STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. BUILDING 00 B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN 46835

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00396293. Survey dates: December 6, 7, 8, 9 and 12, 2022. Facility number: 000275 Provider number: 155656 AIM number: 100290930 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 2 Medicaid: 76 Other: 12 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 13, 2022	F 0000	This facility is requesting Paper Compliance. Thank you	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical			

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

Meeta Anand | Executive Director | 12/22/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on record review and interview, the facility failed to ensure the resident's code status was communicated accurately to staff in 1 of 1 resident reviewed. (Resident 77). Findings included:	F 0578	**F 578** **Based on record review and interview, the facility failed to ensure the resident's code status was communicated accurately to staff in 1 of 1 resident reviewed.**	01/06/2023

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	On 12/8/22 at 4:10 PM, Resident 77's record was reviewed. Diagnoses included transient cerebral ischemic attack, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic atrial fibrillation and cognitive communication deficit. Resident 77's comprehensive Minimum Data Sheet (MDS) assessment, dated 9/14/22, indicated the resident's Brief Interview for Mental Status (BIMS) score was 3. She was alert, oriented to self but not interviewable. The resident's current Power of Attorney, signed 6/4/1992, provided authorization to take care of the resident's medical necessities and authorization for medical treatment. Resident 77's State of Indiana Living Will Declaration, dated 6/4/1992, indicated her desire if at any time she would have an incurable injury, disease, or illness she would be permitted to die naturally with only provision of appropriate nutrition, hydration, medications and medical procedures to provide comfort and alleviate pain. If the resident was unable to give such direction, she wished her family/physician to accept her legal right to refuse medical or surgical treatment and accept the consequence from such refusal. The State of Indiana Out of Hospital Do Not Resuscitate (DNR) Declaration and Order, dated 12/29/21 and signed by the Resident 77's Power of Attorney, indicated if the resident experienced cardiac or pulmonary failure, in a location other than an acute care hospital, cardiopulmonary resuscitation (CPR) procedure would be withheld or withdrawn and she would be permitted to die naturally. The declaration and order was		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice** The deficient practice was immediately corrected on 12/08/2022 for Resident 77. The correct Code status was documented via the physician's order, which is correctly reflected on the face sheet and care plan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(S) will be taken** All residents have the potential to be affected. An audit will be completed on all the residents residing at the facility to ensure that the code status directive is documented by the physician orders and will be reflected as such on the face sheet and care plan. The facility will also ensure that the advanced directive documents are consistent which reflects the resident code status. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur** 1. Medical Records Manager or designee (all nurse managers) and Social Services Director/designee will be educated on the Advanced Directives policy	

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	witnessed by two individuals and signed by her facility physician. Resident 77's medical record indicated her code status was a DNR. A review of the resident's current care plan, dated 12/2/22, indicated the resident/legal representative had formulated an advanced directive of DNR. The resident's care plan indicated the DNR advanced directive preference would be honored, reviewed at care plan conferences and as needed. Resident 77's physician's order, dated 10/14/21, indicated the resident's code status was full code. The order was discontinued on 12/8/22 at 4:39 PM. The resident's code status was changed to a DNR. In an interview on 12/9/22 at 11:15 AM, the DON indicated Resident 77's code status should have reflected the resident was a DNR and not a full code in the physician orders. On 12/9/22 at 3:05 PM, a current policy titled "Advanced Directive Policy", revised 2/2020, provided by the DON, indicated the code status directive will be documented by a physician's order. 3.1-4(l)(5)		2. Code status will be verified to ensure physician order is accurate for every new resident during the morning meeting and to ensure face sheet and care plan reflects the same based on resident/family preference. 3. Advanced Directives will be reviewed quarterly in the care plan conference with the IDT and resident/resident representative as applicable. 4. Advanced Directives will be reviewed and documented with resident/resident representative anytime there is a significant change in condition. 5. If code status is changed during stay, the physician order will reflect that and will be promptly scanned into the medical record; and face sheet and care plan will reflect the new change by Medical Records Manager/Designee. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e; what quality assurance program will be put into place;** 1. Advance Care Planning QA tool will be completed weekly x 1 month and the monthly for 6 months by the Medical Records manager or designee and then quarterly thereafter. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month.	

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			By what date the systemic changes for each deficiency will be completed. Systemic changes will be completed by 01/06/2023	
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.			

