Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#4956	**Fine amount reduced by 35% to $1300 on December 31, 2012, pursuant to Iowa Code section 135C.43A (2011).**			**Date: November 29, 2012**
Touchstone Living Center		**Survey Dates: October 23-24,26, 2012 & November 5-6,13, 2012**		
1800 Indian Hills Drive				
Sioux City, Iowa 51104	**DS**			

		Class	Fine Amount	Correction date
58.19(2)j	**481—58.19 (135C) Required nursing services for residents.** The program plan for nursing facilities shall have the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(2)** *Medication and treatment.* *j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III) **DESCRIPTION:** Based on record review and staff interviews, the facility failed to provide adequate assessment and timely intervention to assure a resident maintained acceptable parameters of nutrition and hydration for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 98 residents. Findings include: 1. An Admission Record identified Resident #1 had an admission date of 9/25/2012 and had diagnosis of Alzheimer's disease, diabetes (type II), essential hypertension, paralysis agitans (loss or impairment of motor function) and a closed femur fracture. Resident #1 had a Minimum Data Set (MDS) assessment with a reference date of 10/1/2012, which reflected the resident had short term memory problems and modified independence in cognitive skills for daily decision making. Resident #1 required extensive assistance with activities of daily living including eating. An encounter with the physician dated 8/23/12 documented Resident #1 actively took Ensure 2 to 3	**I**	**$2,000.00**	**Upon Receipt**

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	times a day, starting on 07/16/12. A Pre-Admit Visit dated 9/20/12 documented Resident #1's normal body weight as 260 pounds but he/she had a 30 pound weight loss over the last year. A Resident Admission Form dated 9/25/12 documented Resident #1 weighed 229 pounds. An Admission Order form dated 9/21/12 documented Resident #1's diet order included supplementation with Ensure 1 can 3 times a day for nutritional deficiency. An Initial Plan of Care dated 9/25/12 identified a goal for nutrition for Resident #1 included eating 75% of his/her meals. The interventions included: a. Serve diet as ordered: low concentrated sweets, no added salt. b. Encourage to eat in a group environment. c. Monitor intake, assist as needed and report. d. Dietitian consult Consent for Psychotropic Medication Use dated 9/30/12 documented the physician ordered Haldol 10 milligrams (mg) 3 times a day and every hour if needed. The side effects of the drug included sedation, drowsiness, confusion and anorexia (loss of appetite). Consent for Psychotropic Medication Use dated 9/30/12 documented the physician ordered Lorazepam 1 mg 3 times a day and every hour if needed. The side effects of the drug included drowsiness, insomnia, agitation, sedation, and change in appetite. A Food/Fluid Intake Log dated September 2012 documented 5 meals at 100%, 25%, 75%, refused, and 50%. The log documented Resident #1 received 4 snacks, 2 at 100%, and 2 refused.			

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	The October Food/Fluid Intake Log dated October 2012 documented only 1 day of food consumption and fluid intake (10/23/2012). The Nurse's Notes reflected the following: a. On 9/26/12 at 9:10 p.m., Resident #1's appetite fair, drank 100% Ensure before meals. The resident's lower extremities (bilateral) had 2 plus edema present. The resident refused to elevate legs in the recliner. b. On 9/27/12 at 7:00 p.m., Resident #1's appetite poor, but drank 100% of the Ensure. c. On 9/29/12 at 10:00 p.m., Resident #1's appetite good refused Ensure, requested Mountain Dew instead. d. On 10/5/12 a late entry documented Resident #1 slept all day 10/2/12, only up for short periods, taking all oral medications. e. On 10/5/2012 at 9:15 p.m., the resident fell. The resident began to voice complaints of pain and the granddaughter requested resident sent to the hospital. On 10/6/2012 at 5:30 a.m. the hospital social worker was contacted and informed facility the resident was admitted due to a right hip fracture. The resident returned on 10/12/2012 at 4:00 p.m. A Dietary Assessment dated 10/2/12 documented Resident #1's meal intakes were variable; offer snacks, Ensure 3 times a day. Resident #1 had medications with nutritional implications including Haldol, Ativan, Actos, Warfarin, Lasix, and Zetia. Resident #1 needed an estimated 2000 calories, 2000 cc's of fluid, and 78 grams			

