

Just the Beginning Case-Based Activity, Part One
Long-Term Care Learning Activity

Item	Description
Objective:	Given a set of scenarios, areas of concern, potential citations, and related regulatory requirements, the surveyor will be able to write the deficient practice statement.
Prior to Class:	This is a two-part activity— <i>Just the Beginning</i> activity is Part One, and <i>The Rest of the Story</i> activity is Part Two. These instructions are for Part One. Part Two directions follow the Part One activity. For Part One, print one copy of the Preceptor Instructor Sheet—Part One (with answers) and one copy of the Scenario: Part One for each new surveyor. Have the Long Term Care regulations (Appendix PP) available. Have flip charts and markers available. Provide copies of the Scope and Severity grid to each new surveyor.
Total Time for Activity:	90 minutes (The time given is approximate.)
Set-Up:	There are three residents from whom to choose. Allow each surveyor to choose which resident they would like to work with. Distribute a copy of the Scenario: Part One for their chosen resident to each new surveyor. Tell them they will have 60 minutes to read their scenario and answer the questions. The Social History is provided.*

Step:	Preceptor Instructions, Part One:	Activity Time:
1.	Distribute a copy of the Scenario: Part One for their chosen resident to each new surveyor. Tell them to read the directions and the scenario. Answer any questions they may have regarding the activity.*	5 min.
2.	Provide time for new surveyors to work through the scenario and the questions. Explain to surveyors they should be prepared to present on the resident and to share their responses to the questions.	60 min.
3.	Allow each surveyor to present their resident, the two areas they decided to investigate, and their answers to the questions.	25 min.
4.	Debrief each scenario by discussing key points and any differences discussed during each presentation. Move on to Part Two of this activity, <i>The Rest of the Story</i> .	25 min.

**For individual assignment, provide direction and support where appropriate during the completion of the scenario. Once completed, review answers against the answer sheet, and discuss the key points together from the scenario. Assign a new resident scenario from this activity as applicable.*

Date:

Surveyor:

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Directions: Read through the scenario and answer the questions. Consider what Critical Pathway(s) you will need to review as you read. Be prepared to share your answers.

Mrs. Grace Naylorson—Scenario: Part One

Social History

Grace Naylorson is a native of Oak Island, North Carolina. Born Grace Nielsen, she married Thomas Naylorson, a shrimp boat captain (shrimper). The Naylorsons had no children as, tragically, Mr. Naylorson was lost at sea during a sudden squall that capsized his boat just weeks after their marriage. Mrs. Naylorson supported herself by creating quilts to sell to the throngs of tourists visiting North Carolina’s Outer Banks. Her handiwork was meticulous and many customers returned to place custom orders with her because of the quality of her work. Mrs. Naylorson has a very stoic approach, which has allowed her to “carry on” despite adversity.

Resident: Grace Naylorson	Review for ADLs and Restraints
Initial Tour	
Mrs. Naylorson (Mrs. N.) is in her room and is wearing a Velcro belt attached to her wheelchair. Her fingernails are long, jagged, and dirty. Teeth appear clean. Nursing Assistant (NA) Sharon, making the bed, says Mrs. N. is total care and can make her needs known. Mrs. N. requests a pain pill, and the NA leaves to tell the nurse. Mrs. N.—Both hands have dark brown debris under long jagged nails. She has the belt in place.	

Survey Scenario Questions:

1. Identify two areas to investigate.
2. Indicate:
 - a. Three areas of the clinical record to review and what information you will be looking for.
 - b. Three observations to be made and what you will be looking for.
 - c. Three individuals to interview and three questions for each person.

Date:
Surveyor:

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Directions: Read through the scenario and answer the questions. Consider what Critical Pathway(s) you will need to review as you read. Be prepared to share your answers.

Mr. Presley Soysen—Scenario: Part One

Social History

Presley Soysen was born in Chapel Hill, North Carolina, in 1942 to a single mother. Presley grew into a very “bookish” man, more comfortable in a library than anywhere else. Presley went on to become a physics professor at the University of North Carolina at Chapel Hill (UNC-CH) and eventually served as the department head for several years prior to retirement. Mr. Soysen has no family or extended family. In his home, he enjoyed the company of a Manx cat named Minx, but surrendered her before coming into the facility.

Resident: Mr. Presley Soysen	Review for Unnecessary Meds and Pressure Ulcers
Stage 1—Staff Interview indicated this resident has a facility-acquired pressure ulcer on the coccyx. The resident also triggered for Stage 2 for 9+ medications.	

Survey Scenario Questions:

1. Identify two areas to investigate.

2. Indicate:
 - a. Three areas of the clinical record to review and what information you will be looking for.

 - b. Three observations to be made and what you will be looking for.

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Mr. Cliff Jenkins—Scenario: Part One

Social History

Mr. Jenkins was born in Maysville, South Carolina, on July 4, 1947. Cliff joined the United States Marine Corps and was shot down over Southeast Asia during the Vietnam War. Mr. Jenkins saw two tours in Vietnam, eventually rising to the rank of Gunnery Sergeant (“Gunny”). Gunny Jenkins served as a Drill Instructor at Parris Island, South Carolina, for 25 years, and retired from the Corps in 2000 with an exemplary service record. Once a Marine, always a Marine, but the separation from the Corps was difficult for him. Now in his late 60s, Gunny Jenkins has no family, other than distant cousins in South Carolina that he has not been in contact with for many years. All of his possessions will fit into his footlocker, where he prefers to keep them.

Resident: Cliff Jenkins	Review for ADLs and Choices
Initial Tour, Room 203, Cliff Jenkins	
Resident is eating breakfast. He has water, orange juice, eggs, sausage, and toast. He has beard stubble and his shirt has dried spillage (chocolate pudding?). Nails are trimmed but dirty. Indicates he cannot tolerate white milk but he gets it every day. Says “Everyone knows” he doesn’t like milk. “It don’t do no good to tell ’em and there ain’t nothing you are going to be able to do about it!!” Milk has been removed from tray and placed on the bedside table behind the privacy curtain. Resident is angry.	

Survey Scenario Questions:

1. Identify two areas to investigate.
2. Indicate:
 - a. Three areas of the clinical record to review and what information you will be looking for.
 - b. Three observations to be made and what you will be looking for.
 - c. Three individuals to interview and three questions for each person.

Just the Beginning Case-Based Activity, Part Two
Long-Term Care Learning Activity

