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

PRINTED: 09/01/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. BUILDING ____ B. WING ____	08/25/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE CARE CENTER	1001 NORTH 500 WEST PROVO, UT 84601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 224 SS=G	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not develop and implement policies and procedures that prohibited neglect. Three out of 21 residents (residents 6, 8 and 18) experienced multiple falls. Incidence of individual falls, within this sample, ranged from two to five. These three residents sustained actual harm as a result of falls. The facility neglected to develop, fully implement and re-evaluate interventions to avoid physical harm associated with falls. Findings include: 1. Resident 8 was admitted to the facility on 6/17/93 with diagnoses which included, Parkinson's disease, meningioma, hypertension, history of breast cancer/mastectomy and dementia. A review of resident 8's medical record was completed on 8/25/05. A quarterly Minimum Data Set (MDS) assessment completed by facility staff on 7/7/05, documented that resident 8 had short and long term memory problems and her cognitive skills	F 224 9/21/05 PoC acceptable completion date 10/21/05 [signature]	F224 A nursing policy and procedure for falls and at risk residents was written by the D.O.N. on 09/01/05. This was implemented by the D.O.N./A.D.O.N. at an inservice with the staff on 09/09/05. This policy and procedure was placed in each Medication book on 09/09/05. All incident reports are entered in to the facility computer weekly and a fall and restraints meeting is held weekly by the D.O.N. Starting 09/16/05 and thereafter weekly. All of these findings are reported at the QA meeting Quarterly by the D.O.N. Starting 09/21/05 and thereafter quarterly. Actual fall care plan and interventions to be completed with each fall by the D.O.N./A.D.O.N. Starting 09/16/05 and with each fall and restraint meeting. The MDS nurse will implement at each MDS/IDT meeting, Injury, high risk for falls care plan updates at least every 90 days and as needed. The D.O.N./A.D.O.N. will review the Nursing Communication book prior to standup meeting to identify falls not reported on incident reports, and to assure once identified that a report is made. This will all be reviewed in standup meeting. To be completed by 10/21/05. Resident 6 Care plan has been updated and resident has been placed on a restorative program for balance and gait training progress is being monitored. Resident 8 Care plane has been updated and resident has been put on a lower	

Utah Department of Health
63934
SEP 16 2005
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 9/15/05

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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F 224	Continued From page 1 for daily decision making were moderately impaired. The facility staff also documented that resident 8 was physically abusive. The facility staff documented that resident 8 was able to transfer and ambulate with extensive assistance. The facility staff documented that resident 8 was incontinent of bowel and bladder. The facility staff documented that resident 8 had fallen within the past 30 days and the last 31-180 days. On 4/6/05 and 7/7/05, facility nurses completed the "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 8. The 4/6/05 assessment, resident 8's assessed score was "21" and the 7/7/05 assessment, resident 8's assessed score was "19". Both assessments indicated that resident 8 was a high risk for falls. A review of resident 8's medical record, revealed a comprehensive care plan dated 4/13/04, last reviewed on 7/7/05, addressing resident 8's fall risk. The care plan documented the following, "Fall 01/02/05, 11/01/04 L (left) hand fx (fracture), 03/08/05, 03/13/05, 5/14/05. There was no evidence documentation that the comprehensive care plan had been updated by facility staff since 5/14/05. On 5/14/05 at 10:00 PM, a nurse's note in resident 8's medical record documented the following entry: "Resident found in a sitting position on the floor in her bedroom [with] her [right] hand reaching through the bedrails to the space underneath her roomates [sic] bed...Pea size blood blister on [right] forefinger..." On 5/14/05 at 10:00 PM, a facility nurse documented the following on an "Resident Incident Report": "...Found on floor across	F 224	bed, floor mat a personal alarm/bed alarm, resident was moved closer to the nurses station to be observed more closely. Resident 18 Care plan has been updated. Resident has been assessed by fall/restraints team and placed on a low bed. Resident objected to this and now has agreed to a personal alarm.	

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F 224	Continued From page 2	F 224		

bedroom [with] hand reaching through bedrails to underneath roomates [sic] bed...blood blister [right] fore finger..."

On 6/29/05 at 12:00 AM, a nurse's note in resident 8's medical record documented the following entry: "[patient] had a fall from the bed, the bed alarm went off [and] we found [patient] on the floor mat on hands and knees with head bent down between hands...[patient] has hematoma on [left] forehead, laceration on bridge of nose [and] skin tear on [left] knee..."

On 6/29/05 at 12:00 AM a facility nurse documented the following on an "Resident Incident Report": "...[Patient] rolled out of bed while attempting to get up found [patient] on hands [and] knees [with] head bent betwn [sic] hands..." Under "type of Injury" the facility nurse marked the box beside laceration and hematoma.

On 7/22/05 at 9:30 PM, a nurse's note in resident 8's medical record documented the following entry: "[patient] sitting on her BR (bathroom) toilet trying to urinate for UA (urinalysis). CNA (certified nursing assistant) left BR saw call light on; found resident sitting up on floor [with approximate] 3 cm (centimeter) gash on back of head..."

On 7/22/05 at about 9:30 PM, a facility nurse documented the following on an "Resident Incident Report": "...Resident was sitting on her toilet trying to urinate for UA (urinalysis) into hat. CNA (certified nursing assistant) left BR (bathroom) [and] was call lite [sic] turned on; found resident sitting up on floor [with] 3 cm (centimeter) gash on back of head..."

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F 224	Continued From page 3 On 7/23/05 at 3:00 AM, a nurse's note in resident 8's medical record documented the following entry: "Resident received back from [local hospital]...[left] rear occipital clean dry [with approximately] 8 staples..." On 7/30/05 at 1:30 AM, a nurse's note in resident 8's medical record documented the following entry: "Res (resident) found on floor on mat next to bed by CNA (certified nursing assistant)...Abrasion found on [left] scapula..." On 7/30/05 at 1:15 AM, a facility nurse documented the following on an "Resident Incident Report": "...Res (resident) found on floor next to bed, on pad...Abrasion to [left] scapula noted..." On 8/19/05 at 11:10 PM, a nurse's note in resident 8's medical record documented the following entry: "...[resident 8] was found sitting up on carpeted floor next to roommates bed. 3cm (centimeter) [by] 1 cm superficial abrasion noted on [left] forehead..." On 8/19/05 at 11:10 PM, a facility nurse documented the following on an "Resident Incident Report": "...[Resident 8] was found sitting up on carpet floor [with] abrasion to forehead..." On 8/23/05 at 2:00 PM, a facility nursing assistant was interviewed. She states that resident 8 had an increase in falls over the past month and a half. She further stated that resident 8 had confusion. On 8/23/05 at 2:10 PM, a facility nurse was interviewed. She stated that resident 8 was a big	F 224		

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F 224	Continued From page 4 fall risk and she had a few falls within the past month. She further stated that no new interventions were put into place they were just "emphasizing on things already in place." On 8/25/05 at 7:15 AM, another facility nursing assistant was interviewed. She stated that resident 8 was a 1 person assist, was incontinent of urine and was a high fall risk. She stated that resident 8 has had a bed alarm in place for as long as she had worked there, which was over 3 weeks. On 8/25/05 at 7:20 AM, a third facility nursing assistant was interviewed. She stated that resident 8 was a maximum assist, was incontinent of urine and could not be left on the toilet alone because she would fall. The nursing assistant stated that she had been working at the facility since January 2005 and that resident 8 had a bed alarm, chair alarm since before the summer of 2005. On 8/25/05 at 7:25 AM, another facility nurse was interviewed. She stated that resident 8 was a high fall risk, was incontinent of urine and due to her confusion could not be left on a toilet alone. The facility nurse stated that she had been at the facility since November of 2004 and that resident 8 had always resided in a room by the nurse's station. She further stated that in March 2005 they implemented a floor mat due to resident 8's falls. She could not recall any other interventions put into place for resident 8's falls. Based on the documentation it was determined that resident 8 had 5 falls from 5/14/05 until 8/19/05. Two of the falls occurred on the evening shift and 3 of the falls occurred on the night shift.	F 224		

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F 224	Continued From page 5 There was no documentation to provide evidence that facility staff developed interventions, individualized to resident 8's needs to reduce her falls or to minimize potential injury. 2. Resident 18 was admitted to the facility on 7/24/05 with diagnoses which included, contusions, elbow replacement, osteoporosis, hypertension and degenerative joint disease. A review of resident 18's medical record was completed on 8/25/05. A admission MDS assessment completed by facility staff on 7/30/05, documented that resident 18 had short and long term memory problems and her cognitive skills for daily decision making were severely impaired. The facility staff also documented that resident 18 was verbally abusive and resisted cares. The facility staff documented that resident 18 required extensive assistance with transfers and was totally dependent with ambulation. The facility staff documented that resident 18 had fallen within the past 31-180 days. On 8/4/05, a facility nurse completed the "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 18. On the assessment, resident 18's assessed score was "12", which indicated the resident at a high fall risk. A review of resident 18's medical record, revealed a comprehensive care plan dated 8/4/05, addressing resident 18's fall risk. There was no documentation to evidence that the comprehensive care plan had been updated by facility staff.	F 224		

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F 224	Continued From page 6 On 8/11/05, a nurse's note in resident 18's medical record documented the following: "Pt (patient) fell today while trying to get into bed by herself she reopened some previous wounds on her legs. She also has a few bruises on her arms..." On 8/11/05 at 11:05 AM, a facility nurse documented the following on a "Resident Incident Report": "...Pt (patient) was trying to get back into bed by herself and fell. She reopened some previous wounds on her legs..." Under "Type of Injury" the facility nurse marked the box indicating that resident 18 received hematomas and abrasions. On 8/16/05 at 4:00 PM, a nurse's note in resident 18's medical record documented the following, "...Pt (patient) fell this AM causing 1x1 cm (centimeter) skin tear to [left] elbow...has multiple skin abrasions from pt attempting to get [up] off toilet per self [and] fell onto floor..." A "Resident Incident Report" could not be located regarding resident 18's fall dated 8/16/05. On 8/25/05 at 7:20 AM, a facility nursing assistant was interviewed. She stated that resident 18 was a high fall risk. She stated that she was not aware of any fall interventions for resident 18. Based on the documentation it was determined that resident 18 had 2 falls since her admission on 7/24/05. One fall occurred on the day shift and the other fall occurred on the evening shift. There was no documentation to provide evidence that facility staff developed interventions,	F 224		

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F 224	Continued From page 7 individualized to resident 18's needs to reduce her falls or to minimize potential injury. 3. Resident 6 was admitted to the facility on 9/9/04 with diagnoses which included, senile dementia, coronary artery bypass graft, osteoarthritis, and gastrointestinal distress. A review of resident 6's medical record was completed on 8/25/05. A quarterly MDS assessment completed by facility staff on 9/14/04, documented that resident 6 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 6 was able to transfer with extensive assistance, and ambulate with limited assistance. The facility staff documented that resident 6 was incontinent of bowel and bladder. On 9/22/04, 12/22/04, 3/23/05, and 6/23/05, facility nurses completed the "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 6. The 9/22/04 assessment, resident 6's assessed score was "14", the 12/22/04 assessment, resident 6's score was "14", the 3/23/05 assessment, resident 6's score was "16", and the 6/23/05 assessment, resident 6's assessed score was "18". All assessments indicated that resident 6 was a high risk for falls. A review of resident 6's medical record, revealed a comprehensive care plan dated 9/22/04, last reviewed on 6/23/05, addressing resident 6's fall risk. The care plan documented the following, "Fall 2/22/05, 3/18/05, 5/14/05, 6/12/05, and	F 224		

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F 224	Continued From page 8	F 224		

6/19/05". There was no documentation or evidence that the comprehensive care plan had been updated by facility staff since 6/23/05.

On 2/22/05 at 2:30 AM, a nurse's note in resident 6's medical record documented the following: "[Pt] found on floor in room. No there residents present, no wandering residents in area when observed. [Pt] assessed moving all extremities no [s/s discomfort with ROM] with assist [pt] amb back to bed without difficulty. Further assessment identified abrasion on posterior radial aspect of forearm with step like lines of injury horizontally and a straight lateral edge to abrasion skin largely intact through area...".

No documentation noted of a "Resident Incident Report" being completed for the 2/22/05 fall.

On 3/18/05, a nurse's note in resident 6's medical record documented the following entry: [Pt] found sitting on the floor next to his bed....four inch linear abrasion on posterior proximal surface on L forearm. The area around the injury site showed pronounced swelling...firm to touch...some tenderness...full range of motion...increased pain with movement...site cleaned and bandaged...no other injuries...MD called..orders taken for L forearm x-ray...".

On 3/18/05, a facility nurse documented the following on an "Resident Incident Report": Pt found sitting next to bed three inch linear abrasion on posterior surface of L forearm".

On 3/25/05, a facility nurse documented the following on an "Resident Incident Report": Noticed resident 6's left hand slightly swollen, no bruising, able to move fingers, no pain....3/26/05

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F 224	Continued From page 9 L hand increased swelling and on fingers - increased bruising - now complains of hurts". No documentation of injury noted on nurse's note for 3/25/05. On 5/14/05, a nurse's note in resident 6's medical record documented the following entry: "[Pt] found on floor in hall. When asked if he hurts he denies any pain. [Pt] had a slight skin tear on outer part of [R] arm. Wound cleaned with alcohol prep and [ABX] oint and Band-Aid applied. [ROM] done with no apparent injuries noted at this time. Will continue to monitor On 5/14/05, no "Resident Incident Report" was completed. On 6/12/05, a nurse's note in resident 6's medical record documented the following entry: "[patient] found on floor in hall with]skin tear to [R] elbow, this was cleaned [with NS et ABX oint et drsg] applied. [Pt]able to move all extremities, but when assisted to his feet [pt] appeared to not be able to bear weight. Dr. call and he ordered x-ray of hip. VS 138/90, 18, 97.5, O2 @ 91 on RA. Will continue to monitor." On 6/12/05, a "Resident Incident Report" stated: Pt found on floor in ahall a skin tear to R elbow. this was cleaned et drsd. Pt assisted to standing position when he attempted to walk he could not bear any weight on R hip." On 6/16/05 a repeat x-ray was ordered as resident 6 was still unable to bear weight. The nurses note dated 6/16/05 document the results of this x-ray: "subtle non displaced fx acetabulum of questionable age. Will continue to monitor."	F 224		

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F 224	Continued From page 10 On 6/19/05 at 9:00AM a nurses note in resident 6's medical record documented the following: "...[Pt] in his w/c had hold of another w/c's handles and pushing it when he went out onto the floor, no injuries are noted...Rt hip is in place...". On 6/19/05 a facility nurse documented the following on an "Resident Incident Report": "...[Pt] in dining room had just finished breakfast grabbed another w/c's handles was pushing it slid out of w/c onto floor no injuries noted alert to self Rt hip tender from other fall." On 6/21/05 at 8:00 PM, a nurse's note in resident 6's medical record documented the following entry: "CNA...reported to nurse that when transferring resident 6 from wheelchair, he dropped to sitting position on floor. CNA lowered him to this position....his back scraped against the pedal of wheelchair leaving a mark...mark was a small scrape. [Pt] didn't appear to be in pain..." No documentation noted of a "Resident Incident Report being completed for the 6/21/05 fall. On 6/23/05 at 2:00 AM, a nurse's not in resident 6's medical record documented the following entry: "results of hip and pelvic x-ray....Rt hip ...hairline fx. Right Acetabulum unchanged as compared with 6/16/05. MD is coming in today and the 7-3 nurse will show him the results." Based on the documentation it was determined that resident 6 had 5 falls from 2/22/05 until 6/21/05. The falls occurred during all shifts, and several nurse's note entries did not document the time of day. Therefore, no pattern could be established.	F 224		

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F 224	Continued From page 11 There was no documentation to provide evidence that facility staff developed interventions, individualized to resident 6's needs to reduce his falls or to minimize potential injury.	F 224		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility did not ensure care in a manner and environment that maintained or enhanced resident's dignity and respect in full recognition of his/her individuality. Specially one resident was left exposed and call lights were not answered in a timely manner. Resident identifier 7. 1. On 8/23/05 at 12:40 PM until 1:02 PM, resident 7 was continuously observed by a nurse surveyor. Resident 7 was in her room and the nurse surveyor was observing her from the hallway. At 12:40 PM resident 7 came out of her bathroom without any pants or under garments on. Resident 7 went and sat on the edge of her bed. At 12:42 PM a male nursing aide was observed to	F 241	F241 Resident 7 has been counseled by nursing staff as to proper dress. Staff inserviced to protect her dignity by closing the privacy curtains or door and staying with her until properly dressed/assisted. All staff will be inserviced by the A.D.O.N or designee on promoting dignity and enhancing each residents individual needs. The importance of answering call lights in a timely manner and in being proactive in meeting each residents individual needs. staffing patterns are to be adjusted to meet the needs of the residents. Continued compliance will be monitored by the A.D.O.N. and Nursing Staff. Audits of call lights via the use of audit tool shall be done and reported to the QA committee for the next three months and then as directed by the QA committee. The D.O.N./A.D.O.N. is responsible for continued compliance. Completed as of 10/21/05.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE CARE CENTER	**1001 NORTH 500 WEST PROVO, UT 84601**

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F 241	Continued From page 12 stop at resident 7's doorway look in at the resident and then continue down the hallway. At 12:44 PM, resident 7 was observed to lay down on her bed and partially cover herself. Her back side was facing the hallway. At 12:58 PM, a female nursing aide went into resident 7's room and completely covered the resident with blankets. Resident 8 stated to the nursing assistant that she was cold. The nursing assistant picked up resident 7's lunch tray and left the room. At 1:02 PM, the nursing assistant returned and assisted the resident with dressing. From 12:40 PM until 12:58 PM, while resident 7 did not have any pants or undergarments on and could be visualized from the hallway, the following people were observed to walk by resident 7's room: 1 facility nurse 1 additional nurse surveyor 1 maintenance person 3 housekeepers 1 distribution person 7 other residents 2 additional nursing assistants 4 family members of other residents. 2. During a confidential group resident interview on 8/24/05 at 9:00 AM, the following was revealed: a. Resident informed surveyors that both he/she and his/her roommate had on several occasions used their personal cell phones to call the nursing station in order to have their call lights answered. b. Out of seven residents interviewed, seven residents showed by raise of hands that they had	F 241		

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F 241	Continued From page 13 waited more than 15 minutes for their call lights to be answered, and that this had occurred on more than one occasion. The residents also stated that the problem was worse on the night shift, and on the weekend. c. Residents stated that the following statements were made to them when staff would enter their rooms to inactivate the call light: "Be back in a minute, Not right now, Just a second, ..." Residents also stated that frequently when staff would make those comments, they would not return to provide care of residents as had been stated. d. One resident stated that the staff often "give you the finger". When asked to explain this statement, the resident signaled with his/her forefinger a "1" as in "one minute". Seven of the seven residents agreed to have witnessed that finger gesture. e. Resident stated that he/she often waited up to 30 minutes for the call light to be answered. This was corroborated by several other residents. 3. On 8/24/05 at 10:55 AM a confidential interview was completed, she/he also stated that her/his call light was often "ignored" for up to 30 minutes at at time. 4. A confidential resident interview was conducted on 8/22/05 at 3:44 PM. The resident stated that, "I have waited as long as 2 hours from 10:00 AM to 12:00 for someone to answered my call light, if I can I come out into the hall and look for someone to help me". 5. A confidential resident interview was	F 241		

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F 241	Continued From page 14 conducted on 8/23/05 at 1:00 PM. The resident stated that, "I can take care of myself , I don't (do not) even pull my call light anymore, since no one comes". 6. A confidential resident interview was conducted on 8/23/05 at 9:00 AM. The resident stated that, "....have waited an hour sometimes for call light to be answered".	F 241		
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not complete a	F 274	F274 A.D.O.N. will place a communication book at each Nurses station and each shift nurse will write a shift report identifying any resident concerns or changes in condition. This book will be reviewed each week by the MDS nurse	

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F 274	Continued From page 15 significant change Minimum Data Set (MDS) assessment for 1 of 21 sample residents (residents 4) who had been documented by the facility as having a significant change in status. Findings include: 1. Resident 4 was admitted to the facility on 6/5/04, with diagnoses which included cellulitis, right sided heart failure, hypertension, edema, congestive heart failure and arthritis. On 1/24/05, an admission comprehensive MDS was completed for resident 4. On 4/15/05, a quarterly MDS was completed for resident 4. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done. The areas that documented significant change included: Resident 4 had a documented decline in Cognitive Skills for Daily Decision Making: a. MDS (1/24/05) Section B4(1- modified independence) b. MDS (4/15/05) Section B4(2- moderately impaired) Resident 4 had a documented decline in Behavioral Symptoms, Verbally Abusive Behavioral Symptoms: a. MDS (1/24/05) Section E4-b (0- behavior not present or behavior was easily altered) b. MDS (4/15/05) Section E4-b (1- behavior was not easily altered)	F 274	and daily by the D.O.N./A.D.O.N. Completed as of 10/21/05. Residents that are identified will be discussed in stand-up meeting and a 14 day assessment reference date will be set for the IDT. The MDS nurse will review the care plan and update it at this time. Completed as of 10/21/05. Resident 4 will have a significant change in condition assessment done with a significant correction of a prior assessment. The D.O.N. will report to the Q.A. team the status of this system quarterly. Completed as of 10/21/05.	

