation of interventions will be performed daily during Clinical Rounds. 4. The DNS and/or the ADNS will audit 5 residents 5 times a week for 4 weeks, 2 x week x 4 weeks, weekly x 4, then monthly x 3 to ensure compliance with validation of effective fall interventions. 5. Data results will be presented by the DNS and/or ADNS, reviewed and analyzed at the centers monthly Quality Assessment and Performance Improvement meeting for three months with a subsequent plan of correction as needed.	

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instructions included placing the resident in a geri chair where staff could provide constant supervision for safety.

Review of a nursing progress note, dated 12/30/14 at 12:57 PM, indicated Resident # 1 was found on the floor lying on his back beside the bed. The nurse assessed the resident and found no injuries. The resident was assisted back to bed. There were no indications interventions had been added to prevent reoccurrence of the fall from the bed. At 11:25 PM, the progress notes indicated the resident had been in the geriatric (geri) chair for most of the shift for supervision.

Nursing progress notes, dated 1/1/15 at 5:34 AM revealed the resident was observed on the floor by the side of the bed. There were no injuries noted. The nurse documented she would continue to monitor. There were no interventions initiated to prevent the resident from falling off the bed.

Review of a Post Fall Evaluation, dated 1/1/15, indicated the resident had fallen at 5:30 AM. The evaluation indicated Resident # 1 was found in his room less than a foot from his bed. The nurse documented at the time of the fall, Resident # 1 appeared weak. Contributing factors were identified as an unsteady gait, history of falls and non-compliance. Interventions to prevent falls included placing the bed in the lowest position and placing the call bell within reach.

On 1/3/15 at 3:54 PM, nursing progress notes documented Resident # 1 was found in his room by a staff member. His feet were propped on the

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bed with his torso in the floor. Assessment revealed no injury. The resident was placed in a geri chair. No other interventions were placed to prevent the resident from falling off the bed.

On 1/7/15 a Post Fall Evaluation was completed for the 12/30/14 fall. Contributing factors included a history of falls. There were no interventions listed on the evaluation to prevent fall reoccurrence.

Review of the care plan revealed an actual fall had been added on 1/7/14. The goal was Resident # 1 would resume usual activities without further incident. Approaches included bed bolsters with a add date of 1/7/15 and continue interventions on the at risk plan, which was added on 1/7/15.

A Post Fall Evaluation had not been completed for Resident # 1 ' s 1/3/15 fall.

Nurse # 7 was interviewed on 1/14/15 at 2:52 PM. Nurse # 7 had been assigned to Resident # 1 during his 12/30/14 fall. She stated after a resident fell, nurses were expected to assess, complete an incident report, notify the family and the physician and document findings in the progress notes. The nurse added the expectation was to place an intervention to prevent fall reoccurrence. Nurse # 7 stated when she found the resident on the floor; the bed was already in a low position. She stated she placed the resident back in bed. She stated she was unsure why she placed him back in bed since he had just fallen out of bed. Nurse # 7 reviewed the 1/7/15 Post Fall Evaluation and her progress note for the 12/30/14 fall and acknowledged she had placed no new interventions.

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The MDS nurse was interviewed on 1/14/15 at 3:26 PM. The MDS nurse stated the interdisciplinary team (IDT), which consisted of the staff development coordinator (SDC) and the Assistant Director of Nursing (ADON) and herself reviewed falls on a daily basis and updated the care plans as needed. The MDS coordinator reviewed the care plan for Resident # 1 and stated education and reminders were not appropriate interventions for a resident with cognitive impairment, such as Resident # 1. The MDS nurse added staff was taught to add interventions after each fall. She reviewed the fall reports and added she could not understand why interventions were not added. The MDS nurse stated the ADON was responsible for review of falls and making sure interventions were implemented.

Nurse # 1 was interviewed on 1/14/15 at 4:04 PM. She stated she had been taught fall interventions were started after the second fall.

Nursing Assistant (NA) # 1 was interviewed on 1/14/15 at 4:44 PM. She stated when sitting in a geri chair, Resident # 1 would swing his legs to the side and try to get out. The NA was unaware the resident could walk with assistance. She added the resident was on fall precautions. Before he was discharged, interventions included bolsters to the side of the bed, a low bed and staff observation.

On 1/14/15 at 4:51 PM, NA # 2 was interviewed. She stated she could not remember if Resident # 1 actually had fallen. Interventions to keep him from falling included " keeping a close eye on him " by sitting him in the geri chair, staff talking

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to him if he tried to get up and using bolsters on his bed.