Item	Description														
Objective:	Given a set of surveyor’s notes, the surveyor will identify possible citations for each scenario while conducting a survey in a long-term care facility with 80% accuracy.														
Prior to Class:	This is a two-part activity. <i>Just the Beginning</i> is Part One. <i>The Rest of the Story</i> is Part Two. These instructions are for Part Two. For Part Two, print one copy of the Preceptor Instructor Sheet—Part Two (with answers) and one copy of each of the Scenario: <i>The Rest of the Story</i> —Part Two for each new surveyor. (Alternative: After completion of Part Two, you could choose to have your new surveyors write a Form CMS-2567 for their resident, based on the information contained within Part One and Part Two of this activity.)														
Total Time for Activity:	90 minutes (The time given is approximate.)														
Set-Up:	There are three residents to choose from. The surveyor will need the notes for their chosen resident. Distribute a copy of the Scenario: <i>The Rest of the Story</i> —Part Two for their chosen resident to each new surveyor. Tell them they will have 60 minutes to read their scenario and answer the questions.														
Step:	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="text-align: right; vertical-align: top;">Activity Time:</th> </tr> </thead> <tbody> <tr> <td>Preceptor Instructions, Part Two:</td> <td></td> </tr> <tr> <td>1. Distribute a copy of the Scenario: <i>The Rest of the Story</i>—Part Two for their chosen resident to each new surveyor. Tell them to read the directions and <i>The Rest of the Story</i> scenario. Answer any questions they may have regarding the activity.*</td> <td style="text-align: right; vertical-align: top;">5 min.</td> </tr> <tr> <td>2. Provide time for new surveyors to work through the scenario and the questions. Explain to surveyors they should be prepared to present on the resident and to share their responses to the questions.</td> <td style="text-align: right; vertical-align: top;">30 min.</td> </tr> <tr> <td>3. Allow each surveyor to present <i>The Rest of the Story</i> for their resident and the answer to their questions.</td> <td style="text-align: right; vertical-align: top;">15 min.</td> </tr> <tr> <td>4. After each presentation the “team” (class) makes a decision about deficient practice and determines severity based on either the severity guidance at the end of an investigative protocol or the Psychosocial Outcome Severity Guide in Appendix P, Part IV.</td> <td style="text-align: right; vertical-align: top;">15 min.</td> </tr> <tr> <td>5. Debrief each scenario by discussing key points and any differences discussed during each presentation.</td> <td style="text-align: right; vertical-align: top;">25 min.</td> </tr> </tbody> </table>		Activity Time:	Preceptor Instructions, Part Two:		1. Distribute a copy of the Scenario: <i>The Rest of the Story</i> —Part Two for their chosen resident to each new surveyor. Tell them to read the directions and <i>The Rest of the Story</i> scenario. Answer any questions they may have regarding the activity.*	5 min.	2. Provide time for new surveyors to work through the scenario and the questions. Explain to surveyors they should be prepared to present on the resident and to share their responses to the questions.	30 min.	3. Allow each surveyor to present <i>The Rest of the Story</i> for their resident and the answer to their questions.	15 min.	4. After each presentation the “team” (class) makes a decision about deficient practice and determines severity based on either the severity guidance at the end of an investigative protocol or the Psychosocial Outcome Severity Guide in Appendix P, Part IV.	15 min.	5. Debrief each scenario by discussing key points and any differences discussed during each presentation.	25 min.
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Just the Beginning Case-Based Activity, Part Two
Long-Term Care Learning Activity

Directions: Read through the surveyor notes on the following pages and answer the questions. Be prepared to share your answers with your preceptor, and/or group.

Mrs. Grace Naylorson—The Rest of the Story: Part Two

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

SURVEYOR NOTES WORKSHEET

Facility Name: _____ Surveyor Name: _____
 Provider Number: _____ Surveyor Number: _____
 Discipline: _____ Observation Dates: From _____ To _____

TAG/CONCERNS	DOCUMENTATION
	Resident: Grace Naylorson #43 Review for ADLs and Restraints
12/10/XX	Initial Tour
9:36AM Observation & Interview	Mrs. Naylorson (Mrs. N.) is in her room and is wearing a Velcro belt attached to her wheelchair. Her fingernails are long, jagged, and dirty. Her teeth appear clean. Nursing Assistant (NA) Sharon, making the bed, says Mrs. N. is total care and can make her needs known. Mrs. N. requests a pain pill and the NA leaves to tell the nurse.
3:50PM Observation	Mrs. N.: Both hands have dark brown debris under long, jagged nails. She has the belt in place.
12/11/XX	
12:25PM Observation & Interview	Mrs. N is in her room eating her lunch with her fingers. Both hands have dark brown debris under jagged nails extending approximately one-quarter inch beyond fingertips. Lunch consists of hamburger patty and potatoes, BLT sandwich, pears, tea, and water. Self-release belt is in place. Positioning is good.
RR DX	Motor vehicle accident (MVA) ('02) with traumatic brain injury, closed skull fracture (Fx.), Fx. lumbar vertebra, left hemiplegia, Cerebrovascular Accident (CVA), dysphagia, and bipolar disorder with behaviors.
Recent MDS	MDS (most recent = 10/10/20XX annual) Cognition: Brief Interview for Mental Status (BIMS) = 8 (moderately impaired) Behavior: Care rejected 1–3 days out of 7 in the look-back period. Activities of Daily Living (ADL): Most indicate the resident requires extensive assistance of one person. Dressing = 3/2, personal hygiene = 3/2. With surface-to-surface transfer, she is only able to stabilize with staff assistance. Mrs. N. is incontinent of Bladder and Bowel (B&B). Falls: none in last 6 months. Restraints = none.

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Long-Term Care Learning Activity

TAG/CONCERNS	DOCUMENTATION
Older MDS	A comparison to the previous MDS (quarterly07/19/20XX) shows Cognition: BIMS = 7.
	Behavior: same, ADLs: same, Balance: same, Falls: Yes—in the last 2-6 months, Restraints: no
ADL CAA	10/10/20XX—Summary included that the resident is able to make her needs known and requires extensive to total assistance from staff for ADLs due to injuries from the motor vehicle accident. The resident does not have contractures and will allow hand-over-hand maneuvering with some ADL tasks. Range of Motion (ROM) is good; no therapy at this time. Is often non-compliant when staff tries to provide care. ACT Mental Health has begun seeing her and Lexapro and Abilify were recently added to her medication schedule. Resident is not a candidate for bladder training. Resident refuses to use adaptive equipment at meals—prefers finger foods to maintain independence. Care Plan for ADLs and behavior.
Restraint CAA	The Restraint CAA did not trigger.
Care Plan	Encourage hand-over-hand guidance with ADLs as much as possible. Provide explanation of care prior and during. Allow time for acceptance and independence. Compliment for neat appearance. When resident resists care, approach again a short time later or have another staff member try to provide the care. Family will also encourage cooperation via the phone if necessary.
MD order	3/7/20XX for self-release belt for poor sitting balance
1:40 PM Observation & Interview	Incontinent care observation—provided by NA Sharon. NA knocked before entering room. Good technique. NA says incontinent care is done q 2-3 hrs. No skin breakdown. NA says Mrs. N. can remove Velcro belt.
1:49 PM Observation & Interview	Resident is able to release Velcro belt per NA Sharon’s request. Ms. N appears pleased to demonstrate that she can remove the belt. Her speech is difficult to understand. “I need it. I feel safer with the belt. I don’t want to fall.” NA Sharon says the resident can remove the belt at will. At 2:05 PM, NA takes Mrs. N. to the bowling activity. Mrs. N. has dark brown debris under long, jagged nails.
12/12/20XX	
8:24 AM Observation	Nails still long and jagged with brown debris embedded. Mrs. N is eating scrambled eggs with her hands. She also has a sausage patty, orange juice, toast with butter, and bowl of blueberries.
RR Qtrly. Assess	Has quarterly restraint assessments. Resident has consistently been able to release Velcro belt.

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TAG/CONCERNS	DOCUMENTATION
9:26 AM Interview	NA Sharon says that she last attempted to clean the resident's nails four days ago on the weekend, but the resident refused. She has not attempted since then and did not report the refusal to the nurse or the on-coming 3-11 shift. Sharon says she has been assigned to care for Mrs. N. during the last three days of survey, but has not attempted to clean or cut her nails during these days.
9:31 AM Observation	Sharon asks Mrs. N. if she can soak her hands in a warm, soapy basin of water. Resident agrees.
9:47 AM Interview	DON says it is part of daily care to ensure residents' nails are trimmed and clean. DON asks Mrs. N. about cutting her fingernails. Mrs. N. initially says no but after quiet explanation she agrees to allow the DON to cut her nails.

Form CMS-807 (7/95)

Survey Questions:

1. What concerns do you have?

2. What tags should be considered for possible citations?

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Directions: Read through the surveyor notes on the following pages and answer the questions. Be prepared to share your answers with your preceptor, and/or group.

Mr. Presley Soysen—The Rest of the Story: Part Two

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

SURVEYOR NOTES WORKSHEET

Facility Name: _____ Surveyor Name: _____
 Provider Number: _____ Surveyor Number: _____
 Discipline: _____ Observation Dates: From _____ To _____

TAG/CONCERNS	DOCUMENTATION
	Mr. Presley Soysen #56 Review for Unnecessary Meds & Pain and Pressure Ulcers
02/10/XX	
	Stage 1—Staff Interview indicated this resident has a facility-acquired pressure ulcer on the coccyx. The resident also triggered for Stage 2 for 9+ medications.
12:28 PM Observation	Res dressed and up in dining room. Has eaten 75% or more of the meal. Able to feed self. Alert to environment but is sitting alone at his table.
RR DX	Diagnoses—glaucoma, hypothyroidism, Chronic Obstructive Pulmonary Disease (COPD), osteoporosis, pressure ulcer—coccyx, dementia—Not Otherwise Specified (NOS), Coronary Artery Disease (CAD), osteoarthritis, and depression
Meds	Aggrenox 25/200 mg 1 cap po BID for CAD, Furosemide 80 mg 1 po bid for Congestive Heart Failure (CHF), Isosorbide MN 20 mg 1 po BID for CAD, Lumigan 0.03% eye gtt 1 gtt in Lt eye for glaucoma, Levothyroxine 88 mcg 1 po QID for hypothyroidism, Meloxicam 15 mg (Mobic) 1 po QID for osteoarthritis, Namenda 10 mg 1 po BID for dementia, Carvedilol 6.25 mg 1 po BID for CAD, Donepezil 10 mg (Aricept) 1 po at hs for dementia, Citalopram 20 mg (Celexa) 1 po QD for depression, Polythyl Glyc 3350 (Miralax) 17 gm in 8 oz H ₂ O po QID for constipation, Vit C 500 mg 1 po BID for healing
Older MDS	N/A
Recent MDS	MDS (most recent = 10/10/20XX annual) Cognition: BIMS = 8 (moderately impaired) Behavior: Care rejected 1–3 days out of 7 in the look-back period. ADLs: Most indicate the resident requires extensive assistance of one person. Dressing = 3/2, personal hygiene = 3/2. With surface-to-surface transfers is only able to stabilize with staff assistance. Incontinent of bowel & bladder.

Just the Beginning Case-Based Activity, Part Two
Long-Term Care Learning Activity

TAG/CONCERNS	DOCUMENTATION
Pressure Ulcer CAA	(from annual MDS 07/13/20XX) Risk but no Pressure Ulcer (PU) at the time of the assessment. Will include on Care Plan.
MD orders	11/15/20XX—Clean coccyx w/NS pat dry, apply Anasept gel to wound. Cover w/4X4 dry dressing. MD ordered labs CBC, BMP, q6 months and Lipid panel yearly
Care Plan	Impaired mobility. Interventions for skin breakdown risk then actual on 11/14/20XX
	Interventions for fluid volume, depression, drug complications
2:20 PM Observation	Resident resting in bed.
12/11/20XX	
8:05 AM Observation	Resident in dining room. Staff member is encouraging Mr. Soysen (Mr. S.) and another resident to eat while engaging them in conversation about the morning activity program. Has orange juice, milk, water, coffee, scrambled eggs, two sausage links, toast with jam, and a bowl of peaches.
8:26 AM Observation	Beginning continuous observation for repositioning. Resident is now in his room and still in wheelchair.
8:39 AM Observation	Mr. S. is still in room in wheelchair and roommate entered the room.
8:58 AM Observation	Nursing Assistant (NA) enters room and asks Mr. S. if he wants to watch TV. Resident says yes. NA turns on TV. The NA then offers Mr. S. some water. He declines and NA leaves the room
9:20 AM Observation & Interview	NA Madeline Marks indicated she is going to put the resident back in bed and will provide incontinent care. Good technique. Positions resident on the left side before leaving the room.
Dietary Notes	11/29/XX—Reviewed labs. Consuming adequate amount of daily calories.
LABs	10/29/11 Albumin within normal limits (WNL)
	11/27/11 CBC WNL except:
	Low: WBC 4.5 k/uL (4.6-10.2)
	RBC: 3.42 M/uL (4.7- 6.10)
	HGB: 10.4 g/dL (13.0-16.5)
	HGBX3: 31.2 (39-45)
	BMP CA Low 8.5 mg/dL
	11/27/11 Prealbumin WNL

Just the Beginning Case-Based Activity, Part Two
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TAG/CONCERNS	DOCUMENTATION
Pharm Consult	11/07/XX—Dx of depression and has been receiving Celexa 20 mg qd since 05/20XX. CMS guidelines indicate that a Gradual Dose Reduction (GDR) should be attempted at least twice in the first year after drug initiation. 12/02/XX Chart does not include documentation of recent behavioral problems. Nursing note to MD = Would it be clinically appropriate to attempt a GDR to reduce potential of experiencing an adverse drug event? MD response on 11/10/XX = Benefit of Celexa at 20 mg po QD outweighs risks. Patient at a stable level of functioning. No change in current dose.
Wound Measure	11/14/XX Excoriation
	11/21/XX = 4.0 X 2.7 X 1.0 cm.
	11/28/XX = 4.0 X 3.0 X 1.4. Undermining 3.0 cm.
	12/5/XX = 5.0 X 3.0 X 2.0. Undermining 4.0 cm. Necrotic tissue in center.
	12/11/XX = 5.5 X 4.0 X 2.3. Undermining 4.5 cm. Necrotic tissue in center.
10:14 AM Observation & Interview	Treatment (Tx) Nurse Becky Williams LPN: “(Resident) had a pain pill about 30 minutes ago. It started out a few months ago as a red excoriation and then it just opened up. It has gotten bigger but this tx. is done every day. The resident is really compromised, and that’s probably why it’s not healing.” Removes wound packing. “We used to pack it with two or three pieces; now we use four or five to pack it.” (Asked if MD was notified about deterioration, Nurse Williams replied, “I probably should.”)
11:11 AM Interview	Unit Manager Deborah Stetson, RN, states Tx Nurse Becky measures wounds for all the residents with pressure ulcers. “If the pressure ulcer worsens, then maybe the treatment isn’t effective; so we should see about changing the order.” Stated she herself did this resident’s Tx one day last week and did not notice necrotic tissue.
11:21 AM Interview	Director of Nursing stated she expects all nursing staff would notify the physician of worsening pressure ulcer by the end of the shift the assessment had been completed. “If the ulcer isn’t getting better, then the physician should be notified to see if he wants to order a change in the treatment or referral to the wound clinic.”

Form CMS-807 (7/95)

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Survey Questions:

1. What concerns do you have?
2. What tags should be considered for possible citations?

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Directions: Read through the surveyor notes on the following pages and answer the questions. Be prepared to share your answers with your preceptor, and/or group.

Mr. Cliff Jenkins—The Rest of the Story: Part Two

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

SURVEYOR NOTES WORKSHEET

Facility Name: _____ Surveyor Name: _____
 Provider Number: _____ Surveyor Number: _____
 Discipline: _____ Observation Dates: From _____ To _____

TAG/CONCERNS	DOCUMENTATION
	Resident: Cliff Jenkins #87 Review for ADLs and Choices
12/10/XX	
8:37 AM Observation & Interview	Initial Tour Room 203 Cliff Jenkins—Resident eating breakfast. Has water, orange juice, eggs, sausage, and toast. Has beard stubble and his nails are trimmed but dirty. Indicates he cannot tolerate white milk, but he gets it every day. Resident indicates that “everyone knows” about his dislike of white milk. “It don’t do no good to tell ’em and there ain’t nothing you are going to be able to do about it!!” Milk has been removed from tray, and placed on bedside table behind the privacy curtain. Resident is angry that the white milk was on his tray.
12/11/XX	
8:22 AM Observation & Interview	Nursing Assistant (NA) Theresa takes breakfast tray to room and removes milk to bedside table behind curtain. Resident says, “Yeah, get it off my tray! I don’t like it, and I’m not going to drink it! If they don’t quit bringing that mess, I’m gonna quit eating!!” Resident is red faced-angry. Resident is unshaven and nails are dirty.
8:24 AM Interview	NA Theresa is aware he doesn’t like white milk. “He told them not to send it; but sometimes they still do send it, and Cliff will tell you to take it off his tray. He doesn’t even want to look at it at all, so I put it back here (behind curtain).” NA told agency nurse about it several weeks ago. “A nurse has to fill out a dietary slip for any changes to be made. I can’t do it.” (ADLs?) “We just set it up for him, and he can do it all himself.”
2:53 PM Interview	NA Stella—says she is often assigned to C. Jenkins and is aware of milk preference. “No he doesn’t like it at all. I’ve written it on his card, but they haven’t changed it. He likes chocolate (milk); and if I deliver his tray, I’ll go get chocolate milk for him. I set the white milk aside because he won’t drink it. (Report dislike to anyone?) “I wrote it on his card three times, I think. If they don’t catch it soon, I’ll say something to the kitchen.”

Just the Beginning Case-Based Activity, Part Two
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TAG/CONCERNS	DOCUMENTATION
RR DX	Diagnoses include pernicious anemia, muscle spasms, Chronic Obstructive Pulmonary Disease (COPD), osteoporosis, cerebral vascular disease, arthritis, depression, Gastroesophageal Reflux Disease (GERD), history of hip fracture (June 2010), and is a current smoker.
Recent MDS	MDS (most recent = 10/04/XX quarterly) Section G—Mr. Jenkins (Mr. J.) is independent or partial assist in all ADLs. Cognition score is 13. No weight loss when compared to prior assessment.
Nutrition CAA	07/14/XX (from admission assessment last year) No concentrated sweets and renal diet. Usually leaves 25% or more of the meal on the tray. Has been seen by dietary regarding food preferences. Prefers to eat meals in his room.
ADL CAA	07/14/XX (from admission assessment last year) Resident requires supervision or minimal assistance with grooming but does not allow staff to assist. Is often resistant to bathing weekly and/or changing clothes daily. Staff will praise for good grooming and assist as needed. Weight loss 2% in last 30 days.
Care Plan	Most recently updated 10/08/XX. ADLs—Will bathe at least weekly and basic grooming daily. Daughter to bring in clothing without holes and facility will provide laundry. Encourage to change clothes daily and brush teeth, comb hair, and wash face daily. If resident is resistant to care, approach again later or have another staff person try to engage. Provide grooming materials at bedside. Nutrition: resident will eat 75–100% of meals. Encourage resident to attend activities involving food. Offer substitutes PRN.
Dietary Notes	07/08/20XX—Food preference list reviewed with resident. List contained the resident’s food preferences within Dietary Summary. Preference is chocolate milk for breakfast. Dislikes not listed.
4:07 PM Interview	Dietary Manager (Matty)—“One of the CNAs told me she’s written it on his card that he doesn’t like white milk, but I have never seen that and I didn’t know it.” “He shouldn’t get it if he doesn’t like it. I’ll take care of it.”
4:20 PM Interview	Informed resident that he will not be getting white milk at breakfast. Resident says, “It doesn’t do any good.” Still appears angry. Roommate nods his head in agreement. Asked about two-day facial stubble. “Yeah, I can do it myself, but I don’t have to shave every day. My beard don’t grow fast.” Asked about nails, resident brushes it off saying, “It don’t matter. I don’t care.” Asked about activities of choice, “I’d rather sit in my room and watch TV. I don’t like those get-togethers.”
12/12/20XX	
2:10 PM Interview	DON—Asked about choices at meals—“The likes and dislikes of our residents should be evaluated, and the guest should get what he or she likes.”

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