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F 274	Continued From page 16 Resident 4 had a documented decline in Behavioral Symptoms, Socially Inappropriate/Disruptive Behavioral Symptoms: a. MDS (1/24/05) Section E4-d (0- behavior not present or behavior was easily altered) b. MDS (4/15/05) Section E4-d (1- behavior was not easily altered) Resident 17 had a documented decline in Bowel Continence: a. MDS (1/24/05) Section H1-b (0- continent) b. MDS (4/15/05) Section H1-b (2-occasionally incontinent) Resident 4 had a documented improvement Bed Mobility: a. MDS (1/24/05) Section G1-b(3= extensive assistance) b. MDS (4/15/05) Section G1-b (2= limited assistance) Resident 4 had a documented improvement in Locomotion on Unit: a. MDS (1/24/05) Section G1-e (4- total dependence) b. MDS (4/15/05) Section G1-e (2- limited assistance)	F 274		
F 278 SS=E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 17 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not ensure that the Minimum Data Set (MDS) assessments accurately reflected residents' status. The facility did not ensure that a registered nurse has signed and certified that the assessments were complete for 9 of 22 sample residents. Resident identifiers 4, 7, 8, 9, 11, 16, 17, 19 and 21.	F 278	F278 The D.O.N. will review the entire MDS assessments due each week with the IDT members to discuss and assure accuracy of data collected. Completed as of 10/21/05. The D.O.N. will sign all MDS assessments. In the absence of the D.O.N. the A.D.O.N. will assume this role. Completed as of 10/21/05 The MDS nurse will assure that all signatures are on the MDS before it is filed. MDS assessments will be reviewed by medical records for all required signatures by periodic audits. The quality Assurance team will review this process quarterly. Completed as of 10/21/05. Resident's that were identified will have a modification performed with the D.O.N. signature to the attestation. Completed as of 10/21/05	

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F 278	Continued From page 18	F 278		

1. Resident 9 was admitted to the facility on 7/12/04 and readmitted on 1/31/05 with diagnoses of chronic fatigue syndrome, cerebral vascular accident, alcohol abuse, cerebral edema, osteoporosis, personality disorder, and neurotic disorder.

On 3/30/05, a Medicare 60 day Minimum Data Set (MDS) assessment completed by facility staff, did not have an RN (registered nurse) signature under section R2a; Signature of Person Coordinating the Assessment, Signature of RN (registered nurse) Assessment Coordinator.

2. Resident 19 was admitted to the facility on 8/4/02 with diagnoses that included alzheimer's disease, heart disease, osteoporosis, alcohol dependent, depressive disorders and cerebral vascular accident.

On 5/31/05, an annual MDS assessment completed by facility staff, did not have an RN (registered nurse) signature under section R2a; Signature of Person Coordinating the Assessment, Signature of RN (registered nurse) Assessment Coordinator.

3. Resident 21 was admitted to the facility on 9/9/04 with diagnoses that included senile dementia with delusions, chronic obstructive pulmonary disease, congested heart failure, arthritis, cerebral vascular accident, atonic bowel and hypothyroidism.

On 3/23/05, an annual MDS assessment completed by facility staff, did not have an RN (registered nurse) signature under section R2a;

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F 278	Continued From page 19 Signature of Person Coordinating the Assessment, Signature of RN (registered nurse) Assessment Coordinator. 4. Resident 4 was admitted to the facility on 6/5/04, with diagnoses which included cellulitis, right sided heart failure, hypertension, edema, congestive heart failure and arthritis. On 7/13/05, a quarterly Minimum Data Set (MDS) assessment completed by facility staff, did not have an RN (registered nurse) signature under section R2a; Signature of Person Coordinating the Assessment, Signature of RN Assessment Coordinator. 5. Resident 7 was readmitted to the facility on 5/5/05 with diagnoses which included peptic ulcer, hypothyroid, bladder hyperactivity, dementia and anxiety. On 5/18/05, an admission MDS assessment completed by facility staff, did not have an RN signature under section R2a; Signature of Person Coordinating the Assessment, Signature of RN Assessment Coordinator. 6. Resident 8 was admitted to the facility on 6/17/93 with diagnoses which included,	F 278		

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F 278	Continued From page 20 Parkinson's disease, meningioma, hypertension, history of breast cancer/mastectomy and dementia. On 4/7/05, an annual MDS assessment completed by facility staff, did not have an RN signature under section R2a; Signature of Person Coordinating the Assessment, Signature of RN Assessment Coordinator. 7. Resident 17 was admitted to the facility on 9/9/04 with diagnoses that included: hemiplegia, Diabetes Mellitus Type Two, Anxiety State, Ventral Hernia, Post Traumatic Head Injury, Osteoporosis, Insomnia, Neurogenic Bladder, Degenerative Joint/ Contracture of Right Hand. Upon review of Resident 17's clinical record on 8/24/05, specifically the 3/16/05 MDS (Minimum Data Sheet) assessment, the record indicated that Resident 17 weighed 000 lbs. Through further investigation of Resident 17's clinical record and interviews with staff, it was verified that Resident 17 did not weigh 000 lbs, proving the inaccuracy of the MDS assessment for 3/16/05. 8. Resident 11 was admitted to the facility on 1/06/05, with diagnoses which included hepatitis B, arteriosclerosis, diabetes mellitus, dementia,	F 278		

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F 278	Continued From page 21 neuropathy, benign prostate hypertrophy, non-psychotic brain syndrome, peptic ulcer disease, and amyloidosis. On 7/14/05, a quarterly Minimum Data Set (MDS) assessment completed by facility staff, did not have an RN (registered nurse) signature under section R2a; Signature of Person Coordinating the Assessment, Signature of RN (registered nurse) Assessment Coordinator. 9. Resident 16 was admitted to the facility on 6/20/05 with diagnoses which included gastrointestinal hemorrhage, hypoosmolality, peripheral vascular disease, hypertension, diverticulitis, ankylosing spondylitis, and asphyxia. On 6/24/05, a admission MDS assessment completed by facility staff, under section K2a, Resident 16's height was documented as 65 inches and in section K2b, Resident 16's weight was documented as 180 pounds. On 7/03/05, a medicare 14-day MDS assessment was completed by the facility staff, under section K2a, Resident 16's height was documented as 75 inches, and in section K2b, Resident 16's weight was documented as 173 pounds.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) 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	F 279		

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F 279	Continued From page 22 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined that the facility did not develop a comprehensive care plan for 2 of 22 sample residents that included measurable objectives and timetables to meet the residents' medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Residents identifer 6 and 10. Findings include: 1. Resident 10 was admitted to the facility on 9/9/04 with diagnoses that included manic-depression, gastric ulcer, COPD, dementia venous insufficiency, and incontinence.	F 279	F279 The MDS nurse will review all care plans with the current MDS every quarter and per annual assessment to reflect the resident's current needs. The goals will have measurable objectives and timetables as to when these goals will be met. All RAP's triggered that have been identified as applicable and needing to be care planned will have a care plan developed by the MDS nurse. Care plans will be reviewed in IDT meetings as are due each week by the MDS nurse. The D.O.N. will oversee this process in the weekly IDT meetings and report to the Q.A. team quarterly. Completed as of 10/21/05. Resident 10 & 6 Care plans will be in place and all raps will be addressed . Completed as of 10/21/05.	

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F 279	Continued From page 23	F 279		

Record review revealed that resident 10's annual MDS (minimum data set) assessment triggered the following RAPs (resident assessment protocols) concerns: Cognitive loss, Delirium, Communication, Urinary Incontinence, Psychosocial well-being, Behavioral symptoms, Activities, Pressure ulcers, ADL (activities of daily living)/rehab program, Mood state, Falls risk, Dehydration risk, and Psychotropic drug use. All of the triggered RAPs were checked by the facility (IDT) interdisciplinary team to be care planned.

Resident 10's medical record contained the following care plans: Behaviors, ADL's, Dehydration, Skin Integrity, Falls, Bladder elimination, Psychotropic meds, and Altered mental status.

There was no documentation in resident 10's clinical record that the RAP's triggered for communication had been care planned. The care plan for resident 10 was incomplete.

2. Resident 6 was admitted to the facility on 9/9/04 with the following diagnoses: senile dementia, coronary artery bypass graft, osteoarthritis, and gastrointestinal distress.

Review of Resident 6's MDS assessment identified the following RAP concerns were triggered: Cognitive loss, Communication, ADL/Rehabilitation potential, Psychosocial well-being, Mood state, Behavioral symptoms, Activities, Falls, and Nutritional status. The IDT had documented that all triggered concerns needed to be care planned.

Resident 6's clinical record contained the

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F 279	Continued From page 24 following care plans: Malnutrition/Dehydration risk, Maintain optimum function and independence, Fall risk, and Altered mental status There was no documentation in Resident 6's chart that the triggered RAP's for Communication, Behavioral symptoms, Psychosocial well-being, Mood state, or Activities were care planned. Resident 6's care plan was incomplete.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 22 sample resident's, Specifically Resident 11 did not receive ted hose therapy as ordered on 4/08/05. Findings include: Resident 11 was admitted on 1/06/05 with diagnosis of hepatitis B, arteriosclerosis,	F 309		

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F 309	Continued From page 25 dementia, diabetes mellitus, neuropathy, benign prostate hypertrophy, non-psychotic brain syndrome, peptic ulcer disease, and amyloidosis. On 8/22/05 Resident 11's medical record was reviewed, the physicians telephone orders dated 4/8/05 documented an order for TED hose bilateral then ace wrap both legs and feet everyday. In the nurse's progress notes dated 5/26/05, documentation was found that central supply had been asked to order TED hose on 5/24/05, and that they still were not in. On 8/23/05 Resident 11's Physician recertification orders were reviewed. There was no documentation found that the TED hose order had been transcribed onto the May, June, July or August Physician recertification orders. On 8/23/05 Resident 11's treatment record was reviewed. Documentation found in April and May's treatment records indicated that the order had been transcribed as to be done at 10:00 AM everyday, however, no documentation was found that the treatment was performed during the month of April or May. There was no documentation that could be found that the TED hose order was performed or transcribed onto the the treatment records of June, or July. No treatment record could be found for August. On 8/25/05 at 8:20 AM a interview was conducted with LPN 1, which she stated that Resident 11 did not have a August treatment record because " he doesn't have any treatments ordered, except for weekly skin checks and weights and we already know that he needs those done".	F 309	F309 Resident 11 was assessed on 09/12/05 and found to have 1+ edema bilaterally. No skin breakdown. Resident refused to wear Ted Hose. Risk Vs Benefits - non-compliance form reviewed and signed by resident. Dr. notified and orders clarified on 09/07/05. All Licensed Nursing staff to be inserviced on 09/26/05, on how to complete a 3-way check system to prevent errors in transcription from month to month, comparing the MAR's, Physician recerts and telephone orders. Licensed Nursing staff also to be inserviced on proper documentation, completion of MAR and protocols to follow if resident non-compliant with medication or treatment as ordered by 10/21/05. Continued compliance will be monitored by medical records completing weekly MRA audit and reporting to D.O.N./A.D.O.N. findings. The findings will be followed up on weekly and bought to the monthly QA committee for three months and then as directed by the QA committee. The D.O.N./A.D.O.N. is responsible for continued compliance. Completed by 10/21/05.	

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F 309	Continued From page 26 On 8/23/05 at 3:15 PM a interview was conducted with the DON (director of nursing), she stated that resident 11's " order for TED hose was not followed through", nor was it discontinued. On 8/24/05 at 1:00 PM a interview was conducted with LPN 1, which she stated that Resident 11 did not have any skin breakdown, but he does have " edema (swelling) of 2+ in both of his lower extremities (legs)".	F 309		
F 322 SS=G	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that for 1 of 22 sample residents, the facility did not ensure that a resident who was being fed by a gastrostomy tube received the appropriate treatment and services to prevent metabolic abnormalities. Resident identifier 20. Findings include: Resident 20 was re-admitted to the facility with diagnose that included acute respiratory failure, pneumonia, urinary tract infection, and vent	F 322		

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F 322	Continued From page 27 dependent. A review of resident 20 medical record revealed that resident 20 was admitted to the facility with a tube feeding of promote at 100 cc's (cubic centimeters) an hour. The dietary admitting assessment dated 7/29/05 documented that the tube feeding provided 2400 calories 150 grams of protein and 2016 cc's of free water. Resident 20 was assessed by the dietitian as needing 2088-2556 calories, 75-92 grams of protein and 1740-2130 cc's of free water. The dietary assessment documented that resident 20 tube feeding was providing 58 grams of protein more than was necessary. The dietitian recommended a change in the tube feeding to Jevity at 95 cc's an hour for 22 hour per day. This change would have provided resident 20 with 2215 calories, 93 grams of protein and 1755 cc's of free water. A review of the nurses notes revealed documentation dated 7/29/05 of the dietitian's recommendations. Further review revealed documentation dated 8/2/05 and 8/9/05 of complaints from resident 20 of nausea and vomiting and of his stomach hurting and of a "full feeling." There is no documentation of notification of the dietitian of these complaints. A monthly nursing summary dated August/ 2005 documented the tube feeding as promote running at 100cc's per hour. A review of the dietitian's progress notes dated 8/16/05 documented the tube feeding as being promote running at 100cc's per hour. She documented that resident 20 was receiving 115% of his calorie needs and 163% of his protein	F 322	F322 Resident 20 was discharged to the hospital on 09/04/05 upon re-admission 09/07/05 tube feeding was assessed to see that it would meet the nutritional and protein needs. Residents 20 has a new malnutrition/dehydration assessments completed with new labs drawn. Diets/enteral feedings have been updated per the Registered Dietician recommendations as of 10/21/05. The Dietary Manager and Nursing Staff have developed a system of communication to keep Registered Dietician informed of any complications or concerns meeting nutritional needs. A binder will be kept at each nurse's station for nursing staff to alert Dietary Manager of concerns or complications. The Dietary Manager and the A.D.O.N. or designee will check book on a daily basis and address those concerns by calling the Registered Dietician to evaluate or the Medical Director for necessary orders. The registered Dietician will provide copies of recommendations to the Dietary Manager and the A.D.O.N. or designee. The recommendations are to be followed up on within 72 hours with documentation of action taken. All residents on naso-gastric or gastrostomy will have a tube feeding analysis worksheet report completed monthly as of 09/06/05. Continued compliance will be monitored by the Dietary Manager and	

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F 322	Continued From page 28 needs. She recommenced to change to Jevity at 95 cc's per hour. The Manual of Clinical Dietetics documents common problems with enteral feedings and documents that metabolic complications including clinical conditions, may be exacerbated by formula composition or amount delivered. (Manual of Clinical Dietetics; sixth edition, pg. 607) An observation of resident 20's tube feeding revealed that resident 20 was receiving Jevity at 95 cc's per hour. In an interview with a nurse familiar with resident 20 she stated that the formula had been changed recently but she was not sure when. She also stated that resident 20 was tolerating the change. An interview with the dietary manager on 8/24/05 at 2:40 PM she stated that she was not sure when the dietitian's recommendation were actually implemented.	F 322	A.D.O.N. or designee at the weekly weight meetings as of 09/06/05. Findings will be documented on significant weight change report. Findings will be bought to monthly QA committee meeting. The Dietary manager and A.D.O.N. is responsible for continued compliance. Completed as of 10/21/05.	
F 325 SS=G	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview it was determined that the facility did not ensure that residents maintained acceptable	F 325		

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parameters of nutritional status as evidenced by 3 of sampled residents (residents 2, 18 and 21) experienced significant weight loss with interventions which were not timely to prevent further weight decline. In addition, these residents had a laboratory value reflecting malnutrition.

Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000).

Findings include:

1. Resident 18 was admitted to the facility on 7/24/05 with diagnoses which included, contusions, elbow replacement, osteoporosis, hypertension and degenerative joint disease.

A review of resident 18's medical record was completed on 8/25/05.

A review of resident 18's weight revealed the following:

Admit Weight 7/24/05 77 lbs (pounds)
7/30/05 77.2 lbs
8/6/05 78.1 lbs
8/13/05 Refused
8/20/05 74.6 lbs

On 8/24/05, the ADON (assistant director of nurses) and a physical therapist weighed resident 18. The physical therapist stated that resident

F325
The facility is committed to assuring acceptable parameters of nutritional status with no weight loss of 5% in one month, 7.5% in 3 months or 10% in 6 months unless the residents clinical condition demonstrates that this is not possible.

Residents 2, 18 &21 have all had new malnutrition/dehydration assessments completed with new labs drawn. Diets/enteral feedings have been updated per the Registered Dietician recommendations as of 09/16/05.

The Dietary Manager or designee will complete all initial dietary nutritional assessments on all new admits within 5 days of admission and then quarterly there after or as indicated with a change in condition or weight loss. Registered Dietician to be contacted. Recommendations to be followed up by A.D.O.N. or designee within 72 hours.

All new admits shall be placed on weekly weights X4 weeks or until stable. Any resident with a 3% weight loss in one month shall be placed on weekly weights and diet evaluated to ensure that nutritional needs are met.

All Nursing staff will be inserviced by 09/26/05 on the proper documentation of meal % and providing the necessary assistance each individual resident needs.

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F 325	Continued From page 30 18's weight was 74.4 lbs. Between 8/6/05 and 8/20/05 (14 days) resident 18 lost 3.5 lbs (4.48%) which is significant. Between 8/6/05 and 8/24/05 (18 days) resident 18 lost 3.7 lbs (4.73%) which is significant. A lab (laboratory) value taken at the hospital (prior to resident 18's admission to the facility) and dated 5/25/05 showed an albumin (protein) level of 3.0 g/dl. An albumin level of less than 2.4 g/dl is considered a severe protein deficit, an albumin level of 2.4-2.9 g/dl is considered a moderate visceral protein deficit and an albumin of 3.0-3.5 g/dl is considered a mild protein deficit. (Reference guidance: Manual of clinical dietetics, American Dietetic Association, 6th edition, 2000, page 22). The albumin of 3.0 g/dl dated 5/25/05 was the most current in resident 18's medical record and the decreased albumin was acknowledged by the registered dietitian (RD) on her admit note dated 8/5/05. An admission minimum date set (MDS) assessment was completed on 7/30/05. The MDS documented under section K., Oral/Nutritional Status, 1. Oral problems- problem with chewing and no problems with swallowing and no mouth pain. A physician's order dated 7/25/05 documented that resident 18 was to receive a regular diet. An initial nutritional assessment for resident 18 was completed by the dietary manager on 8/3/05. The dietary manager documented that resident 18 was receiving a mechanical soft diet due to chewing problems. She also documented that	F 325	Nursing staff will be inserviced by 09/26/05 on how to read a tray card to ensure the proper diet is being served to each resident. Dietary Manager will audit at least one time per week all 3 meals and check at least 10 trays to assure that diets as ordered are being served to the residents. Dietary Manager or designee will observe enteral feeding pumps and verify amount being received with current diet order. All 2Kal supplements will be placed on the MAR's with a % for proper documentation of intake. Continued compliance will be monitored by Dietary Manager or designee audits of meals, medical records MAR audits of 2Kal supplements, supervisor of CNA, Audits of Meal %, and at weekly weight meetings via the significant weight change report. Findings will be bought to the monthly QA meeting. The Dietary Manager and A.D.O.N. is responsible for continued compliance. Completed as of 10/21/05.	

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resident 18 was to receive a 2 cal med pass 4 times a day, a multivitamin with minerals, albumin level in 1 month, 8 ounces (oz) of extra fluid each meal, 8 oz extra fluid between meals, hydration cart, 4 oz orange juice or vit C fortified juice and 8 oz Whole milk with meals. The dietary manager documented the following, "...Current intake of Mech (mechanical) soft diet averages 51% which meets her nutritional needs...Need extensive assistance [with] meals [due to] blindness." The dietary manager documented the following regarding resident 18's nutritional needs, "...Kcal (calorie) needs...990-1230...%needed (cal) 45-56%...Protein needs...40 or 49...% needed (pro) 50-61%..."