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	of protein per day. The assessment documented Resident #1's skin intact. A hospital History and Physical dated 10/5/12 documented Resident #1 admitted after a fall with a right hip fracture. Resident #1 recently transferred to the nursing facility because of increasing agitation behavior, and apparently took Haldol and Ativan and was more lethargic than usual. The impression included: a. Altered mental status in the setting of advanced dementia, most likely due to metabolic encephalopathy (brain malfunction) versus drug effect. b. Acute on chronic renal failure, most likely secondary to dehydration in the setting of altered mental status. c. Hyperkalemia (high potassium level). d. Urinary tract infection (UTI). e. Dehydration would start on intravenous (IV) hydration. g. Right hip fracture due to a fall possibly osteoporotic in nature. The plan documented Resident #1 definitely at high risk for surgery based on his/her current medical status. Resident #1 would benefit from medical stabilization prior to surgical repair. They would start IV hydration, recheck the potassium level, and start on Rocephin for the UTI. A hospital Patient Discharge Instruction sheet dated 10/12/12 documented Resident #1's weight on admission 10/6/12 at 2:25 a.m. at 218 pounds and15 ounces. The discharge instructions directed to please assist and encourage with all feeds and meals. A General Chemistry laboratory report dated 10/12/12 documented Resident #1's albumin (main protein in human blood) low at 2.0 with a reference range of 3.5 to 5), and total protein low at 5.8 with a reference range of			

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	6.5 to 8.2. A facility Resident Admission Form dated 10/12/12 lacked an admission weight for Resident #1 on return from the hospital. A hand written note dated 10/13/12 noted Resident #1 as ill and too lethargic, and not weighed. The clinical record lacked other attempts to weigh Resident #1 until 10/21/12 (8 days later). A Weight record for Resident #1 dated 10/21/12 documented the resident weighed 207#. The admission weight on 9/25/12 of 229 pounds minus the 207 pounds equaled a 22 pound or a 9.6% weight loss in 1 month with a 5% loss in 1 month or a 10% loss in 6 months significant. A Food/Fluid Intake Log dated October 2012 lacked documentation of meal or snack intakes until dinner on 10/23/12. The Nurse's Notes reflected the following: a. On 10/12/12 at 4:00 p.m. documented Resident #1 ate approximately 50% (day returned to facility from hospital) b. On 10/13/12 at 1:45 p.m. documented Resident #1 ate 75% of lunch. c. On 10/14/12 at 2:15 p.m. documented Resident #1 refused breakfast and ate 25% for lunch, fluids encouraged. At 10:15 p.m. Resident #1's appetite poor, ate bites at dinner with 200 cc's. d. On 10/15/12 at 9:05 p.m. documented Resident #1's appetite good.			

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	e. On 10/16/12 at 12:30 p.m. documented Resident #1 with a very poor appetite. f. On 10/17/12 at 7:45 p.m. documented Resident #1 ate 75% of supper and drank 360 cc's. g. On 10/18/12 at 9:00 p.m. documented Resident #1's appetite fair. h. On 10/19/12 at 9:48 p.m. documented Resident #1 ate 75% of dinner. i. On 10/22/12 at 10:00 p.m. documented Resident #1's appetite poor, with much encouragement to eat. j. On 10/23/12 at 3:00 p.m. documented staff called the physician's office regarding Resident #1's initial admission weight and the resident's current weight. A Medication Administration Record for October 2012 documented Resident #1 received Ensure 1 can 3 times a day from 10/01/12 to 10/05/12 when it was suspended for Resident #1's admission to the hospital. Resident #1 returned to the facility on 10/12/12, but received no Ensure from 10/12/12 thru 10/24/12 when he/she transferred to a mental health facility. On 10/24/12 at 10:33 a.m. Resident #1's family member was interviewed and stated the facility obtained orders for medications to help with behaviors and it went "downhill" from there. Resident #1 became like a zombie and would not take food and fluids real well. On 10/24/12 at 11:09 a.m. Staff A (Licensed Practical Nurse (LPN)) was interviewed and stated she worked full time in the area Resident #1 resided. Staff A stated the first couple of days Resident #1 did okay eating and drinking fine. On about the third day Resident #1 had			

