PSYCHOSOCIAL CONSULTANTS

800-419-2849

Recent Survey Issues September to April2018

Resident Council Meetings:

Residents not aware of Resident Council Meeting is held.

Weight Loss issues:

o Reason for weight loss not assessed as related to missing dentures

Request/Refuse/Treatment/Advanced Directives

- o Advanced Directives Acknowledgement form signed by resident/representative.
- o Resident missing an Advanced Directive

Environmental/Home-Like Environment:

o No personalized items in long -term resident's room (photos, artwork, etc)

Resident Rights/Person Centered Care/Dignity:

- Photo of resident posted on social media
- o CNA calling adult brief "resident's diaper" in a negative manner
- Eye drops being administered in dining room- dignity issue
- Resident food preferences not followed
- o Resident served food that resident previously indicated she did not want
- Resident found with maggots in foot wound

Hospice:

- o No CP re: end of life care
- Hospice staff name and phone number not on resident's chart for easy access
- Lack of IDT communication with hospice agency

Care Planning:

- o No BaseLine Care Plan within 48 hours of admission. Frequently cited.
- No Comprehensive Care Plan with 15 days of admission.
- Care Plans not updated as resident condition changed
- Comprehensive Care Plan did not adequately address resident's foot wound and maggots
- No Comprehensive Care Plan until day 41 of admission
- Care Plans not individualized- computer generated without individualizing
- o Problems & interventions realistic?

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Grievance:

- Grievance reports with no follow-up or resolution
- o Grievance reports not completed despite the grievance being addressed and resolved
- SSD not informed of resident grievance

Theft and Loss:

- Two discharged resident's belongings mixed in with each others
- Lack of documentation that resident/representative was satisfied with resolution
- Lack of documenting that resident was informed, in writing, the risk of keeping cash at bedside

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Medically-related Social Service:

- Res failed to receive requested podiatry services.
- o Lack of f/u or support visit following injury related to alleged abuse.
- SSD asked by Surveyors if she had a "script of questions" when investigating abuse complaints

o SSD

Behavior Management/Psychotropic Medications:

- o PRN Seroquel used beyond the 14 days allowed in new regulations. Cited several times.
- No consent for psychotropic medication.
- o Behavior monitored does not match orders.
- No GDR documented
- No documentation of potential triggers prior to medication being prescribed
- Behaviors related to psychiatric diagnosis or symptoms of dementia?
- Justifications for GDRs and no GDRs

Inventories:

- No Inventory in chart- frequently cited
- Glasses indicated on MDS not listed on Inventory
- o Inventory not closed out at discharge
- o Items in resident's room not on Inventory.
- Inventory lacking 2 signatures

Discharge Planning:

- o Notice of transfer/discharge not faxed when resident was admitted to hospital-cited frequently
- Lack of SS discharge planning notes- need to demonstrate "sufficient preparation for d/c"
- Ombudsman not informed of resident discharge

POLST:

POLST indicates No DNR, no order chart.

MD orders say "follow the POLST"- POLST was not signed by MD.

No MD signature on POLST

MD section incomplete

MISC.

- o Comprehensive Care Plan not reviewed with resident/representative
- No P & P for vision services, including monitoring appointments
- o Residents not aware of where Survey Results are posted
- o Resident's personal food in refrigerator not dated
- Quality Assurance program did not address repeated issues regarding inadequate wound care