STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. BUILDING _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY SPIRIT RETIREMENT HOME	1701 WEST 25TH STREET SIOUX CITY, IA 51103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 11/14/2019 The following deficiencies relate to investigation of mandatories #82648-M, and #85103-M, and complaint #83087-A, and facility reported incident #85410-I. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 patients. (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 requisite to continued program participation.

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F 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility policy review and interview, the facility failed to notify the Physician and the Resident Representative of a significant weight loss for 1 of 8 sampled (Resident #9). The facility reported a census of 76. Findings include: 1. The Minimum Data Set (MDS) dated 7/12/19 documented Resident #9 had diagnoses of dysphagia, hip fracture, depression, age-related osteoporosis and ataxia. Resident #9 had severe cognitive impairments.	F 580		

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F 580	Continued From page 2	F 580		

The MDS dated 7/12/19 revealed Resident #9 required extensive assistance of one staff with bed mobility, transfers, dressing and personal hygiene. Resident #9 had a significant unplanned weight loss of 5% or more in 30 days or 10% or more in 180 days and had a mechanically altered therapeutic diet.

The Care Plan dated 6/27/19 revealed Resident #9 had Speech Therapy services, 2 Cal (supplement) 80 cubic centimeters (cc) twice a day, document intakes daily, provide appetite stimulant medication and weigh every month and as needed.

The Weights and Vitals Summary sheet revealed Resident #9 weighed 103 pounds on 6/14/19 and 101 pounds 6/20/19.

The Nutritional Risk Assessment dated 6/20/19 documented Resident #9 current weight low for her but expressed she got enough to eat. The Dietitian recommended 2 Cal supplement 80 cc he resident stated her current weight is low for her but expressed she got enough to eat. The Dietitian recommended staff administer 2 Cal supplement 80 cc's three times a day.

The Weight and Vitals Summary dated 7/11/19 documented Resident #9 weighed 89 pounds.

The Progress Notes dated 7/11/19 documented Resident #9 had a severe weight loss of 12% in 30 days and again recommended staff administer 2 Cal supplement 80 cc's three times a day.

A Physician Order/FAX sheet dated 7/22/19 revealed a request for 2 Cal 80 cc's twice a day for added nutrition. The Physician responded

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F 580	Continued From page 3 "yes" on 7/23/19. The Weights and Vitals Summary sheet dated 9/2/19 documented Resident #9 weighed 86 pounds a 16.5% weight loss since admission on 6/14/19 (80 days). The Clinical Record lacked documentation to show the facility notified the Physician or Resident Representative. During an interview on 9/12/19 at 9:08 a.m., the Dietitian stated the nursing staff are responsible for Physician and Resident Representative notification for significant weight loss. She stated a copy of her weekly report is provided to the Food Service Supervisor and Director of Nurses (DON). The Dietitian reported an ongoing issue with no follow-through with her reports for quite a while. During interview on 9/12/19 at 12:38 p.m., the Resident Representative reported the facility did not inform him of the weight loss. The Change in Resident's Condition policy dated May 2008 directed the staff to promptly notify the resident, the Physician, and or representative of changes in the Resident's medical/mental condition and/or status. The Nursing Supervisor or Charge Nurse will notify the resident attending physician or on call physician when there has been a significant change in condition (physical/emotional/mental). Unless otherwise instructed by the Resident, the Nurse Supervisor/Charge Nurse will notify the Resident's Representative when there is a significant change in the Resident's physical, mental or psychosocial status.	F 580		

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file review, facility policy review and interviews, facility failed to properly screen contracted temporary staff prior to hire for 1 of 1 reviewed (Staff B) and failed to ensure employees completed the Dependent Adult Abuse Training for Mandatory Reporters for 1 of 1 sampled (Staff A). The facility reported a census of 76. Findings include: 1. According to the Temporary Staffing Agency email dated 9/25/19 at 6:10 p.m., Staff B (Nurse Aide) worked the afternoon shift at the facility on 4/7/19, 4/8/19, 4/10/19, 4/11/19, 4/12/19, 4/13/19, 4/14/19, 4/20/19 and 4/21/19. The Temporary Staffing Agency reported Staff B no longer worked for the Agency and her personnel file could not be located. The Agency failed to provide documentation to reflect Staff B had a Criminal Background Registries check and an Abuse Registry check prior to hire.	F 607		

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F 607	Continued From page 5 The Abuse, Neglect and/or Misappropriation of Resident Funds or Property and Exploitation Prohibition policy revised 11/2017 directed to completed Criminal Background checks according to state rules and federal regulations. When employing Temporary ("agency") staff the organization providing the employees will conduct the background checks. 2. The facility hired Staff A (Nurse Aide) on 3/1/19. Staff A's personnel file failed to contain documentation of the Dependent Adult Abuse Training for Mandatory Reporters. During interview on 8/30/19 at 3:40 p.m., the Director of Nurses stated she checked with Staff A's former employer and found she had not had training while employed there. The Abuse, Neglect and/or Misappropriation of Resident Funds or Property and Exploitation Prohibition policy revised 11/2017 directed to educate staff upon orientation and periodically thereafter regarding the policies concerning abuse, neglect, misappropriation of resident's funds/property, and how to handle resident-to-resident aggression and injuries of unknown source.	F 607		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		

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F 684	Continued From page 6 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility policy reviews and interviews, the facility failed to provide treatment and care in accordance with professional standards of care for 1 of 2 sampled (Resident #1). The facility reported a census of 76. Findings include: 1. The Minimum Data Set (MDS) dated 2/26/19 documented Resident #1 had diagnoses of Parkinson's disease, chronic atrial fibrillation, anemia, chronic obstructive pulmonary disorder and pulmonary hypertension. Resident #1 had severe cognitive impairments. Resident #1 required extensive assistance of 2 staff for bed mobility, transfer, dressing hygiene, toilet use, bathing and wheelchair mobility. The Care Plan dated 9/15/17 identified Resident #1 dependent on staff for all activities of daily living and directed staff to transfer Resident #1 with a sit to stand lift and move the foot platform midline for ease of transfer. The Progress Note dated 4/7/19 at 11:15 p.m., completed by Staff D, (Licensed Practical Nurse) documented at 8:45 p.m. Staff A (Nurse Aide) and Staff B (Nurse Aide) reported they attempted to transfer Resident #1 to the bed with the sit to stand lift. Staff A and Staff B had Resident #1 up in the lift when the handle on the lift stuck. Staff A and Staff B attempted to lower Resident #1 into her wheelchair. Resident #1's foot slipped off the foot platform and Staff B stood behind Resident	F 684		

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F 684	Continued From page 7	F 684		

#1 and assisted her to sit on the floor against the bed. Staff A and Staff B reported Resident #1 did not hit her head. Staff E (Registered Nurse) assessed Resident #1 and noted no injuries. Staff notified Resident #1's husband of the incident.

During interview on 8/29/19 at 2:45 p.m., Staff D (Licensed Practical Nurse) stated she consulted with Staff E (Registered Nurse), after the incident for direction as this was the first time she had an incident occur while working. Staff E told her she did not have to complete an incident report or notify the physician because staff assist the resident to the floor and did not actually fall, but she should document it in the Progress Notes and notify the family. Staff D stated that she told oncoming nurse, Staff F (Licensed Practical Nurse) what happened in report.

During interview on 8/29/19 at 11:05 p.m., Staff F (Licensed Practical Nurse) confirmed Staff D informed him Resident #1 fell from the sit to stand lift on her shift. Staff F remembered going to Resident #1's room and checking on her. Staff F did not do an assessment Resident #1 and did not document he checked on her. Staff F stated that if a resident had an incident on the previous shift the nurses do vital signs and assess the resident. Staff F stated the nurse should have completed an incident report at the time of the incident because it was an unusual occurrence. He further stated that at that time nurses documented follow-up assessments of this report every shift for 72 hours. Staff F could not recall if he reported the incident to the oncoming nurse, Staff C.

During interview on 8/23/19 at 9:15 a.m., Staff C

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F 684	Continued From page 8 (Registered Nurse) stated no one reported the incident to him he arrived at 6:00 a.m. on 4/8/19. Staff G (Nurse Aide) approached him between 7:30 a.m. 9:00 a.m. and reported Resident #1 winced when she touched her right leg. Staff C assessed Resident #1. Resident #1 had an abrasion to her right great toe but no bruising on her right leg. Staff G performed passive range of motion. Resident #1 did not wince but had decreased range of motion due to Parkinson's disease. Staff C reported her had head no signs of injury. Staff C observed the staff transfer Resident #1 with the sit to stand lift. Resident #1 had no issues on her back, buttocks or posterior legs. Resident #1 denied pain. However, Staff C noted nonverbal signs of pain while in the sit to stand lift. Staff C stated he felt like something was not right. Staff C called Resident #1's husband about her change and the husband informed him of the incident the prior evening. Staff C stated had he known she had fallen he would have handled it a bit differently and would not have gotten the resident up. He sent the resident to her primary care physician, rather than the emergency room, per her husband's request, as he was able to get an appointment in 20 minutes after he called. Staff C stated a fall is when the resident's found on the floor or assisted to the floor. The nurse on duty and required physician and family notification should have completed an incident report. A resident is to be assessed every shift for 72 hours after an incident and the actual incident report passed on every shift as at that time all follow-up assessments were documented on the incident report. A Progress Note dated 4/8/19 at 8:07 p.m., revealed Resident #1 admitted to the hospital with a femur fracture.	F 684		

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F 684	Continued From page 9 The History & Physical dated 4/8/19, revealed Resident #1 admitted to the hospital for sepsis likely from urinary tract, hypoxia, and acute fracture of the upper aspect of the right medial femoral condyle with mild-to-moderate fragment separation. The X-Ray Report dated 4/8/19 documented Resident #1 had osteopenic bones. The X-ray report of the right knee dated 4/8/19 documented the distal femur fracture just above the femoral component of knee arthroplasty, worrisome for acute fracture. The undated Falls Practice Guidelines directed the staff to complete an Incident Report/Unplanned Occurrence Report and communicate the fall to the family/guardian and attending physician. The guideline directed the staff to do the following: a.Communicate to all shifts and other health care team members that the resident has fallen, changes in resident condition should be communicated using the SBAR process. b. The Care Plan should be updated with any new interventions to prevent further falls, therapy should be notified and referral made. c. Nurse aide care card should be updated. d. documentation in the medical record should include notification of MD and responsible party. e. 72 hours documentation that includes assessment for injury, pain and effectiveness of	F 684		

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F 684	Continued From page 10 post fall intervention During interview on 9/5/19 at 5:32 p.m., the Physician stated he expected to be notified of all falls and incidents. He stated that it is plausible the resident did not exhibit signs or symptoms of injury until later but the resident should have been assessed every shift after the occurrence. He stated staff should have communicated the fall to each shift.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, reviews of manufacturer's guidelines and interviews, the facility failed to provide adequate nursing supervision and training to prevent accidents for 2 of 9 sampled (Residents #1 and #9). The facility reported a census of 76. Findings include: 1. The Minimum Data Set (MDS) dated 2/26/19, documented Resident #1 had diagnoses of Parkinson's disease, chronic atrial fibrillation, anemia, chronic obstructive pulmonary disorder and pulmonary hypertension. Resident #1 had severe cognitive impairments. Resident #1	F 689		

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F 689	Continued From page 11	F 689		

required extensive assistance of 2 staff for bed mobility, transfer, dressing hygiene, toilet use, bathing and wheelchair mobility.

The Care Plan dated 9/15/17 identified Resident #1 dependent on staff for all activities of daily living and directed staff to transfer Resident #1 with a sit to stand lift and move the foot platform midline for ease of transfer.

The Progress Note dated 4/7/19 at 11:15 p.m., completed by Staff D, (Licensed Practical Nurse) documented at 8:45 p.m., Staff A (Nurse Aide) and Staff B (Nurse Aide) reported they attempted to transfer Resident #1 to bed with a sit to stand lift. Staff A and Staff B had Resident #1 up in the lift when the handle on the lift stuck and failed to lower. Staff A and Staff B attempted to lower Resident #1 into her wheelchair. Resident #1's foot slipped off the foot platform. Staff B assisted Resident #1 to sit on the floor against the bed. Staff A and Staff B reported Resident #1 did not hit her head. Staff E (Registered Nurse) assessed Resident #1 and noted no injuries. Staff notified Resident #1's husband of the incident.

During interview on 8/21/19 at 3:40 p.m., Staff A stated that she and Staff B transferred Resident #1 from the wheelchair to bed. Resident #1's husband left the room when the staff started to transfer Resident #1. Staff A placed the lift harness behind Resident #1 and attached it to the sit to stand lift. Staff A did not fasten the safety belt of the harness around Resident #1's waist because it was "common knowledge" that her husband did not want it used. Resident #1's husband felt it was too tight around her. Staff A lifted Resident #1 up with the lift. Staff A and Staff

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B noticed Resident #1's right foot slid off behind the platform. Staff A could not position the lift near the bed or wheelchair due to Resident #1's foot. Resident #1weakened and started to slip out of the unfastened harness. Staff B positioned herself behind Resident #1 and lowered Resident #1 to a sitting position on the floor. Staff A stated the lift malfunctioned. Once extended it suddenly would not operate. Staff A did not activate the emergency stop switch. Staff A attempted to use the manual button to lower the lift but it failed. Staff A reported they were scrambling because Resident #1 weakened. Staff A stated said she did not know the lift had a safety strap/sling that could go under the resident's buttocks if they were sliding down until she received education on it after the incident.

During interview on 9/5/19 at 1:50 p.m., Staff B stated she assisted Staff A to transfer Resident #1 with the sit to stand lift without the safety harness fastened. Staff B reported Resident #1's spouse asked them on prior occasions not to fasten the safety harness. On the day of the incident, she and Staff A were getting ready to transfer the resident from the wheelchair to her bed. Her spouse had been there but left before the transfer. Staff B said she then went behind the resident's wheelchair because Staff A had the controls of the lift. She stated the EZ Stand lifted the resident to a standing position and suddenly the lift would not work and the resident's buttocks started to go down. She stated she had to do something so she moved the wheelchair and saw the resident's right foot on the back raised edge of the footrest. She stood behind the resident and she slid down her torso and legs and sat on the floor. Staff B stated the resident slid down slowly with her body supported. Staff B stated the

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F 689	Continued From page 13	F 689		

resident sat on the floor and her lower legs supported her back.

During an observation 9/5/19 at 1:50 p.m., the surveyor obtained and EZ Stand from the facility and acted as Resident #1 and requested Staff B do everything as she had done for Resident #1 on the night of the incident. Staff B placed the harness around the surveyor's back. Staff B failed to fasten the safety belt and the calf strap. When questioned why she did not fasten the safety belts, Staff B reported she thought Staff A did because she had control of the lift.

The Progress Note dated 4/8/19 at 11:37 a.m., completed by Staff C (Registered Nurse), documented Resident #1 had right leg pain when staff touched or reposition the right leg, exhibited lethargy and could not focus when spoken to. At 10:45 a.m., Resident #1's spouse transported her to a doctor's appointment.

A Progress Note dated 4/8/19 at 8:07 p.m., revealed Resident #1 admitted to the hospital with a femur fracture.

The History & Physical dated 4/8/19, revealed Resident #1 admitted to the hospital for sepsis likely from urinary tract, hypoxia, and acute fracture of the upper aspect of the right medial femoral condyle with mild-to-moderate fragment separation.

The X-Ray Report dated 4/8/19 documented Resident #1 had osteopenic bones.

The X-ray report of the right knee dated 4/8/19 documented the distal femur fracture just above the femoral component of knee arthroplasty,

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	165266	A. BUILDING _____ B. WING _____	C 10/17/2019

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F 689	Continued From page 14 worrisome for acute fracture. The EZ Way Smart Stand Manufacturer Operator's Instructions directed the following: Attach harness: 1. Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm resting 2-3 inches below the underarm. 2. For the safety of the patient, securely fasten the safety strap around the patient's torso. 3. Secure the buckle and pull the strap to tighten. Attach harness to the EZ Way Smart Stand: With the lift arm in the lowest position, attach the harness to the hooks at the end of the EZ Way Smart Stand arm using the loops at the end of the harness. Use the shortest loops when possible. To ensure the patient safety and comfort, make sure you use the same color loop on each side. Raise the patient: 1. Position the patient's arms on the outside of the harness and have tem lace their hands on the padded handles. 2. With the hand control in-hand, stand beside the patient. Verify the loops are properly hooked inside the "pigtail" at the end of the EZ Way Smart Stand arms and the Safety Catch is in place, blocking the strap from exiting the pigtail. Press the UP button, as the patient is raised, simultaneously tighten the safety strap buckled around their torso.	F 689		

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F 689	Continued From page 15 During interview on 8/23/19 at 2:45 p.m., the Maintenance Supervisor stated the emergency switch on the lift used during the incident was locked in the "up" position and would not release. He had to replace the switch. However, the manual switch that would have allowed the lift to lower slowly with minimal pressure on the lift arms was functional. He feels that it may have been a lack of training that the staff did not use it. He stated that emergency stop switches on the lift can go bad easily but all of them have the manual lowering switch. During interview on 9/4/19 at 4:21 p.m., with the Administrator present, Resident #1's Husband stated that he never instructed staff not to use the harness safety belt when using the lift to transfer his wife but he occasionally reminded staff not to place the belt directly over her PEG (feeding) tube site. During interview on 9/5/19 at 5:32 p.m., the Physician stated she had been chair-ridden for ten plus years and had "very fragile bones" that could have broken very easily without trauma. The Physician indicated he previously talked to the resident's husband about this. He stated the fracture of the femur contributed to her death but it was not a significant factor. 2. The MDS dated 7/12/19 documented Resident #9 had diagnoses of left hip fracture, age-related osteoporosis, ataxia and depression. Resident #9 had severe cognitive impairments. Resident #9 required extensive assistance of staff with bed mobility and walking, utilized a walker and a wheelchair for mobility and had 1 fall without injury.	F 689		

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F 689	Continued From page 16	F 689		

The Occupational Therapy Plan of Care dated 8/14/19, documented Resident #9 suffered a left hip fracture and right humeral fracture on 6/10/19 (prior to admission) as a result of a fall.

The Care Plan dated 6/19/19 identified Resident #9 had an actual fall with minor skin abrasion due to unsteady gait and poor safety awareness due to cognitive deficits, used antidepressant medication and required assistance with mobility due to weakness. The update on 9/6/19 directed staff to assist Resident #9 from the dining area when finished with meals and redirect attempts to stand up on own when in the wheelchair, assist to the dining area and assist with eating and then remove from the dining area to the nurse station after eating.

The Morse Fall Scale dated 6/14/19, revealed Resident #9 had a score of "90" which indicated high risk for falls.

On 9/6/19 at 2:50 p.m., Staff M (Dietary Aide) reported she observed Resident #9 in the dining room on two occasions without staff supervision when the falls occurred. Staff M stated it is a facility policy for nursing staff to supervise the dining room when occupied by residents.

An Incident Report dated 9/2/19 at 9:59 a.m., completed by Staff K (Registered Nurse), documented Dietary staff reported Resident #9 on the floor in the dining room. The Staff found Resident #9 on her back. Resident #9 had adequate range of motion and no noted injuries but resident complained of a headache in the back of her head.

An Incident Report dated 9/6/19 at 10:57 a.m.,

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F 689	Continued From page 17 completed by Staff K, documented the Staff found Resident #9 sitting on the floor in the dining room with the wheelchair at the table. Resident #9 walked 10 feet independently, became weak, and went to the floor. Resident #9 struck her upper back and back of the head on the table. During interview on 9/6/19 at 3:25 p.m., Staff K stated she had the medication cart outside the dining room. Staff K reported she could not visualize the whole dining area from the cart. Staff K prepared medications and not always attentive to the dining room activity. She stated Staff M alerted her on 9/2 and 9/6 of Resident #9's falls. Staff K reported today she was down the hall administering medications when Staff M summoned her. Staff M stated it is difficult to supervise the dining room and pass medications in a timely manner as not all residents are in the dining room at the same time. During interview on 9/6/19 at 4:55 p.m., the Director of Nurses (DON) stated she would address the dining room supervision immediately. On 9/11/19, the DON presented a copy of the dining room supervision plan implemented on 9/7/19, which directed specific staff to supervise the dining room at specific times through the day. The plan directed the staff to remain in the dining room with residents still eating.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		

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F 692	Continued From page 18 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, the facility failed to assure residents maintain acceptable parameters of nutritional status in order to prevent significant weight loss for 1 of 1 sampled (Resident #9). The facility reported a cenuss of 76. Findings include: 1. The Minimum Data Set (MDS) dated 7/12/19 documented Resident #9 had diagnoses of dysphagia, hip fracture, depression, age-related osteoporosis and ataxia. Resident #9 had severe cognitive impairments. The MDS dated 7/12/19 revealed Resident #9 required extensive assistance of one staff with bed mobility, transfers, dressing and personal hygiene. Resident #9 had a significant unplanned weight loss of 5% or more in 30 days or 10% or more in 180 days and had a mechanically altered	F 692		

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F 692	Continued From page 19 therapeutic diet. The Care Plan dated 6/27/19 revealed Resident #9 had Speech Therapy services, 2 Cal (supplement) 80 cubic centimeters (cc) twice a day, document intakes daily, provide appetite stimulant medication and weigh every month and as needed. The Weights and Vitals Summary sheet revealed Resident #9 weighed 103 pounds on 6/14/19 and 101 pounds 6/20/19. The Nutritional Risk Assessment dated 6/20/19 documented Resident #9 current weight low for her but expressed she got enough to eat. The Dietitian recommended 2 Cal supplement 80 cc he resident stated her current weight is low for her but expressed she got enough to eat. The Dietitian recommended staff administer 2 Cal supplement 80 cc's three times a day. The Weight and Vitals Summary dated 7/11/19 documented Resident #9 weighed 89 pounds. The Progress Notes dated 7/11/19 documented Resident #9 had a severe weight loss of 12% in 30 days and again recommended staff administer 2 Cal supplement 80 cc's three times a day. A Physician Order/FAX sheet dated 7/22/19 revealed a request for 2 Cal 80 cc's twice a day for added nutrition. The Physician responded "yes" on 7/23/19. Review of the Medication Administration Records (MAR's) for July, August and September, 2019 revealed the order directed staff administer 2 Cal two times a day for weight loss did not contain	F 692		

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F 692	Continued From page 20 how may cc's. The MAR for August and September documented the same order with the additional request to document the percentage the resident consumed each time administered. The amount documented in the "percentage" box ranged from "sips" to 120 ml (milliliters) unable to tell if the amounts are percentages or actual amounts administered. During interview on 9/11/19 at 4:10 p.m., Staff J (Licensed Practical Nurse) acknowledged the order does not reflect the amount of 2 Cal supplement to administer but she had been trained to give 120 ml and the order should reflect that amount. During interview on 9/11/19 at 4:15 p.m., Staff K (Registered Nurse) acknowledged the order does not reflect the amount of 2 Cal supplement to be administered but she gives the resident 120 ml because she likes it and many other residents are given 120 ml. She consistently administers 120 ml to the resident and documents either 100% or 120 ml. During interview on 9/11/19 at 4:25 p.m., Staff L (Licensed Practical Nurse) acknowledged the order does not reflect the amount of 2 Cal supplement to be administered but she thinks it is supposed to be 80 cc's. The Weights and Vitals Summary sheet documented Resident #9 weighed 86 pounds on 9/2/19 which calculated as a 16.5% weight loss since admission on 6/14/19 (80 days). Review of the resident's clinical record revealed no documentation of physician or responsible party notification of the severe weight loss.	F 692		

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F 692	Continued From page 21 During an interview on 9/12/19 at 9:08 a.m., the Dietitian stated the nursing staff are responsible for Physician and Resident Representative notification for significant weight loss. She stated a copy of her weekly report is provided to the Food Service Supervisor and Director of Nurses (DON). The Dietitian reported an ongoing issue with no follow-through with her reports for quite a while. The Dietitian reviewed the 2 Cal order on the resident's MAR's for July-September, 2019 and acknowledged the order lacks an amount to be administered she had recommended the supplement be administered TID, but the MAR reflects the facility requested an order for it to be administered 2 times a day (BID). The Nutritional Risk Assessment dated 9/12/19 documented Resident # has had a 4% weight loss per month, noted the order currently on the MAR fails to contain the amount to give to the resident and recommended the 2 Cal supplement be increased to 120 cc TID.	F 692		

Holy Spirit Retirement Home - Plan of Correction

Complaint/Facility Reported Incident Investigation

Exit Date: 10/17/19

F580

1. The physician and resident representative were notified of the weight loss of resident #9.

2. The nurse managers will review the weight loss report for all residents for Oct. and assure the physician and resident representative have been notified of significant weight changes.

3. The nurses will be re-educated on notifying the resident representative and physician of significant weight changes.

4. The nurse managers will review significant weight changes weekly for 3 months to assure the physician and resident representative have been notified. Results of these audits will be taken to QAPI for review/revision as appropriate.

5. Date of compliance: 11/14/19

F607

1. Staff A is currently not on the active staff schedule. She will complete Dependent Adult Abuse Training prior to returning to the active schedule. Background checks have been requested for the temporary CNA. The temporary CNA has not since worked in the facility.

2. Staff files will be audited to assure all staff have current Dependent Adult Abuse training within 6 months of hire and one hour refresher in 3 years and all background checks are completed prior to hire. Dependent Adult Abuse training will be completed for any staff that does not have the training per regulation. All background checks of Holy Spirit staff have been verified. The temporary agencies have been contacted and have sent proof of background check and Dependent Adult Abuse training for all of their staff being sent to Holy Spirit.

3. The new hire orientation checklist has been revised to assure Dependent Adult Abuse Training is received within 6 months of hire. The education director or designee will track this training for staff. The new hire checklist includes completion of background check. Temporary agencies have been notified that their staff may only be eligible to work at Holy Spirit if proof of background check and Dependent Adult Abuse training have been received by the HR Director or DON at Holy Spirit.

4. The Education Director or designee will do a random audit weekly x4 weeks, then monthly x 3 months to assure all new orientees receive the Dependent Adult Abuse Training per policy. The HR director or designee will do a random weekly audit of new hire files and temporary staff working at Holy Spirit to assure proof of background check is in the file x4 weeks, then monthly x3 months. Results of audits will be taken to QAPI for review/revision as appropriate.

5. Date of Compliance: 11/14/19

F684

1. Resident #1 is no longer a resident of this facility. Staff D, E and F have been re-educated on assessment and documentation following change of condition or incident.

2. Nurses will receive education on change of condition and incident follow up assessment and documentation to assure all residents receive treatment and care according to professional standards.

3. The Orientation process has been updated to enhance training on change of condition and incident assessment and documentation.

4. The DON or designee will audit 2 x weekly for documentation of assessment following change of condition or incident. Result of the audits will be taken to QAPI for review/revision as appropriate.

5. 11/14/19

F689

1. Resident #1 is no longer a resident of this facility. Resident # 9's care plan is being followed for supervision in the dining room. CNA A and B were re-educated on the proper use of the E-Z stand. Nursing staff was re-educated on responsibilities for supervision in the dining rooms at meals. All EZ stands were inspected by maintenance to confirm lifts are in proper working order.

2. All nursing staff will receive re-education on the proper use of the E-Z stand and on responsibilities for supervision in the dining rooms at meals.

3. The orientation checklist has been enhanced to include competencies on E-Z stand operation. The daily assignment sheets for nursing will include assignments for dining room supervision during meals.

4. The DON or designee will perform random E-Z stand operation audits 2x/week to assure proper operation for 4 weeks, then weekly for 4 weeks, then monthly x 3 months. The DON or designee will perform random dining room audits to assure proper supervision during meals 2x/week for w weeks, then weekly x 4 weeks, then monthly x 3. Results of audits will be taken to QAPI for review/revision as appropriate.

5. Date of Compliance: 10/30/19

F692

1. Resident #9 has currently gained weight and is no longer a weight loss. All RD recommendations for Resident #9 are being followed.

2. All residents will be reviewed for significant weight loss/gain by the DON or designee to assure RD recommendations are being followed.

3. The nurses will be re-educated on the weight policy. The IDT will meet with the RD weekly to review weight concerns and recommendations.

4. The DON or designee will do a random audit weekly to assure RD recommendations are in place to prevent significant weight loss x 3 months. Results of these audits will be taken to QAPI for review/revision as appropriate.

5. 11/14/19