A nutritional care plan for resident 18 was completed on 8/3/05. The facility's documented goals for resident 18 were, "...Resident will have albumin WNL (within normal limits) by 90 days. Resident will have no significant weight change i.e. <2% x 1 week, <5% x 1 month, <7.5% x 3 months, <10% x 6 months by TNR (till next review)..." The facility documented the following approaches, "...MVI (multivitamin)/MVI with minerals, Diet mech (mechanical) soft...Monitor daily intakes...Monitor weights monthly/weekly, Restorative Dining, Supplements as ordered, 4 oz (ounces) orange juice every day..."

On 8/5/05, the facility's RD co-signed the dietary managers assessment dated 8/3/05. In addition the RD completed a progress note which documented the following, "...Wt 77# (pounds) (100% IWR)...Alb (albumin) (5/23/05) 3.0 [decreased]. Res (resident) currently consumes 51% of mech (mechanical) soft diet which meets est (estimated) needs. Rec (recommend) 1. SNP (special nutritional program) diet to ensure

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res is getting adequate nutrition 2. 2 oz (ounces) 2.0 supp (supplement) QID (four times a day) 3. 8 oz whole milk TID (three times a day) 4. MVI (multivitamin) [with] min (minerals) & 5. weekly wts (weights)..."

A review of the physician's orders provided no documented evidence that orders were written for the recommendations by the RD.

On 8/23/05, resident 18's lunch was observed. At 12:25 PM, a facility nursing aide brought resident 18 her lunch. For lunch, resident 18, was served tapioca pudding, chicken breast, mixed vegetables, 1 piece of bread, rice, 4 oz of orange juice and 6 oz of milk. The resident was observed to be in her room laying in bed, there were no staff in the resident's room assisting her. Resident 18 was observed to eat 100% of the tapioca pudding, 50% of the chicken breast and 3 ozs of the milk. at 1:00 PM a facility nursing assistant went into resident 18's room and stated to the resident "you done?" and took the tray. The nursing assistant was not observed to assist resident 18 with her meal, encourage resident 18 to eat more of the meal or offer resident 18 an alternative.

Resident 18's diet card was reviewed on 8/23/05. Facility staff documented that resident 18 was to receive a regular SNP (special need program) diet. For breakfast resident 18 was to receive juice, whole milk and hot cereal. For lunch resident 18 was to receive juice water and whole milk. For dinner resident 18 was to receive water and whole milk.

On 8/23/05 at 1:30 PM, the dietary manager was interviewed. The dietary manager stated that for

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F 325	Continued From page 33 lunch resident on the SNP diet were to receive whole mild and an additional pudding cup besides the tapioca. On 8/23/05, resident 18 was not observed to receive the additional pudding cup. In addition, resident 18 was not observed to receive a mechanical soft diet as recommended by the dietary manager and RD. On 8/25/05 at 7:20 AM, a facility nursing assistant was interviewed. She stated that resident 18 ate on her own. She further stated that the resident does not eat a lot of food but she does eat. A review of resident 18's "Weekly Meal Chart" from 7/24/05 until 8/23/05 revealed resident 18 received 90 meals. Forty-six of the 90 meals provided had no documentation that any of the meals were consumed. Out of the 44 meals that the facility documented on it revealed that resident 18 consumed 50% or less 23 times. According to the dietary manager's nutritional assessment, dated 8/3/05 and co-signed by the RD on 8/5/05, resident 18 needed to consume 45-56% of her meals to meet her caloric needs and 50-61% of her meals to meet her protein needs. The dietary manager and RD would not be able to accurately calculate if resident 18 was receiving the required calories and protein due to the fact that the facility nursing staff were not consistently documenting resident 18's meal intake. It should be noted that according to the dietary managers calculations and the documentation of meal intakes, resident 18 was not receiving enough calories and protein to meet her nutritional needs.	F 325		

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F 325	Continued From page 34 A nurse caring for resident 18 was interviewed on 8/23/05 at 8:20 AM. The nurse caring for resident 18 stated that whoever receives medpass will have it written on their MAR (medication administration record). A review of resident 18's MAR for July 2005 and August 2005 was completed. The MAR's had no documented evidence that resident 18 was receiving the 2.0 med pass four times a day or a multivitamin with minerals as recommended by the dietary manager on 8/3/05 and the RD on 8/5/05. On 8/24/05 at 2:25 PM, the dietary manager was interviewed. The dietary manager stated that she knew resident 18 had had a significant weight loss. The dietary manager stated that resident 18 had not been reviewed in the skin and weight meeting since her admission, but was scheduled to be reviewed in the skin and weight meeting on 8/25/05. The dietary manager stated that she did not notify an RD about resident 18's significant weight loss. The dietary manager stated that she figures out the meal percentages by what the nursing assistants write on the meal sheets. She stated she does not use the meals not documented. The dietary manager stated that normally the recommendations are taken to the skin and weight meeting, but resident 18's recommendations were never followed through with. ".	F 325		

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2. Resident 2 was admitted to the facility with diagnose which included sepsis, hypoglycemia, UTI (urinary tract infection), quadriplegia and gastrointestinal anthrax.

A review of resident 2's admission assessment also revealed that resident 2 had a stage two pressure ulcer on his coccyx, a stage 4 on his right ankle and a stage 2 on the inner side of his right ankle.

Resident 2 was admitted to the facility with a weight documented as 179 lbs. (pounds) the following weights were recorded for resident 2:

February 179 lbs.
March 171 lbs.
April 163 lbs., 162 lbs., 162 lbs.
May 162 lbs., 163 lbs., 164 lbs., 163 lbs., 162 lbs.,
June 163 lbs.
July 164 lbs., 160 lbs., 159 lbs., 162 lbs., 159 lbs.
August 159 lbs., 156 lbs., 154 lbs

From February to August (6 months) resident 2 had a 14% weight loss, which was significant. From July to August resident 2 had a 6.09% weight loss which was significant.

A review of the enteral feeding review dated 1/8/05 documented resident 2's nutritional needs as being 2414 calories, 121 grams of protein and 2414 cc's of water per day. The dietitian documented that resident 2 had been admitted to the facility with a tube feeding running at 80 cc's per hour which would have provided 1920 calories, 120 grams of protein and 2573 cc's of

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free water. This tube feeding was providing 494 calories below the nutritional requirement of resident 2. The dietitian recommended an increase in the tube feeding to 100 cc's per hour to meet the resident's needs for calories, protein and water.

A physician order dated 2/4/05 and signed by the physician documented an order to lower the tube feeding to 75 cc's per hour due to weight gain. It should be noted that no documentation of weight gain was found in resident 2's medical record.

A monthly nutrition at risk/subacute review was completed on 3/28/05 by the consultant dietitian. She documented that the current tube feeding (promote at 75 cc's per hour) was not meeting resident 2's nutritional needs. A dietary progress note dated 4/12/05 documented that resident 2's had lost 16 1/2 lbs. in 90 days which represented 9.2% weight loss. A recommendation to increase the tube feeding to 85 cc's was documented. A dietary progress note signed by the dietitian and dated 4/19/05 documented that resident 2's nutritional needs were not being met and recommenced an increase in the tube feeding to 85 cc's per hour to check for tolerance and then another increase to 95 cc's per hour.

A physician order dated 4/17/05 and again on 4/22/05 both signed by the physician ordered an increase in the tube feeding to 85 cc's per hour.

A review of the IDT (interdisciplinary team) meeting notes revealed documentation of resident 2's tube feeding as running at 95 cc's an hour.

A monthly nursing summary for the month of

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June documented resident 2's tube feeding as running at 75 cc's an hour. The monthly nursing summary for the months of July and August documented the tube feeding as running at 85 cc's an hour.

Observations by the surveyor of resident 2's tube feeding on 8/23/05 at 2:15 PM and 3:10 PM and on 8/24/05 at 9:07 AM and 2:00 PM revealed resident 2's tube feeding running at 85 cc's an hour.

In an interview with the dietary manager on 8/24/05 at 2:40 PM she stated that her notes had documented that resident 2's tube feeding was running at 95 cc's and hour. She also stated that resident 2 was never discussed in the skin and weight meetings.

3. Resident 21 was admitted to the facility on 9/9/04 with diagnoses that included senile dementia with delusions, chronic obstructive pulmonary disease, congested heart failure, arthritis, cerebral vascular accident, atonic bowel and hypothyroidism.

A review of resident 21's medical record was completed on 8/24/05, which revealed the following:

The physician's re-certification orders dated 8/05, documented that resident 21 was to have a weekly weight done. There was no evidence that weekly weights were being done after 5/12/05.

Admit Weight 9/9/04 106.4 lbs.
6/20/05 100 lbs.

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7/2/05 100.7 lbs.
8/6/05 89.8 lbs.

On 8/24/05 resident 21 was weighted by two staff members with a surveyor present, resident weighed 86.5 lbs. From 7/2/05 to 8/6/05 (34 days) resident 21 lost 10.9 lbs. (10%) which is significant. From 8/6/05 to 8/24/05 (18 days) resident 21 lost 3.3 lbs. (3%).

A review of the dietary notes documented the following:
6/20/05, "Current wt (weight) 100# (lbs) 88% of SWR current intake of SNP (special nutrition program), NAS (no added sugar), Puree (blended food) averages 100 %. Also is offered 8 oz (ounces) extra water /c (with) meals TID (three times a day). Review of labs of 5/20/05 indicate osmol (Osmolite an electrolyte test) of 309^.... Will recommend nursing assist and encourages (sic) more to help insure she is taking in what she needs".
7/1/05, "Reviewed assessment & (and) concern. Orders appropriate".

The meal chart administration record for 8/05 documented meals from breakfast on 8/1/05 to breakfast on 8/24/05. Seventy meals were documented, 13 meals were refused, 11 meals had documentation that resident 21 ate more than 50% of the meal. There were 46 meals that resident 21 consumed 50% or less of each meal..

On 6/23/05 the Malnutrition/Dehydration quarterly assessment was done with a total score of 21. The Total Score rating for the Malnutrition/Dehydration form documents 10 or higher = Additional High Nutritional Risk.

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F 325	Continued From page 39 The nutritional care plan documents that resident 21 is a total feeder and requires additional water with meals, it also documents the goals for resident 21 as "...Resident will have albumin WNL by 90 days. Resident will have no significant weight change. The facility documented the following approaches, "...Diet puree SNP NAS, extra 8 oz of water with each meal." A lab value taken on 3/4/05 documented an albumin level of 3.3 g/dl., this level represented a mild protein deficit. In an interview, on 8/24/05 at 2:30 PM, staff member 1 said that resident 21 received supplements for as long as she could remember, and that she (resident 21) needed them (supplements). There was no evidence on the medical record that a supplement was ordered or given to resident 21. Staff member 1 confirmed that no documentation could be found in the Physician's orders or the MAR (medication administration record). In an interview with two staff members, staff member 2 stated " ....weight was stable so we moved her to monthly weights....I think it was one of the nurses that told us we could move her to monthly weights". Staff member 3 agreed with staff member 2's statement.	F 325		
F 326 SS=G	483.25(i)(2) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem.	F 326		

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F 326	Continued From page 40 This REQUIREMENT is not met as evidenced by: 2. Resident 2 was admitted to the facility with diagnose which included sepsis, hypoglycemia, UTI (urinary tract infection), quadriplegia and gastrointestinal anthrax. A review of resident 2's admission assessment also revealed that resident 2 had a stage two pressure ulcer on his coccyx, a stage 4 on his right ankle and a stage 2 on the inner side of his right ankle. From February to August (6 months) resident 2 had a 14% weight loss, which was significant. From July to August resident 2 had a 6.09% weight loss which was significant. A review of the enteral feeding review dated 1/8/05 documented resident 2's nutritional needs as being 2414 calories, 121 grams of protein and 2414 cc's of water per day. The dietitian documented that resident 2 had been admitted to the facility with a tube feeding running at 80 cc's per hour which would have provided 1920 calories, 120 grams of protein and 2573 cc's of free water. This tube feeding was providing 494 calories below the nutritional requirement of resident 2. The dietitian recommended an increase in the tube feeding to 100 cc's per hour to meet the resident's needs for calories, protein and water. A monthly nutrition at risk/subacute review was completed on 3/28/05 by the consultant dietitian. She documented that the current tube feeding (promote at 75 cc's per hour) was not meeting resident 2's nutritional needs. A dietary progress note dated 4/12/05 documented that resident 2's	F 326	F326 The facility is committed to assuring the resident receives a therapeutic diet when there is a nutritional problem. Residents 2, 7 &18 have all had new malnutrition/dehydration assessments completed with new labs drawn. Diets/enteral feedings have been updated per the Registered Dietician recommendations as of 09/16/05. Resident 18 has been placed on a restorative dinning program and will be monitored in the main dining room by nursing staff. The Dietary Manager or designee will complete all initial dietary nutritional assessments on all new admits within 5 days of admission and then quarterly there after or as indicated with a change in condition or weight loss. Registered Dietician to be contacted. Recommendations to be followed up by A.D.O.N. or designee within 72 hours. All new admits shall be placed on weekly weights X4 weeks or until stable. Any resident with a 3% weight loss in one month shall be placed on weekly weights and diet evaluated to ensure that nutritional needs are met. All Nursing staff will be inserviced by 09/26/05 on the proper documentation of meal % and providing the necessary assistance each individual resident needs. Nursing staff will be inserviced by 09/26/05 on how to read a tray card to ensure the proper diet is being served to	

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F 326	Continued From page 41 had lost 16 1/2 lbs. in 90 days which represented 9.2% weight loss. A recommendation to increase the tube feeding to 85 cc's was documented. A dietary progress note signed by the dietitian and dated 4/19/05 documented that resident 2's nutritional needs were not being met and recommenced an increase in the tube feeding to 85 cc's per hour to check for tolerance and then another increase to 95 cc's per hour. Observations by the surveyor of resident 2's tube feeding on 8/23/05 at 2:15 PM and 3:10 PM and on 8/24/05 at 9:07 AM and 2:00 PM revealed resident 2's tube feeding running at 85 cc's an hour. In an interview with the dietary manager on 8/24/05 at 2:40 PM she stated that her notes had documented that resident 2's tube feeding was running at 95 cc's and hour. Based on observation, interview and medical record review, it was determined that for 3 of 22 sample residents (Residents 2, 7 and 18) the facility did not ensure that each resident received a therapeutic diet when there was a nutritional problem as evidenced by: resident 18 who experienced significant weight loss and had low protein level did not receive a SNP (special needs program) mechanical soft diet and high caloric supplement as recommended by the facility's registered dietitian, resident 7 had low proteins levels and did not receive high caloric supplements per physician orders and resident 2 who experienced a significant weight loss and had multiple pressure sores and did not receive	F 326	each resident. Dietary Manager will audit at least one time per week all 3 meals and check at least 10 trays to assure that diets as ordered are being served to the residents. Dietary Manager or designee will observe enteral feeding pumps and verify amount being received with current diet order. All 2Kal supplements will be placed on the MAR's with a % for proper documentation of intake. Continued compliance will be monitored by Dietary Manager or designee audits of meals, medical records MAR audits of 2Kal supplements, supervisor of CNA, Audits of Meal %, and at weekly weight meetings via the significant weight change report. Findings will be bought to the monthly QA meeting. The Dietary Manager and A.D.O.N. is responsible for continued compliance. Completed as of 10/21/05.	

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F 326	Continued From page 42 the recommended calories neccessry to aid in weight gain and healing. Findings include: 2. Resident 7 was readmitted to the facility on 5/5/05 with diagnoses which included peptic ulcer, hypothyroid, bladder hyperactivity, dementia and anxiety. A review of resident 7's medical record was completed on 8/25/05. A lab value taken at the facility and dated 5/13/05 showed an albumin level of 2.8 g/dl. An albumin level of 2.4-2.9 g/dl is considered a moderate visceral protein deficit. (Reference guidance: Manual of clinical dietetics, American Dietetic Association, 6th edition, 2000, page 22). Another lab value taken at the facility and dated 6/14/05 showed an albumin level of 2.6 g/dl. On 6/9/05, a physician's order documented the following, "...Med Pass 2.0 120 cc TID (three times a day)...2 Cal TID 120 cc..." A nurse caring for resident 7 was interviewed on 8/23/05 at 8:20 AM. The nurse caring for resident 7 stated that whoever receives med pass will have it written on their MAR (medication administration record). A review of resident 7's MAR for June 2005 through August 2005 was completed. The MAR's had no documented evidence that resident 7 was receiving the 2.0 med pass three times a day as ordered by the physician on 6/9/05. On 8/23/05, resident 7's breakfast and lunch were	F 326		

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observed. Resident 7 was not observed to receive the Med Pass 2.0 or 2 Cal with her meals.

3. Resident 18 was admitted to the facility on 7/24/05 with diagnoses which included, contusions, elbow replacement, osteoporosis, hypertension and degenerative joint disease.

A review of resident 18's medical record was completed on 8/25/05.

Between 8/6/05 and 8/20/05 (14 days) resident 18 lost 3.5 lbs (4.48%) which is significant.

Between 8/6/05 and 8/24/05 (18 days) resident 18 lost 3.7 lbs (4.73%) which is significant.

A lab (laboratory) value taken at the hospital (prior to resident 18's admission to the facility) and dated 5/25/05 showed an albumin (protein) level of 3.0 g/dl. An albumin level of 3.0-3.5 g/dl is considered a mild protein deficit. (Reference guidance: Manual of clinical dietetics, American Dietetic Association, 6th edition, 2000, page 22).

A physician's order dated 7/25/05 documented that resident 18 was to receive a regular diet.

An admission minimum date set (MDS) assessment was completed on 7/30/05. The MDS documented under section K., Oral/Nutritional Status, 1. Oral problems- problem with chewing and no problems with swallowing and no mouth pain.

Ten days after admission, on 8/3/05 an initial nutritional assessment for resident 18 was completed by the dietary manager. The dietary manager documented that resident 18 was

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receiving a mechanical soft diet due to chewing problems. She also documented that resident 18 was to receive a 2 cal med pass 4 times a day, a multivitamin with minerals, 8 ounces (oz) of extra fluid each meal, 8 oz extra fluid between meals, hydration cart, 4 oz orange juice or vit C fortified juice and 8 oz whole milk with meals.

A nutritional care plan for resident 18 was completed on 8/3/05. The facility's documented goals for resident 18 were, "...Resident will have albumin WNL (within normal limits) by 90 days. Resident will have no significant weight change i.e. <2% x 1 week, <5% x 1 month, <7.5% x 3 months, <10% x 6 months by TNR (till next review)..." The facility documented the following approaches, "...Diet mech (mechanical) soft... Supplements as ordered, 4 oz (ounces) orange juice every day..."

On 8/5/05, the facility's RD co-signed the dietary managers assessment dated 8/3/05. In addition the RD completed a progress note which documented the following, "...Wt 77# (pounds) (100% IWR)...Alb (albumin) (5/23/05) 3.0 [decreased]. Res (resident) currently consumes 51% of mech (mechanical) soft diet which meets est (estimated) needs. Rec (recommend) 1. SNP (special nutritional program) diet to ensure res is getting adequate nutrition 2. 2 oz (ounces) 2.0 supp (supplement) QID (four times a day) 3. 8 oz whole milk TID (three times a day) 4. MVI (multivitamin) [with] min (minerals)..."

A review of the physician's orders provided no documented evidence that orders were written for the recommendations by the RD.

On 8/23/05, resident 18's lunch was observed.