An interview was held with the Director of Nursing (DON) on 1/14/15 at 5:11 PM. She stated after a resident fell, nurses were expected to place interventions to prevent fall reoccurrence. The nurses are also taught to complete a post fall evaluation. The DON stated fall risk evaluations were completed on admission, readmission and quarterly. If a resident scored at a high risk for falls on admission, interventions placed were to keep the call bell in reach and education if cognitively able. The DON stated she was unaware of what interventions had been placed for Resident # 1 to prevent falls.

A telephone interview was held with Nurse # 3 on 1/15/15 at 8:20 AM. Nurse # 3 was assigned to the resident on 1/1/15 when he fell. She stated the resident was found lying face up between the bed and the heater. After assessment, the resident was placed back in bed. She stated she continued to monitor Resident # 1 for the remainder of the shift. The nurse stated Resident # 1 was unable to follow directions/commands. Interventions to prevent falls included a low bed and keeping the call bell close. The nurse added when the resident fell, the bed was low; she added Resident # 1 was unable to use the call bell. The nurse acknowledged that while she had been taught to add interventions to prevent fall reoccurrence, she had not done so on 1/1/15. There was no reason given.

The SDC was interviewed on 1/15/15 at 8:37 AM. She stated staff are taught to place interventions after resident falls to prevent reoccurrence. The SDC added a step by step guide of what nurses

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should do after falls could be found at the nurse ' s station.

On 1/15/15 at 9:19 AM, NA # 4 was interviewed. She had been assigned to Resident # 1 on 1/3/15 when he fell. The NA sated she had not been the one to find the resident, but was unable to recall the staff member that found Resident # 1 on the floor. The NA stated she was unaware the resident required fall precautions. She stated on 1/3/15, she was told, by the nurse who had talked to the ADON, that she needed to get Resident # 1 out of bed first and place him in a geri chair for observation. At the time of the 1/3/15 fall, NA # 4 stated there were no bed bolsters, mats or alarms in place for fall prevention.

At 9:43 AM on 1/15/15, Nurse # 4 was interviewed. Nurse # 4 had been assigned to Resident # 1 when he fell on 1/3/15. The nurse stated she had been alerted to the resident ' s fall from by a staff member from another unit. Nurse # 4 stated she found Resident # 1 with his feet on the bed and his upper body on the floor. After assessment, he was placed in a geri chair in the hall. The nurse stated she had placed no new interventions, but was unsure why she had not. She added the facility did not use alarms. During orientation, the nurse stated she had been shown a list of potential fall interventions to use, but was unsure where that list was kept. Nurse # 4 stated she had not been taught that a post fall evaluation was necessary.

Nurse # 5 was interviewed on 1/15/15 at 10:42 AM. She stated she had observed the resident sit up on the side of the bed by himself, but had not relayed that information to any other staff member.

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F 323	Continued From page 13 On 1/15/15 at 11:31 AM, the ADON was interviewed. She stated she was responsible for the fall program at the facility. She stated when a resident fell; the fall was reviewed the next day. Information reviewed for the fall included nurse ' s notes, the post fall evaluation and the fall scene investigation. The IDT team tried to determine the root cause of the fall and place appropriate interventions. The ADON stated when Resident # 1 was assessed as a high risk for falls on his 12/3/14 admission, interventions placed to prevent falls included providing a safe environment, low bed and meeting the resident ' s need. She added these were the standard precautions given to all residents. The ADON reviewed the information for Resident # 1 ' s 12/30/14 fall and acknowledged there were no interventions placed to prevent reoccurrence. She added she had no idea why the post fall evaluation was not completed until 1/7/15 and did not review the 1/7/15 evaluation until after the resident was discharged. The ADON reviewed the 1/1/15 fall for Resident # 1 and acknowledged no new interventions for fall prevention were initiated. She added a call bell was not appropriate as an intervention because the resident was unable to use the call bell. The ADON stated the IDT team had not reviewed the 1/3/15 fall because it had not been linked to the 24 hour report in the computer system. The ADON stated fall care plans were usually started on admission if the resident scored at high risk. She stated Resident # 1 did not have a fall care plan until after his third fall because she was on the floor doing supervisory work. The Administrator was interviewed on 1/15/15 at 12:35 PM. She stated the fall risk meetings were	F 323		