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	behaviors and refused to eat at breakfast, and then ate well at lunch. After starting on psychotropic medications, Resident #1 became very lethargic and did not eat well, at most 25%. Resident #1 drank diet soda and the Ensure which had been given at meals. On 10/25/12 at 9:45 a.m. Staff A stated Resident #1 did not eat and drink well when sedated, only for a couple of days and she would pass it on between shifts. Staff A said they were basically reporting on behaviors at that time. During an interview on 10/24/12 at 11:20 a.m. Staff B (Certified Nursing Assistant (CNA)) stated after Resident #1 started medications he/she was so “out of it” that he/she couldn't walk. Resident #1 did not eat or drink well; he/she was too out of it. On 10/25/12 at 9:55 a.m. Staff B stated Resident #1 did not eat or drink well when lethargic on medications. Staff B reported this to the oncoming CNA and the nurse. They tried to get him/her to drink soda but there was really nothing they could since he was so “out of it” (not alert). During an interview on 10/24/12 at 1:56 p.m. Staff C LPN stated (prior to the fracture) they told her that on Wednesday Resident #1 slept more. Staff had trouble getting him/her to eat. They encouraged the best they could. Resident #1 drank soda and Ensure. During an interview on 10/24/12 at 2:15 p.m. Staff D CNA stated (prior to the fracture) Resident #1 would wake up and mumble a little bit. They had to feed him/her, and it took a long time. They kept saying to open his/her mouth and he/she wouldn't. Resident #1 was so sleepy she/he didn't drink much of anything except soda. He/she was so sleepy he/she wouldn't eat snacks. During an interview on 10/25/12 at 9:10 a.m. the Director			

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	of Nursing (DON) stated she would ask the nurse consultant, but the facility didn't have policies. The DON stated if a resident did not eat or drink well, she expected staff to notify the physician. During an interview on 10/25/12 at 10:15 a.m. the Nurse Consultant stated when a resident is admitted or re-admitted; staff were to document intakes for 7 days. In Resident #1's case they did not document very well. They planned to change the documentation to the Kiosk instead of paper. On 10/25/12 at 12:51 p.m. the facility Dietician was interviewed and stated she did a dietary assessment when Resident #1 first came in to the facility. She stated generally staff only kept track of intakes on admission or assessment periods. She said sometimes if she couldn't find intakes she would have to ask staff how residents ate. She stated in her opinion, if a resident experienced poor appetite or reduced intakes; they should assess intakes and hydration. She stated the Ensure should have started again on readmission, a weight taken, and intakes documented. On 10/26/12 at 11:22 a.m. the Dietician further stated Ensure was a medical nutritional supplement that provided extra calories and protein. She was not aware Resident #1 had wounds on his/her legs upon admission. She stated if the wounds were not pressure ulcers she would not necessarily recommend additional supplement and Resident #1 already received Ensure for increased protein. She stated if Resident #1 had stasis ulcers she wouldn't recommend increased protein because it wouldn't get there anyway. She stated the albumin could be low due to acute illness and further evaluation would be needed. During an interview on 11/05/12 at 8:13 p.m. the Wound Nurse stated she saw Resident #1 when he/she was			

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	hospitalized. She stated the ulcers on Resident #1's legs were from venous insufficiency or stasis ulcers. She stated wounds do not heal well with poor nutrition including inadequate protein intake. The Wound Nurse stated she pulled up Resident #1's dietary assessment (from the hospital) and read he/she needed assistance with meals and received a dietary supplement. She didn't know if he received Ensure specifically, but some kind of nutritional supplement. During an interview on 10/25/12 at 10:49 a.m. the Physician's nurse stated they were aware of Resident #1's behaviors, but not aware of the lethargy he/she experienced after the initiation of the psychotropic medication. The physician would not expect the facility to notify her of this, because the Psychiatric Practitioner was in charge of those medications. The physician also did not expect the facility to call every day when the resident didn't eat or drink well. The facility notified them on 9/28/12 that Resident #1 did not eat well, so they knew. The physician would expect the facility to assess the resident's intakes, weights, and hydration. The facility policy Intake Documentation Guidelines identified the purpose to document all intakes on all residents during a measured time frame based on their MDS schedule. This assured that at time periods during the resident's nursing home stay they looked at the resident's food and fluid intake. The procedure directed upon admission and on the resident's MDS schedule they would document intake for the scheduled period prior to the MDS due date (7 days). This allowed the Dietician and nursing staff to assure all residents were not suffering unintended weight loss. It also assured staff that residents ate a well- balanced diet. Nursing and dietary staff could provide nutritional education based on their intake and choices.			

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	FACILITY RESPONSE:			

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