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F 326	Continued From page 45 For lunch, resident 18, was served tapioca pudding, chicken breast, mixed vegetables, 1 piece of bread, rice, 4 oz of orange juice and 6 oz of milk. Resident 18's diet card was reviewed on 8/23/05. Facility staff documented that resident 18 was to receive a regular SNP (special need program) diet. For breakfast resident 18 was to receive juice, whole milk and hot cereal. For lunch resident 18 was to receive juice, water and whole milk. For dinner resident 18 was to receive water and whole milk. On 8/23/05 at 1:30 PM, the dietary manager was interviewed. The dietary manager stated that for lunch residents on the SNP diet were to receive whole milk and an additional pudding cup besides the tapioca. On 8/23/05, resident 18 was not observed to receive the additional pudding cup. In addition, resident 18 was not observed to receive a mechanical soft diet as recommended by the dietary manager and RD. A nurse caring for resident 18 was interviewed on 8/23/05 at 8:20 AM. The nurse caring for resident 18 stated that whoever receives med pass will have it written on their MAR (medication administration record). A review of resident 18's MAR for July 2005 and August 2005 was completed. The MAR's had no documented evidence that resident 18 was receiving the 2.0 med pass four times a day as recommended by the dietary manager on 8/3/05 and the RD on 8/5/05.	F 326		

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F 326	Continued From page 46 On 8/24/05 at 2:25 PM, the dietary manager was interviewed. The dietary manager stated that normally the recommendations are taken to the skin and weight meeting, but resident 18's recommendations were never followed through with.	F 326	F387 Medical Records and the A.D.O.N. or designated Licensed Nurse will track the physician visits ensuring that Residents are seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident 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 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that 2 of 22 sample residents (Resident 7 and 8) were not seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days as required. Findings include: 1. Resident 7 was readmitted to the facility on 5/5/05 with diagnoses which included peptic ulcer, hypothyroid, bladder hyperactivity, dementia and anxiety. A review of resident 7's medical record revealed that the resident had been seen by a physician 5/10/05, 5/17/05 and 5/24/05.	F 387	A tracking form and computer system will log these visits and keep the physician informed of who needs to be seen each week ensuring compliance with the required physician visits. The Medical Records and A.D.O.N. is responsible for continued compliance. To be completed by 10/21/05. Resident 7 was seen by the physician on 08/11/05, 09/13/05 Resident 8 was seen by the physician on 8/30/085	

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F 387	Continued From page 47 Resident 7 should have been seen by a physician on or around 6/24/05 and 7/24/05. There was no documentation in the medical record to provide evidence that resident 7 had been seen by a physician on or around 6/24/05 and 7/24/05. 2. Resident 8 was admitted to the facility on 6/17/97 with diagnoses which included, Parkinson's disease, meningioma, hypertension, history of breast cancer/mastectomy and dementia. A review of resident 8's medical record revealed that the resident had been seen by a physician on 5/24/05. Resident 8 should have been seen by a physician on or around 7/24/05. There was no documentation in the medical record to provide evidence that resident 8 had been seen by a physician on or around 7/24/05. On 8/23/05 and 8/24/05, the facility administration was asked by the survey team to find record of the missing physician visits for residents 7 and 8. They were unable to locate documentation for any of the missing physician visits.	F 387		
F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 426		

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F 426	Continued From page 48 the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility did not ensure that pharmaceutical services, including procedures to assure the accurate administering of all drugs, were met for 1 of 22 sample residents. Resident identifier 5. Findings include: Resident 5 was readmitted to the facility on 7/7/05 with diagnoses that included Alcohol abuse, seizures, cirrhosis of the liver, cerebral vascular accident, osteoporosis, chronic obstructive pulmonary disease, and hemangioma intercranial. Review of resident 5's medical was completed on 8/23/05. The Physician's telephone order dated 7/24/05 documented that celebrex (medication for arthritis) 200 mg. (milligram) was to be given once a week. The Physician's recertification orders for August 2005, documented that celebrex 200 mg. was to given once a day. Review of the MAR (medication administration review) documented celebrex 200 mg. PO (by mouth) Q WK (every week), there was no evidence that celebrex had been given during August 2005 as ordered for resident 5. The last dose of celebrex 200 mg. daily was on 7/31/05 with the weekly doses due on 8/7 , 8/14, and 8/21/05. In an interview with the ADON (Assistant Director	F 426	F426 As of 09/07/05 all telephone orders, white and pink copies will be placed in the medical records box for more accurate transcription into the computer. A three way check process will be implemented to assure accuracy of the MAR's, TAR's, physician recerts and to assure that the correct medication to match the medication administration records. A new system (Acufil) will be implement to decrease the potential for medication errors as of 10/21/05. Resident 5's medication orders will be reviewed with the M.D. and the order has been discontinued as of 09/13/05. The pharmacy consultant and the D.O.N. will review the effectiveness of the new system monthly, as needed, and in QA meetings quarterly as of 10/21/05.	

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F 426	Continued From page 49 of Nursing) She confirmed that celebrex had not been given as ordered for resident 5.	F 426	F502 The facility is committed to providing and obtaining laboratory services as ordered by the physician with timely responses as indicated.	
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: 2. Resident 2 was admitted to the facility with diagnose which included sepsis, hypoglycemia, UTI (urinary tract infection), quadriplegia and gastrointestinal anthrax. A review of resident 2 medical record revealed a physician's order dated 1/21/05 and signed by the physician. The order documented that a PT (protime) and INR (international normalized ratio) was to be done every two weeks starting on 1/28/05. A review of resident 2's lab record documented that the labs were completed every two weeks until 4/22/05. There was documentation of labs being completed once in May (5/27/05) once in June (6/10/05) and once in July (7/29/05). There were no PT and INR test completed for August. The facility could find no documentation that the missing labs were completed. Based on observation, medical record review, and interviews it determined that the facility did not meet the needs of 2 of 22 sample residents for laboratory services as ordered. Resident	F 502	Resident's 2 & 10 physician & lab orders were reviewed and updated. Labs were found to be Within normal limits. The facility shall develop a new policy and procedure in conjunction with the laboratory services contracted by the facility. See attached Policy & Procedure. The night nurse will audit all labs to see that they are received within 24 hours or per the lab processing timelines and follow up with the proper documentation. The A.D.O.N. or designee will do a weekly audit x2 months then monthly to ensure the policy and procedure, laboratory services are being completed and followed up on in a timely manner. The findings will be brought to the monthly QA meeting. The D.O.N. and A.D.O.N. is responsible for continued compliance. To be completed by 10/21/05.	

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F 502	Continued From page 50 Identifiers: 2, 10 Findings Include: Resident 10 was admitted to the facility on 9/9/04 with the following diagnoses: manic-depressive, chronic obstructive pulmonary disease, morbid obesity, Iron deficient anemia, gastric ulcer with hemorrhage, dementia, hypertension, venous insufficiency, personality disorder, incontinence, and cardiovascular disease. Resident 10's Physician Recertification orders upon admission and monthly as of August 2005 indicate that resident 10 was to have a Lipid Panel with Liver Function tests Q (every) six months. Clinical record review revealed no documentation of the Lipid profile tests being performed between 9/04 and 8/05. During meetings with facility's department heads including the Administrator, DON (Director of Nursing), ADON (Assistant Director of Nursing), and the Medical Records staff, documentation of these tests was requested. As of the 8/25/05 exit from the facility, there was no evidence that these lab tests were drawn as ordered.	F 502		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 51 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not maintain clinical records in accordance with professional standards that were complete, accurately documented, readily accessible and systematically organized for 13 of 22 sample residents. Resident identifers 6, 7, 8, 10, 11, 12, 13, 15, 16, 17, 18, 19, 21. Finding s include: 1. Resident 7 was readmitted to the facility on 5/5/05 with diagnoses which included peptic ulcer, hypothyroid, bladder hyperactivity, dementia and anxiety. A Review of resident 7's medical record was completed on 8/25/05. A physician's order dated 6/9/05, documented that resident 7 was to have weekly weights. A review of resident 7's medical record provided	F 514	F514 Weight, skin checks & Meal charts will be audited by medical records weekly to assure proper documentation is completed according to POC (including resident 6,7,8,10,11,12,13,15,17,18,19,21)(16 has been discharged) and report results to D.O.N. weekly and QA committee monthly. Medical records will review all current clinical records to assure 15 months of MDS are under the same tab in the clinical record and that forms are all filed in the proper clinical record.Paient trail leave/discharge orders in resident 18's chart was removed & filed in the proper clinical record. Lab results found in resident 16's chart was removed & filed in the proper clinical record. PASRR found in resident 15's chart was removed & filed in the proper clinical record. Medical records will monitor chart organization/filing Q monthly and report results to QA committee monthly. Completed as of 10/21/05.	

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documented evidence that weights were completed on 6/11/05, 6/18/05, 7/2/05 and 8/6/05.

There was no documentation to provided evidence that weights were completed on or around 6/25/05, 7/9/05, 7/16/05, 7/23/05, 7/30/05, 8/13/05 and 8/20/05.

The physical therapist aide who weighs the residents was interviewed on 8/23/05. He stated that if a resident's weight is stable then they are taken off of weekly weights. He stated that a physician's order is not written to discontinue weekly weights.

A review of resident 7's "Weekly Meal Chart" from 5/6/05 until 8/23/05 revealed resident 7 received 328 meals. One hundred and thirty-two of the 328 meals provided had no documentation that any of the meals were consumed.

2. Resident 8 was admitted to the facility on 6/17/97 with diagnoses which included, Parkinson's disease, meningioma, hypertension, history of breast cancer/mastectomy and dementia.

On 8/23/05, resident 8's medical record was completely reviewed by a nurse surveyor.

The medical record contained two annual MDS dated 4/8/04 and 4/7/04 and three quarterly MDS's dated 7/8/04, 10/8/04 and 1/7/05. No other MDS ' s were in resident 9 ' s medical record. The medical record should have contained 15 months of MDS assessments.

On 8/24/05 at approximately 4:00 PM, the corporate trainer stated that she found the 15

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months of MDS in the medical record. She stated that they were not all together under the same tab.

3. Resident 18 was admitted to the facility on 7/24/05 with diagnoses which included, contusions, elbow replacement, osteoporosis, hypertension and degenerative joint disease.

A Review of resident 18's medical record was completed on 8/25/05.

Resident 18's admission orders dated 7/25/04, documented that resident 18 was to have skin checks performed weekly. A review of resident 18's physician re-certification orders for 8/05 also documented that resident 18 was to have weekly skin checks.

A review of resident 18's medical record provided documented evidence that skin checks were completed on the following dates: 7/24/05 and 8/7/05.

There was no documentation in the medical record to provide evidence that resident 18 had skin assessments completed on or around 7/31/05, 8/14/05 and 8/21/05

On 8/23/05 and 8/24/05, the facility administration was asked by the survey team to find record of the missing skin assessments for resident 18. They were unable to locate documentation for any of the missing skin assessments.

A review of resident 18's "Weekly Meal Chart" from 7/24/05 until 8/23/05 revealed resident 18 received 90 meals. Forty-six of the 90 meals provided had no documentation that any of the

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meals were consumed.

A review was conducted on 8/25/05 of Resident 18's medical record, documentation was found of another persons "Patient Trial Leave/Discharge Orders" from a local hospital. Review of this information provided documented evidence that the dietary manager and registered dietitian based resident 18's nutritional assessment on diagnoses documented on this information.

4. Resident 17 was admitted to the facility on 9/9/04 with the following diagnoses: hemiplegia, diabetes mellitus type two, anxiety, ventral hernia, post traumatic head injury, osteoporosis, insomnia, neurogenic bladder, degenerative joint/ contracture of right hand.

A Review of resident 17's medical record was completed on 8/24/05.

resident 17's admission orders dated 9/9/04, documented that resident 17 was to have skin checks performed weekly. A review of resident 17's physician recertification orders from 4/05 through 8/05 also documented that resident 17 was to have weekly skin checks.

On 8/23/05 at about 3:30 PM, the ADON (Assistant Director of Nursing)was interviewed. The ADON stated that the weekly skin checks were to be documented on the weekly skin check sheet located in each residents' medical record.

A review of resident 17's medical record provided documented evidence that skin checks were

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completed on the following dates: 4/16/05, 4/25/05, 5/6/05, 5/13/05 and 5/28/05.

There was no documentation in the medical record to provide evidence that resident 17 had skin assessments completed on or around 4/1/05, 4/7/05, 4/11/05, 5/1/05, 5/20/05, 6/5/05, 6/12/05, 6/19/05, 6/26/05, 7/1/05, 7/8/05, 7/15/05, 7/22/05, 7/29/05, 8/5/05, 8/12/05 and 8/19/05.

On 8/23/05 and 8/24/05, the facility administration was asked by the survey team to find record of the missing skin assessments for resident 17. They were unable to locate documentation for any of the missing skin assessments.

5. Resident 10 was admitted to the facility on 9/9/04 with the following diagnoses: manic-depressive, chronic obstructive pulmonary disease, morbid obesity, iron deficient anemia, gastric ulcer with hemorrhage, dementia, hypertension, venous insufficiency, personality disorder, incontinence, and cardiovascular disease.

A Review of resident 10's medical record was completed on 8/23/05.

Resident 10's admission orders dated 9/9/04, documented that resident 17 was to have skin checks performed weekly. A review of resident 10's physician recertification orders from 4/05 through 8/05 also documented that resident 10 was to have weekly skin checks.

A review of resident 10's medical record provided documented evidence that skin checks were completed on the following dates: 5/24/05, 7/4/05, 7/14/05, 7/19/05, and 7/24/05.

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There was no documentation in the medical record to provide evidence that resident 10 had skin assessments completed on or around 4/1/05, 4/7/05, 4/11/05, 4/16/05, 4/23/05, 5/1/05, 5/8/05, 5/15/05, 5/30/05, 6/5/05, 6/12/05, 6/19/05, 6/26/05, 7/30/05, 8/6/05, 8/113/05 and 8/20/05.

On 8/23/05 and 8/24/05, the facility administration was asked by the survey team to find record of the missing skin assessments for resident 10. They were unable to locate documentation for any of the missing skin assessments.

6. Resident 6 was admitted to the facility on 9/9/04 with the following diagnoses: senile dementia, coronary artery bypass graft, osteoarthritis, and gastrointestinal distress.

A Review of Resident 6's medical record was completed on 8/23/05.

Resident 6's admission orders dated 9/9/04, documented that resident 6 was to have skin checks performed weekly. A review of resident 6's physician recertification orders from 4/05 through 8/05 also documented that resident 6 was to have weekly skin checks.

A review of resident 6's medical record provided documented evidence that skin checks were completed on the following dates: 7/14/05, 7/16/05, 7/19/05, and 7/26/05.

There was no documentation in the medical record to provide evidence that resident 6 had skin assessments completed on or around 4/1/05, 4/7/05, 4/11/05, 4/16/05, 4/23/05, 5/1/05,

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F 514	Continued From page 57 5/8/05, 5/15/05, 5/22/05, 5/30/05, 6/5/05, 6/12/05, 6/19/05, 6/26/05, 7/1/05, 7/7/05, 8/1/05, 8/8/05, 8/15/05 and 8/22/05. On 8/23/05 and 8/24/05, the facility administration was asked by the survey team to find record of the missing skin assessments for resident 6. They were unable to locate documentation for any of the missing skin assessments. Further interview with the ADON on 8/24/05 revealed that upon hire of ADON approximately 3 weeks prior, the weekly skin checks had been poorly documented. The ADON stated that many goals had been made to improve the facility, and documentation of weekly skin assessments was one of those goals. 7. Resident 11 was admitted to the facility on 1/06/05 with the following diagnoses: diabetes mellitus, hepatitis B, arteriosclerosis, dementia, neuropathy, benign prostate hypertrophy, non-psychotic brain syndrome, peptic ulcer disease, and amyloses. A review of resident 11's medical record was completed on 8/22/05. Resident 11's physician recertification orders dated June, July and August 2005, documented that resident 11 was to have skin checks performed weekly. A review of resident 11's medical record provided documented evidence that skin checks were completed on the following dates: 8/2/05 and 8/07/05.	F 514		

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There was no documentation in the medical record to provide evidence that resident 11 had skin assessments completed on or around 6/1/05, 6/8/05, 6/15/05, 6/22/05, 6/29/05, 7/7/05, 7/14/05, 7/21/05, 7/28/05, 8/14/05, 8/21/05, and 8/28/05.

8. Resident 12 was admitted to the facility on 9/09/04 with the following diagnoses: Alzheimer disease.

A review of resident 12's medical record was completed on 8/23/05.

Resident 12's physician recertification orders dated June and July 2005, documented that resident 12 was to have skin checks performed weekly.

A review of resident 12's medical record provided documented evidence that skin checks were completed on the following dates: 7/4/05, 7/16/05, 7/24/05, and 7/26/05.

There was no documentation in the medical record to provide evidence that resident 16 had skin assessments completed on or around 6/01/05, 6/8/05, 6/15/05, 6/22/05, 6/29/05, and 7/31/05.

9. Resident 16 was admitted to the facility on 6/20/05 with the following diagnoses: gastrointestinal hemorrhage, hypoosmolality, peripheral vascular disease, diverticulitis, hypertension, ankylosing spondylitis, and asphyxia.

A review was conducted on 8/25/05 of resident 16's closed medical record, documentation was

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found of another persons laboratory results.

10. Resident 15 was admitted to the facility on 4/07/05 with the following diagnoses: urosepsis, dehydration, aspiration, subdural hematoma, atrial fibrillation, hypertension, seizure disorder, anemia, depression, and senile dementia.

A review was conducted on 8/25/05 of resident 15's closed medical record, documentation was found of another persons PASRR (preadmission screening resident review), and ADL (activities of daily living) flow sheet.

11. Resident 13 was admitted to the facility on 8/9/00 with diagnoses that included cerebral vascular accident with depression, arthritis, osteoporosis, bladder dysfunction,anemia, and hemiplegia.

A Review of resident 13's medical record was completed on 8/25/05.

A original physician's order dated 8/9/00 and the physician's recertification dated 8/05, documented that resident 13 was to have weekly weights.

A review of resident 13's medical record provided documented evidence that skin assessment was completed on 7/17/05.

There was no documentation to provided evidence that skin assessments were completed on or around 6/25/05, 7/9/05, 7/23/05, 7/30/05, 8/13/05 and 8/20/05.

12. Resident 19 was admitted to the facility on 8/4/02 with diagnoses that included 8/4/02 with

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F 514	Continued From page 60 diagnoses that included alzheimer's disease, heart disease, osteoporosis, alcohol dependent, depressive disorders and cerebral vascular accident. A review of resident 19's medical record was completed on 8/25/05. A original physician's order dated 8/30/02 and the physician's recertification dated 8/05, documented that resident 19 was to have weekly skin assessments. A review of resident 19's medical record provided documented evidence that skin assessments were completed on 7/3/05, 7/10/05 and 7/17/05 There was no documentation to provided evidence that skin assessments were completed on or around 6/11/05, 6/4/05, 6/25/05, 7/23/05, 7/30/05, 8/13/05 and 8/20/05. 13. Resident 21 was admitted to the facility on 9/9/04 with diagnoses that included senile dementia with delusions, chronic obstructive pulmonary disease, congested heart failure, arthritis, cerebral vascular accident, atonic bowel and hypothyroidism. A review of resident 21's medical record was completed on 8/24/05. A original physician's order dated 9/9/04 and the physician's recertification dated 8/05, documented that resident 21 was to have weekly skin assessments and weekly weights. A review of resident 21's medical record provided documented evidence that skin assessments	F 514		

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F 514	Continued From page 61 were completed on 7/4/05, 7/11/05, 7/14/05 and 7/24/05. There was no documentation to provided evidence that skin assessments were completed on or around 5/30/05, 6/13/05, 6/27/05, 7/31/05, 8/7/05, 8/14/05 and 8/21/05. Resident 21's weekly weights were completed on 3/19/05, 3/28/05, 4/2/05, 4/11/05, 4/16/05 4/23/05, 5/21/05, 5/28/05, 6/5/05, 7/2/05 and 8/6/05. There was no documentation to provide evidence that resident 21's weight was assessed on 4/30/05, 5/7/05, 5/14/05,6/11/05, 6/18/05, 6/25/05, 7/9/05, 7/16/05, 7/23/05,7/30/05, 8/13/05 and 8/20/05. In an interview with two staff members, staff member 2 stated " ....weight was stable so we moved her (resident 21) to monthly weights....I think it was one of the nurses that told us we could move her to monthly weights". Staff member 3 agreed with staff member 2's statement.	F 514		

EAST LAKE CARE CI ER

NURSING PROCEDURE FOR FALLS AND AT RISK RESIDENTS

1. Fall Risk Assessment

A. A Fall Risk Assessment will be completed on all residents within the first 24 hours of admission, and every 90 days or when a significant change in condition occurs (MDS nurse)
B. Residents whose score on the Fall Risk Assessment indicates that they are at risk for falls will be added to the Resident List – High Risk For Falls.
D. The Resident List – High Risk For Falls will be located in the front of the Medication Administration Record (MARs) .
E. A licensed nurse will review and update the Resident List form on a monthly basis.
F. The MDS nurse will complete the Fall Risk Assessment on admit and every 90 days. When the score indicates the resident to be at risk or no longer at risk the MDS nurse will add or remove the resident from the Resident List in front of the MARs.

