4. Systems to monitor the effectiveness:
   a) The Unit Managers and/or Team Leaders will randomly audit the ADL and Meal Intake/hydration documentation for a total of 50 residents weekly x 4 weeks, then monthly thereafter with re-education as necessary.
   b) Findings will be reported monthly to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.

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 patient. (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 required to continued program participation.
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wheelchair was used for locomotion.

Medical record revealed an unlabeled form on which the resident’s intake at meals was documented. Continued review of this form revealed on November 1, 10, 15, 20, 23, 25, and 28, 2011, the resident’s intake was 10 - 25% at lunch but there was no documentation of rehydration. Further review of the form revealed on November 1, 4, 5, 10, 20, 23, and 25, 2011, the resident’s intake at dinner was 10 - 50% but there was no documentation of rehydration. Continued review of the form revealed on November 1, 3, 4, 7, 8, 9, 11, 12, 13, 14, 18, 20, 21, 22, 23, and 30, 2011, there was no documentation of rehydration during early morning care.

Medical record review of the ADL (Activities of Daily Living) Flow Sheet revealed spaces for documentation each shift of the resident’s ability to perform as well as the amount of support needed for bed mobility, transfer ability, eating, and toileting. Review of the data for the month of November revealed 216 blanks where the self performance and support provided were not documented for the resident.

During interview on January 3, 2012, at 4:00 p.m., in the conference room, the Director of Nursing confirmed there were many times there was no documentation of the resident’s ability to perform tasks, the staff support needed by the resident to perform the tasks and that fluids had been offered. The DON confirmed the medical record was incomplete and did not reflect the care that had been provided.

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1. Corrective action for residents affected:
   a) Resident #8 discharged on 12/7/11.
   b) The DON and Nursing Supervisor completed an audit of ADL and Meal Intake/hydration documentation on current residents for compliance; deficient practices addressed with staff responsible for resident documentation.

2. Identification of others who could be affected by the deficient practice:
   All residents have the potential to be affected by this practice.

3. Measures put in place to ensure deficient practice does not reoccur:
   a) The Nurse Educator inserviced facility CNAs on daily ADL and Meal Intake/hydration documentation. New CNAs will be inserviced during the orientation process.
   b) Nurse Educator inserviced Unit Managers/Team Leaders on random audit for completion of ADL and Meal Intake/hydration documentation. New Unit Managers/Team Leaders will be inserviced during the orientation process.