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F 323	Continued From page 14 held after staff had been made aware of a resident fall. She stated the intervention for the 12/30/15 fall was to place the resident in view. This had been placed by the IDT team and not the nurse. She stated after the 1/1/15 fall, the IDT team had decided to place bolsters on the bed. She stated she had no idea why the bolsters were not started until 1/7/15. The Administrator stated using the call bell for and intervention was useless since Resident # 1 had not been cognitively able to use the call bell. The Administrator acknowledged appropriate interventions had not been added after each fall. She stated the facility could have done more such as reviewed medications and labs and involved the resident in activities. The DON was interviewed on 1/15/15 at 1:05 PM. She stated taking 7 days to complete a Post Fall Evaluation was unacceptable. She added when the IDT team decided on a fall intervention, it was the responsibility of the ADON to make sure the interventions are placed and to notify staff of the new interventions. The IDT team reviews all notes for 72 hours after a fall to make sure documentation continues per facility policy. This was done during clinical rounds. The DON stated no interventions were added and a post fall evaluation was not completed for the 1/3/15 fall because the notes were not reviewed for the 72 hours.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325		2/12/15

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F 325	Continued From page 15 status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and the Registered Dietician (RD), the facility failed to place interventions to halt the continued weight loss and failed to accurately document the percentage of a nutritional supplement given for weight loss for 1 of 3 sampled residents (Resident #1) reviewed for weight loss. Findings included: Resident #1 was admitted on 12/3/14 with diagnoses that included protein calorie malnutrition, dysphagia, anorexia and dementia without behaviors. Review of the weight record indicated on 12/3/14, Resident #1's weight was recorded as 165.5 pounds. A Nutrition Service Note, dated 12/3/14 at 6:34 PM, indicated food preferences had been obtained from a family member. An order, written by the registered dietician on 12/3/14 and signed by the physician indicated Resident #1's diet was changed to a no added salt, mechanical soft diet with sugar substitutes. A liquid nutritional supplement was not added to the order.	F 325	1. Resident #1 is no longer in the facility. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or the Registered Dietician will perform a one time audit with current resident population to determine residents with weight loss and validate the implementation of interventions to halt continued weight loss. Newly admitted residents will be assessed for weight loss and interventions put in place to halt weight loss on admission. 3. The Staff Development Coordinator will re-educate the Licensed Nurses to the centers policy and procedures regarding accurate documentation with an emphasis on documenting the percentage of a nutritional supplement given for weight loss by 2/9/2015. The percentage of supplements consumed will be recorded on the Medication Administration Record by the Licensed Nurse. Residents with supplement orders to be reviewed in the weekly Standards of Care Meeting by the RD to validate the presence of documentation to reflect the supplement amount consumed and the need for	

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F 325	Continued From page 16 Review of the Nutrition/Nursing Communication form, dated 12/3/14, indicated the resident would receive a mechanical soft diet. A nutritional supplement was not listed on the communication form. The form was signed by the registered dietician. Review of the care plan for Resident #1, developed 12/3/14, did not address any nutritional issues including the protein calorie malnutrition, the dysphagia or the anorexia. The Medical Nutrition Therapy Assessment, dated 12/9/14, and completed by the registered dietician indicated Resident #1 was on a no added salt diet. Boost (a liquid nutritional supplement) at 237 milliliters was documented as received three times daily with meals. The most recent weight was recorded as 165.5 pounds. The section for usual body weight had been left blank. The total calories estimated as needed per day was calculated as1880 to 2256. Total protein needs were calculated as 75-90 grams per day. Fluid needs were estimated to be 2256 milliliters per day. Under Nutrition Diagnosis, Increased Nutrient Needs was highlighted in bold print related to protein as evidenced by a prealbumin of 7.6. Calculations for actual intake were not seen on the assessment. The Admission Minimum Data Set (MDS), dated 12/10/14, indicated Resident #1 had short and long term memory impairment with severely impaired cognitive skills for daily decision making. The resident had no behaviors or rejection of care identified. Resident #1 was identified as totally dependent on staff for all activities of daily living. The MDS coded the resident's weight as 166 pounds.	F 325	changes. The above information will be included in the new employee orientation program for Licensed nurses. 4. The DNS and/or the ADNS will audit 5 resident medication administration records 2 x weekly x 4 then weekly x 4 and monthly x 3 to validate accurate documentation of the percentage of a nutritional supplement given for weight loss. 5. Data results will be presented by the DNS and/or the RD, reviewed and analyzed at the centers monthly Quality Assessment and Performance Improvement meeting by the Interdisciplinary Team for three months with a subsequent plan of correction as needed.	