2. Plan Of Care

A. Once a resident has been identified by the Fall Risk Assessment as at risk, the Injury, High Risk For Care Plan will be implemented by the MDS nurse. Every fall will be documented on the Actual Fall Care Plan by the licensed nurse. The approaches to prevent further falls will be dated as implemented with each fall.
B. The plan of care will be re-evaluated with each fall by the licensed nurse. Every 90 days and with a change in condition the MDS nurse will update the Injury, High Risk For Falls care plan and the Fall Risk Assessment (if the assessment score changes the MDS nurse will change this on the Resident List)

3. Intervention

A. The MDS nurse will provide the nursing administration with the scores from the Fall Risk Assessments completed each week. A Fall and Restraint meeting will be held weekly to review all new falls and admits for appropriate interventions. All incident reports will be reviewed at the weekly meeting.
B. Falls and residents with changes in condition will be reviewed in weekly restorative meeting for intervention by the RNA program or Therapy. If deemed appropriate the M.D. will be notified of the need for therapy consult.
C. All residents who have repeat falls or decline in condition will be screened by therapy.
D. Nursing will attempt to identify any underlying causes of falls or decline by reviewing medication, labs, and any recent changes in environment, physical or mental status.

4. The Timber Program

A. The Timber program will be implemented on all residents that are identified at risk for falls.
B. Residents on the Timber program will have a symbol placed on the door, bed, and assistive devices. The licensed nurses will review these monthly by matching the Resident List – High Risk For Falls with the Timber symbols.

5. Meetings

A. Fall and Restraint: D.O.N. , Environmental Manager, Lead C.N.A. , Restorative aide,
B. Meeting will be held weekly and conducted by the D.O.N.

Procedure Implemented 09/2005

RESIDENT LIST - HIGH RISK FOR FALLS

Instructions: Place all residents who score $\geq$ 13 on the Fall Risk Assessment Scale and those who fall on this tracking form.

- Place in the MAR for quick reference. Please review and update this form monthly.

MONTH:

Resident Rm #	Resident Name	Fall Risk Assessment Score		Date of Initial Fall	Date of Fall	Date of Fall	Date of Fall
		Admission or Latest Fall Assess Date	Score				

FALL, ACTUAL	NURSING CARE PLAN	DATE:
RESIDENT:	ROOM#	PHYSICIAN:

GOAL / OBJECTIVE

The resident will:

1.__________experience no falls on a daily basis through the next care plan meeting.
. date / initials

2.__________experience no injury related to falling through next care plan meeting.
. date / initials

DATE(S) OF FALL(S): Initial Fall Date:__________ signature of nurse:______________________

. 2nd Fall Date:__________ signature of nurse:______________________

. 3rd Fall Date:__________ signature of nurse:______________________

	1st Fall	2nd Fall	3rd Fall
NURSING APPROACHES – IMMEDIATE (do all that apply, date and initial) Prior to lifting resident from floor, assess for pain or injury including: a. abnormal alignment or positioning b. impaired movement – extremity abduction or adduction c. tenderness, bruising, redness, swelling, skin tears, wounds or bleeding	date initial	date initial	date initial
Obtain vital signs: Temp._____Pulse______Resp.______ B/P_________ If diabetic- assess blood glucose__________	date initial	date initial	date initial
NOTIFY M.D., FAMILY , D.O.N. OR A.D.O.N. , IMMEDIATELY FOR THE FOLLOWING: Obvious deformity, any complaints of severe pain, hip pain with change/inability to walk, head injury, abnormal neuro status, new onset of confusion, laceration requiring suture, and abnormal vital signs.	date initial	date initial	date initial
TREATMENT FOR SEVERE INJURY or SUSPECTED HEAD INJURY while awaiting medical transport: a. V.S. every 15 minutes with neuro checks. b. immobilize and apply ice to affected area as indicated. c. if bleeding apply direct pressure with clean 4 x 4 d. have aide stay with and reassure the resident	date initial	date Initial	date initial
FALL with no apparent injury: notify family as soon as possible, inform M.D. and D.O.N. within 24 hours: Treatment of resident with no apparent acute injury: a. reassure resident and give pain medication as ordered if indicated b. vital signs q 4 hours x 2, then q shift with nurses note x 72 hours. c. provide comfort measures as indicated.	date initial	date initial	date initial
ADD – INJURY, HIGH RISK FOR FALLs CARE PLAN to resident chart			
INITIATE ALERT CHARTING PROTOCOL			
INITIATE THE TIMBER PROGRAM			
ADD RESIDENT TO THE RESIDENT LIST – High Risk for Falls in front of the M.A.R.s			
MAKE A DETAILED NURSES NOTE and INITIATE INTERVENTIONS AS LISTED ON THE BACK OF THIS FORM.			

PLAN OF ACTION TO PREVENT REOCCURRENCE:

____Staff Inservice ____Medical Intervention

____Therapy Screen/ Eval. ____Medication Changes by M.D.

____Care Plan Revision ____Restorative Nursing Program

____Psych Consult / Social Service ____Restraint assessment

OTHER PLAN OF ACTION:____

FALL RISK INTERVENTION GUIDELINE / TOOL		
DATE	INITIAL	INTERVENTION
		Orient and reorient on an ongoing basis to room and unit.
		Continually educate the resident regarding safety issues.
		Examine footwear for proper fit, repair, and non-skid soles and replace if needed.
		Assess assistive devices for proper fit and use. Provide instruction as needed.
		Be sure bed is in lowest position and locked in place.
		Keep room free of clutter and ensure objects the resident needs are in reach.
		Ensure adequate lighting and place call light in reach.
		Answer call lights promptly and ensure call lights in working order.
		Monitor for changes in mental, emotional, or physical condition.
		Monitor medications for possible side effects that could contribute to falls.
		Encourage exercise and mobility to maximize strength, balance, and coordination.
		Clean up spills immediately.
		Make sure glasses are clean, properly fitted , and worn.
		Encourage self-mobile residents to rise slowly and be sure of steadiness before walking.
		Instruct the resident what to do if a fall occurs. Encourage to call for help, and wait for staff.
		Teach proper body positioning.
		Inform the resident and family that the resident is on the fall risk prevention program.
		Implement the Timber Program.
		Explain to the resident and family why thet may be likely to fall. (medication…)
		Anticipate needs by assessing normal routines.
		Provide routine schedule for bathroom use.
		Assess for signs and symptoms of discomfort and assist as indicated.
		Check resident q half hour if restrained and every 1 –2 hours otherwise.
		Obtain consults as appropriate (P.T., O.T., restorative, activities, social services, pharmacy)
		Assess need for lab tests and consult with M.D. for orders.
		Assess for personal alarms or side rails.
		Assess sleep patterns to ensure adequate rest.
		Encourage activities and social interaction. Avoid isolation.
		If possible move closer to the nurses station for increased observation.
		Assess medications and times given to decrease risk of periods of unsteadiness.

THE DIRECTOR OF NURSING WILL TRACK FALLS AND REPORT TRENDS TO INTERDISCIPLINARY TEAM AS NEEDED. THE MDS NURSE WILL USE THIS FORM TO UPDATE THE FALL CARE PLAN EVERY 90 DAYS.

RESIDENT:______________________________ ROOM#___________ M.D.____________________________

CALL LIGHT AUDIT

Date	Time	Rm #	Response Time	Person completing Audit	Comments

Res #11

BENEFIT vs. RISK

(refusal to accept treatment, or comply with M.D. order)

Resident : [redacted]

Area of Concern : Ted Hose

BENEFITS	RISKS
↓ edema (Swelling)	increased edema (Swelling)
reduce risk of	Possible development of
developing a bloodclot	a blood clot
increase comfort	decreased comfort in
improve circulation to extremities	walking c̄ edema
Shoes & socks will fit	poor circulation esp
better	to feet - develop
	Stasis ulcers

The above information has been reviewed with me. I understand the potential risks of my noncompliance and the benefits of compliance with current physician's orders.

[redacted]
Resident/ Responsible Party Signature

9/7/05
Date

✓ MD notified
✓ Care plan completed
___ Family Notified

Diane Schmidt RN/ADON

Res #11

PHYSICIAN'S TELEPHONE ORDERS

Form 982P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

Name of Facility: ELCC			Address		
[redacted]		First Name	Admission Number	Room No.	Attending Physician: Grant

Date Ordered	Time Ordered	Date Discont.	Orders
9/7/15			D/C Ted Hose d/t non-compliance

Signature of Nurse Receiving Order	☐ Resident Notified ☐ Family Notified	Signature of Physician	Date
Diane Schmidt		[signature]	

		Initials			Initials			Initials		
	On MD Order Sheet			Med/Tx Sheet			Date & Time			Communicated / Read Back
	Pharmacy			Nurses Notes			Pt. Care Plan			Signed

ORIGINAL COPY-Physician Please Sign and Return

Triple Check procedure

Triple check include the following:
1. Check the next months physician recertification orders against the current physician recertification orders and follow up on any discrepancies.
2. Check the current MAR's and against the new months MAR's paying close attention to the times and doses.
3. Check the MAR's to the medication to the chart. There must be a medication for each order.

Triple check will begin at least 5 days prior to the end of the month.

CNA flow sheets and meal % sheets need to come out 5 days prior to the end of the month. Check the current CNA flow sheets and Meal % sheets against the new months.

MEDICATION AUDIT

RESIDENT NAME	DATE	TIME	MEDICATION DR. ORDER	NOT CHARTED	REFUSED NOT CHARTED	INITIALS SIGN BOTTOM PAGE

Res # 20

TUBE FEEDING ANALYSIS WORKSHEET REPORT

East Lake Care Center (EL)

Worksheet Date: 9/8/2005

Resident Name: [redacted] ***Room:*** W 410 B ***M/R #:*** 3115567

General Information:

Age: 61.1 ***Gender:*** M ***Height:*** 66.00 ***Weight:*** 99.00 ***BMI:*** 16.02

Resident Diagnoses:

293.84	Anxiety Disorder Oth Dis	564.00	Constipation Nos
506.0	Fum/Vapor Bronc/Pneumon	496	Chr Airway Obstruct Nec
518.81	Acute Respiratry Failure	480.9	Viral Pneumonia Nos
599.0	Urin Tract Infection Nos	715.90	Osteoarthros Nos-Unspec

Current tube feeding order:

PROMOTE AT 95 CC HR X 24HRS, 240 CC H2O FLUSH BID

Date of order: 9/7/2005

Calculations are based on the following information:

Method of formula delivery: Pump

	Formula	Cc	Cal/Cc	Pro/Cc	Water/Cc
Primary formula:	Promote	2,280.00	0.99	0.06	0.83
Supplemental formula:	NP				

Other fluids: ***Total in 24 hrs*** NP -OR- ***Bolus/flushes*** 480.00

Activity Factor and value: 1.20 Confined to bed
Stress/Injury Factor value: 1.70
Protein Factor value: 2.00

* - designates this factor was provided by the user and was used during nutritional calculations

CALCULATION RESULTS:

	CALORIES	PROTEIN	FLUIDS
Recommended:	2,250.16	90.00	1,350.00
Received:	2,251.50	140.60	2,361.00

Lab Data:

9/4/05	Hbg	10.9	9/4/05	FBS	58	9/4/05	Hct	32.1
9/4/05	K	2.1	9/4/05	Albumin	3.4	9/4/05	Creatine	.3

OTHER LAB DATA:

Current Meds/Vitamins/Mineral Supplements:

K+

ADDITIONAL NOTES

Calories adequate, Protein increased due to pressure ulcer, Fluids Creatine level low so increased fluids would be benificial.

SIGNATURE: [signature] DATE: 9/8/05

Note: Formulas and default constant values may vary from those selected by some healthcare professionals. Since the selection of some values for use in the calculations are dependent on other relevant clinical findings, it is strongly recommended that nutritional assessments be reviewed by a qualified healthcare professional.

Ass- DON

DIETARY RECOMMENDATIONS

ROOM	RESIDENT'S NAME	NUTRITIONAL PROBLEM	RECOMMENDATIONS	FOLLOW UP DATE
412	[redacted]	Res. diet not offering enough cal for body wt.	(1) house health shake once/day (~ 300 cal)	See 70. + N.N. 9/14/05
405	[redacted]	Sig wt gain 30 lbs x 1mo	(1) Re-weigh Resident	Re-weigh completed 9/15/05

Date Submitted: 9/13/05 Recommendations to: ELC

Date due to Dietary: 9/16/05 From: [redacted]

RETURN TO DIETARY DEPARTMENT IN 72 HOURS FROM DATE SUBMITTED ON THIS SHEET

Form 107 (01-02)

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Crandall & Associates Consulting Dietitians, Inc.

SIGNIFICANT WEIGHT CHANGE REPORT

(Do not thin from chart)

Resident:_______________________________ Rm #________ Physician:________________

Date weight loss / gain identified:__________________ IBW____________ UBW__________

Current weight______________ Previous weight_______________ Percent change________ %

Avg% of PO intake at meals______________ Dining Location________________________

Current diet:____

Supplements:____________________________________ Avg % of intake______________ %

Possible reason for weight change:____

Wounds: ____

Advanced Directives: Y or N   Feeding tubes: Y or N

Medications:____

Labs:	Lab Value	Date:	Labs:	Lab value	Date:
Albumin			Pre-Albumin		
Total Protein			RBC		
Glucose			Hgb		
Calcium			Hct		

Interventions / Recommendations:____

____

____

Committee members present:	Date:

Meal Audits

Date	Meal Time	Residents Initials	Diet per D.O.	Diet as ordered Yes	NO	Person completing Diet Audit	Comments

CL6200b

Example

East Lake Care Center
For the month of: September 2005

MEDICATION ADMINISTRATION RECORD

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DIETARY SUPPLEMENT																																
4 OZ OJ QD Start Date: 6/9/2005 served c̄ Breakfast Tray	0800																															
	%																															
MED PASS 2.0 120 CC TID Start Date: 6/9/2005 Please observe & indicate the % drank!	0800	[illegible]	CP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	JB	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																
	%	100	100	100	50	100	100	100	100	50	100	100	[illegible]	100	[illegible]	100																
	1200	[illegible]	CP	[illegible]	[illegible]	[illegible]	[illegible]	JB	[illegible]	JB	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																	
	%	[illegible]	0	100	100	[illegible]	80	100	100	100	75	[illegible]	[illegible]	100	[illegible]																	
	1700	[illegible]	CP	[illegible]	[illegible]	[illegible]	[illegible]	JB	JB	JB	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																	
	%	50	100	100	100	0	100	100	50	50	[illegible]	50	[illegible]	100	[illegible]																	
MEDICATIONS																																
FAMOTIDINE(PEPCID) 20MG 1 TAB PO BID DX: PEPTIC ULCER NOS Start Date: 5/5/2005	0800	[illegible]	CP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																
	2000	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	SA																	
CALCIUM 500/ W-VIT D BID DX: FRACTURE RISK Start Date: 5/12/2005	0800	[illegible]	CP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	JB	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																
	2000	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	SA																	
OXYCONTIN 20MG SR 2 TABS QHS 2 tabs = 40mg DX: PAIN Start Date: 5/5/2005	2000	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	SA																	

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.
[redacted]	[illegible]	[redacted]	CP				
		pt refused 2000 meds 9/3 wasted Bw					

CODE STATUS

DNR

ADVANCED DIRECTIVES

LIVING WILL & ADVANCE DIRECTIVES

Dx:		
296.32 Recurr Depr Psychos-Mod	596.51 Hypertonicity Of Bladder	290.0 Senile Dementia Uncomp
533.90 Peptic Ulcer Nos	333.1 Tremor Nec	722.52 Lumb/Lumbosac Disc Degen
244.9 Hypothyroidism Nos	721.3 Lumbosacral Spondylosis	401.9 Hypertension Nos

Allergies: None Known

Physician: GRANGE, TIMOTHY MD
Phys. Ph: (801) 949-8467

Alt. Phys:
Alt. Phys. Ph:

Ht: 62 **Wt:** 129.00
M/R No.: 4115807

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
[redacted]			[redacted]	[redacted]	[redacted]

Page: 1

CL6200b

Example

East Lake Care Center
For the month of: September 2005

MEDICATION ADMINISTRATION RECORD

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ZYPREXA 2.5 MG QD PRN DX: DELUSIONS/AGITATION Start Date: 8/16/2005 Give 1QAM/PRN Δ ZYPREXA ZYDIS 9/13/05	PRN			[illegible]					DW	JB			-	[illegible]	[illegible]																	
	TIME									[illegible]																						
	INIT																															
MYLANTA 15 CC PO QID DAILY PRN DX: Start Date: 7/25/2005	PRN																															
	TIME																															
	INIT																															
ATIVAN 1/2 MG PO [illegible] PRN MRX1 DX: ANXIOUS FEATURES Start Date: 8/16/2005 Give 1QAM/PRN	PRN						[illegible]		DW	JB																						
	TIME				[illegible]					[illegible]																						
	INIT				[illegible]																											
Med Pass 2.0 100cc qid wt. Loss 8/30/05 Please observe and indicate % drank	0800	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																	
	%	100	[illegible]	100		100	[illegible]	100	[illegible]	[illegible]	[illegible]	75	10	100	100																	
	1200	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																	
	%	[illegible]	[illegible]	100	10	100	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	75	100	100	100																	
	1600		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																	
	%		[illegible]	100	10	100	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	50	[illegible]	100	100																	
	H.S.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	SA																	
	%	[illegible]	50	[illegible]	[illegible]	[illegible]	[illegible]	100	[illegible]	[illegible]	[illegible]	[illegible]	100	[illegible]	∅																	

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

CODE STATUS

DNR

Dx:			
	920 Contusion Face/Scalp/Nck	733.00 Osteoporosis Nos	427.89 Cardiac Dysrhythmias Nec
	923.10 Contusion Of Forearm	599.0 Urin Tract Infection Nos	427.69 Premature Beats Nec
	V43.62 Joint Replaced Elbow	401.9 Hypertension Nos	780.99 Other General Symptoms

Allergies: SULFA, MORPHINE

Physician: GRANGE, TIMOTHY MD *Alt. Phys:* *Ht:* 56 *Wt:* 74.60
Phys. Ph: (801) 949-8467 *Alt. Phys. Ph:* *M/R No.:* 7055874

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date

Page: 3

Warning slip / documentation
Date:__________________
CNA responsible for documentation:

____

Date due of documentation not complete

_______ ____________________
_______ ____________________
_______ ____________________
_______ ____________________
_______ ____________________

Comments:______________________

____

This slip must be completed within 48 hours and returned to the DON if not and if 3 warning slips in 30 days an official counseling form will be issued

Warning slip / documentation
Date:__________________
CNA responsible for documentation:

____

Date due of documentation not complete

_______ ____________________
_______ ____________________
_______ ____________________
_______ ____________________
_______ ____________________

Comments:______________________

____

This slip must be completed within 48 hours and returned to the DON if not and if 3 warning slips in 30 days an official counseling form will be issued

Warning slip / documentation
Date:__________________
CNA responsible for documentation:

____

Date due of documentation not complete

_______ ____________________
_______ ____________________
_______ ____________________
_______ ____________________
_______ ____________________

Comments:______________________

____

This slip must be completed within 48 hours and returned to the DON if not and if 3 warning slips in 30 days an official counseling form will be issued

Warning slip / documentation
Date:__________________
CNA responsible for documentation:

____

Date due of documentation not complete

_______ ____________________
_______ ____________________
_______ ____________________
_______ ____________________
_______ ____________________

Comments:______________________

____

This slip must be completed within 48 hours and returned to the DON if not and if 3 warning slips in 30 days an official counseling form will be issued

UTRITIONA SK REVIEW

Advance Directives: DNR TF/TPN Support: ☐ Yes ☐ No ☐ Not Available IV Support: ☐ Yes ☐ No ☐ Not Available

Sex: ☐ M ☒ F Date of Birth: 10-1-17 Age: 87 Height: 56" Admit Wt: 114 UWR: 90-101 IWR: 73-91

Type of Review (I = Initial; A = Annual; COC = Change of Condition): ________ Date: 9-9-05

Nutritional Data

Current Wt: 89 Adj. obesity wt: ______
% IWR: 100% BMI: 15
Variance: -1% x 1mo, -11% x 3mo -10% x 6mo
☒ Weekly weights

Diet Order: SNP, NAS, Puree 8oz extra H2O c̄ meals
% Intake: 66%

Supplement Order: 2.0 Med Pass 120cc QID
% Intake: ______

Comments:

Meal Location: ☒ DR ☐ Room ☒ Assist ☐ Restorative ☐ Other: ______
Adaptive Device: ______

Meds with Nutritional Implication:
1. Exelon - MVI
2. KCL - Vit D
3. Motrin
4. ~~Lasix~~ - Ativan
5. Singulair
6. ASA
7. Senekot
8. Synthroid
9. Fosamax
10. Namenda

Skin Integrity: Stg 1 2 3 4 (Intact)
Location: ______

Date: 5-20-05 ☒ Not Recent
HGB ______ BUN 31↑ K 4.8
HCT ______ CREAT 1.1 NA 147↑
MCV ______ OSM 309 GLUC 78
PAB ______ ALB 3.3 3-4-05

Other Pertinent Diagnosis/ Conditions:
Dementia c̄ delusions
Hypokalemia
Pain
CHF
COPD
Constipation
Hypothyroidism
~~Fosamax~~
Osteoporosis
Senile Delusions

Risk Scoring for Pressure Ulcers, Dehydration, Nutrition

Risk Factors	Score Key			Resident Status (Circle appropriate status)	P	D	NR
Weight Status Gain or Loss * Does not apply to BMI			0	Stable within past 3 mo., BMI 19-27			
	P	D	1	< 5% x 1 mo, < 7.5% x 3 mo, < 10% x 6 mo wt change			
	P*	D*	3	≥ 5% x 1 mo, ≥ 7.5% x 3 mo, ≥ 10% x 6 mo wt change or (BMI < 19) or > 27	P	D	3
Oral Food Intake			0	Intake meets estimated needs (meals & supplement)			0
	P		1	Intake meets 50-75% of estimated needs (meals & supplement)			
	P		3	Intake meets <50% of estimated needs (meals & supplement)			
Oral Fluid Intake			0	Consumes 1500-2000 ml/day (AEB > 75-100% meal intake)			0
		D	1	Consumes 1000-1499 ml/day (AEB 50-75% meal intake)			
		D	3	Consumes < 1000 ml/day (AEB < 50% meal intake)			
Oral Function			0	Teeth/dentures in good condition, no chewing or swallowing problems			
			1	(Chewing problems), teeth in poor repair, ill fitting dentures, refusing to wear dentures, edentulous, taste and sensory changes, controlled swallowing/ dysphagia problem			1
		D	3	Aspirates, difficulty swallowing w/choking episodes, dysphagia			
Feeding Ability			0	Independent while dining			
			1	Limited feeding assistance or supervision while dining			
		D	3	(Total dependence while dining), TF, TPN, mouth pain		D	3
Mental Function * With comatose and semi comatose			0	Alert and Oriented			
		D	1	Disoriented, Aphasic, Confused, early/mod Dementia			
	P*	D	3	Comatose, Semi Comatose, Lethargic, Delirious, Paranoid, Alzheimer's, (Dementia), OBS, Depression	P		3
Nut'l Related Medications * If laxative or diuretic		D*	0	0-1 drugs (Based on the following types of drugs: Antibiotics, (Diuretics), Psychotropics, Laxatives, (Steroids), Chemotherapy, Hypoglycemia)			
		D*	1	2-4 drugs			
		D*	3	(5 or more drugs)		D	3
Skin Condition			0	(Skin Intact)			0
	P		1	Stg I / II pressure ulcer, skin tears not healing, stasis ulcers, fecal or bladder incontinence, surgical wound w/drainage, Hx PU			
	P		3	Stg III / IV pressure ulcer or multiple impaired areas			
Nutritional Related Lab Values * Albumin and Prealbumin only			0	Albumin and all other nutrition related lab values WNL			0
	P*		1	Albumin 3.0-3.4 g/dl or Prealbumin 10-15 mg/dl or 1-2 other abnormal nutrition related labs			
	P*		3	Albumin <3.0 g/dl or Prealbumin < 10 or 3-5 other abnormal nutrition related labs			
Relevant Conditions and Diagnoses * See Specific Condition/ Diagnosis			0	HTN, DM, Heart Disease, Controlled Diseases			
	P*	D*	1	(P): Fx, (COPD), Edema, Recent CVA, Bedridden/ ↓ Mobility (D): (Constipation), Diarrhea, Infection, UTI, Fever, (CHF) (No P or D): Alcohol/Drug Abuse, Anemia, Anorexia, Food Intolerances/ Allergies, GERD, Hx GI Bleed, (Osteoporosis), Parkinsons, Poor Circulation, Recent Surgery	P	D	1
	P*	D*	3	(P): Advanced Cancer, Aids, Dialysis, Malnutrition, Radiation/Chemo Therapy, Septicemia, Uncontrolled DM (D): Active GI Bleed, Aids, Chronic N/V, Dehydration/ Hypovolemia, Dialysis, ESRD, Fecal Impaction, Malnutrition, Uncontrolled DM (No P or D): Gastrectomy, Liver Failure, Ostomy, Other Uncontrolled Diseases			

RISK TOTALS FOR PRESSURE ULCER, DEHYDRATION, AND NUTRITION: 2 5 14

Resident: [redacted] ID#: [redacted]

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NUTRITIONAL ASSESSMENT

CALORIE / PROTEIN / HYDRATION NEEDS

Kcal needs	Protein needs	Hydration needs
Kcal needs: (**IWR** circled) / ABW / Adjusted for: ☐ obesity ☐ para ☐ quad ☐ amputee) (**maintenance** circled) / wt gain / ↑ needs)	Protein needs: (**IWR** circled) / ABW / Adjusted for: ☐ obesity ☐ para ☐ quad ☐ amputee) (normal / (**at risk** circled) / healing / repletion)	Hydration needs: (**IWR** circled) / ABW / Adjusted for: ☐ obesity ☐ para ☐ quad ☐ amputee)
990-1230 cal (30 Kcal/Kg factor)	33-41 gms (1.0 gm/Kg factor)	not <1500 ml (30 cc/Kg factor)
% needed (cal) 45-56%	% needed (pro) 41-51%	

RISK TOTALS FOR PRESSURE ULCER, DEHYDRATION AND NUTRITION

Resident Scored at Risk for: (Scoring from page 1)

Total Score		No	Moderate	High
2 P	Pressure Ulcers	☐	☒	☐
5 D	Dehydration	☐	☐	☒
14 NR	Malnutrition / Weight Loss	☐	☐	☒

Key:

- P = Pressure Ulcer Risk Score = (0) No Risk or (1-2) Moderate Risk or (≥3) High Risk
- D = Dehydration Risk Score = (0) No Risk or (1-2) Moderate Risk or (≥3) High Risk
- NR = Nutritional Risk Score = (0-3) No/Low Risk or (4-9) Moderate Risk or (≥10) High Risk

NUTRITIONAL MDS TRIGGERS AND PROBLEMS

- ☒ Chewing / Swallowing problems
- ☐ Complaints of taste of food
- ☒ Constipation
- ☐ Decreased Albumin / Prealbumin
- ☐ Diagnosis of Dehydration
- ☐ Diagnosis of Malnutrition
- ☒ Food/Drug Interaction
- ☒ Leaves 25% plus at most meals
- ☒ Mechanically Altered / Therapeutic Diet
- ☐ Pressure Ulcer Stg ___
- ☒ Significant weight loss (circled) / gain
- ☐ TF / TPN / IV
- ☐ < 90% of IWR / < 19 BMI
- ☐ Hospice Care
- ☒ Elevated Osmolality
- ☐ Morbidly Obese
- ☐ ___
- ☐ ___
- ☐ ___
- ☐ ___

RECOMMENDATIONS

- ☒ (circled) 8 oz extra fluid each meal
- ☐ 8 oz extra fluid between meals
- ☐ Hydration Cart
- ☐ 4 oz orange juice or Vit C fortified juice
- ☐ 8 oz Whole Milk with Meals
- ☐ Speech Evaluation
- ☐ ↑ fiber with: ___
- ☐ Special Nutrition Program
- ☒ (circled) 2 cal med pass ___ oz qid / tid / bid / qd
- ☐ Multivitamin with minerals
- ☐ 220 mg Zinc Sulfate every day
- ☐ 500 mg Vit C bid
- ☐ Albumin Level
- ☐ Prealbumin Level
- ☐ BUN level
- ☐ Weekly Weights
- ☐ Assist with feeding
- ☐ Discuss in NAR Meeting
- ☐ ___
- ☐ ___
- ☐ ___

SUMMARY

9/9/05: wt: 89# (100% IWR) BMI 15. Res c̄ sig. wt. loss 11% x 3mos, 10% x 6mos. Skin intact. No new labs avail. Res currently consumes 100% of SNP, NAS pureed diet c̄ 8oz extra H2O @ meals. Res also receives 2.0 med pass supp 120cc QID. Current diet order meets est needs. Note res was [illegible] remeasured & was found to be 56". Res @ high nutrition & dehydration risk. However, all interventions currently in place. If res continues c̄ continued wt. loss, will reassess & consider diet to provide more calories to prevent wt. loss. No recs @ this time. Cont c̄ current POC. Will monit & f/u prn

Proceed to progress notes for further recommendations and summary

DM/DT: ___ Date: 9-9-05

RD: ___ Date: 9/9/05

Resident: ___ ID#

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UTRITIONA SK REVIEW

Advance Directives: TF/TPN Support: ☐ Yes ☐ No ☐ Not Available IV Support: ☐ Yes ☐ No ☐ Not Available

Sex: ☐ M ☒ F Date of Birth: 7-1-23 Age: 82 Height: 56" (4'8") Admit Wt: 77 (7-24-05) UWR: 75-79 IWR: 73-91

Type of Review (I = Initial; A = Annual; COC = Change of Condition): ______ Date: 9-9-05

Nutritional Data

Current Wt: 79 Adj. obesity wt: ______
% IWR: 100% BMI: 17.7
Variance: +5.3% x 1 mo. +2.6% x 2 mo.
☒ Weekly weights

Diet Order: SNP Mech Soft
% Intake: 72%

Supplement Order: Med Pass 2.6 100 cc QID
% Intake: ______

Comments:

Meal Location: ☒ DR ☐ Room ☐ Assist ☐ Restorative ☐ Other: ______
Adaptive Device: ______

Meds with Nutritional Implication:
1. Colace - Tylenol
2. Senna
3. Percocet
4. Remeron
5. Zyprexa
6. Norvasc
7. ASA
8. Vit D
9. Fesol
10. Ativan

Skin Integrity: Stg 1 2 3 4 (Intact)
Location: ______

Date: 9-2-05 ☐ Not Recent
HGB 12.0 BUN 22↑ K 4.2
HCT 37.3 CREAT 0.5↓ NA 139
MCV 93.5 OSM 289 GLUC 61↓
PAB ______ ALB 3.1↓

Other Pertinent Diagnosis/ Conditions:
Constipation COPD
Delusions PVC
Agitation Alterted Mental Status
Osteoporosis Severe
UTI
HTN
Cardiac Dysrhythmias
Elbow Joint Replaced

Risk Scoring for Pressure Ulcers, Dehydration, Nutrition

Risk Factors	Score Key			Resident Status (Circle appropriate status)	P	D	NR
Weight Status Gain or Loss * Does not apply to BMI			0	Stable within past 3 mo., BMI 19-27			
	P	D	1	< 5% x 1 mo, < 7.5% x 3 mo, < 10% x 6 mo wt change			
	P*	D*	3	≥ 5% x 1 mo, ≥ 7.5% x 3 mo, ≥ 10% x 6 mo wt change or (BMI) < 19 or > 27			3
Oral Food Intake			0	Intake meets estimated needs (meals & supplement)			
	P		1	Intake meets 50-75% of estimated needs (meals & supplement)	P		1
	P		3	Intake meets <50% of estimated needs (meals & supplement)			
Oral Fluid Intake			0	Consumes 1500-2000 ml/day (AEB > 75-100% meal intake)			
		D	1	Consumes 1000-1499 ml/day (AEB 50-75% meal intake)		D	1
		D	3	Consumes < 1000 ml/day (AEB < 50% meal intake)			
Oral Function			0	Teeth/dentures in good condition, no chewing or swallowing problems			
			1	(Chewing problems) teeth in poor repair, ill fitting dentures, refusing to wear dentures, edentulous, taste and sensory changes, controlled swallowing/ dysphagia problem			1
		D	3	Aspirates, difficulty swallowing w/choking episodes, dysphagia			
Feeding Ability			0	Independent while dining			
			1	Limited feeding assistance or (supervision while dining)			1
		D	3	Total dependence while dining, TF, TPN, mouth pain			
Mental Function * With comatose and semi comatose			0	Alert and Oriented			
		D	1	Disoriented, Aphasic, (Confused) early/ mod Dementia			
	P*	D	3	Comatose, Semi Comatose, Lethargic, Delirious, Paranoid, Alzheimer's, (Dementia) OBS, Depression		D	3
Nut'l Related Medications * If laxative or diuretic		D*	0	0-1 drugs (Based on the following types of drugs: Antibiotics, (Diuretics) (Psychotropics) (Laxatives) Steroids, Chemotherapy, Hypoglycemia)			
		D*	1	2-4 drugs			
		D*	3	5 or more drugs		D	3
Skin Condition			0	Skin Intact			0
	P		1	Stg I /II pressure ulcer, skin tears not healing, stasis ulcers, fecal or bladder incontinence, surgical wound w/drainage, Hx PU			
	P		3	Stg III / IV pressure ulcer or multiple impaired areas			
Nutritional Related Lab Values * Albumin and Prealbumin only			0	Albumin and all other nutrition related lab values WNL			
	P*		1	Albumin 3.0-3.4 g/dl or Prealbumin 10-15 mg/dl or 1-2 other abnormal nutrition related labs	P		1
	P*		3	Albumin <3.0 g/dl or Prealbumin < 10 or 3-5 other abnormal nutrition related labs			
Relevant Conditions and Diagnoses * See Specific Condition/ Diagnosis			0	(HTN) DM, Heart Disease, Controlled Diseases			
	P*	D*	1	(P): Fx (COPD) Edema, Recent CVA, Bedridden/ (↓ Mobility) (D) (Constipation) Diarrhea, Infection (UTI) Fever, CHF (No P or D): Alcohol/Drug Abuse, Anemia, Anorexia, Food Intolerances/ Allergies, GERD, Hx GI Bleed, Osteoporosis, Parkinsons, Poor Circulation, Recent Surgery	P	D	1
	P*	D*	3	(P): Advanced Cancer, Aids, Dialysis, Malnutrition, Radiation/Chemo Therapy, Septicemia, Uncontrolled DM (D): Active GI Bleed, Aids, Chronic N/V, Dehydration/ Hypovolemia, Dialysis, ESRD, Fecal Impaction, Malnutrition, Uncontrolled DM (No P or D): Gastrectomy, Liver Failure, Ostomy, Other Uncontrolled Diseases			
RISK TOTALS FOR PRESSURE ULCER, DEHYDRATION, AND NUTRITION:					3	4	15

Resident: [redacted] 213 ID#:

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NUTRITIONA[illegible] [illegible]ESSMENT

CALORIE / PROTEIN / HYDRATION NEEDS

Kcal needs	Protein needs	Hydration needs
Kcal needs: (IWR) / ABW / Adjusted for: ☐ obesity ☐ para ☐ quad ☐ amputee) (maintenance) / wt gain / ↑ needs) 990-1230 cal (30Kcal/Kg factor) % needed (cal) 45-56%	Protein needs: ((IWR) / ABW / Adjusted for: ☐ obesity ☐ para ☐ quad ☐ amputee) (normal / (at risk) / healing / (repletion) 40-49 gms (1.2gm/Kg factor) % needed (pro) 50-61%	Hydration needs: ((IWR) / ABW / Adjusted for: ☐ obesity ☐ para ☐ quad ☐ amputee) not < 1500 ml (30cc/Kg factor)

RISK TOTALS FOR PRESSURE ULCER, DEHYDRATION AND NUTRITION

Resident Scored at Risk for: (Scoring from page 1)

Total Score			No	Moderate	High
3	P	Pressure Ulcers	☐ No	☐ Moderate	☒ High
4	D	Dehydration	☐ No	☐ Moderate	☒ High
15	NR	Malnutrition / Weight Loss	☐ No	☐ Moderate	☒ High

Key:

P = Pressure Ulcer Risk Score = (0) No Risk or (1-2) Moderate Risk or (≥3) High Risk
D = Dehydration Risk Score = (0) No Risk or (1-2) Moderate Risk or (≥3) High Risk
NR = Nutritional Risk Score = (0-3) No/Low Risk or (4-9) Moderate Risk or (≥10) High Risk

NUTRITIONAL MDS TRIGGERS AND PROBLEMS

☒ (Chewing) / Swallowing problems	☒ (Leaves 25% plus at most meals)	☐ Elevated Osmolality
☐ Complaints of taste of food	☒ (Mechanically Altered) / Therapeutic Diet	☐ Morbidly Obese
☒ (Constipation)	☐ Pressure Ulcer Stg ____	☐ ____
☒ (Decreased Albumin) / Prealbumin	☐ Significant weight loss / gain	☐ ____
☐ Diagnosis of Dehydration	☐ TF / TPN / IV	☐ ____
☐ Diagnosis of Malnutrition	☐ < 90% of IWR / (< 19 BMI)	☐ ____
☐ Food/Drug Interaction	☐ Hospice Care	☐ ____

RECOMMENDATIONS

☐ 8 oz extra fluid each meal	☒ Special Nutrition Program	☐ BUN level
☐ 8 oz extra fluid between meals	☒ 2 cal med pass 100cc qid / tid / bid / QID	☒ Weekly Weights
☒ Hydration Cart	☒ Multivitamin with minerals	☐ Assist with feeding
☒ 4 oz orange juice or Vit C fortified juice	☐ 220 mg Zinc Sulfate every day	☒ Discuss in NAR Meeting
☒ 8 oz Whole Milk with Meals	☐ 500 mg Vit C bid	☐ ____
☐ Speech Evaluation	☐ Albumin Level	☐ ____
☐ ↑ fiber with: ____	☐ Prealbumin Level	☐ ____

SUMMARY

Resident is a very confused 82 yr old female. Current wt 79# within IBWR 73-91, +5.3% x 1 mo, +2.6% x 2 mo. Wt gain is good improvement. Current meal intake of SNP Mech Soft diet averages 72%. Intake has improved in past week from 25%. She is still angry and refuses assistance most of the time but when redirected and encouraged she will feed self. SNP diet and 2.0 med pass of which intake is 50% does meet her needs. Skin intact but remains fragile & tears easily. Recent lab indicates Alb of 3.1. Diet & SNP will also meet Protein needs if intake remains 50-60%. Nursing to continue monitoring and encouraging intake and assist when needed or as Ira will allow. 9/19/05 Reviewed assessment & concur, agree. Exec will f/u pm [illegible]

Proceed to progress notes for further recommendations and summary

DM/DT: [redacted] Date: 9-9-05

RD: [redacted] D Date: 9/19/05

Resident: [redacted] 213 ID#

Form 103 (01/05)

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ENTERAL FEEDING REVIEW

DIAGNOSES RELATED TO NEED FOR ENTERAL THERAPY

- [ ] AIDS / HIV*
- [ ] Alcoholic / Hepatic Encephalopathy*
- [ ] Alzheimer's Disease / Senile Dementia / OBS+
- [ ] Amyotrophic Lateral Sclerosis
- [ ] Anoxic Encephalopathy*
- [x] Brain Stem Injury / Tumor / Astrocytoma
- [ ] Bulbar Paralysis / Palsy
- [ ] Cancer of the Brain / Upper GI Tract
- [ ] Cerebral Aneurysm / Infarction
- [ ] Cerebral Palsy (Severe)
- [ ] Cerebrovascular Insufficiency+
- [ ] Chronic Brain Syndrome+
- [ ] Closed Head Injury
- [ ] Comatose
- [ ] CVA / Old CVA with Residuals
- [ ] CVA with Hemiplegia
- [ ] Degenerative Brain Disease+
- [ ] Drug Overdose*
- [ ] Duodenal Obstruction (J Tube Only)
- [ ] Encephalopathy*
- [ ] Esophageal Obstruction (Permanent)
- [ ] Esophageal Paralysis
- [ ] Esophageal Perforation (Permanent)
- [ ] Fistula-Esophagotracheal
- [ ] Fistula-Gastroesophageal / Gastrojejunal
- [ ] Gastrectomy – Total or Partial (J Tube Only)
- [ ] Gastric Outlet Obstruction (J Tube Only)
- [ ] Glioblastoma
- [ ] Guillain-Barre Syndrome
- [ ] Multi-Infarct Dementia*
- [ ] Multiple Sclerosis
- [ ] Myasthenia Gravis
- [ ] Parkinson's Disease*
- [x] Spastic Quadriparesis
- [ ] Subarachnoid Hemorrhage
- [ ] Subdural Hematoma

