STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

(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
E 000	Initial Comments An unannounced recertification survey was conducted from 11/01/21 - 11/05/21. The facility was found to be in compliance with 42 CFR 483.73. Emergency Preparedness. Event ID# IM5911	E 000		
F 000	INITIAL COMMENTS An unannounced on-site annual recertification survey was conducted at this facility from 11/01/21 - 11/05/21. Event ID#IM5911.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		12/3/21

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

Electronically Signed | 12/02/2021

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, personal sitter, and staff interviews the facility failed to maintain dignity by not responding to the call light for a bedbound resident who required assistance with incontinence care resulting in the resident being soiled for an extended period before receiving incontinence care for 1 of 1 resident reviewed for dignity (Resident # 73). Findings included: Resident #73 was admitted to the facility on 06/08/19. Her diagnoses included neuromuscular dysfunction of bladder, diabetes and congestive heart failure. A care plan dated 06/21/21 revealed Resident #73 required assistance with activities of daily living (ADL's) related to pain and impaired mobility. The goal of care included; ADL's would be completed with staff support as appropriate to achieve the highest practical level of functioning	F 550	F 550 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) On 11/3/21, Nurse Aide # 6 with oversight by the Director of Nursing provided incontinent care to Resident # 73. On 11/30/21, resident interviews completed with all alert and oriented residents in regard to call light response time. This audit is to ensure staff respond to call lights timely to meet the needs of the resident. The Unit Managers and Assistant Director of Nursing will address all concerns identified during the audit. Audit will be completed by 11/30/21. On 11/30/21, 100% skin assessment was completed on by the Clinical Coordinators and hall nurses on non-alert residents. No areas of concern were identified. On 11/19/2021, the Director of Nursing initiated an in-service will all staff to include nurses, aides, dietary,	

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F 550	Continued From page 2 through the next review. Interventions included in part; one person to provide extensive to total assistance for incontinence of bowel and bladder. The Minimum Data Set (MDS) quarterly assessment dated 09/01/21 revealed Resident #73 was cognitively intact. She exhibited no behaviors and no rejection of care and required extensive one person assistance with bed mobility, toileting, and hygiene. She had impaired range of motion of her bilateral lower extremities. She had an external urinary catheter and was incontinent of bowel. Her skin was intact. An observation of the 100 hall on 11/03/21 at 11:45 AM revealed Resident #73's call light was on. Upon entering the room, Resident #73 who was alert and oriented stated she had a bowel movement, and she turned her call light on an hour ago around 10:45 AM and no staff had responded to the call light. The resident's private sitter was in her room and stated she had been in the room for approximately 45 minutes and the call light had been on the entire time with no staff response. On 11/03/21 at 11:50 AM the Director of Nursing (DON) and Nurse Aide #6 were notified by the surveyor of Resident #73 needing assistance with incontinence care. Nurse Aide #6 was observed entering the resident's room at that time to provide care. An interview was conducted on 11/03/21 at 1:00 PM with Nurse Aide #6. She stated Resident #73 was not on her assignment at that time and she didn't recall seeing her call light alarming for any length of time. She stated she usually responded to call lights within a few minutes.	F 550	housekeeping, activities, administrative staff, Assistant Director of Nursing, Staff Development Coordinator, Unit Mangers regarding to Responding to Call Lights. Emphasis of this in-service is on the responsibility of all staff to initiate response to any call light timely and obtaining the appropriate person to ensure resident needs met and dignity is maintained to include timely incontinence care. In-service will be completed by 12/3/21. Any staff member that has not worked and received the in-service will receive the in-service via certified mail. An enclosed letter with instructions to read and sign education and return to Director of Nursing or Staff Development Coordinator prior to the start of the next scheduled shift. All newly hired staff will be in-serviced by the Staff Facilitator during orientation in regard to answering call lights timely. The Unit Mangers, Charge Nurse, or Manger on Duty will audit 10% of all residents call lights are answered timely to include resident # 73. This audit is to ensure call lights are answered timely and ensure resident needs met and dignity is maintained to include timely incontinence care weekly x 4 weeks and then monthly x 1 month utilizing a Call Light Audit Tool. All identified areas of concern will be addressed during the audit by answering a call light and ensuring appropriate timely care is provided by the Unit Mangers, Charge Nurse, or Manger on Duty. The Director of Nursing will review and initial the Call Light Audit Tool weekly x 4 weeks and monthly x 1 month for completion and	

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F 550	Continued From page 3 A follow up interview was conducted with Resident #73 on 11/03/21 at 2:52 PM. She stated she had to wait long periods at times for staff to answer the call lights and she was bed bound and depended on staff to assist her with incontinence care. She stated she had a private sitter in her room for 4 hours each day Monday through Friday, but the sitter was not expected to provide incontinence care and stated that staff were aware that the private sitter did not provide incontinence care. She stated her skin was intact, and indicated she had no irritation, redness, or skin breakdown on her perineum or sacral area. An interview was conducted on 11/04/21 at 2:22 PM with Nurse Aide #7. She stated Resident #73 was on her assignment on 11/03/21 and stated she took her lunch break from 11:30 AM -12:00 PM and didn't recall seeing the resident's call light on before she left the floor. She stated another Nurse Aide (#6) was also on the floor to answer call lights while she was on her break and she also notified the Nurse (#5) on the floor that she was taking her lunch break. She stated when she returned from lunch the Nurse Aide (#6) told her she provided incontinence care to Resident #73, but the Nurse Aide didn't mention anything regarding the resident having to wait for an hour for someone to respond to her call light. She stated she usually answered call lights right away when they alarmed. An interview was conducted on 11/04/21 at 3:00 PM with Nurse #5. He stated he was assigned to Resident #73 on 11/03/21. He reported he did not recall seeing the call light alarming for any length of time. He stated Nurse Aide #7 did notify him that she left the floor to take her lunch break	F 550	to ensure all areas of concern have been addressed. The Social Worker will interview 10% of all alert & oriented residents to include resident # 73. This audit is to ensure call lights are answered timely and ensure resident needs met and dignity is maintained to include timely incontinence care weekly x 4 weeks and then monthly x 1 month utilizing a Call Light Interview Audit Tool. All identified areas of concern will be addressed during the audit by the Social Worker. The Director of Nursing will review and initial the Call Light Interview Audit Tool weekly x 4 weeks and monthly x 1 month for completion and to ensure all areas of concern have been addressed. The Director of Nursing will forward the results of the Call Light Audit Tool and the Call Light Interview Audit Tool the Executive QA Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 550	Continued From page 4 during that time and another Nurse Aide (#6) was on the floor that could have assisted Resident #73 with incontinence care. An interview was conducted on 11/04/21 at 3:30 PM with the DON. She indicated Resident #73 was incontinent of bowel and could voice her needs. She stated the Nurse Aide assigned to Resident #73 was on her lunch break during the time the call light was on. She stated staff should have answered the call light in a timely manner. An interview was conducted on 11/04/21 at 4:29 PM with the Administrator. He stated Resident #73 was oriented and reliable. He stated Resident #73 should not have waited for one hour to receive incontinence care and he expected staff to respond to call lights within a timely manner.	F 550		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		12/3/21

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F 656	Continued From page 5 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement a specific plan of care for nutrition to document oral intake for 4 of 9 residents observed for nutrition (Resident's #32, #44, #88 and #107) and failed to implement a plan of care for the treatment of pressure ulcers by not administering a supplement ordered by the physician for 1 of 5 resident's reviewed for pressure ulcers, Resident #88. Findings included: 1) Resident #88 was admitted to the facility on 02/07/20 with diagnoses that included	F 656	F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) Residents # 32 and # 107 no longer reside at the facility. Residents # 44 and # 88 oral intake documentation was reviewed on 11/30/21 by the Director of Nursing to ensure oral intake was accurately documented in clinical record. Resident # 88 Medication Administration Record (MAR) was reviewed and revised on 11/5/21 by the Director of Nursing for supplements ordered by the physician to include Prostat.	

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F 656	Continued From page 6 protein-calorie malnutrition, anemia, pressure ulcer left heel, and chronic kidney disease. An annual Minimum Data Set (MDS) assessment dated 10/09/21 documented Resident #88 had severely impaired cognition. She had a poor appetite on 2 to 6 of the days during the assessment period. She required supervision for eating. She had a weight loss not on a prescribed weight loss program and weighed 129 pounds. She was on a mechanically altered diet. Review of the care plan dated 10/12/21 for Resident #88 revealed the following focus areas: Restorative Nursing: requires assistance to maintain maximum function of self-sufficiency for eating related to cognitive deficit-at risk for complications. The goal was for Resident #88 to participate in the restorative feeding program. An intervention was to document meal and fluid intake for each meal. Review of the documentation for Resident #88 for amount eaten in the months of October 2021 and November 2021 revealed the percentage of meal intake was not recorded or documented for 52 meals. In an interview with the Director of Nursing (DON) on 11/04/21 at 3:45 PM she stated she would expect staff to document the percentage of each meal eaten by Resident #88. 2) Resident #88 was admitted to the facility on 02/07/20 with diagnoses that included protein-calorie malnutrition, anemia, pressure ulcer left heel, and chronic kidney disease. Resident #88 had an in-house acquired,	F 656	A 100% audit of all oral intake documentation from 11/23/21-11/29/21 was initiated on ¬¬¬12/1/21 by the Director of Nursing (DON), including oral intake documentation for residents # 44 and # 88. This audit to ensure that all oral intake is accurately documented in the clinical record. Any residents identified with areas of concerns will be addressed during the audit by the Director of Nursing, to include assessing resident and notification to the physician and staff education. This audit will be completed by 12/3/21. A 100% audit of all supplement orders was initiated on ¬¬¬11/5/21 by the DON/Wound Nurse Manager to ensure that all supplement orders were transcribed accurately and documented after administration on the Medication Administration Record (MAR) to include resident # 88. Any residents identified with areas of concerns will be addressed during the audit by the Wound Nurse Manager to include notification of the physician and updating supplement orders when indicated by 12/3/21. On 11/29/21, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants to include agency nurses and nursing assistants in regard to oral intake documentation in the clinical record. Inservice will be completed by 12/3/21. Any staff member that has not worked and received the in-service will receive the in-service via certified mail. An enclosed letter with instructions to read and sign education and return to Director of Nursing or Staff	

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F 656	Continued From page 7 unstageable pressure ulcer on her left medial foot. This ulcer developed on 09/07/21. An annual MDS assessment dated 10/09/21 documented she was dependent for toilet use and required extensive assistance for personal hygiene, dressing, transfers, and bed mobility. She had one unstageable pressure ulcer present on admission. She received pressure ulcer care, a pressure reducing device for her chair and bed, and nutrition or hydration intervention to manage skin problems. A care plan revised on 10/12/21 for Resident #88 included a focus area started on 09/07/21 of: Pressure ulcer to left foot: At risk for complications (refused foam boots). The goal was for the ulcer to not worsen through the next review. One of the interventions was to give supplements as ordered by the physician. The following physician order was written on 10/06/21 (to start on 10/07/21 at 8:00 AM): Prostat three times a day for wound healing. Give at 8:00 AM, 12:00 PM and 8:00 PM. Review of the October 2021 and November 2021 Medication Administration Records (MAR's) on 11/04/21 revealed the physician order for Prostat was not included. In an interview with the Director of Nursing (DON) on 11/04/21 at 3:45 pm she stated she would have expected the Prostat order to appear on the MAR and be administered as directed. She reviewed the MAR's for October 2021 and November 2021 and confirmed the order to give the Prostat was not included. She stated it had not appeared on the MAR for administration	F 656	Development Coordinator prior to the start of the next scheduled shift. All newly hired nurses and nursing assistants will be in-serviced during orientation by the Staff Development Coordinator in regard to oral intake documentation. On 11/29/21, the Staff Development Coordinator initiated an in-service with all nurses to include agency nurses in regard to supplement orders being transcribed accurately and correctly documented in the clinical record to populate on the Medication Administration Record (MAR). Inservice will be completed by 12/3/21. Any staff member that has not worked and received the in-service will receive the in-service via certified mail. An enclosed letter with instructions to read and sign education and return to Director of Nursing or Staff Development Coordinator prior to the start of the next scheduled shift. All newly hired nurses will be in-serviced during orientation by the Staff Development Coordinator in regard to supplement order transcription and documentation. 10% of all residents to include resident # 44 and # 88 for oral intake documentation in clinical record and physician's orders for supplements will be compared to the MAR by the ADON, Unit coordinators, and unit managers weekly x 4 weeks then monthly x 1 month utilizing the Transcription/Documentation Audit Tool. This audit is to ensure that all oral intake is correctly documented in the clinical record and orders to include supplements were transcribed accurately to the MAR and is documented on the MAR after	

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F 656	Continued From page 8 because when it was entered into the system it was classified as a supplement for dietary. She did not know why when dietary received an order for Prostat, (which is provided by nursing), they did not bring it to the attention of nursing to be entered into the system correctly to appear on the MAR for administration. In a telephone interview on 11/05/21 at 2:09 PM with Nurse #7 she stated had received the Prostat order and entered it into the system. She thought if she put the Prostat order in the computer as a supplement it would have shown up on the MAR to be given to aide in the resident's wound healing. She reported she had been taught earlier that day how to enter this type of order into the system as "other" in order for it to appear on the MAR for administration. She understood she had entered the order incorrectly and the Prostat supplement had not been given. 3. Resident #44 was originally admitted to the facility on 09/07/20 and readmitted on 09/07/21 after hospitalization due to a diagnoses of fracture to right femur. The MDS significant change assessment dated 09/14/21 revealed Resident #44 was moderately cognitively impaired and required supervision with one assist with eating. The resident ' s weight was recorded as 152 pounds (lbs.) during this assessment and she was on a mechanically altered diet and a therapeutic diet. A review of Resident #44 ' s care plan updated on 09/14/21 revealed a plan of care for state of nourishment with a goal to not display a significant weight loss through next review with	F 656	supplement is provided. The DON will review and initial the Transcription/Documentation Audit Tool weekly x 4weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Director of Nursing will present the findings of the Transcription/Documentation Audit Tools to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Transcription/Documentation Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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interventions in place to include, in part, supplements for increased nutritional needs, provide diet as ordered, and record percentage of meal intake.

An observation of Resident #44 on 11/02/21 at 10:00 AM revealed the resident received her breakfast tray. Resident #38 was noted to have juice and milk which was consumed 100% and she also consumed 100% of a bowl of cold cereal and had 75% of her oatmeal consumed which she was still eating.

An observation of Resident #44 on 11/02/21 at 1:20 PM revealed she had eaten ½ of her dinner roll, a cookie and some of her potatoes. She was drinking her soda and had water as well.

An observation of Resident #44 on 11/02/21 at 1:45 PM revealed she still had her tray in front of her, but she stated she was done. She had consumed 50 % of her meal and ½ of her dinner roll.

An observation of Nurse Aide (NA) #3 on 11/02/21 at 5:45 PM revealed NA #3 removed Resident #44 ' s lunch tray from her room which she was noted to have eaten ½ of her dinner roll, a cookie and about 50% of her meal and placed it on the dietary cart.

A review on 11/03/21 of the November Activity of Daily Living (ADL) documentation sheet for Resident #44 for amount eaten for each meal for 11/1/21 and 11/2/21 had no documentation recorded as to the percentage consumed.

An interview was conducted with NA #3 via phone on 11/05/21 at 3:22 PM. NA #3 reported part of

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the Nurse Aides ' responsibility was to document the amount of food consumed by the resident. NA #3 stated she usually worked from 7:00 AM - 7:00 PM and was responsible for documenting the intake of all 3 meals. NA #3 confirmed she had removed the lunch and dinner trays from the resident ' s room on 11/02/21, but that she did not document on the amount consumed on both 11/01/21 and 11/02/21 and stated, "That was on me, I had forgotten to chart it." The NA stated she understood the importance of documenting the resident ' s oral intake and was aware the resident was being monitored for weight loss.

An interview was conducted with the Registered Dietician (RD) on 11/03/21 at 3:52 PM. The RD reported the best way she could assess a resident ' s oral intake was to look at the amount or percentage (%) eaten or consumed by reviewing the ADL documentation sheets for each shift.

An interview was conducted with the Director of Nursing (DON) on 11/04/21 at 5:00 PM. The DON confirmed the resident had a specific care plan intervention to record the resident's intake and when she reviewed the last 3 months for the ADL documentation to include 11/01/21 and 11/02/21, she confirmed the staff were not documenting the intake each shift. The DON stated the information should be recorded as planned because this was the best indicator for the RD and the Physician to know how the resident was eating, especially if they had ordered any kind of medication to help with her appetite and to see if the medication was effective. The DON stated the staff have had been in-serviced and educated regarding documentation and the importance of it and she

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expected them to document the % of food consumed in the ADL sheets every shift.

An interview was conducted with the Nurse Practioner (NP) via phone on 11/05/21 at 2:15 PM. The NP stated she would review the ADL documentation to see how the resident was eating and if her appetite had improved. She stated more often than not the documentation was incomplete.

4) Resident #107 was admitted to the facility on 04/27/21. Her diagnoses included in part; End Stage Renal Disease, Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, and Dialysis Dependent.

A care plan dated 08/31/21 revealed Resident #107 had a plan of care in place for nutrition. The goal of care was resident would not experience dehydration through the next review. Interventions included in part: provide diet with fluid restrictions, observe for signs and symptoms of dehydration, record percentage of meal intake, monitor weights and labs, and notify the physician as needed.

Review of the meal intake documentation for Resident #107 for amount eaten from 09/01/21 - 11/04/21 revealed the percentage of meal intake was not recorded or documented for 147 meals.

The Minimum Data Set (MDS) quarterly assessment dated 10/19/21 indicated Resident #107 was cognitively intact. She exhibited no behaviors, and no rejection of care. She required supervision with one person assistance for activities of daily living and was independent with set up assistance with eating. She had no weight

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loss or gain and received a therapeutic diet. She had a Stage 3 pressure wound to her left heel. She received dialysis treatments three days a week.

An interview was conducted on 11/04/21 at 4:16 PM with Nurse Aide #6. She stated nurse aides were responsible for documenting meal intake in the electronic medical record. She indicated she didn't always remember to document meal intakes but would report to nurses if resident refused meals or if resident didn't eat well.

An interview was conducted on 11/04/21 at 5:01 PM with the Director of Nursing (DON). She stated the nurse aides were responsible for recording meal intake in the electronic medical record. She stated her expectation was for staff to follow the care plan interventions and record meal intake for Resident #107 every shift.
Example #5

Resident #32 was admitted to the facility on 08/20/21. Her diagnoses included: dementia, and Alzheimer's.

Resident #32's Admission (MDS) dated 08/27/21 revealed resident had severe cognitive impairments.

Resident #32's Care Plan dated 08/27/21 listed: Resident's state of nourishment related to diagnosis of Alzheimer's disease, and dementia. Resident was on supplements to aid with prevention of weight loss. Her nutrition interventions included: record percentage (%) of meal intake.

A review of Resident #32's Electronic Medical

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Record (EMR) amount % eaten from 09/01/21 through 11/03/21 revealed: 16-days with no entries for % meal intake for any of the 3 meals (with no explanation why % of meal intake entries were blank), 27-days with 1 or 2 entries for % meals eaten, and 22-days had all 3 meals entries for % of meal intake. EMR review from 09/01/21 through 11/03/21 revealed 43 days out of a total of 65 days reviewed had one or more daily % meal eaten entries not recorded for % of meal intake, nor found in any of the resident's medical records.

An interview on 11/02/21 at 1:15 PM with Nurse #2 revealed Resident #32's daily % meal eaten was trending down, along with her weight, which Nurse #2 felt was due to the resident's end stage dementia. Nurse #2 said it was important for nursing aides (NAs) to document resident's % meal eaten in the EMR daily, and to consistently follow her current nutritional care plan. So, the MD or Registered Dietitian (RD) would know if or when to adjust her diet, supplements, or need for additional interventions.

An interview on 11/02/21 at 3:37 PM with the Registered Dietitian (RD) revealed due to Resident #32 fluctuating weights, it was important for nursing staff to have documented the % of meals eaten, along with the % of two fortified nutritional supplements, given two times per day, and for staff to consistently document % of each meal eaten daily, and they did not.

An interview on 11/04/21 at 3:30 PM with Director of Nursing (DON) revealed it was her expectation that all of Resident #32's nutritional care plan interventions to have been followed completely, with daily % of every meal eaten documented in

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F 656	Continued From page 14 resident's EMR and was not.	F 656		
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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews, and physician interview the facility failed to follow a Physician (MD) order by not notifying the physician of a weight gain greater than 3 pounds (lbs.) in 24 hours (hrs.) and failed to obtain a reweight to verify the weight gain for 1 of 9 residents reviewed for nutrition. (Resident #82) Findings included: Resident #82 was admitted on 11/22/19. His active diagnoses included, in part, congestive heart failure (CHF), diabetes and chronic kidney disease. A physician order written to start on 06/04/21 revealed to notify MD if daily weight was 3 lbs. or greater in 24 hrs. or 5 lbs. or greater in a week. Resident #82's annual Minimum Data Set (MDS) dated 07/23/21 revealed resident had minor cognitive impairments.	F 684	F684 Quality of Care CFR(s): 483.25 Resident #82 was re-weighed on 11/3/21 by the Restorative Aide #1. Resident #82 was seen by the attending provider on 11/3/21 for weight gain greater than 3 pounds in a 24-hour period. On 11/30/21, 100% of residents current weights were initiated to be obtained to include resident # 82 weight by the Restorative Aides with oversight of the Director of Nursing. During the audit any resident identified with a 3-pound weight gain in 24 hours or 5-pound weight gain within 7 days was re-weighed for verification of weight. Any identified areas of concerns were addressed during the audit by the hall nurses to include notification to the physician as well as documentation in the clinical record. The audit will be completed by 12/3/21. On 11/29/21 a 100% in-service was initiated by the Staff Development Coordinator with all nurses and nursing	12/3/21

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F 684	Continued From page 15 Resident #82's Care Plan dated 10/22/21 listed: Resident was at risk for potential fluid volume deficit and was at risk for complications. Resident was at risk for severe kidney failure due to chronic kidney disease (CKD) with interventions to include to monitor weights and notify physician of significant change. Review of Resident #82's daily weight on 10/31/21 was 272 lbs. and his daily weight on 11/01/21 was 278 lbs. a weight gain of 6.0 lbs. in 24 hours. Resident #82's Medical Administration Record (MAR) dated 11/01/21 revealed to obtain daily weights and report weight gain greater than 3 lbs. in 24 hours or 5 lbs. in a week (started 06/04/21). Recorded weights in Resident #82's MAR dated 10/31/21 was 272 lbs. and his recorded weight on 11/01/21 recorded by Medication Aide (MA) #1 was 278 lbs. a weight gain of 6.0 lbs. in 24 hours and had been signed off as completed as evidenced by nursing initials and a check mark and recorded in the MAR for 10/31/21 and 11/01/21. An interview on 11/04/21 at 2:20 PM with Resident #82 revealed he was eating and drinking well, used his electric wheelchair to go wherever he wanted, and currently had no pain or difficulty breathing. He said his weights were being done in his electric wheelchair each time he was weighed, which was not every day, and that his wheelchair weight was written on the side of his wheelchair (159.5 lbs.). An interview on 11/03/21 at 10:45 AM with MA #1 revealed she recorded Resident #82's weight on	F 684	assistants to include agency nurses and nursing assistants with emphasis on (1) notifying the physician of a weight changes per physician orders. (2) Obtaining a re-weight for any resident with significant weight changes. (3) Documentation of weights in the clinical record. The in-service will be completed by 12/3/21. Any staff member that has not worked and received the in-service will receive the in-service via certified mail. An enclosed letter with instructions to read and sign education and return to Director of Nursing or Staff Development Coordinator prior to the start of the next scheduled shift. All newly hired nurses and nursing assistants will be in-serviced by the Staff Development Coordinator during orientation in regard to weight changes. 10% review of all residents' weights to include resident # 82 will be completed by the Clinical Coordinators, Nurse Supervisors, and Assistant Director of Nursing weekly x 4 weeks then monthly x 1 month utilizing the Weight Audit Tool. This audit is to ensure all residents with weight changes to include weight gains was re-weighed to verify weight changes and physician is notified of weight changes and notification of the physician and resident/resident representative. The Director of Nursing will review and initial the Weight Audit Tool x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will present the findings of the Weight Audit Tool to the Executive Quality Assurance (QA) committee	

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11/01/21 into their Electronic Medication Administration Record (EMAR) system and did not notice that Resident #82's entered weight value of 278 lbs. had turned red. The MA explained whenever she entered a residents' weight into their EMAR system and it turned red, this signified a significant weight change and for her to notify her nurse and then her nurse would have the resident re-weighed as well as notify the MD about resident's weight change. MA #1 said she was not aware of the MD order.

An interview on 11/03/21 at 9:06 AM with Unit Manager #1 revealed on 11/01/21, Resident #82's Medication Aide (MA) #1 should have informed her of Resident #82's 6 lb. weight gain so she could have notified their MD and have the resident reweighed per facility's weight policy.

An interview on 11/02/21 at 3:37 PM with the Registered Dietitian (RD) revealed Resident #82 had daily weights for CHF and it was important to follow the resident's weights and fluids. The RD said after she was shown Resident #82's documented 24-hour 6 lb. weight gain on 11/01/21 and an MD order to be notified if the resident gained greater than 3 lbs. or more in 24 hours, then she would have expected for the Unit Manager to call the MD and document it in the nurses progress notes.

An interview on 11/04/21 at 3:30 PM with the Director of Nursing (DON) revealed it was her expectation that on 11/01/21 Resident #82's MD should have been notified of resident's 6 lb. weight gain per the physician's order.

An interview on 11/02/21 at 4:25 PM with MD revealed this was the first time he had heard of

monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Weight Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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F 684	Continued From page 17 Resident #82's six-pound weight gain on 11/01/21, and that no staff had reported to him any weight concerns including Resident #82's 24-hour weight gain from 10/31/21 thru 11/01/21. MD revealed he expected to be notified if Resident #82's daily weights were greater than 3 lbs. in one day or 5 lbs. in a week related to resident having a diagnosis of CHF. MD said he was not made aware or notified by nursing staff of resident's 6 lb. weight gain from 10/31/21-11/01/21 and should have been. MD stated the nursing staff should have also verified the 11/01/21 weight gain by doing a reweight and did not. MD said Resident #82's 6 lb. weight on 11/01/21 had no health outcome, but he still expected to have been notified for possible treatment.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with 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, observation and staff interviews the facility failed to follow a physician	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	12/3/21

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F 686	Continued From page 18 order to administer a supplement (Prostat) three times a day to promote wound healing for 1 of 4 residents reviewed for pressure ulcer care, Resident #88. Findings included: Resident #88 was admitted to the facility on 02/07/20. Her diagnoses included, in part: Stage 3 pressure ulcer on the left medial foot in-house acquired, protein-calorie malnutrition, anemia, and chronic kidney disease. An annual MDS (Minimum Data Set) assessment dated 10/09/21 documented Resident #88 had severely impaired cognition. She had a poor appetite on 2 to 6 days and rejected care on 4 to 6 days during the assessment period. Her behaviors had worsened compared to the prior assessment. She was dependent for toilet use and required extensive assistance for personal hygiene, dressing, transfers and bed mobility. She required supervision for eating and locomotion. She was always incontinent of bladder and occasionally incontinent of bowel. She weighed 129 pounds and had a weight loss. She was on a mechanically altered diet. She had one unstageable pressure ulcer present on admission. She received pressure ulcer care, a pressure reducing device for her chair and bed, and nutrition or hydration intervention to manage skin problems. A care plan revised on 10/12/21 for Resident #88 included a focus area started on 09/07/21 of: Pressure ulcer to left foot: At risk for complications (refused foam boots). The goal was for the ulcer to not worsen through the next review. One of the interventions was to give	F 686	Resident # 88 Medication Administration Record (MAR) was reviewed and revised on 11/4/21 by the Director of Nursing for supplements ordered by the physician to include Prostat. A 100% audit of all supplement orders was initiated on 11/5/21 by the Director of Nursing, Wound care Manager and registered dietitian to ensure that all supplement orders were transcribed accurately and documented after administration on the Medication Administration Record (MAR) to include resident # 88. Any residents identified with areas of concerns will be addressed during the audit by the registered dietitian, and wound care nurse manager to include notification of the physician and updating supplement orders when indicated by 12/3/21. 100% of current residents with wounds to include resident #88, wounds were physically assessed with measurements obtained and documented in the electronic medical records by the Treatment Nurse. The purpose of the audit is to observe for any deterioration of wounds and evaluate the effectiveness of the current treatment plan. The physician will be notified for any changes by the Treatment Nurse, Clinical Coordinator, or Assistant Director of Nursing during the audit for any identified areas of concern. Audit will be completed by 12/3/21. On 11/29/21, the Staff Development Coordinator initiated an in-service with all nurses to include agency nurses in regard to supplement orders being transcribed accurately and correctly documented in	

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F 686	Continued From page 19 supplements as ordered by the physician. The following physician order was written on 10/06/21 (to start on 10/07/21 at 8:00 AM): Prostat three times a day for wound healing. Give at 8:00 AM, 12:00 PM and 8:00 PM. Review of the October 2021 and November 2021 Medication Administration Records (MAR's) on 11/04/21 revealed the physician order for Prostat was not included. Review of the weekly wound assessment flow sheets revealed the Stage 3 pressure ulcer on her left medial foot measured 1.0 CM (Centimeters) x 0.8 CM x 0 CM on 09/16/21 and 0.7 CM x 0.7 CM x 0 CM on 10/28/21. All measurements were taken length x width x depth. The wound had improved. An observation of wound care for Resident #88 was made on 11/04/21 at 2:30 PM. The wound care nurse washed her hands before removing the old bandage from the left medial foot. There was no visible exudate on the old bandage. The nurse removed her gloves after removing the old dressing and washed her hands. After donning new gloves, she cleansed the wound using a 4 x 4 gauze pad soaked with normal saline. Medihoney was applied to the wound and covered with Polymem sliver and a dry border dressing. The base of the wound had presented with a yellow slough. In an interview with the Director of Nursing (DON) on 11/04/21 at 3:45 pm she stated she would have expected the Prostat order to appear on the MAR and be administered as directed. She reviewed the MAR's for October 2021 and	F 686	the clinical record to populate on the Medication Administration Record (MAR). Inservice will be completed by 12/3/21. Any staff member that has not worked and received the in-service will receive the in-service via certified mail. An enclosed letter with instructions to read and sign education and return to Director of Nursing or Staff Development Coordinator prior to the start of the next scheduled shift. All newly hired nurses will be in-serviced during orientation by the Staff Development Coordinator in regard to supplement order transcription and documentation. 10% of all residents to include resident # 88 for physician's orders for supplements will be compared to the MAR by the Unit Coordinators, and Assistant director of nursing weekly x 4 weeks then monthly x 1 month utilizing the Transcription/Documentation Audit Tool. This audit is to ensure that all supplements were transcribed accurately to the MAR and is documented on the MAR after supplement is provided. The Director of Nursing will review and initial the Transcription/Documentation Audit Tool weekly x 4weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Director of Nursing will present the findings of the Transcription/Documentation Audit Tools to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Transcription/Documentation Audit Tool to	

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F 686	Continued From page 20 November 2021 and confirmed the order to give the Prostat was not included. She stated it had not appeared on the MAR for administration because when it was entered into the system it was classified as a supplement for dietary. She did not know why when dietary received an order for Prostat, (which is provided by nursing), they did not bring it to the attention of nursing to be entered into the system correctly to appear on the MAR for administration. She stated she would correct the error. At 4:30 PM she provided documentation showing the order had been fixed in the system and would begin to appear on the MAR for administration: Prostat 30 ML (Millileters) three times a day for wound healing. In a telephone interview on 11/05/21 at 2:09 PM with Nurse #7 she stated had received the Prostat order and entered it into the system. She thought if she put the Prostat order in the computer as a supplement it would have shown up on the MAR to be given to aide in the resident's wound healing. She reported she had been taught earlier that day how to enter this type of order into the system as "other" in order for it to appear on the MAR for administration. She understood she had entered the order incorrectly and the Prostat supplement had not been given.	F 686	determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 692 SS=E	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 comprehensive assessment, the facility must ensure that a resident-	F 692		12/3/21

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F 692	Continued From page 21 §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 observations, record review, staff, Nurse Practitioner (NP), Registered Dietician (RD), and Physician (MD) interviews, the facility failed to provide two nutritional supplements as recommended for a resident with weight loss (Resident #44) and failed to complete weekly weights as ordered for 2 of 9 residents reviewed for nutrition (Resident #44 and #32). Findings included: 1a Resident #44 was originally admitted to the facility on 09/07/20 and readmitted on 09/07/21 after hospitalization due to a diagnoses of fracture to right femur. Review of the Registered Dietician (RD) recommendations revealed on 09/07/21 the RD recommended fortified ice cream nutritional supplement 90 ml (milliliters) two times a day for prevention of weight loss with lunch and dinner tray.	F 692	F692 Nutrition/ Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) F692 Nutrition/ Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) On 11/3/21, fortified shakes with all meals and fortified ice cream with lunch and dinner orders for resident #44 was corrected in Electronic Record under the appropriate category by the Floor Nurse working the resident #44 assignment. On 11/3/21 a dietary slip was completed and provided to the Dietary Manger to ensure supplements were served on meal tray. Resident #32 no longer resides in the facility. Resident #44 and # 32 was re-weighed on 11/3/21 by the Restorative Aide. Resident #44 was seen by the attending physician 12/2/21 for weight changes related to inconsistent weight monitoring. A 100% audit of all supplement orders was initiated on ¬¬¬11/5/21 by the	