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F 325	Continued From page 17 On 12/14/14, the resident's weight was recorded as 160.6 pounds. This reflected a weight loss of 5 pounds in 11 days. A Medical Nutrition Therapy Assessment, dated 12/17/14 at 4:15 PM, indicated the resident was eating well on a no added salt, mechanical soft diet. The RD documented the resident had good meal intake and monitoring would continue. Resident #1's weight was recorded as 158.3 pounds on 12/21/14. This reflected a 7.2 pound weight loss in 18 days. On 12/28/14, the resident's weight was recorded as 158 pounds. From 12/24/14 to 12/31/14, the Individual Resident Meal Intake Record indicated Resident #1's breakfast intake ranged from 25% to 100 % with a 7 day average of 83%. Lunch intake for the resident ranged from refused (12/30/14) to 100% with a 7 day average of 82%. The average intake for dinner ranged from 25% to 60% with a 7 day average of 41% intake of food. Review of the December 2014 Medication Administration Record (MAR), revealed an entry that indicated Resident #1 received Boost (a liquid nutritional supplement), 237 milliliters with all meals. The sections were B (breakfast), L (lunch) and D (dinner). The nurses had initialed as given, but the percentage of the supplement consumed by Resident # 1 was not documented. Review of the January 2015 Individual Resident Meal Intake Record revealed the following: · January 1- refused all foods and fluids	F 325		

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· January 2-refused all food and fluid
· January 3-refused all food. Received 240 ml of fluid for breakfast and 240 ml of fluid for lunch
· January 4-ate 10% of breakfast and received 120 ml of fluid, refused lunch and drank 240 ml of fluid

Review of the January 2015 MAR indicated Resident #1 received Boost, 1 can three times a day with meals. The start date was listed as 12/3/14. There was no indication of the percentage of the supplement consumed by Resident #1.

Review of the Meal Tray Card (used by dietary staff to identify food dislikes/likes, type of diet and supplements that should be added to meal trays) did not include an entry for the Boost.

Nursing progress notes for 1/4/15 at 11:30 AM indicated the resident's pulse rate was elevated between 112 and 120. The nurse noted the resident was lethargic and pocketing food. The physician was notified and orders received to send Resident #1 to the hospital for evaluation. Resident #1 was admitted to the hospital.

Readmission notes for 1/6/15 at 4:41 PM indicated Resident #1 had been discharged with diagnoses that included altered mental status, hypernatremia and acute renal failure.

An interview was held with Nurse #1 on 1/14/15 at 4:04 PM. The nurse stated that typically, Resident #1 ate and drank well. She stated if a change in intake were noted, she would pass it on to the next shift. If the resident's poor intake continued, by the second day she would call the physician. The nurse stated she worked January

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1st and 2nd, 2015 and did not remember calling the physician about Resident #1's intake. The nurse reviewed the intake record. She stated no one had reported the resident's lack of intake to her and she was not aware he had eaten nothing for 2 days.

Nursing Assistant (NA) #2 was interviewed on 1/14/15 at 4:51 PM. She stated the resident's appetite had been poor during his entire facility stay. The NA added, the resident would clamp his mouth shut or let food sit on the tip of his tongue. The NA stated she had told nurses, but could not recall which nurses she had told. The NA reviewed the schedule and verified she had worked the 3-11 shifts on 1/2/15. She also reviewed the Meal Intake Record for 1/2/15 and stated an " R " meant the resident refused his meal. The NA stated she was unaware the resident had refused food and fluid during the supper meal on 1/2/15.

The Director of Nursing (DON) was interviewed on 1/14/15 at 5:11 PM. The DON stated if a resident typically ate and then all of a sudden refused meals, she expected the physician to be notified. The DON stated the physician had been aware of a decreased intake for Resident #1 when the physician came into the facility on 12/31/14. She added she would have expected one of the nurses to notify the registered dietician (RD) or the physician that Resident #1 was only drinking ½ of the ordered supplement, since the supplement had been ordered for weight loss. The DON stated if Resident #1 had not consumed the entire supplement, his weight would continue to decline, as it did. The DON reviewed the nurse's notes for January 1-4, 2015. She stated she would have expected the nurse

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that documented on 1/3/15 her knowledge that the resident's intake had been worse for 3 days to have contacted the physician. The DON added that one of the nurses that worked during that period of time should have alerted the physician that Resident #1 had quit eating all together. The DON stated she was unaware the resident had quit eating.

The RD was interviewed on 1/14/15 at 5:50 PM. She stated she was in the facility twice weekly. The RD stated on admission she had reviewed food preferences with Resident #1's family member and had added a supplement to be given with meals three times a day for weight loss. She stated she wanted the supplement to be given to Resident during meals by the staff member that fed him so she could be sure Resident #1 actually received the supplement. The RD stated she could also ask how much of the supplement Resident #1 consumed. The RD stated the only interventions placed for Resident #1's weight loss were those initiated on admission, which included the Boost. She added she had not been notified of the resident's refusal to eat until 1/6/14 when he was readmitted after hospitalization. The RD stated she would ask staff how much the resident consumed of the Boost and thought Resident #1 consumed the can of Boost, but on review of the MAR documentation, she added there was no way to tell how much Resident #1 actually drank.

Nurse #3 was interviewed via telephone on 1/15/15 at 8:20 AM. The nurse stated Resident #1's intake was poor. During medication pass, she would prepare 120 mls (milliliters) of Boost. The nurse added Resident #1 consumed "sips at best."

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NA #3 was interviewed on 1/15/15 at 8:52 AM. She stated at first, Resident #1 ate pretty good and then his appetite went down. Before the resident was sent to the hospital on 1/4/15, he averaged eating 50-75% of his breakfast and lunch. The NA added Resident #1 drank the fluids provided on his meal tray. The NA stated the nutritional supplement was not delivered on the meal tray. Typically, it was given either by the nurse or the nurse would give it to a NA to be given. NA #3 stated the resident usually drank about 120 mls of the supplement. She added she would report the percentage to her nurse for the day. The NA stated if a resident refused to eat or drink she reported the refusal to the nurse. The NA stated she had documented Resident #1's intake for 1/3/15 and 1/4/15. She added she was sure she had reported the lack of intake to a nurse, but was unable to remember to whom she had reported Resident #1's intake.

NA #4 was interviewed on 1/15/15 at 9:19 AM. She stated when the resident first arrived he ate slowly and often it took multiple staff to get him to eat. Typically, the NA stated, Resident #1ate a good breakfast and then consumed 25-50% of lunch. The NA stated she had worked with the resident on 1/3/15 and recorded the breakfast intake. She stated the 240 mls represented the supplement only and no food or other fluids. She stated she had reported the refusal of the food to the nurse.

The Dietary Manager (DM) was interviewed on 1/15/15 at 9:22 AM. He stated the dietary department provided some supplements. He stated he added supplement orders as the RD directed. The DM stated the RD had not asked if

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any resident actually consumed the supplement. He added he had seen supplements come back to the kitchen unopened, but he did not know to whom those particular supplements had been sent. The DM stated he did not send the Boost with Resident #1's meals because the dietary department had only Boost pudding and not cans of Boost. The DM was unaware Resident #1's intake from 1/1/15 to 1/4/15 had been little to none.

Nurse #4 was interviewed on 1/15/15 at 9:43 AM. She stated when she reported to work on Saturday, January 3, 2015; she received report that Resident #1 pocketed food. The nurse stated previously the resident's family member or a therapist would feed the resident. She added it took a long time to feed him, but as long as you gave the resident time he would eat. After he was discharged from therapy and the family member was not there to feed him, his intake declined. On 1/4/15, the nurse stated a NA reported to her the resident's lack of eating. She called the physician who ordered the resident be transported to the hospital for probably dehydration. Nurse #4 also stated the physician told her to ask the family if they wished to have a feeding tube placed. The nurse reviewed the nurse's notes and the documentation about declined intake and the meal intake record and stated she would have expected someone to call about his lack of food intake prior to 1/4/15. The nurse stated she was unsure if the nutritional supplement was on the meal tray. She added she usually gave Resident #1 at least 120 mls once during her day shift. She added the percentage of supplement consumed by Resident #1 was not listed on the MAR.

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On 1/15/15 at 10:42 AM, Nurse #5 was interviewed. She acknowledged she had written the note on 1/3/15 that indicated the resident had poor intake for 3 days. The nurse stated she had received a report during shift change that Resident #1 was pocketing food. When the NA notified her of the poor intake for 3 days, this was the first time she had been made aware. She was unable to recall which NA reported the poor intake. The nurse stated when she received the information about Resident #1's poor intake; she documented that information in the nurse's notes. She admitted she was unaware until review of the meal intake record at this time that he had not taken any food for 3 days. She stated she did not notify the physician of poor intake for 3 days because it was late and at the end of her shift. Nurse # 5 stated the Boost was given during medication pass and did not come on the meal tray. She stated Resident #1 would usually drink sips to 120 mls. In retrospect, Nurse #5 stated she should have notified the physician of Resident #1's declining intake.

Nurse #6 was interviewed on 1/15/15 at 12:04 PM. She stated she worked the 3-11 shifts. The nurse stated Resident #1's food intake was variable. After he returned from the hospital on 1/6/14 with an order for thickened liquids, the nurse reported the resident's fluid intake was better. Prior to that, the nurse stated fluids had to be "spooned" into his mouth. Nurse #6 stated she had worked 1/2/14 on the 3-11 shift; adding she had not received any reports concerning the resident's poor intake. Nurse #6 added she gave the resident approximately 120 mls of nutritional supplement on her shift. She added this was done intermittently over the course of the shift. She stated looking at the MAR, there was no way

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to tell how much of the supplement the resident consumed. The nurse stated the RD had not inquired how much of the supplement the resident consumed.

Nurse #2 was interviewed on 1/15/15 at 12:17 PM. She stated only today had she started documenting the percentage of supplements consumed by each resident. Prior to today, the nurse stated she had only signed the entry as the supplement was given. The nurse stated the RD did review the MAR, but had not asked about the percentage of supplement consumed. The nurse added the RD would have had no idea of how much supplement was consumed by looking at the MAR since the percentage was not documented.

An interview was held with the Administrator on 1/15/15 at 12:35 PM. She stated she found no order for the nutritional supplement. She added it was the facility's policy to have an order for supplements given for weight loss. She stated supplements given with meals should have the supplements included on the meal tray. The Administrator stated she had no idea nutritional supplements were not delivered on meal trays until the Dietary Manager had told her that day. She stated she would have expected the nurses to call the physician on 1/1/15 when the resident went from eating his meals to consuming nothing. She added she would have expected the nurses to notify the physician and the RD that Resident #1 consumed only half of the nutritional supplement. She acknowledged the amount of supplement consumed needed to be documented so no one would have to guess at the amount consumed. She stated the fact that Resident #1 only received ½ of the intended nutritional

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F 325	Continued From page 25 supplement possibly could have contributed to his continued weight loss. The Administrator added she thought more interventions should have been added to halt the resident's weight loss. Nurse #1 was interviewed on 1/15/15 at 12:35 PM. She stated the RD would ask if a resident accepted a supplement, but had not inquired about the percentage consumed. Nurse #7 was interviewed on 1/15/15 at 1:08 PM. She stated the RD had not questioned her about the percentage of a supplement residents consumed. She added if she feels there is a problem, then she told the RD.	F 325		
F 327 SS=G	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 observations, staff interviews and review of medical records, the facility failed to follow a physician ' s order to push fluids and failed to assure the resident met the minimum fluid requirements for 1 of 3 sampled residents (Resident #1) which resulted in hospitalization with a diagnosis of dehydration. Findings included: Resident #1 was admitted on 12/3/14 with diagnoses that included protein calorie malnutrition, anorexia, dehydration and dementia.	F 327	1. Resident #1 is no longer in the facility. 2. The Director of Nursing Services, Assistant Director of Nursing, and/or Staff Development Coordinator will perform a one time audit on the current resident population to validate residents with an order to push/encourage fluids. New orders to push/encourage fluids will be transcribed to the MAR to include intake. Intake will be totaled each shift. 3. The Staff Development Coordinator	2/12/15

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F 327	Continued From page 26 Laboratory (lab) results, dated 12/05/14, indicated a Blood Urea Nitrogen (BUN) level of 18 milligrams per deciliter (mg/dl) (BUN is a blood test that may be used to determine dehydration. The normal range is 7-18 mg/dl). Resident #1 ' s creatinine (a high creatinine level in the blood may also indicate dehydration) was 1.2 mg/dl (the normal range for creatinine is 0.6-1.3mg/dl) and his sodium was reported as 145 millimole per liter (mmol/L) (Elevated sodium levels may indicate dehydration. The normal range for sodium is 136-145mmol/L). Review of a 12/9/14 Medical Nutrition Therapy Assessment, completed by the registered dietician (RD), indicated Resident #1's estimated daily fluid needs were 2256 milliliters (mls) per day. On 12/12/14, Resident #1's BUN had increased to 20 mg/dl, his creatinine had remained at 1.2 mg/dl and his sodium had increased to a level of 150 mmol/L. Review of 12/15/14 lab results indicated Resident #1's BUN had risen to 24 mg/dl, his creatinine was recorded as 1.4 mg/dl and his sodium was recorded as 148. The results had been faxed to the physician. The physician had returned the copy of the labs with the results of the creatinine, sodium, potassium and chloride circled. The physician had hand written the words, push fluids with a line drawn from what he had written to the results of the labs. Review of telephone orders for 12/15/14 did not reveal the order to push fluids had been written. Review of the December 2014 Medication	F 327	will re-educate the Licensed Nurses regarding meeting the minimum fluid requirements to prevent dehydration by 2/9/2015. The minimum daily fluid requirement will be transcribed on the Medication Administration Record by the Registered Dietician and/or the Licensed Nurse. The above information will be included in the new employee orientation program for Licensed Nurses. This information will be reviewed weekly in the Standards of Care Meeting to ensure ongoing compliance. 4. The DNS and/or the ADNS will audit 5 resident consumption sheets and medication administration records 2 x weekly x 4 weeks, then weekly x 4 and monthly x 3 to ensure that identified residents are meeting the minimum fluid requirements to prevent dehydration. 5. Data results will be presented by the DNS and/or RD, reviewed and analyzed at the centers monthly Quality Assessment and Performance Improvement meeting by the Interdisciplinary Team for three months with a subsequent plan of correction as needed.	

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Administration Record (MAR) did not reveal the order to push fluids had been transcribed.

Lab results for 12/19/14 indicated a BUN of 20 mg/dl, creatinine of 1.2 mg/dl and sodium level of 148 mmol/L. Review of progress notes, written by Nurse # 6 on 12/19/14 at 6:16 PM, indicated the labs were faxed to the physician with no new orders obtained.

On 12/26/14, labs were again drawn with the results of BUN 26 mg/dl and sodium 153 mmol/L obtained. The physician had hand written on the lab results to push fluids. There was no indentifying information that noted which staff member had taken the lab results from the printer and filed the lab results.

Review of the physician's telephone orders for 12/26/14 and the December 2014 MAR failed to reveal the order to push fluids had been transcribed.

Review of physician's telephone orders for 12/30/14 indicated an order had been obtained to push fluids and to recheck Resident #1's lab work in one week. The facility nurse had signed off on the order on 12/30/14 at 6:00 PM.

On 12/30/14 at 6:21 PM, Nurse #6 documented the physician had reviewed Resident #1's lab work and had faxed new orders to push fluids and repeat the lab work in a week. Review of the MAR indicated the order had not been transcribed.

Resident #1's care plan, with a review date of 12/30/14, indicated he had renal failure with a kidney injury. Goals were identified as Resident

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#1 would have adequate fluid volume balance as evidenced by good skin turgor, pink and moist mucous membranes and sufficient fluid intake. Interventions to achieve the goal included giving fluids as ordered-restrict or give as ordered.

Physician progress notes, dated 12/31/14, indicated Resident #1 was doing fair. The physician documented the resident was drowsy and dehydrated. The physician documented the resident had an increased sodium and his plan was to recheck the lab work.

Review of the December 2014 Individual Resident Meal Intake Record indicated the resident's fluid intake ranged from a low of 360 mls on 12/20/14 to a high of 1200 mls on 12/31/14.

Review of the January 2015 Individual Resident Meal Intake Record indicated on January 1st and January 2nd, Resident #1 had no fluid intake. On January 3rd, his fluid intake totaled 480 mls and prior to his hospitalization on January 4th, his fluid intake totaled 360 mls.

Nursing progress notes, dated 1/4/15 at 11:30 AM indicated Resident #1 had a pulse that ranged between 112 beats per minute to 120 beats per minute (the average heart rate is considered to be 70 beats per minute). The resident was described as lethargic. The nurse notified the physician. The nurse documented the physician ordered the resident to be sent to the hospital for evaluation and added he was probably dehydrated.