Constipation

* Are acceptable with additional documentation

\+ Require speech assessment to demonstrate Dysphagia

FUNCTIONAL IMPAIRMENT

Resident has a functional impairment that makes adequate oral nourishment impossible: [x] YES [ ] NO

Dysphagia R/T Comatose

ANTHROPOMETRICS

Quad

Sex: M Age: 32 Ht: 74 Adm Wt: 177 Current Wt: 154 UWR: 157-179 IWR: 142-182 % IWR: 95 (Use Midpoint)

Planned Wt Change Program: Y / N Recent Wt Loss / Gain: Na / Y / N 10 %, in 6 mos BMI: 19.9

PERTINENT LABORATORY DATA

Date	9/6/08												
Lab	Hgb	Hct	MCV	NA	K	BUN	Creat	CA	PO_4	Alb	BS	Pre Alb	Other
Value	13.8	42.6	92.4	149↑	4.5	21↑	0.4↓	9.4	–	3.7	125↑		osmo. ult 315

SKIN INTEGRITY

Pressure Ulcer: [ ] No [x] Yes Stage [illegible] Location: coccyx, heels

MEDICATIONS WITH NUTRITION IMPLICATIONS

Colastin, MOM, Namenda, Lexapro, Zanaflex, Coumadin, Tylenol, Bantrum, Baclofen

TF ORDER/DIET ORDER

A. TF Order: Promote 105 cc/° x 24° H2O Flush Order: 240 cc QID

B. Diet: Ø Supplement: Ø Diet Intake: ↑ Supplement Intake: Ø

C. Type of Tube: [ ] NG [ ] Gastric [x] PEG [ ] Jejunostomy D. Method of Feeding: [ ] Bolus [ ] Gravity [x] Pump

ASSESSMENT OF NUTRIENT NEEDS

Kcal needs for: (ABW) / Adjusted for: obesity / para / quad / amputee) 2450 Calories (Maintenance / Wt Gain or Loss / Increased Needs) (35 kcal/kg) Factor AEB ______ % meals/TF

Pro Needs for: (ABW) / Adjusted for: obesity / para / quad / amputee) 105-140 Grams Protein (Normal / Healing / Repletion) (1.5-2.0 g/kg) Factor AEB ______ % meals/TF

Hydration needs for: (ABW) / Adjusted for: obesity / para / quad / amputee) 2100 cc (30 cc/kg) Factor

ASSESSMENT OF TF ORDER

					NUTRITION PROVIDED	NUTRIENT NEEDS	DIFFERENCE
1) Calories:	105 cc/hr × 1.0 cal/cc × 24 hrs	= ______ calories	× 100 strength	=	2520	2450	+70
	______ cc/bolus fdg × [illegible] × ______	= [illegible]	× ______ strength	=	Calories	Calories	Calories
2) Protein:	122.5 grams protein/1000 cc	× 2.52 # cc - 1000 cc provided			157.5 gms Protein	105-140 gms Protein	+18-53 gms Protein
3) Fluid:	2520 total cc in formula × 84 % H2O supplied by formula	= 2117 Free H2O	+ 960 cc H2O flush	=	3077 Total Free H2O	2100 Total Free H2O	+977 Total Free H2O

Resident [redacted] ID#

Form 112 (04/02)

Initial / Annual / Change in Tube Feeding Assessment

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Assessment of TF Order Continued:

A. Does feeding, as ordered, provide 100% RDA for vitamins and minerals? ☑ Yes ☐ No

B. Does feeding, as ordered, meet all nutrient needs? ☑ Yes ☐ No If no, what is not met? ______

C. Intolerance: ☐ Vomiting ☐ Diarrhea ☐ Aspiration ☐ Distention ☐ Residuals ☐ Nausea ☐ Other ______

D. % Calories Needs Provided from TF: ☐ 1-25% ☐ 26-50% ☐ 51-75% ☑ 75-100%

E. Average Fluid Intake Per Day by IV / TF / TPN in past 7 days: ☐ None ☐ 1-500 cc/d ☐ 501-1000 cc/d ☐ 1001-1500 cc/d ☐ 1501-2000 cc/d ☑ 2001+ cc/d

F. Advance Directives: ☐ Yes ☐ No ☐ N/A

PUMP JUSTIFICATIONS

Please indicate the reason documented in the medical record that supports the use of a pump

- ☐ resident has history of aspiration pneumonia
- ☐ resident experienced diarrhea on gravity feedings
- ☐ resident has severe reflux disorder / vomiting
- ☐ resident has chronic renal failure (fluid overload)
- ☐ resident experienced regurgitation / aspiration with gravity feedings
- ☐ resident experiences dumping syndrome with gravity feedings
- ☐ resident is diabetic needing slow infusion to regulate glucose levels
- ☐ resident is fluid restricted CHF patient (fluid overload)
- ☐ resident requires flow rate < 100 ml/hr
- ☐ Other ______

PRODUCT JUSTIFICATION

- ☐ Resident diagnosed with HIV or AIDS with one of the following symptoms: CD4 < 400; Serum albumin < 3.0; > 5% wt loss; intractable diarrhea.
- ☐ Significantly delayed gastric emptying (a) repeated vomiting or high gastric residuals on standard products, OR (b) jejunal feeding with intolerance to other products.
- ☐ Maldigestion/malabsorption (a) intolerance to intact nutrients evidenced by diarrhea; OR (b) anticipate malabsorption of intact nutrients due to history of diarrhea or extensive GI pathology; OR (c) clinical or biochemical evidence of impaired gut function (positive xylose, lactulose or mannitol tests).
- ☐ Insulin dependent diabetes mellitus with unstable glucose levels documented on standard formula which are controlled on specialty formula.
- ☐ Hepatic diseases - Tolerates less than 50 grams of protein per day; abnormal liver function tests; anticipated encephalopathy.
- ☐ Pancreatic diseases - elevated serum lipase and/or amylase or abdominal pain with intact nutrients; requires bowel rest to reduce pancreatic stimulation.
- ☐ Renal diseases - Tolerates less than 50 grams protein per day. Increased BUN (>40) and creatinine (>2.0). Serum electrolytes are elevated (Na, K, PO4, Mg)
- ☐ Pulmonary impairment diseases - Patient exhibits retention of CO2 in the serum due to pulmonary insufficiency OR weaning from chronic mechanical ventilation.
- ☐ Sepsis/infection (non-HIV immunocompromise) Metabolic stress with or at risk of infection including sepsis, infected pressure ulcers and infected ventilator dependent patients. Albumin <3.0.
- ☑ Other Res c ↑ pro needs 2° PU ST I, II, III. increased needs for healing

ASSESSMENT RECOMMENDATIONS

9/19/05: wt 154# (95% IBW based on mid point). BMI 19.9. Res c recent wt loss of 10% x6 mos. Res c PU ST I, II, III on coccyx & heels. labs 9/19/05: alb 3.7 WNL, BUN 29 ↑, creat 0.6 ↓, osm 315 - elevated. current TF order Promote 105 cc/° x 24° c 240cc H2O QID which provides 2520 kcal, 158g pro, & 3177 cc H2O which meets 100% + of est needs. Note difficult to accurately assess res needs r/t res is sedentary & quadriplegic. Res c ↑ pro needs 2° PU & ~~increased pro~~ ↑ need for healing. current TF provides adequate pro for healing & should promote wt. gain. Will watch res & if wt gain occurs too rapidly, will rec ↓ TF to avoid refeeding syndrome & excess wt gain ↑ RBS @ this time. Note PAB requested on 9/1/05. Will f/u c PAB when avail. Cont c current orders - will cont. to monit. & f/u prn — [signature] RD

DM/DT: [redacted] Date: 9-9-05 RD: [redacted] Date: 9/19/05

Resident [redacted]	ID#

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TUBE FEEDING ANALYSIS WORKSHEET REPORT

East Lake Care Center (EL)

Worksheet Date: 9/8/2005

Resident Name: [redacted] ***Room:*** W 400 A ***M/R #:*** 4125713

General Information:

Age: 26.6 ***Gender:*** M ***Height:*** 77.00 ***Weight:*** 153.80 ***BMI:*** 18.29

Resident Diagnoses:

564.00	Constipation Nos	486	Pneumonia, Organism Nos
E819.8	Traffic Acc Nos-Pers Nec*	344.00	Quadriplegia, Unspecifd
599.0	Urin Tract Infection Nos	453.8	Venous Thrombosis Nec
251.2	Hypoglycemia Nos	368.45	Gen Visual Contraction

Current tube feeding order: Promote 100 cc Q HR * 24 HRS with H20 flushes of 240 cc QID

Date of order: 8/25/2005

Calculations are based on the following information:

Method of formula delivery: Pump

	Formula	*Cc*	*Cal/Cc*	*Pro/Cc*	*Water/Cc*
Primary formula:	Promote	2,400.00	0.99	0.06	0.83
Supplemental formula:	NP				

Other fluids: ***Total in 24 hrs*** NP -OR- ***Bolus/flushes*** 960.00

Activity Factor and value: 1.10 Comatose
Stress/Injury Factor value: 1.20 *
Protein Factor value: 1.50 *

* - designates this factor was provided by the user and was used during nutritional calculations

CALCULATION RESULTS:

	CALORIES	PROTEIN	FLUIDS
Recommended:	2,398.55	104.86	2,097.27
Received:	2,370.00	148.00	2,940.00

Lab Data:

8/19/05	Albumin	3.6	8/19/05	Glucose	115	8/19/05	Hbg	12.2
8/19/05	Hct	37.3						

OTHER LAB DATA: Total Protein 7.0 Calcium 9.1

Current Meds/Vitamins/Mineral Supplements:

MOM 30 cc per TF

ADDITIONAL NOTES

RD assessed status quo on 9/1/2005. Recommended increasing tube feeding to 105 cc Promote per HR * 24 HRS. Will follow-up with recommendations. RD & RN noted pressure ulcers. Resident is currently meeting protien needs for healing. Fluids adequate at this fime as related to lab results (2970SM).

SIGNATURE: [redacted] **DATE:** 9/8/2005

Note: Formulas and default constant values may vary from those selected by some healthcare professionals. Since the selection of some values for use in the calculations are dependent on other relevant clinical findings, it is strongly recommended that nutritional assessments be reviewed by a qualified healthcare professional.

Physician 60 day reviews - new admits shall be seen 30, 60, 90 days and then 60 days thereafter
Medicare must be seen every 30 days

Resident	Physician	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Sept	Oct	Nov

Res #7

EL [redacted]

Room: 213 UNIT: 2

Sept 13, 2005

ALLERGIES: see med list

LABS: see chart

Admit 5/5/2005

DOB 2/13/1926

Sex f

Patient seen due to multiple medical problems requiring ECF care. See the HP and other notes in the chart for details. No significant change in PMH, SH, FH unless noted. Status of many chronic problems included in AP section.

Hx summary: 79 yo ww with dementia, HTN, pud, lbp. Ischial sore. Unable to care for self at home. widowed.

CC/ROS: ∅ fever, chest or abdominal pain, dyspnea, nausea, dysuria
✓ Apparently negative but limited by dementia

EXAM:
✓ AF, VSS
(see nurse notes)
Temp
BP
HR
RR
wt
CV: R RR ___murmur ∅ hyperimpulse Tr edema (occ irreg.) Crackles soft.
PULM: ✓ CTA, nonlabored
on room air (unless noted on O2 ____L/min)
ABD: ✓ soft, NT, 0 mass/hernia/organomegaly
EXT: ✓ warm, no cyanosis
SKIN: ✓ No rash or induration
HENT: ✓ nonicteric, neck supple, no eye inf
NEURO: ✓ NAD; alert.
AFFECT: ___ Bright ✓ Flat ___ Anxious
Speech: ___wnl. ___Other: Minimal
Strength: Moves all 4.
MOBILITY: ✓ Amb ___Walker/can ___WC ___Min
Short distances, stooped.

TestDate	Test	Result	Notes:
6-14-05	Cr	1.2	
	B12	232	
	tsh		

8/12 TSH .14 on 150
Hct 37.8
Cr 1.3

ASSESSMENTS

PLAN

Continue ECF care.

Diagnosis (stable unless noted)	ConditionNote:
HY Left buttock sore (old scar dehiscence)	Dressings until healed
Dementia	5-10: begin Memantine + Rivastigmine
Delusions, anxiety, depressive features	Risperdol, haldol on admit; Celexa 5/10
Hypothyroidism	Synthroid, follow TSH → Dose ↓d recently.
HTN	Rx as needed
Fracture risk factors	Fosamax, Ca, Vit D
Hx PUD	Rx as needed
Chronic back pain	
Anemia	

Hx: ⓡ nephrectomy.
Hx knee replacement.

Labs, Medications, chart notes and the total plan of care were reviewed and the patient is recertified for long-term care.

Tim Grange, MD √2 3 dc (31 / 32)

Res # 1

EL [redacted]

Room: 213 UNIT: 2

Aug 11, 2005

ALLERGIES: see med list

LABS: see chart

Admit 5/5/2005

DOB 2/13/1926

Sex f

Patient seen due to multiple medical problems requiring ECF care. See the HP and other notes in the chart for details. No significant change in PMH, SH, FH unless noted. Status of many chronic problems included in AP section.

Hx summary: 79 yo ww with dementia, HTN, pud, lbp. Ischial sore. Unable to care for self at home

6/14: Cr 1.2
B12 232

CC/ROS: ___ fever,chest or abdominal pain, dyspnea, nausea, dysuria
___Apparently negative but limited by dementia

EXAM:

___AF, VSS
(see nurse notes)
Temp
BP
HR
RR
wt

CV: ✓ RR ___murmur __hyperimpulse ___ edema

PULM: ✓ CTA, nonlabored
on room air (unless noted on O2 ____L/min)

ABD: ✓ soft, NT, 0 mass/hernia/organomegaly

EXT: ___ warm, no cyanosis

SKIN: __ No rash or induration

HENT: __nonicteric, neck supple, no eye inf

Poor historian.

NEURO: ✓ NAD; alert.
AFFECT: ✓ Bright ___ Flat ___ Anxious
Speech: ✓ wnl. ___Other:
Strength:

MOBILITY: ___ Amb ✓ Walker/can ___WC ___Min

ASSESSMENTS

Diagnosis (stable unless noted)	ConditionNote:
Left buttock sore (old scar dehiscence)	Dressings until healed
Dementia	5-10: begin Memantine + Rivastigmine
Delusions, anxiety, depressive features	Risperdol, haldol on admit; Celexa 5/10
Hypothyroidism	Synthroid, follow TSH ✓
HTN	Rx as needed
Fracture risk factors	Fosamax, Ca, Vit D
Hx PUD	Rx as needed
Chronic back pain	

Breast → Rev.

PLAN

Continue ECF care.

Labs, Medications, chart notes and the total plan of care were reviewed and the patient is recertified for long-term care.

Tim Grange, MD 1/3 dc (31 / 32)

Res # 8

EL [redacted]

Room: 313 UNIT: 3

Aug 30 2005

ALLERGIES: see med list

LABS: see chart

Admit

DOB 10/29/1923

Sex F

Patient seen due to multiple medical problems requiring ECF care. See the HP and other notes in the chart for details. No significant change in PMH, SH, FH unless noted. Status of many chronic problems included in AP section.

Hx summary: Dementia, Parkinsons, falls, weakness, left breast cancer. Sister Kay.

CC/ROS: Ø fever,chest or abdominal pain, dyspnea, nausea, dysuria
____Apparently negative but limited by dementia

EXAM: ✓
✓ AF, VSS
(see nurse notes)
Temp
BP
HR
RR
wt

TestDate	Test	Result	Notes:
11-2-04	TSH	2.0	
11-2-04	B12	700	

ferritin 13 on 4/29.

CV: R RR ___murmur __hyperimpulse ___ edema

PULM: ✓ CTA, nonlabored
on room air (unless noted on O2 ____L/min)

ABD: ✓ soft, NT, 0 mass/hernia/organomegaly

EXT: ✓ warm, no cyanosis

SKIN: ✓ No rash or induration

HENT: ✓ nonicteric, neck supple, no eye inf

NEURO: ✓ NAD; alert.
AFFECT: ✓ Bright ___ Flat ___ Anxious
Speech: ___ wnl. ___Other: Dysarthric. Short sentences.
Strength: Grips 4/5.
MOBILITY: ___ Amb ___Walker/can ✓ WC ___Min

ASSESSMENTS

Diagnosis (stable unless noted)

ConditionNote:

Diagnosis	ConditionNote
Dementia since at least 1996	Memantine 11-04
Parkinson's disease Dx 1990	Sinemet, Eldepryl
Falls & increased fracture risk	Fosamax, Calcium, Vit D
Left mastectomy for cancer	
HTN	Lisinopril
Constipation	Rx — Miralax, Colace, MOM.
Borderline microcytosis without anemia. Iron	→ Rx iron.
Weakness — tolerates w/c.	

PLAN

Continue ECF care.

Labs, Medications, chart notes and the total plan of care were reviewed and the patient is recertified for long-term care.

Tim Grange, MD 1 2 3 dc (31 / 32)

LABORATORY SERVICES
483.75 (j)

F502 **Laboratory services:**

F503 This facility provides Laboratory Services under arrangements from a laboratory that meets requirements specified in Federal and Utah State regulations and meets the needs of all residents. This facility maintains a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver to perform tests categorized as waivered under CLIA.

The facility assumes responsibility for the quality and timeliness of laboratory services.

F504 All laboratory services are provided upon the order of the resident's attending physician or a consultant physician as authorized by the attending physician. The prescribing physician is

F505 promptly notified of the findings of all laboratory tests.

F506 The facility assists residents with transportation arrangements to and from the source of laboratory service, if the resident needs assistance.

F507 Laboratory reports are filed in each resident's clinical record. Laboratory reports are dated and contain the name and address of the testing laboratory.

Lab Policy and Procedures

Protocol:

1. All laboratory services are provide upon the order of the residents's attending physician or consultant physician.
2. Upon receiving the physicians order, the nurse will place the labs ordered on the LABORATORY SERVICES - DAILY WORKSHEET in the notebook provided by the contracted laboratory services (IHC)
3. The nurse will fill out the laboratory requisition sheet indicating the laboratory services requested with an appropriate diagnosis.
   A. The nightshift nurse is responsible to check the laboratory services daily worksheet each night for services requested. That nurse is to check and see that the requisition sheet is completed and ready for the next mornings blood draws. If not completed the nightshift nurse will complete the requisition sheet.
4. The contracted laboratory services (IHC) will fax all lab reports within 24 hours to the facility unless other processing timelines are indicated.
5. Upon receiving the laboratory findings the nurse will review and fax the report to the attending physician or consultant. A nurses note will be written in each individuals chart indicating the laboratory results were received, indicating if there were any significant or critical lab values. **If there is any critical lab values the physician is to be contacted and verbally notified of the findings. Documentation is to include the physician's plan of action to address these critical lab values.**
6. All laboratory reports will have written on the bottom:
   A. Date and Time of report being faxed to physician or physician contacted verbally
   B. The words **faxed** or **physician contacted** written
   C. Noted by the Licensed Nurses Name and Title
7. After noting the laboratory results and making a nurses note (documentation) the nurse will file the lab results in lab section of the chart with the most current on top.
8. The nightshift nurse will check the Laboratory services daily worksheet each night for lab draws done that day. That nurse will check the nurses notes to see that the laboratory results were received and a copy of the lab results are in the chart. If not the night nurse will call the laboratory services and request those lab results be faxed over so the necessary follow up can be done. (Protocol 5, 6, and 7)
8. If all protocols have been completed then the night nurse is to highlight out that line for the indicated resident on the laboratory services daily worksheet.
9. If a lab has not been drawn per physician order or the consultant the Director of nursing or designee is to be notified. The Director of nursing or designee will follow up daily until the lab is completed or alternative interventions are implemented.
10. If the resident refuses to have lab drawn, the nurse must document the reason for refusal and notify the physician. The resident has the right to refuse. Nurse must write a telephone order to discontinue the lab order per refusal and notification of the physician.

Routine Lab orders - Medical records will print off a lab list when the monthly recertification orders are printed and be given to the designated nurse to place on the Laboratory Services Worksheets.

