



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/03/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOUNT VERNON		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 EAST DIVISION STREET MOUNT VERNON, WA 98273		
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F 327 SS=G	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess and/or monitor hydration status for two of four residents who required monitoring of fluid status (Residents 2 and 4). Failure to monitor, document, assess and care plan for hydration status resulted in harm for Resident 2 who developed severe dehydration, acute renal failure and urinal tract infection (UTI) that required hospitalization for treatment. Failure to monitor output placed Resident 4 at risk for inadequate fluid intake to meet hydration needs.</p> <p>Findings include:</p> <p>1. Resident 2 was admitted in the end of [REDACTED] 2013 with multiple diagnoses including recent hospitalization for [REDACTED] and [REDACTED]. He had a history of [REDACTED] with resultant [REDACTED] and difficulty [REDACTED]. He had a [REDACTED] for [REDACTED] and a [REDACTED] for [REDACTED] when admitted.</p> <p>Admission orders, dated [REDACTED] 13, included daily [REDACTED] for 3 days post admission and monitor [REDACTED] and [REDACTED] every shift with totals every 24 hours. Review of clinical records of Resident 2 revealed no evidence of 24 hour totals for [REDACTED] during his 4 days in the facility. The record documented [REDACTED] of approximately</p>	F 327	<p><b>F 327</b></p> <p><b>Correction as it relates to the resident:</b> Resident 2 no longer resides in the facility.</p> <p>Resident 4 completed her course of [REDACTED] and the [REDACTED] monitoring was discontinued.</p> <p><b>Action taken to protect residents in similar situations:</b> Residents on [REDACTED] monitoring will have completed documentation, assessment and care plan.</p> <p><b>Measures taken or systems altered to ensure the problem does not recur:</b> The nursing assistants were re-educated on [REDACTED] documentation by the Staff Development Coordinator (SDC).</p> <p>The Licensed Nurses were re-educated on completing [REDACTED] and [REDACTED] documentation, assessing [REDACTED], documenting findings and physician notification by the SDC.</p> <p>The Director of Nursing/designee will review [REDACTED] documentation daily. On-going daily review will be modified based on findings. Facility will follow up for issues of non-compliance.</p> <p>The Nutrition/Hydration committee will review residents identified at risk for dehydration and the minutes will be forwarded to the Director of Nursing to review that follow-up is completed including identification of risk factors, evaluation of interventions and care plan revision.</p>	11/29/14

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

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OMB NO. 0938-0391

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██████████ in 72 hours between ██████████/13 to ██████████/13. On ██████████/13 Resident 2 developed a severe ██████████ and a decrease in level of ██████████ (he could no longer ██████████ or open his ██████████). He was sent to the hospital for evaluation.

Hospital records were requested on ██████████/13 and received on ██████████/13. Review of the hospital records on ██████████/13 revealed Resident 2 was admitted to the hospital with ██████████ severe ██████████ and ██████████) and severe ██████████ with ██████████. He was unable to ██████████ at admission.

On 12/02/13 at 2:45 p.m., the Director of Nursing Services (DNS) reported nursing staff were to document ██████████ for all newly admitted residents for 7 days from admission to establish a baseline hydration status. The night shift nurse should total ██████████ each 24 hours and determine whether a resident had any risk for dehydration. They should look at skin and oral membranes for moisture/dryness. She expected nursing staff to assess the data for indication of change in condition or possible dehydration. The DNS had no had no information why the nursing staff did not follow the facility standard for hydration assessment.

Additionally, review of the facility investigation for possible ██████████ of Resident 2 during his stay in the facility revealed on 11/05/13, Staff C wrote by noon on 11/04/13 Resident 2 had no interest in food or liquids. He ██████████ "only ██████████ during the morning. His ██████████ was approximately 1 ██████████ of "██████████" color.

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**Plans to monitor performance to ensure solution is sustained:**  
The results of the audits will be reviewed by the facility Performance Improvement committee for 3 months to identify trends and the need for system revision.

**Date Certain: January 29, 2014**

**Title of Person Responsible for Compliance:**  
The Director of Nursing

1/29/14

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F 327	<p>Continued From page 3</p> <p>Resident 2 "no longer [redacted] his [redacted] or [redacted] to direct [redacted]"</p> <p>On [redacted] 13 at 11:58 a/m., the consulting dietician reported she conducted an admission nutrition assessment for all residents on Mondays (her day to visit the facility). She included hydration status in her nutrition assessment. The consulting dietician stated she checks for dry mouth, dry skin, thirst complaints from residents and fluid intake if it is available from a resident's records. She wrote her assessment for Resident 2 on [redacted] 13.</p> <p>Review of the nutrition assessment of Resident 2 revealed his average [redacted] was [redacted] of breakfast, [redacted] of lunch, and [redacted] of dinner. She noted his [redacted] was [redacted]. In a separate note, dated [redacted] 13, the consulting dietician noted the family of Resident 2 was "concerned about his [redacted]" The consulting dietician documented Resident 2's weight was [redacted] in the [redacted] since admission. She calculated Resident 2 needed approximately [redacted]. Review of the [redacted] record of Resident 2 revealed his [redacted] totaled [redacted] on [redacted] 13. It decreased to [redacted] and [redacted] on the next 3 days.</p> <p>Review of the care plan for Resident 2 revealed no evidence of identification of [redacted] status as an issue or concern for him. There were no interventions or goals for monitoring, assessing or maintain [redacted] status for Resident 2.</p> <p>On 01/03/14 at 10:25 a.m., Staff A reported facility policy was all new admissions had [redacted] monitoring for 7 days, if they were on [redacted]</p>	F 327		

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F 327	<p>Continued From page 4</p> <p>if they have a urinary catheter, and/or when in nursing judgment it was appropriate. Nursing staff was expected to review I&amp;O data and skin assessments, skin turgor, renal laboratory test results as part of hydration assessment for residents. They could initiate I&amp;O monitoring for a short time for any resident. Staff A stated nursing should have care planned [REDACTED] for Resident 2.</p> <p>2. Resident 4 was most recently re-admitted in [REDACTED] 2013. Her multiple diagnoses included [REDACTED] and [REDACTED]. She had a [REDACTED]. On [REDACTED]/13, her physician ordered [REDACTED] for treatment of [REDACTED].</p> <p>On 12/02/13 at 09:25 a.m., Resident 4 reported she drank lots of fluids as she had concerns for her [REDACTED].</p> <p>Review of the clinical record revealed she was on [REDACTED] monitoring for every shift. Night shift was instructed to total the 24 hour [REDACTED] and [REDACTED]. There was no evidence of documentation of 24 hour totals for either [REDACTED] or [REDACTED].</p> <p>On 01/03/14 at 11:07 a.m., Staff B reported she had no information when staff were last trained on hydration monitoring and assessment prior to December 2013.</p>	F 327		
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