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F 692	Continued From page 22 The Minimum Data Set (MDS) significant change assessment dated 09/14/21 revealed the resident was moderately cognitively impaired and required supervision with one assist with eating. The resident ' s weight was recorded as 152 pounds (lbs.) during this assessment and she was on a mechanically altered diet and a therapeutic diet. A review of Resident #44 ' s care plan updated on 09/14/21 revealed a plan of care for state of nourishment with a goal to not display a significant weight loss through next review with interventions in place to include supplements for increased nutritional needs, provide diet as ordered, record percentage of meal intake, refer to dietician for evaluation and recommendations, set up tray and encourage consumption of meal, and obtain weights per facility protocol. A review of the weight recordings for Resident #44 revealed the resident ' s weight was 152 lbs. before being sent to the hospital on 09/05/21, on 09/08/21 weight was 152 lbs., on 09/30/21 weight was 140 lbs., on 10/06/21 weight was 141 lbs., and the weight on 10/20/21 was 140 lbs. Progress note written on 10/19/21 by the RD read, in part, resident being monitored for high risk related to recent significant weight loss trigger of 11 lbs. in one month. PO (oral) intakes are variable on therapeutic diet 24-50%. Continues with fortified ice cream supplement with lunch and dinner trays and recently started an appetite stimulant medication on 10/12/21 to aid with appetite and oral intake. Recommendations included to continue with appetite stimulant medication to see if meal intakes improve and will recommend adding supplement fortified shakes with all meals to aid	F 692	Director of Nursing, and the Wound Care Nurse to ensure that all supplement orders were transcribed accurately and documented after administration on point of care task and dietary slips were completed as indication to include resident # 44. Any residents identified with areas of concerns will be addressed during the audit by the Director of Nursing to include notification of the physician and updating supplement orders when indicated by 12/3/21. On 12/1/21, 100% of residents current weights were obtained to include residents # 44 weight by the Restorative Aides with oversight of the Director of Nursing. During the audit any resident identified with a 5% weight changes over 30 days and 10% weight changes over 180 days was re-weighed for verification of weight. Any identified areas of concerns were addressed during the audit by the hall nurses to include notification to the physician as well as documentation in the clinical record. The audit will be completed by 12/3/21. On 11/29/21, the Staff Development Coordinator initiated an in-service with all nurses to include agency nurses in regard to supplement orders being transcribed accurately and correctly documented in the clinical record to populate in the electronic record. All dietary supplements require a dietary slip to be completed and provided to the Dietary department to ensure supplements are provide on meal trays as prescribed. Inservice will be completed by 12/3/21. Any staff member that has not worked and received the	

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F 692	Continued From page 23 with prevention of weight loss. Review of the RD recommendations revealed on 10/19/21 the RD recommended fortified shakes nutritional supplement with all meals to aid with prevention of weight loss. An observation of Resident #44 on 11/02/21 at 10:00 AM revealed the resident received her breakfast tray with the dietary ticket (a dietary description of what the resident should receive on her meal trays). The dietary ticket did not indicate the resident was to receive fortified shakes with all meals. There were no nutritional supplements added to her tray. An observation of Resident #44 on 11/02/21 at 12:55 PM revealed the resident received her lunch tray with the dietary ticket. The dietary ticket did not indicate the resident was to receive fortified shakes with all meals or fortified ice cream with lunch and dinner. The lunch tray did not have either one of these nutritional supplements on the tray. An observation of Resident #44 on 11/02/21 at 1:20 PM revealed she had eaten ½ of her dinner roll, the cookie and some of her potatoes. She was drinking her soda and had water as well. There were no nutritional supplements added to her tray. An observation of Resident #44 on 11/02/21 at 1:45 PM revealed she still had her tray in front of her and had consumed 50 % of her meal and ½ of her dinner roll. There were no nutritional supplements added to her tray. An observation of Resident #44 at 6:00 PM	F 692	in-service will receive the in-service via certified mail. An enclosed letter with instructions to read and sign education and return to Director of Nursing or Staff Development Coordinator prior to the start of the next scheduled shift. All newly hired nurses will be in-serviced during orientation by the Staff Development Coordinator in regard to supplement order transcription and documentation. On 11/29/21 a 100% in-service was initiated by the Staff Development Coordinator with all nurses and nursing assistants to include agency nurses and nursing assistants with emphasis on (1) notifying the physician of a weight changes per physician orders. (2) Obtaining a re-weight for any resident with significant weight changes. (3) Documentation of weights in the clinical record. (4) Obtaining weekly weights as ordered. (5) If weight cannot be obtained by assigned staff members, then the responsibility is defaulted to the hall nurse. The in-service will be completed by 12/3/21. Any staff member that has not worked and received the in-service will receive the in-service via certified mail. An enclosed letter with instructions to read and sign education and return to Director of Nursing or Staff Development Coordinator prior to the start of the next scheduled shift. All newly hired nurses and nursing assistants will be in-serviced by the Staff Development Coordinator during orientation in regard to weight changes. 10% of all residents to include resident # 44 physician's orders for supplements will	

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F 692	Continued From page 24 revealed the resident had received her dinner tray with the dietary ticket which did not indicate the resident was to receive fortified shakes or fortified ice cream. The dinner tray did not have either one of these nutritional supplements on the tray. An observation of Resident #44 on 11/03/21 at 9:00 AM revealed the resident received her breakfast tray with the dietary ticket. The dietary ticket did not indicate the resident was to receive fortified shakes with all meals. The breakfast tray did not have the fortified shake supplement on the tray. An interview was conducted with Nurse Aide (NA) #5 on 11/03/21 at 9:00 AM . NA #5 stated if a resident were to receive fortified shakes or fortified ice cream the supplements would be on their trays when they arrived from the kitchen. NA #5 stated she did not recall Resident #44 having either one of these supplements on her tray. NA #5 stated Resident #44 ate slowly but she usually ate 75% of her food and 100% of her fluids. An interview was conducted with the Dietary Manager (DM) on 11/03/21 at 10:40 AM. The DM stated whenever supplements were added to the resident ' s meal trays, the RD would put the recommendation in the system, or the NP or Physician would put the order in the system and the nurses would write a dietary notification slip and give it to her to put the supplements in place. The DM stated she kept a log of all residents who received supplements which she provided. The list did not include that Resident #44 was to receive fortified shakes with all meals or fortified ice cream with lunch and dinner. The DM reviewed the resident ' s dietary ticket and it did not include either supplement to be delivered.	F 692	be compared to the electronic record and the meal trays by the Assistant Director of Nursing, Unit Coordinators weekly x 4 weeks then monthly x 1 month utilizing the Transcription/Documentation Audit Tool. This audit is to ensure that all orders to include supplements were transcribed accurately to the electronic record, dietary slips are completed, and dietary supplements are provided as prescribed on the meal tray to include documented in the clinical record after supplement is consumed. The Director of Nursing will review and initial the Transcription/Documentation Audit Tool weekly x 4weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. 10% review of all residents' weights to include # 44 and residents with weight changes to include 5% weight changes over 30 days and 10% weight changes over 180 days was re-weighed for verification of weight and notification of the physician and resident/resident representative. The Director of Nursing will review and initial the Weight Audit Tool x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will present the findings of the Transcription/Documentation Audit Tools and Weight Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Transcription/Documentation Audit Tool and Weight Audit Tool to determine trends	

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The DM reported she had no knowledge of Resident #44 supposed to be receiving these supplements.

An interview was conducted with the RD on 11/03/21 at 3:52 PM. The RD stated she implemented supplements if a resident ' s oral intake was not where it needed to be or if they had a weight loss. The RD stated Resident #44 had a significant weight loss so she implemented the fortified shakes for all meals and the fortified ice cream which had more protein. The RD stated she recommended the fortified ice cream on 09/07/21 and the fortified shakes on 10/19/21. She stated once she put the recommendations in the EMAR (electronic medical administration record), the nurse confirmed the recommendation, and they would write a diet slip to notify the Dietary Manager. She stated since she had put the recommendation in she assumed nursing would notify the Dietary Manager. The RD stated she did not know the resident had not been receiving the fortified shakes or the fortified ice cream.

An interview was conducted with Nurse #6 on 11/04/21 at 9:30 AM. Nurse #6 reviewed the recommendations in the EMAR and reported the recommendations had been put in by the RD. She stated the process was: once the recommendation was put in the EMAR, the nurses confirmed the recommendation and then wrote out a dietary slip to be given to the Dietary Manager. Nurse #6 stated the dietary slips were kept in a box at the nurse ' s station. Nurse #6 looked through the box for the dietary order of fortified shakes and fortified ice cream for Resident #44 and stated there was no slip. Nurse #6 stated they kept a copy of the slip in this

and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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box and the DM got the original. Nurse #6 stated the recommendations for the supplements were confirmed in the EMAR, but the nurses (Nurse #2 and Nurse #6) did not complete a dietary slip to be given to the DM.

An interview was conducted with Nurse #2 via phone on 11/05/21 at 3:27 PM. Nurse #2 stated she had been the nurse to confirm the recommendation for the fortified ice cream in the EMAR on 09/07/21. Nurse #2 stated she thought the RD would be responsible for completing the dietary slip for the Dietary Manager. Nurse #2 stated she was not aware Resident #44 had not been receiving her supplements but added she had been eating better since she was started on the appetite stimulant.

An interview was conducted with the Director of Nursing (DON) on 11/04/21 at 5:00 PM. The DON confirmed the recommendations were put in the EMAR system and were confirmed by the nurses, but they failed to complete the dietary slip to inform the DM to add the supplement to Resident #44 ' s meal trays as ordered. The DON added when the recommendations were put into the EMAR it was put under "dietary" which would have made the supplements appear on the Activity of Daily Living (ADL) task which the nurse aides used to record oral intake each day and each shift. The DON could not explain why the supplements were not appearing on the ADL sheets so that the Nurse Aides could document the consumption.

An interview was conducted with the Nurse Practioner (NP) via phone on 11/05/21 at 2:15 PM. The NP stated she reviewed the weights during her routine visits and looked for trends of

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losing or gaining weight. She stated she saw the recommendations for the supplements for Resident #44 but did not realize the resident was not receiving them. The NP stated Resident #44 was also started on an appetite stimulant medication and she had been eating better per the nurses and the nurse aides.

1b. Review of the Nurse Practioner (NP) order written on 09/08/21 revealed a weekly weight order starting on 09/08/21 for 4 weeks.

A review of the September Medication Administration Record (MAR) revealed a weight was obtained on 09/08/21 and recorded as 152 lbs., the weight on 09/15/21 and 09/22/21 had a number "9" recorded, but no weight was documented and there was no weight recorded under 09/29/21.

An interview was conducted with NA #2 on 11/03/21 at 11:00 AM who reported she obtained a weight for Resident #44 today via wheelchair scale and her weight was 139 lbs. NA #2 stated she also worked as a Restorative Aide (RA) when she was not a NA, and as a RA, she was responsible for obtaining the residents daily and weekly weights. NA #2 stated at times the RAs were both re-assigned to the floor as NAs, leaving the responsibility of weights to fall back on the residents ' nurse or NA to obtain and document the weight.

An interview was conducted with Nurse #6 on 11/04/21 at 9:00 AM. Nurse #6 stated she recorded "9" in the MAR which indicated the weight was not obtained and there was a nursing note. In reviewing the nursing notes on 09/15/21 and 09/22/21, the notes indicated the Restorative

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Aides (RA) were not able to obtain the weights due to being reassigned. Nurse #6 stated when the RAs were on the floor, they usually obtained the daily and weekly weights. Nurse #6 stated that she supposed the nurse or the nurse aide could have obtained the weight on those days and should have carried out the order even though the RAs were not available.

Review of the NP order written on 10/06/21 revealed weekly weights every day shift every Wednesday for 2 months. On 10/12/21, an NP order was written for appetite stimulant medication 7.5 milligrams (mg) to be given at night daily.

Review of the October MAR revealed the weights were obtained on 10/06/21 and recorded as 141 lbs., and on 10/20/21 it was recorded as 140 lbs., but the weights on 10/13/21 and 10/27/21 were recorded as "NA."

An interview with Nurse #2 on 11/02/21 at 12:17 PM revealed "NA" meant non applicable and added if a resident was not available at the time when the nurse aide was trying to obtain the weight, she would document "NA." Nurse #2 stated sometimes it was difficult getting the resident to the scale due to timing on the resident ' s part. Nurse #2 stated she would document NA and notify the oncoming shift that she did not obtain the weight. Nurse #2 stated she should have obtained the weight because it was physician ordered and she was being monitored for weight loss.

An interview was conducted with the RD on 11/03/21 at 3:52 PM. The RD stated she reviewed the weights of all the residents all the

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time. She stated she was aware there were orders for Resident #44 to have weekly weights and noticed there were gaps in the weight recordings indicating missing weights. The RD stated she expected the nursing staff to obtain the weights as ordered especially since the resident was being monitored for weight loss and was supposed to be getting supplements to help her gain the weight back. The RD stated the staff needed to be more consistent with how they weigh the residents as well and should use the same equipment each time to ensure the accuracy of the weights, and added, if a discrepancy was noted, the staff should reweigh the resident to ensure the accuracy of the weight.

An interview with the DON on 11/04/21 at 5:00 PM revealed that although the RAs were not available to obtain the weights on 09/15/21 and 09/22/21, the nurse or nurse aide should have obtained the resident ' s weight as ordered on those days. The DON stated it was not the sole responsibility of the RAs to get the daily and weekly weights. The DON also stated that "NA" was not an acceptable abbreviation to use and the weight should have been obtained as ordered.

An interview was conducted with the NP via phone on 11/05/21 at 2:15 PM. The NP stated she ordered the weekly weights in September when Resident #38 returned from the hospital because residents can be at high risk for weight loss after being hospitalized and a weight loss may happen. The NP stated she would have expected the nurse or nurse aide to obtain the weights as ordered. The NP stated she had implemented the order for weekly weights for 2 months on 10/06/21 because Resident #44 was

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losing weight, had symptoms of poor appetite and she was started on the appetite stimulant medication. The NP stated she wanted to see how well she was responding to the medication by obtaining weekly weights. The NP stated, as a provider, if she put an order in she would expect it to get done, and if it was not done, she would expect an explanation as to why.
Example #2

Resident #32 was admitted to the facility on 08/20/21. Her diagnoses included: dementia, and Alzheimer's.

Resident #32's (MDS) dated 08/27/21 revealed resident had severe cognitive impairments.

Resident #32's Care Plan dated 08/27/21 listed: Resident's state of nourishment related to diagnosis of Alzheimer's disease, and dementia. Resident was on supplements to aid with prevention of weight loss. Her nutrition interventions included: record percentage of meal intake, and monitor weights.

Resident #32's wheelchair weights listed: 08/23/21 - 120 lbs., 09/02/21 - 118 lbs., 09/15/21 - 109 lbs., 10/05/21-109 lbs., 10/13/21-105 lbs., and 10/20/21 - 107 lbs.

Physician orders for November/2021 listed: Weekly weight every Wednesday for 2 months to start 09/29/21, Remeron medication for appetite stimulation, and two fortified nutritional supplements two times per day.

A review of Resident #32's Electronic Medical Record (EMR) physician order (MD) for weekly weight (every Wednesday for 2-months) starting

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09/29/21, revealed 2 of the last 6 Wednesday weights were not done per MD order (Wednesday 09/29/21 and Wednesday 10/20/21), nor found in any of the resident's medical records.

A physician note dated 10/25/21 for Resident #32 revealed surveillance of resident with advanced dementia and decreased appetite. Continue weekly weights, continue Remeron, and continue dietary supplements.

An interview on 11/02/21 at 3:37 PM with the Registered Dietitian (RD) revealed Resident #32 had weekly weights on 09/02/21-118 lbs., 09/15/21-109 lbs., 10/05/21-109 lbs., and 10/20/21- 107 lbs. did not make sense to her when she reviewed them in the resident's EMR. RD said due to the resident's fluctuating weights the facility's staff should have re-weighed the resident to verify her greater than 5% weight loss from 09/02/21 through 09/15/21 and did not. RD also revealed Resident #32's weekly weights (every Wednesday) were not completed per MD order for the weeks of 09/29/21 and 10/20/21 and should have.

An interview on 11/03/21 at 8:40 AM with (NA) #1 & NA #2 revealed they were also the only two (RAs) in the facility and were responsible for doing residents weights, including Resident #32's weekly weights, and then entered those weights into residents EMR. NA #1 & #2 both said, if a weekly or daily weight value was left blank in the resident's EMR or on the weekly weight sheet, it was because they (RA's) were both re-assigned to the floor as NAs, leaving the responsibility of weights to fall back on the residents' nurse or NA to do and document the weight. RA's said if resident's weekly EMR weight was left blank, then

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F 692	Continued From page 32 the weight was most likely not done by the nurse or NA, since the two RAs were pulled to the floor, and were not there to do it. RAs further clarified that they only do weights, and do not know when it was necessary to do a re-weight, because they could only enter that day's weight into the computer and did not have access to any of the resident's previous weights or physician orders. Both RAs said it was the nurse's responsibility to ask for a re-weight, not them. An interview on 11/03/21 at 9:06 AM with Unit Manager #1 revealed Resident #32's weekly weights (on Wednesday) were not done every week per MD order or entered in the resident's EMR for the weeks of 09/29/21 and 10/20/21 by either the RAs or nurse assigned to the resident and should have. Facility's weight policy dated 08/2012 read in part, when weight changes occur, the frequency of weight monitoring will be specified as the resident's condition warrants. As directed by the physician. And if significant gain occurs (5% in 30 days, 10% in 180 days, or a total gradual weight loss or significant gain occurs), the following steps will be taken: Resident will be re-weighed as indication, and physician will be notified for possible interventions as appropriate. An interview on 11/04/21 at 3:30 PM with Director of Nursing (DON) revealed Resident #32's weekly weights (on Wednesday) were not done every week per MD order for the weeks of 09/29/21 and 10/20/21 and should have.	F 692		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility	F 886		12/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING _____ B. WING _____	11/05/2021

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F 886	Continued From page 33	F 886		

must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:

§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not
limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with
COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of

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F 886	Continued From page 34 each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to follow their policy and procedures and the CMS (Centers for Medicare and Medicaid Services) Interim Final Rule (IFC), CMS-3401-IFC, by not wearing full PPE (Personal Protective Equipment) when collecting specimens from 2 of 2 staff members observed during specimen collection for COVID 19 testing. This failure occurred during the COVID 19 pandemic. Findings included: The facility policy "Guidelines for Point of Care (POC) Antigen Testing" under "Safety Precautions for Testing" dictated: "Proper infection Control measures must be followed to	F 886	F886 COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) On 11/3/21 Infection Control Preventionist was in-serviced on proper infection control measures to include full personal protective equipment during specimen collection for covid -19 testing. Proper collection personal protective equipment and handling which includes KN-95/N 95, eye protection, gloves, and gown. In-Servicing was completed by the Director of Nursing. On 11/30/21, the Director of Nursing initiated an audit with return demonstration with Infection Control Preventionist and Staff Development Coordinator to ensure that as designated	

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F 886	Continued From page 35 include use of FULL Personal Protective Equipment during specimen collection and handling which includes a KN-95/N-95 (or face mask, if a respirator is not available), eye protection, gloves and a gown." This policy was revised on 10/01/2020. An observation of the facility Admission Coordinator being tested for COVID 19 by the facility Infection Control Preventionist on 11/03/21 at 2:10 revealed the Infection Control Preventionist washed her hands and donned a mask and gloves prior to collecting the specimen for a rapid COVID 19 test. She explained she did not wear her goggles because they "fogged up" and she never wore a gown when administering COVID 19 tests. A second observation was made on 11/03/21 at 2:25 PM. The Infection Control Preventionist was observed administering a COVID 19 test to Dietary Aide #1. The Infection Control Preventionist donned a mask, gloves and goggles prior to collecting the specimen to send to the laboratory. She pointed out at the conclusion of the test that her goggles had fogged up. She did not wear a gown. In an interview with the facility Administrator on 11/03/21 at 4:10 PM he stated he expected anyone administering a COVID 19 test to wear full PPE for infection control purposes according to the facility policy and procedures. He reported he had not been aware the Infection Control Preventionist had not been wearing full PPE when she collected specimens for COVID 19 testing.	F 886	staff that perform covid 19 specimen collection wear appropriate PPE while obtaining specimens. Personal protective equipment required during specimen collection include donning KN-95/N 95, eye protection, gloves, and gown prior to obtaining specimen. The Director of Nursing will address all concerns identified during the audit to include education of the staff. Audit will be completed by 12/3/21. On 11/30/21, the Director of Nursing completed a 100% audit of all covid 19 specimen collections completed. This audit is to ensure that appropriate personal protective equipment is donned prior to specimen collection. The Director of Nursing will address all identified areas of concern during the audit to include prohibiting the specimen collection and re-education of staff during the audit. On 11/29/21, the Staff Development Coordinator initiated an in-service with all staff regarding personal protective equipment. This education is to ensure that all staff are aware that covid 19 specimen collection requires wearing appropriate PPE to include donning a KN-95/N 95, eye protection, gloves, and gown prior to obtaining specimen. In-service will be completed by 12/3/21. All newly hired staff will be in-serviced by the Staff Development Coordinator during orientation in regard to PPE and covid 19 specimen collection. The Director of Nursing will observe 10% of covid 19 specimen collections weekly x 4 weeks and then monthly x 1 month. This audit is to ensure that staff were	

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F 886	Continued From page 36	F 886	wearing appropriate personal protective equipment required during specimen collection include donning KN-95/N 95, eye protection, gloves, and gown prior to obtaining specimen. The Administrator will review the Covid 19 Testing Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will forward the results of the Covid 19 Testing Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 month. The QAPI Committee will meet monthly x 2 months and review the PPE/Handwashing Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	