The Hospital History and Physical (H & P), dated 1/4/15, indicated the family member reported

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decreased oral intake over the past week. The hospital physician documented Resident #1's lab work was checked on 12/26/14 and nursing home staff had been advised to increase the resident's fluid intake. The physician also documented Resident #1 had a November 2014 admission with a diagnosis of dehydration. Under Physical Examination, the physician documented Resident #1's oral mucosa as dry. Lab work revealed a sodium of 159 mmol/L, a BUN of 62 mg/dl and a creatinine of 1.6 mg/dl. Under Assessment and Plan, the hospital physician documented acute encephalopathy multifactorial, recent dehydration, hypernatremia and acute urinary tract infection most likely as the causes. He also documented the hypernatremia was most likely due to the dehydration. The plan was to rehydrate.

Review of hospital forms dated 1/6/15 listed dehydration as an active problem for Resident #1.

Nurse #7 was interviewed on 1/14/15 at 2:52 PM. She stated the term push fluids meant to give fluids during medication pass and with meals. If a physician had ordered push fluids for a resident, the nurse stated it would have been entered on the MAR and all fluids given would be documented. The nurse was unaware the resident had received an order to push fluid.

On 1/14/15 at 4:04 PM, Nurse #1 was interviewed. She stated an order to push fluids meant she was supposed to encourage as much fluid as possible and then to document on the intake and output sheet the amount of fluid taken. Nurse #1 stated she would also include the intake amount in her nurse's notes and on the MAR. The nurse added she was unaware Resident #1 had an order to push fluids.

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The Director of Nursing (DON) was interviewed on 1/14/15 at 5:11 PM. She stated fluids documented on the meal intake form only represented the fluids received at meals. She stated if a nurse received an order to push fluids, the nurse was expected to transcribe that order to the MAR, divide the entry by shifts and initial fluids were encouraged.

The RD was interviewed on 1/14/15 at 5:50 PM. She stated fluids documented on the meal intake record only represented fluids received on the meal tray. She added there was no system in place to document supplements or extra fluids given throughout the day.

Nurse #3 was interviewed via telephone on 1/15/15 at 8:20 AM. She stated any order to push fluids was placed on the MAR. The nurse could not remember if Resident #1 had an order to push fluids.

On 1/15/15 at 8:52 AM, Nursing Assistant (NA) #3 was interviewed. She stated fluids documented on the meal intake record only represented fluids received during meals. She was not sure where other fluids received would be documented. She stated prior to Resident #1's hospitalization on 1/4/15, he would typically drink the water, juice and hot tea that was provided on his meal trays.

NA #4 was interviewed on 1/15/15 at 9:19 AM. She stated initially Resident #1 drank pretty well. On his breakfast tray he received water, juice and milk and for lunch usually tea and water. She stated she recorded only the fluids received on the meal tray. The NA stated she had worked with Resident #1 on 1/2/15 and 1/3/15. The NA

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stated she had reported the resident was not eating and drinking to the nurse.

Nurse #4 was interviewed on 1/15/15 at 9:43 AM. She stated orders to push fluids were to be placed on the MAR. Nurse #4 stated she had been unaware Resident #1 had an order to push fluids until 1/4/15 when she reviewed the chart prior to sending him to the hospital. She stated the facility had the ability to give intravenous fluids, but was unsure this would have made a difference in the outcome for Resident #1.

On 1/15/15 at 10:42 PM, Nurse #5 was interviewed. She stated after the NA reported the resident ' s poor intake of fluids and food on 1/3/15, she assessed Resident #1. The nurse stated she found Resident #1's mucous membranes to be dry. She added his lips were also dry. Nurse #5 could not remember if the resident's skin tented (tenting is a term used to describe dehydration. Tenting appears when the skin is pinched and the skin remains in a tented position after the skin is released). She stated she did not notify the physician of the resident's lack of oral intake or the signs of dehydration because it was late and near the end of her shift. Nurse #5 stated an order to push fluids was expected to be written on the MAR. The nurse added she had been unaware Resident #1 had an order to push fluids.

Nurse #6 was interviewed on 1/15/15 at 12:04 PM. She stated when an order is received to push fluids; it was placed on the MAR. The nurse acknowledged she was the nurse that received the 12/30/14 physician's order to push fluids for Resident #1. She stated the order should have been placed on the MAR and had no explanation

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F 327	Continued From page 32 why she had not placed the order on the MAR. Nurse #6 stated she had relayed the information regarding the order to push fluids verbally to the other nurses.	F 327		