Triple Check Procedures

Triple check includes the following:

1.Check the next month's P.O. against the current's months P.O
- Follow up on any discrepancies

2.Check the current months MAR's to the new month's MAR's
- Paying close attention to the times and doses

3.Check the MAR's to the medication in the cart.
- there must be a med for every order

Hydration sheets – Each U.M. do their own
Behavior Sheets – Each U.M. do their own
Meal intake sheets – Medical Records
Restraint release forms – Medical Records
Functional Maintenance Sheets -
Pain Assessment Sheets – Each U.M do their own

We will do each unit as a team to speed up the process, and to get other eyes to catch any hard to see mistakes. Please plan accordingly. Triple check will begin 3-5 days prior to the end of the month. However, you need to have your individual forms ready before this time.

Please paper-clip all of the forms specific to each pt together to make it easier to put in the books at night. Also, please make sure that all the pt.'s have name tags in the med book, some don't and it causes trouble for our agency nurses.

IHC Laboratory Services
IHC A Service of Intermountain Health Care

Clinical Laboratory Requisition

Date:____________

Utah Valley Reg. Med. Cntr.
1034 North 500 West
Provo, UT 84605
Phone: (801) 357-7021
Fax: (801) 356-0046

____
Physician

LOC:LLAKE or LOC:YLLC
East Lake Care Center
1001 North 500 West
Provo, UT 84604
Phone: (801) 377-9661
Fax : (801) 377-9747

SHADED AREAS MUST BE COMPLETED

Patient Legal Name: Last First MI	Patient SSN: - -	Sex:
Street:	Patient DOB:	MRN:
City, State: ZIP:	Home #:( ) -	☐ Bill physician or institution
Guarantor: DOB: SSN - -	Work #: ( ) -	☐ Bill patient insurance
		☐ Bill Medicare / Medicaid

Primary Insurance:	Secondary Insurance:
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Policy Number:	Policy Number:
Insur. Address:	Insur. Address:
Patient Relation:	Patient Relation:

Nursing Home Information

Room number______
☐ Medicare Part A (Lab will bill facility)
☐ Medicare Part B (Lab will bill Medicare)
☐ Other (bill as instructed)

Fax results to: ________

DIAGNOSES OR SIGNS / SYMPTOMS

A B
C D

Circle for **STAT**

Date Collected	Collected by:
/ /	
Time Collected	Number of tubes
: am / pm	

TESTS PRINTED IN RED ARE MEDICARE LIMITED COVERAGE AND MAY REQUIRE AN ADVANCE BENEFICIARY NOTICE (ABN)

AMA Panels

Please refer to reverse side for description of panels.

- ☐ **Acute Hepatitis Panel**
- ☐ **Basic Metabolic Panel**
- ☐ **Comp Metabolic Panel**
- ☐ **Electrolyte Panel**
- ☐ **General Health Panel**

(ABN required for Medicare patients)

☐ Reflex free T4 if TSH Abnormal

- ☐ **Hepatic Function Panel**
- ☐ **Lipid Panel (12 hour fast)**
- ☐ **Obstetric Panel (2)**
- ☐ **Renal Function Panel**

- ☐ ALT (SGPT)
- ☐ ANA
- ☐ AST (SGOT)
- ☐ Albumin
- ☐ Alk Phosphatase
- ☐ Amylase

Arthritis
- ☐ Uric Acid
- ☐ Sed Rate
- ☐ ANA
- ☐ Rheumatoid Factor

- ☐ B12
- ☐ BUN
- ☐ Bilirubin, conj & unconj
- ☐ Bilirubin, total
- ☐ Bilirubin, neonatal
- ☐ CA 125
- ☐ Calcium, ionized
- ☐ Calcium, total
- ☐ Carbamazepine(Tegretol)

Cardiovascular Risk Assessment
Screening test – not covered by Medicare
Risk is calculated from Lipid Panel and hsCRP.
- ☐ Lipid Panel (12 hour fast)
- ☐ hsCRP (High Sensitivity CRP)
- ☐ Homocysteine
- ☐ Fasting Plasma Glucose

- ☐ CK, total
- ☐ CKMB (includes total and index)
- ☐ CBC auto diff (3, 4)
- ☐ CBC no diff (3)
- ☐ CBC manual diff (3)
- ☐ CEA
- ☐ Chloride
- ☐ Cholesterol, total
- ☐ CO_2
- ☐ Creatinine
- ☐ Creatinine Clearance

HT:________WT:________
- ☐ Digoxin
- ☐ Estradiol
- ☐ FSH
- ☐ Ferritin
- ☐ Folate
- ☐ GGT
- ☐ Glucose
- ☐ HbA1c (glycohemoglobin)
- ☐ H. Pylori Ab, serum
- ☐ H. Pylori stool Ag
- ☐ hCG (Preg. Test, qual) ☐ serum ☐ urine
- ☐ hCG Quantitative, serum
- ☐ hCG Tumor marker
- ☐ Hematocrit (Hct)
- ☐ Hemoglobin (Hgb)

Hepatitis, Chronic
- ☐ Anti-HBc, total
- ☐ Anti-HBs
- ☐ Anti-HCV(1)
- ☐ HBsAg(1)

- ☐ HIV-1&2 Ab - see HIV notice below(1)
- ☐ Homocysteine
- ☐ Immunofixation c̄ Interp ☐ serum ☐ urine
- ☐ Iron
- ☐ Iron / TIBC
- ☐ LDH
- ☐ LH
- ☐ Lithium
- ☐ Magnesium
- ☐ Mono Screen (EBV Nuclear IgM)
- ☐ MonoSpot (Heterophile)

- ☐ Myoglobin
- ☐ Occult blood, diagnostic
- ☐ PSA, diagnostic
- ☐ PT / INR
- ☐ PTT
- ☐ Phenytoin (Dilantin)
- ☐ Phosphorus
- ☐ Potassium
- ☐ Prolactin
- ☐ Protein Electrophoresis c̄ Interp (6) ☐ serum ☐ urine
- ☐ RPR
- ☐ Rheumatoid factor
- ☐ Rubella Ab, IgG
- ☐ Rubeola Ab, IgG screen
- ☐ Sed Rate (ESR)
- ☐ Sodium
- ☐ Thyroxine, Free (FT_4)
- ☐ Troponin I
- ☐ TSH (only)
- ☐ TSH c̄ Free T_4 if abnormal (7)
- ☐ Testosterone, total, free & bioavailable & SHBG
- ☐ Testosterone, total only
- ☐ Total Protein
- ☐ Triglycerides (12 hour fast)
- ☐ Uric acid
- ☐ UA w/Microscopic if indicated (8)
- ☐ UA dipstick only
- ☐ UA dipstick and microscopic
- ☐ Urine Microalbumin (24 hr) (13)
- ☐ Urine Microalb / Creat ratio (random), w/dipstick screen (11)
- ☐ Urine, 24 hr protein
- ☐ Valproic acid (Depakote)
- ☐ WBC

MEDICARE SCREENING
- ☐ Glucose Screen (5) (V77.1)
- ☐ Occult Blood (5)
- ☐ PSA (5) (V76.44)

Lipid Screen (14)
☐Chol ☐HDL ☐Trig ☐Panel
for: (indicate one)
☐ V81.0 ☐ V81.1 ☐ V81.2
see back for definitions

Microbiology (9)/Infectious Diseases
- ☐ AFB (TB), with smear — Source(required) ________
- ☐ Culture, routine (aerobic) — Source(required) ________
- ☐ Culture, anaerobic (includes routine (aerobic) unless otherwise specified) — Source(required) ________
- ☐ C. Diff Toxins
- ☐ Chlamydia PCR — Source(required) ________
- ☐ Chlamydia/GC PCR — Source(required) ________
- ☐ Fungal Culture — Source(required) ________
- ☐ Giardia AG, stool
- ☐ Gonococcus (GC) PCR — Source(required) ________
- ☐ Herpes simplex PCR — Source(required) ________
- ☐ OB Group B Strep — Penicillin Allergy Yes No
- ☐ Rapid Strep (Group A) (12)
- ☐ Strep Culture (Group A)
- ☐ Stool culture (10)
- ☐ Throat Culture (Full)
- ☐ Urine culture
  - ☐ Clean catch
  - ☐ Cath specimen

[ ] VENIPUNCTURE

[ ] Please fax

Other:

NOTES & REFLEX CRITERIA ON REVERSE SIDE

MEDICARE NOTICE

Any testing for Medicare patients should meet the Medicare definitions for medical necessity. Medicare generally does not cover routine screening tests (Shown in red).

HIV Testing

I understand that HIV testing at IHC is confidential, but not anonymous. I authorize IHC to perform an HIV test.
Patient signature
____

IHC LAB-250-2 / 1-05

By submission of this requisition, the ordering physician certifies that the billing information provided is accurate and that Medicare has been determined to be the primary payor for these services, unless otherwise indicated.

LAB COPY

Physician Signature:________________________

LABORATORY SERVICES - DAILY WORKSHEET Month:

Resident name	Date due	Lab test ordered	Doctor (full name)	Diagnosis	initial date	Original received

LABORATORY SERVICES - WEEKLY WORKSHEET Month:

Resident name	Date due	Lab test ordered	Doctor (full name)	Diagnosis	initial date	Original received

LABORATORY SERVICES - MONTHLY WORKSHEET Month:

Resident name	Date due	Lab test ordered	Doctor (full name)	Diagnosis	initial date	Original received

Dayshift and nightshift will share in doing the weekly's. If Medicare the nurse will mark on the form " Weekly "

A skin check must be done!!!

Weekly nurses notes and skin assessments -- use the designated forms! **The narrative form goes in the chart in the nurses notes**
The skin check form is in the med book behind the treatment sheets.

West (100 Hall) Am shift: 6:00am to 2:00pm Noc shift: 6:00pm to 6:00am

Dayshift

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
100A	102A	107A	110A	113A	116A	119
100B	102B	107B	110B	113B	116B	120A
101A	103	108A	111A	114A	117A	120B
101B	105A	108B	111B	114B	117B	121A
Night Shift						
104A	105B	109A	112A	115	118A	121B
104B	106A	109B	112B		118B	124A
	106B	124B	201			
		200				

ALL MONTHLY SUMMARRIES ARE TO BE DONE BY THE NIGHT SHIFT!!!

Weekly nurses notes and skin assessments -- use the designated forms! The narrative form goes in the chart in the nurses notes
The skin check form is in the med book behind the treatment sheets.

North # 3 Am shift: 6:00am to 2:00pm Noc shift: 6:00pm to 6:00am

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
202 A	205 A	207 A	210 A	212 A	215 A	204 B
202 B	205 B	207 B	210 B	212 B	215 B	209 B
203 A	206 A	208 A	211 A	213 A	216 A	211 B
203 B	206 B	208 B		213 B	216 B	
204 A		209 A	214 A	214 B		

217 is on North # 1
#218 is on North # 2

Dayshift will do all weekly notes!!!

Weekly nurses notes and skin assessments -- use the designated forms! The narrative form goes in the chart in the nurses notes
The skin check form is in the med book behind the treatment sheets.

North # 1 Am shift: 6:00am to 6:00pm Noc: shift: 6:00pm to 6:00am **At midnight takes over the rest of 300 hall**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
301 A	306 A	310 A	303	305 A	310 B	217
301 B	306 B	309 A	304 A	305 B	312 A	307 A
302	300 A	309 B	304 B	308 A	312 B	307 B
				308 B		300 B

North # 2 Am shift: 6:00am to 2:00pm Noc shift: 6:00pm to midnight

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
313 A	315	317 A	318	314	320 A	218
313 B	316 A	317 B	319 A	319 B	320 B	323 A
	316 B				321	323 B

Dayshift will do all weekly's. If Medicare the nurse will mark on the form " Weekly "
A skin check must be done!!!

Weekly nurses notes and skin assessments -- use the designated forms! The narrative form goes in the chart in the nurses notes
The skin check form is in the med book behind the treatment sheets.

West (100 Hall) Am shift: 6:00am to 2:00pm Noc shift: 6:00pm to 6:00am

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
400	405	404	410	413	403	416
401	406	408	411	414	415	417
402	407	409	412			

Narrative Form

WEEKLY CHARTING RECORD

Date:	Resident:	Room:
Primary Diagnosis:		

Vital signs: B/P_____ P_____ R_____ Temp_______ O2stat%_____ @_____L/Min. Weight_____

Mental Status: Alert/Oriented x 0 1 2 3 4 Disoriented Y N Occ. Alert___ Lethargic___ Comatose___

Cognition: Short term memory loss_____ Long-term memory loss_____

Ability to understand others: Always_____ Usually_____ Sometimes_____ Never_____

Mood/Behavior: Quiet___ Angry___ Fearful___ Restless___ Combative___ Crying___ Resist cares____ Isolates___ Repetitive physical movements___ Anxious___ Wanders___ Verbally abusive___ Other_____________

Ambulation: Independent___ Supervision___ Limited asst___ Ext. asst___ Total dep___

Mobility: Walker___ W/C self propelled___ W/C staff propelled___ Steady Gait___ Unsteady gait___

Transfers: Independent___ Supervision___ Limited asst___ Ext. asst___ Total dep.___

Transfer Aid: Hoyer___ Slide board___ Trapeze___ Bed rails for bed mobility___

Cardiac Function: H/R regular___ H/R irregular___ Tachy___ Brady___ Homan's sign___ Edema Y N Where_______________ Amount_______________

Respiratory Function: WNL___ SOB___ Tachy___ Brady___ Resp TX's___ Lung sounds_______________

Abdomen/GI: WNL___ Distended___ Tender___ Bowel sounds present___ Bowel sounds absent___ Nausea___ Vomiting___

Bladder: Continent___ Incontinent___ Foley catheter Y / N - (output)_________ Frequency_________ Burning___ Cloudy___ Odor___ Briefs used Y / N

Bowel: Bowel movement Y / N Continent___ Incontinent___ Constipated___ Diarrhea___

Nutrition/Hydration: Adequate___ Fair___ Poor___ Encourage fluids___ Encourage food___ IV___ Tube feeding Y / N Rate_________ Snack Y / N

Integumentary: WNL___ Bruising___ Surgical wound___ Ulcer___ Rash___ Abrasion___ Skin tear___ Excoriation___ Lesion___ Turn/reposition___ Float heels___ Heel protectors___ Specialty (where) ____________________ Treatment: ____________________

Infection: ____________________ Treatment: ____________________

Pain Today: Yes No Where _______________ Mild___ Moderate___ Severe___

DATE	TIME	NURSING NOTES

Narrative Form

WEEKLY CHARTING RECORD

Date:	Resident:	Room:
Primary Diagnosis:		

Vital signs: B/P_____ P_____ R_____ Temp________ O2stat%_____ @_____L/Min. Weight_____

Mental Status: Alert/Oriented x 0 1 2 3 4 Disoriented Y N Occ. Alert___ Lethargic___ Comatose___

Cognition: Short term memory loss_____ Long-term memory loss_____

Ability to understand others: Always_____ Usually_____ Sometimes_____ Never_____

Mood/Behavior: Quiet___ Angry___ Fearful___ Restless___ Combative___ Crying___ Resist cares_____ Isolates___ Repetitive physical movements___ Anxious___ Wanders___ Verbally abusive___ Other_____________

Ambulation: Independent___ Supervision___ Limited asst___ Ext. asst___ Total dep___

Mobility: Walker___ W/C self propelled___ W/C staff propelled___ Steady Gait___ Unsteady gait___

Transfers: Independent___ Supervision___ Limited asst___ Ext. asst___ Total dep.___

Transfer Aid: Hoyer___ Slide board___ Trapeze___ Bed rails for bed mobility___

Cardiac Function: H/R regular___ H/R irregular___ Tachy___ Brady___ Homan's sign___ Edema Y N Where_______________ Amount_______________

Respiratory Function: WNL___ SOB___ Tachy___ Brady___ Resp TX's___ Lung sounds_______________

Abdomen/GI: WNL___ Distended___ Tender___ Bowel sounds present___ Bowel sounds absent___ Nausea___ Vomiting___

Bladder: Continent___ Incontinent___ Foley catheter Y / N - (output)_________ Frequency_________ Burning___ Cloudy___ Odor___ Briefs used Y / N

Bowel: Bowel movement Y / N Continent___ Incontinent___ Constipated___ Diarrhea___

Nutrition/Hydration: Adequate___ Fair___ Poor___ Encourage fluids___ Encourage food___ IV___ Tube feeding Y / N Rate_________ Snack Y / N

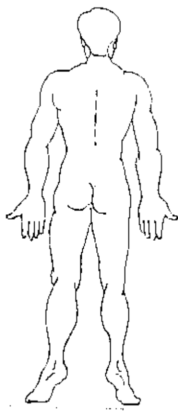
Integumentary: WNL___ Bruising___ Surgical wound___ Ulcer___ Rash___ Abrasion___ Skin tear___ Excoriation___ Lesion___ Turn/reposition___ Float heels___ Heel protectors___ Specialty (where) ____________________ Treatment: ______________________________

Infection: ______________________ Treatment: ______________________________

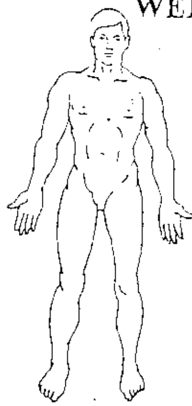
Pain Today: Yes No Where ________________ Mild___ Moderate___ Severe___

DATE	TIME	NURSING NOTES

WEEKLY SKIN CHECKS



BACK



FRONT

WEEK ONE

Is there a skin integrity problem?

Description

____

____

____

____

Pressure reduction/wheelchair mat? Y __ N __

Pressure reduction/relief mattress? Y __ N __

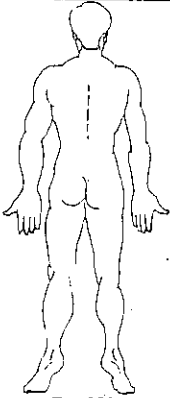
MD notified/orders for new problem? Y __ N __

Wound care protocol implemented? Y __ N __

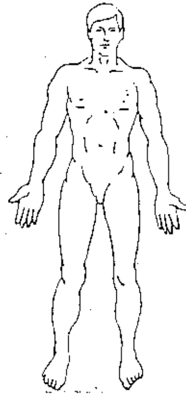
Care plan updated? Y __ N __

______________________________ __________

Nurse Signature Date



BACK



FRONT

WEEK TWO

Is there a skin integrity problem?

Description

____

____

____

____

Pressure reduction/wheelchair mat? Y __ N __

Pressure reduction/relief mattress? Y __ N __

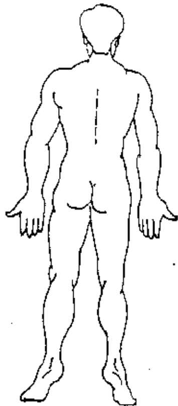
MD notified/orders for new problem? Y __ N __

Wound care protocol implemented? Y __ N __

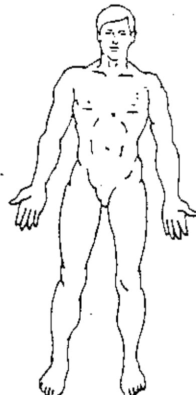
Care plan updated? Y __ N __

______________________________ __________

Nurse Signature Date



BACK



FRONT

WEEK THREE

Is there a skin integrity problem?

Description

____

____

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____

Pressure reduction/wheelchair mat? Y __ N __

Pressure reduction/relief mattress? Y __ N __

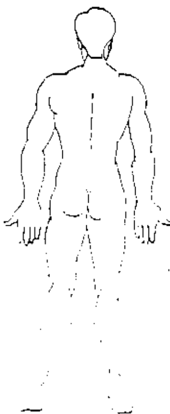
MD notified/orders for new problem? Y __ N __

Wound care protocol implemented? Y __ N __

Care plan updated? Y __ N __

______________________________ __________

Nurse Signature Date



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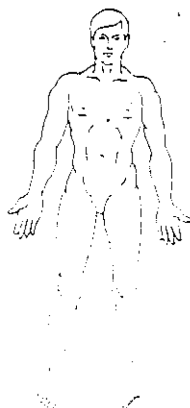

FRONT

WEEK FOUR

Is there a skin integrity problem?

Description

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____

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____

Pressure reduction/wheelchair mat? Y __ N __

Pressure reduction/relief mattress? Y __ N __

MD notified/orders for new problem? Y __ N __

Wound care protocol implemented? Y __ N __

Care plan updated? Y __ N __

______________________________ __________

Nurse Signature Date

Resident's Name: Date: