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| F 000 | INITIAL COMMENTS<br><br>Correction Date _____<br><br>Investigation of complaints #88264-C, #88563-C, #91911-C, and #91913-C completed 7/14-28/20 resulted in the following deficiencies. Complaint #86563-C was not substantiated. Compliants #88264 , #91911 and #91913 were substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(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-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(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);<br>(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<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(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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(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 record review and staff interview, the facility failed to notify the resident's representative and/or physician of changes for 2 of 4 residents reviewed (Resident #1 and #2). The facility reported a census of 36 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 12/20/19, Resident #1 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required limited assistance with eating. The resident had diagnoses including Parkinson's disease.

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a. Resident #1's Progress Notes dated 12/17/19 at 7:53 p.m. documented Speech Therapy (ST) recommendations received and changed the resident's fluids from thin to honey thickened (consistency). ST observed the resident coughing/choking on liquids.

The clinical record lacked any notification of the ST recommendation to the physician or the resident's representative.

b. The Facility Weight Policy and Procedure, provided by the facility, dated 11/12/18 documented resident's weight information was recorded and calculated in Point Click Care (PCC), with significant changes reported to the physician. For resident's with body mass index (BMI) of >19 (normal range), 3% in 14 days, 5% in 30 days, 7.5% in 90 days, and 10% in 180 days.

The Resident #1's weight record documented the resident weighed:
a. 12/13/19 at 1:39 p.m. 128.6 lbs on admission.
b. 12/18/19 at 10:08 a.m. 124.4 lbs (3.2% loss in less than 1 week)
c. 12/26/19 at 8:31 a.m. 120.4 lbs (6.4% loss in 2 weeks)
d. 1/2/20 at 10:44 a.m. 114.2 lbs (11.2% weight loss 3 weeks).

The clinical record lacked documentation the facility notified the ARNP or the resident representative of the 12/18/19 or 12/26/19 significant weight losses.

The Progress Notes dated 1/2/20 at 3:30 p.m.

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documented the Power of Attorney (POA) stated the resident had lost weight since admission and did not need to lose anymore weight. New order received to change diet to regular.

A facsimile (fax) dated 1/2/20 notified the ARNP Resident #1 had an order from ST for honey nectar liquids. The POA signed a waiver stating she waved the thickened liquids. She said he lost weight and down to 114# from admit of 120#. The fax returned to change to regular diet. The fax failed to provide the correct admission weight and did not reflect the resident's significant weight losses.

During an interview on 7/14/20 at 1:35 p.m., the resident's representative stated the facility did not notify her of the diet change. The resident did not like the thickened liquids and lost weight. She said the facility did not even know how much weight the resident lost.

During an interview on 7/16/20 at 10:31 a.m., the Administrator stated the Dietician should have identified the weight loss.

2) According to the MDS assessment dated 6/17/20, Resident #2 scored 2 on the BIMS indicating severe cognitive impairment. The resident required supervision with eating. The resident had diagnoses including hip fracture.

a. The Care Plan, revised 6/19/20, identified the resident had a nutritional problem related to variable intakes at meals and nutritional needs not always being met with her lack of appetite. The interventions included to

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monitor/record/report to the physician as needed, signs and symptoms of malnutrition including significant weight loss of 3# in 1 week, >5% in 1 month, >7.5% in 3 months, and >10% in 6 months.

Resident #2's weight record documented the resident weighed:
a. 6/11/2020, 165.4 lbs on admision.
b. 6/12/2020, 164.6 lbs.
c. 6/17/2020, 163.8 lbs.
d. 6/20/2020, 158.6 lbs (a 5.2# weight loss in less than 1 week)
e. 6/23/2020, 155.8 lbs (a 5.8% loss in 2 weeks).

The clinical record lacked documentation the facility notified the physician or the resident representative of the resident's significant weight loss per direction of the resident's comprehensive care plan.

b. Skilled Charting dated 6/22/20 at 1:05 p.m. documented Resident #2 had bladder distention, when stood for commode urine ran out of the resident. The note documented the facility would notify the on-call.

The clinical record lacked any documentation the facility notified the physician of the bladder distention, or follow-up of the condition.

A Physical Therapy Daily Treatment note dated 6/23/20, documented the resident holding in urine, and unable to control bladder during movement. The physical appearance and smell of the urine suggested a urinary tract infection (UTI).

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The Progress Notes dated 6/23/20 at 1:42 p.m. documented a Nursing Note Late Entry:
Staff and therapy informed the nurse the resident had distention of the lower abdomen. When therapies got the resident up to work with her, she was dry, but when standing the resident had urine running out of her. Staff stated the urine had a foul odor and appeared very concentrated. Staff obtained a clean catch urine sample and dipped it with elevated ketones and leucocytes. Staff sent a fax to the Advanced Registered Nurse Practitioner (ARNP) for a urinalysis (UA) with culture and sensitivity (C&S) if indicated. The urine urine sample appeared dark amber and odorous.

The clinical record lacked documentation the facility notified the physician of the lower abdominal distention or follow up of the condition.

The Progress Notes dated 6/24/20 at 1:38 p.m. documented the ARNP called results from lab work with noted abnormalities and stated the resident needed to go to the emergency room (ER) for evaluation and treatment. At 3:00 p.m. the ambulance transported the resident to the ER. At 6:47 p.m. the ER reported the resident admitted to acute care with compression fracture of the lumbar vertebrae.

An Emergency Medicine report dated 6/24/20 documented a computed tamography (CT) scan of the pelvis showed prominent distention of the urinary bladder. Diagnoses included acute retention of urine. The Emergency Department (ED) course included dark urine with 2,150 cc's output on catheter placement, stool burden possibly causing urine retention.

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| F 580 | Continued From page 6<br>During an interview on 7/20/20 at 9:19 a.m. the resident's family member stated the resident was very uncomfortable and they drained over 2 liters of coffee colored urine from her bladder.<br><br>During an interview on 7/27/20 at 8:12 a.m. the resident's ARNP provider stated she found no notification from the facility of the distended bladder on 6/22/20. She said she would expect notification of a distended bladder. | F 580 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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 practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for a resident with a change in condition for 1 of 4 residents reviewed (Resident #2). The facility reported a census of 36 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) assessment, dated 6/17/20, Resident #2 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assist with toilet use. | F 684 | | |

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| F 684 | Continued From page 7 | F 684 | | |

The resident had diagnoses including hip fracture.

Skilled Charting dated 6/22/20 at 1:05 p.m. documented the resident had bladder distention, when stood for commode urine ran out of the resident. The note documented the facility would notify the on-call.

The clinical record lacked any documentation the facility notified the physician of the bladder distention, or follow-up of the condition.

A Physical Therapy Daily Treatment note dated 6/23/20 documented the resident holding in urine, and unable to control bladder during movement. The physical appearance and smell of the urine suggested a urinary tract infection (UTI).

The Progress Notes dated 6/23/20 at 1:42 p.m. documented a Nursing Note Late Entry:
Staff and therapy informed the nurse the resident had distention of the lower abdomen. When therapies got the resident up to work with her, she was dry, but when standing the resident had urine running out of her. Staff stated the urine had a foul odor and appeared very concentrated. Staff obtained a clean catch urine sample and dipped it with elevated ketones and leucocytes. Staff sent a fax to the Advanced Registered Nurse Practitioner (ARNP) for a urinalysis (UA) with culture and sensitivity (C&S) if indicated. The urine urine sample appeared dark amber and odorous.

The clinical record lacked documentation the facility notified the physician of the lower abdominal distention or follow up of the condition.

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The Progress Notes dated 6/24/20 at 1:38 p.m. documented the ARNP called results from lab work with noted abnormalities, and stated the resident needed to go to the emergency room (ER) for evaluation and treatment. At 3:00 p.m. the ambulance transported the resident to the ER. At 6:47 p.m. the ER reported the resident admitted to acute care with compression fracture of the lumbar vertebrae.

An Emergency Medicine report dated 6/24/20 documented a computed tamography (CT) scan of the pelvis showed prominent distention of the urinary bladder. Diagnoses included acute retention of urine. The Emergency Department (ED) course included dark urine with 2,150 cc's output on catheter placement, stool burden possibly causing urine retention.

During an interview on 7/15/20 at 11:15 a.m. the ARNP in the ER 6/24/20 stated if the resident had bladder distention a day or 2 before the (hospital) admission she would expect her to be monitored. She stated the resident was very uncomfortable before placement of the catheter.

During an interview on 7/15/20 at 12:45 p.m. Staff B, Licensed Practical Nurse (LPN) stated she did the skilled assessment 6/22/20. She did not see a skilled assessment on 6/23/20 or 6/24/20 (Nurse's Notes showed she worked/documented on those days). She thought the resident had 600 cc's out when she collected the urine sample 6/23/20, very dark and odorous urine. She did not know if the resident had bladder distention 6/23/20 (although she had documented report of abdominal distention) or 6/24/20.

During an interview on 7/15/20 at 1:40 p.m. Staff

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| F 684 | Continued From page 9<br>A, Certified Nursing Assistant (CNA) stated the resident held her urine, and when she did go it was really strong.<br><br>During an interview on 7/15/20 at 3:06 p.m. Staff D, CNA stated the resident had difficulty urinating.<br><br>During an interview on 7/16/20 at 9 a.m. the Physical Therapist stated she thought the resident tried to hold her urine. When she stood with her arms around her, the urine drained out of her, appeared dark (brown) and was foul smelling. She said the resident had weak abdominal and bladder muscles, and she needed to flex and give effort to urinate.<br><br>During an interview on 7/20/20 at 9:19 a.m. the resident's family member stated the resident was very uncomfortable and they drained over 2 liters of coffee colored urine from her bladder.<br><br>During an interview on 7/27/20 at 8:12 a.m. the resident's ARNP provider stated she found no notification from the facility of the distended bladder on 6/22/20. She said she would expect notification of a distended bladder. She probably would have had the facility do a straight catheter, and depending on the amount of residual, possibly left the catheter in. She said 2,150 cc's was a hefty amount of retention. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with | F 686 | | |

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professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to assure a resident without pressure ulcers did not develop pressure ulcers for 1 of 2 residents reviewed (Resident #2). The facility reported a census of 36 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 6/17/20, Resident #2 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, dressing, toilet use, and personal hygiene. The resident depended on staff for transfer.The resident had diagnoses including hip fracture. The resident had a risk for developing a pressure ulcer, but did not have a pressure ulcer. The resident did not have a turn/reposition schedule.

A hospital Discharge Summary dated 6/11/20 documented the resident was status post open reduction and internal fixation of a fracture of the right hip. The resident had impaired mobility and ADL's.

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An Admit Screener dated 6/11/20 at 12:54 p.m. documented the resident needed extensive assistance with bed mobility. The screener identified no pressure ulcers.

A Braden Scale for Predicting Pressure Sore Risk dated 6/11/20 at 2:57 p.m. identified the resident at risk for developing pressure ulcers. The risk factors included, the resident chairfast, ability to walk severely limited or non-existent, could not bear weight and/or must be assisted into a chair or wheelchair, very limited mobility, making occasional slight changes in body or extremity position independently, a problem with friction and shear requiring moderate to maximum assistance in moving, or frequently slid down in bed or chair, requiring frequent repositioning with maximum assistance.

A Baseline Care Plan dated 6/11/20 identified the resident with a pressure reduction mattress to bed and cushion. The Care Plan identified the resident needed 2 plus assist with bed mobility, but did not indicate a turn/reposition plan.

A Resident Status Sheet lacked any direction for positioning or supportive devices.

The Progress Notes dated 6/24/20 at 1:38 p.m. documented the Advanced Registered Nurse Practitioner (ARNP) called results from lab work with noted abnormalities, and stated the resident needed to go to the emergency room (ER) for evaluation and treatment. At 3:00 p.m. the ambulance transported the resident to the ER. At 6:47 p.m. the ER reported the resident admitted to acute care with compression fracture of the lumbar vertebrae.

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A hospital record dated 6/24/20 documented the resident admitted with a deep tissue injury to the right heel, appearing purple, painful, and nonblanchable.

According to the National Pressure Ulcer Advisory Panel (NPUAP) Deep Tissue Pressure Injury presents as persistent non-blanchable deep red, maroon or purple discoloration of intact or non-intact skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

During an interview on 7/15/20 at 11:15 a.m. the ARNP in the emergency room on 6/24/20 stated the pressure ulcer would have occurred at the facility due to prolonged pressure.

During an interview on 7/15/20 at 1:40 p.m. Staff A, Certified Nursing Assistant (CNA) stated the resident sat in the recliner or stayed in bed. They repositioned the resident from her back to the unaffected side. She was not sure but thought they put a pillow under her legs in the recliner and cushioned boots in bed.

During an interview on 7/15/20 at 1:55 p.m. Staff C, CNA stated she worked with the resident once. She didn't recall using pillows or heel boots for the resident.

During an interview on 7/15/20 at 3:06 p.m. Staff D, CNA stated they repositioned the resident every 2 hours from back to unaffected side. She did not think the resident had boots in her room. She said if they put a pillow under her feet and wedge between her legs she would kick them out.

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| F 686 | Continued From page 13<br><br>During an interview on 7/16/20 at 10:25 a.m. the Director of Nursing stated she thought they started heel elevators on the resident 6/22/20 when she started showing a decline. Prior to that she had a standard pressure reduction mattress on the bed. She thought the heels hung over the end of the recliner footrest. The resident had no turn schedule or specific pressure reduction interventions for the heels prior to that.<br><br>The facility undated Standard for Prevention of Pressure Ulcers, indicated to prevent the development of pressure ulcers in residents whenever possible. Prevention measures should include but not limited to assessment of risk upon admission, every week for 4 weeks and quarterly, appropriate skin and incontinent care, adequate nutrition and the addition of supplements as needed, identification of disease diagnoses and co-morbid conditions which increase risk, relief/reduction of pressure as needed, continued education of residents, families, and staff relative to the prevention of injury to the skin. Nursing care should include, but not limited to turning and repositioning at least every 2 hours, incontinent care every 2 hours and as needed, assessment of nutrition and hydration with referrals as needed, institution of measures to reduce the effects of pressure, friction, and shear. | F 686 | | |
| F 692 SS=G | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§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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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 record review and staff interview the facility failed to assure residents maintained acceptable parameters of nutritional status and sufficient fluid intake to maintain hydration for 2 of 4 residents reviewed (Resident #1 and #2). The facility reported a census of 36 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment, dated 12/20/19, Resident #1 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required limited assistance with eating. The resident had diagnoses including Parkinson's disease.

The comprehensive Care Plan identified the resident with altered nutrition. The goal included the resident would not have a significant weight loss through the next review date. The

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interventions included (12/23/19) use weighted/built up utensils as recommended by therapy, the resident chose to eat and drink food and fluids that were not honey thickened consistency, allow resident to eat at own pace, diet per physicians order, observe and document food and fluid consumption 3 times a day (TID), and report to nurse if not eating or taking fluids. Observe and provide for changing needs. Offer snacks TID, offer substitutions for foods not eaten, and family member brought in foods the resident may enjoy such as bomb pops, and cereals he enjoyed at home. Supervised table with meals, provide cues as needed (prn), and assist resident with meals as needed.

The Progress Notes dated 12/17/19 at 7:53 p.m. documented Speech Therapy (ST) recommendations received and changed the resident's fluids from thin to honey thickened (consistency). ST observed the resident coughing/choking on liquids.

The clinical record lacked any notification of the diet change to the ARNP or the resident's representative.

A Nutrition/Dietary Note dated 12/22/19 at 10:03 a.m. documented the resident had impaired swallow and assessed by ST who changed the thickness of his liquids to honey. Resident unhappy with the thickened liquids and had complaints. The Registered Dietician (RD) questioned if the resident would be a candidate for the Frazier water protocol to assist with hydration. Goal to meet nutritional needs and avoid aspiration.

A form dated 12/22/19 regarding Resident #1's

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diet included the resident needed 1,745 cc fluid daily.

The Frazier Free Water Protocol was developed with the aim of providing patients with dysphagia (difficulty swallowing) an option to consume thin (i.e. unthickened) water in-between mealtimes. A systematic review was conducted of research published in peer-reviewed journals. Allowing a patient free water decreases the risk of dehydration, increases patient compliance with swallowing precautions, improves patient quality of life.

The clinical record lacked any documentation the interdisciplinary team notified of or considered implementing the Frazier water protocol to help with the resident's hydration.

A Meals fluid report documented the resident had the following intakes:
a. 1/1/20, 1270 cc's,
b. 1/2/20, 1080 cc's,
c. 1/3/20, 960 cc's,
d. 1/4/20, 1640 cc's,
e. 1/5/20, 1080 cc's,
f. 1/6/20, 1290 cc's.
All daily fluid intakes fell below the resident's estimated needs of 1,745 cc's.

The resident's weight record documented the resident weighed:
a. 12/13/19, 128.6# on admission.
b. 12/18/19, 124.4 lbs (3.2% loss in less than 1 week).
c. 12/26/19, 120.4 lbs (a 6.4% loss in 13 days).
d. 1/2/20, 114.2 lbs (an 11.2% weight loss 3 weeks).
The record showed the resident had significant

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weight losses (per facility policy) with each weight after admission.

The clinical record lacked documentation the facility identified the significant weight losses on 12/18/19, 12/26/19 or 1/2/20.

A facsimile (fax) dated 1/2/20 notified the ARNP the resident had an order from ST for honey nectar liquids. The Power of Attorney (POA) signed a waiver stating she waved the thickened liquids. She said he lost weight and down to 114# from admit of 120. The fax returned to change to regular diet. The notification of the ST recommendation was 2 weeks after the fact. The fax failed to provide the correct admission weight and did not reflect the resident's significant weight loss.

The Progress Notes dated 1/2/20 at 3:30 p.m. documented the POA stated the resident had lost weight since admission and did not need to lose anymore weight. New order received to change diet to regular.

The Progress Notes dated 1/7/20 at 3:11 p.m. documented the resident had audible expiratory wheezes in bilateral (lung) lobes, and nebulizer treatment given. Vital signs included blood pressure 142/80, pulse 88, respirations 32, and temperature 99.2 degrees. The resident stated he felt crappy again. The Primary Care Provider (PCP) would like the resident seen in the emergency room (ER) for evaluation due to wheezing.

The Progress Notes dated 1/7/20 at 11:53 p.m. documented the resident admitted to acute level of care with a high sodium at 167. The resident

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had a chest x-ray, but unsure of the results. The resident received antibiotics, fluids, and nebulizer treatments. The resident's oxygen (O2) saturation (sat) held steady around 94% on 2 Liters per nasal cannula (NC) while remaining tachycardic (rapid pulse) and tachypneic (rapid respirations).

An Emergency Department note dated 1/7/20 identified the resident's diagnoses included hypernatremia (elevated sodium), pneumonia bilaterally, hypokalemia (low potassium), weight loss, and acute kidney injury. The resident weighed 109# (down and additional 5# from 1/2/20). The emergency department (ED) course included intravenous (IV) antibiotics and IV fluids.

A fax dated 1/8/20 (while the resident remained hospitalized) notified the ARNP the resident had a significant weight loss from admission, down 11.2%.

The Progress Notes dated 1/9/20 at 7:48 a.m. documented the resident had a significant weight loss since admission. The December weight recorded at 128.6 lbs. The January weight 114.2# down 11.2%. The resident's Power of Attorney (POA) felt the weight loss related to thickened liquids that were ordered. The diet changed to regular with regular liquids as requested by POA 1/2/20. The resident remained in acute care. They would continue to monitor.

During an interview on 7/14/20 at 1:35 p.m. the resident's representative stated the facility did not notify her of the diet change thickened liquids. The resident did not like the thickened liquids and lost weight. The facility did not even know how much weight the resident lost, and did not offer any supplements related to the weight loss.

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During an interview on 7/15/20 at 1:50 p.m. Staff A, Certified Nursing Assistant (CNA) stated the resident snacked on foods the family brought in. She said he picked at meals. She thought the resident used to graze all day when at home. She said the resident needed assistance if not finger foods and opening things.

During an interview on 7/15/20 at 3:45 p.m. the Director of Nursing (DON) stated she put out information on the Frazier water protocol. On subsequent interview on 7/16/20 at 10:31 a.m. the DON stated she found no documentation they discussed implementing the water protocol for the resident.

During an interview on 7/16/20 at 9:38 a.m. the ST stated she did not recall anyone asking her about the Frazier water protocol and had nothing in her notes about it.

During an interview on 7/16/20 at 10:31 a.m. the Administrator stated the Dietician should have identified the weight loss. The Dietician told her she didn't think the computer calculated weight loss accurately. The Administrator stated she calculated the weight loss at the same loss as the computer.

During an interview on 7/27/20 at 8:40 a.m. the Emergency Room physician stated the resident had dehydration on admit to the hospital and had lost a significant amount of weight.

The Facility Weight Policy and Procedure provided by the facility dated 11/12/18 documented resident's weight information was recorded and calculated in Point Click Care

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(PCC), with significant changes reported to the physician. For resident's with body mass index (BMI) of >19 (normal range), 3% in 14 days, 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. The Registered Dietician (RD) would assess each resident with a significant weight change, make appropriate recommendations to physicians and update the resident's plan of care

2) According to the MDS assessment, dated 6/17/20, Resident #2 scored 2 on the BIMS indicating severe cognitive impairment. The resident required supervision with eating. The resident had diagnoses including hip fracture.

The Care Plan, revised 6/19/20, identified the resident had a nutritional problem related to variable intakes at meals and nutritional needs not always being met with her lack of appetite. The interventions included monitor/record/report to physician as needed signs and symptoms of malnutrition significant weight loss of 3# in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Provide power pudding at PM snack and ice cream shake at bedtime (HS). RD to evaluate and make diet change recommendations PRN.

The Progress Notes dated 6/16/20 at 2:57 p.m. documented the resident took medication crushed in pudding, had a shower, and refused lunch. The resident very sleepy and rested quietly in the recliner in the afternoon.

A Nutrition/Dietary note dated 6/19/20 at 9:10 a.m. documented serving the resident a regular diet with cut up meat. The resident had nutritional

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risk with Alzheimer's disease, right femur fracture with an incision, and hypothyroid. The resident had Calcium 600 with vitamin D in place and appropriate for healing. The resident's appetite and fluid intake variable at meals. Planned daily snack of power pudding in the p.m. and ice cream shake at bedtime (HS) for extra nutrition. The resident refused meals 5 times since admission, proceed to care plan for nutrition to avoid significant weight change. At 9:13 a.m. the Dietician documented the resident's estimated needs of 1865 kcal, 75 g protein and 2,240 cc's fluid per day.

A Snack record showed the resident received no p.m. or HS snacks from 6/19/20 through 6/24/20.

The resident's fluid intake records at meals, with snacks, and between meals and snacks showed the following daily totals:
a. 6/15/20, 720 cc's,
b. 6/16/20, 360 cc's,
c. 6/17/20, 940 cc's,
d. 6/18/20, 420 cc's,
e. 6/19/20, 340 cc's,
f. 6/20/20, 360 cc's,
g. 6/21/20, 540 cc's,
h. 6/22/20, 170 cc's,
i. 6/23/20, 515 cc's.
All totals well below the resident's estimated daily fluid needs of 2,240 cc's.

The resident's weight record documented the resident weighed:
a. 6/11/2020 14:30 165.4 lbs
b. 6/12/2020 10:12 164.6 lbs
c. 6/17/2020 14:05 163.8 lbs
d. 6/20/2020 09:11 158.6 lbs (a 5.2# weight loss in less than 1 week)

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| F 692 | Continued From page 22<br>e. 6/23/2020 13:19 155.8 lbs ( a 5.8% loss in 2 weeks).<br><br>The Progress Notes dated 6/22/20 at 1:25 p.m. documented the resident continued with skilled nursing, pleasantly forgetful, and pleasant with staff and therapies. The resident up for meals and appetite continued poor. The resident spent a lot of time sleeping in the recliner or bed.<br><br>The Progress Notes dated 6/22/20 at 4:18 p.m. documented a return fax received from the ARNP with new orders to obtain blood for a complete metabolic panel (CMP), complete blood count (CBC), thyroid stimulating hormone (TSH), and Lipid panel on 6/24/20.<br><br>The clinical record lacked a fax to the ARNP on 6/22/20.<br><br>The Progress Notes dated 6/24/20 at 1:38 p.m. documented the ARNP called results from lab work with noted abnormality and stated the resident needed to go to the emergency room (ER) for evaluation and treatment. At 3:00 p.m. the ambulance transported the resident to the ER. At 6:47 p.m. the ER reported the resident admitted with a compression fracture of the lumbar vertebrae.<br><br>An Emergency Medicine report dated 6/24/20 documented the resident's diagnoses included acute retention of urine, compression fracture of L1 vertebrae, adult failure to thrive, hypernatremia, hypokalemia, and normocytic anemia,<br><br>During an interview on 7/15/20 at 11:15 a.m. the ARNP in the ER 6/24/20 stated the resident had | F 692 | | |

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an acute kidney injury due to dehydration. Her electrolytes were off. They gave her IV fluids overnight and assisted with eating and drinking due to weakness. She had significant weight loss from not eating.

During an interview on 7/15/20 at 12:45 p.m. Staff B, Licensed Practical Nurse (LPN) stated she thought the resident ate and drank well when assisted by staff.

During an interview on 7/15/20 at 1:40 p.m. Staff A, CNA stated the resident didn't want to eat. Sometimes she fed herself, other times she needed assist.

During an interview on 7/15/20 at 1:55 p.m. Staff C, CNA stated the resident a picky eater, but enjoyed her coffee. She said the kitchen documented fluids with meals, and CNA's documented fluids with snacks and between meals including water.

During an interview on 7/15/20 at 3:06 p.m. Staff D, CNA stated they fed the resident if needed, but she didn't eat or drink much.

During an interview on 7/16/20 at 9:58 a.m. the Administrator stated at this time the Dietician worked remotely. They had a new Dietary Supervisor and she was not yet doing all the paper work the Dietician used to do. She is in the process of getting her to do the initial intakes. She said each resident had a diet card in the kitchen with likes and dislikes, but when discharged they were wiped down with no record of it. She said they did have an e-mail from the Dietician about the resident getting a power pudding in the p.m. and an ice cream shake at

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| F 692 | Continued From page 24<br>HS. They do not have documentation she received the supplements. She said the Dietary Supervisor said they went out, but not documented given. She said they would be documented under snacks. She said she fed the resident 6/22/20 for breakfast and she didn't eat well but she drank coffee and juice which were not documented on the intake record. She stated they had documentation issues.<br><br>During an interview on 7/27/20 at 8:12 a.m. the resident's ARNP provider stated she ordered the lab work on 6/22/20 (for 6/24/20) because the resident had recent surgery. She said it was not due to a notification (fax) from the facility. | F 692 | | |