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	(vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be			

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	discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on observation, interview, and record review, the facility failed to ensure discharge planning was provided for 1 of 2 residents reviewed (Resident 93). Findings include: During a record review on 12/12/22 at 9:37 AM, a Minimum Data Set (MDS) dated 10/17/22 indicated Resident 93 was discharged from the facility to the community. An MDS dated 10/11/22 indicated Resident 93 had diagnoses including non-Alzheimer's dementia, hyperlipidemia, and hypertension. The MDS indicated Resident 93 had a Basic Interview for Mental Status (BIMS) score of 9/15 indicating Resident 93 was cognitively impaired. Section Q of the MDS indicated Resident 93 intended to stay in long term care. A care plan dated 10/10/22 indicated Resident 93 had a goal of remaining in the facility for appropriate care and supervision. The care plan indicated a return to the community was not feasible due to a need for 24-hour care. A progress note dated 10/17/22 at 10:24 AM by Nurse Practitioner 3 did not indicate an anticipated discharge. No progress notes after that time were available for review in the medical record. Progress notes reviewed between the admission date 10/4/22 and 10/17/22 did not	F 0660	**F 660** **Based on observation, interview, and record review, the facility failed to ensure discharge planning was provided for 1 of 2 residents reviewed.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident 93 was discharged on 10/17/2022 – no negative outcome of alleged deficient practice **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(S) will be taken** All residents have the potential to be affected. Social Services Director or designee will ensure that the Discharge Planning Policy (see attached) is followed for all residents being discharged from the facility which will include discussing discharge plan at admission with resident/caregiver, collaboration between IDT and resident/caregiver, communication between facility and discharging facility, complete documentation	01/06/2023

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	include discussion of discharge plans. A Transition of Care/Discharge Summary dated 10/17/22 indicated Resident 93 would discharge to an Assisted Living facility. The form was partially filled out, with no documentation in the areas of goals of stay, recapitulation of stay, continence, dental, nutritional status, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems. "No data available" was indicated in the areas of care team providers, scheduled appointments, community contacts, treatment/procedures, medical equipment, and discharge medications. A Notice of Transfer or Discharge form dated 10/17/22 indicated Resident 93 was being transferred to another nursing facility. The form indicated the transfer or discharge was necessary to meet Resident 93's welfare and Resident 93's needs could not be met in the facility. During an interview on 12/12/22 at 10:47, the Director of Nursing indicated the assisted living facility came to assess Resident 93, accepted her for admission and wanted to transfer right away. Discharge forms were started, but the facility did not have time to finish them at the time of discharge. A current facility policy, last revised 3/22 indicated discharge goals should be identified upon admission and the interdisciplinary team should collaborate with caregivers/support persons to formulate a discharge plan. The policy also indicated discharge instructions should be reviewed and signed by a resident's representative with a copy provided to the representative.		of discharge instructions and discharge summary, and physician/NP involvement in the discharge process. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur** The following measures and systemic changes will be put in place to ensure that the deficient practice does not recur. 1. Interdisciplinary Team members will be educated on the discharge planning policy and Discharge checklist. 2. Social Services Director or Designee will complete the Discharge checklist for all residents identified to have discharge planning goals and an active discharge plan to ensure all components of discharge planning are addressed (see attached). This will ensure collaboration between facility and caregiver/support persons, discharge instructions by the nurse and/or nurse manager, communication between facility and discharging facility, and physician discharge orders. 3. IDT (Interdisciplinary Team) will review the discharge documents to ensure discharge planning and process is completed per policy. **How the corrective action(s)will be monitored to ensure the**	

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	No documents displaying a collaboration between staff and caregiver/support persons for Resident 93 were available for review at the time of exit. No signed document containing discharge instructions was available for review at the time of exit. No records contianing communication between the facility and the assisted living facility regarding care needs, medication orders, or medical equipment needed was available for review at the time of exit. 3.1-12(a)(18)(19)		**deficient practice will not recur, i.e., what quality assurance program will be put into place.** 1. Social Services Director or designee will complete the Discharge Planning QAPI tool weekly x 4 weeks and then monthly x 6 months. After this, the Social Services Director or designee will follow the Social Services QAPI calendar for Discharge Planning. 2. This information will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month. **By what date the systemic changes for each deficiency will be completed.** Systemic changes for this deficiency will be completed by 01/06/2023	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 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. Based on interview and record review the facility failed to ensure physician orders were followed for 1 of 2 residents reviewed. (Resident 41)	F 0684	**F 684** **Based on interview and record review, the facility failed to ensure physician orders were**	01/06/2023

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	Findings include: A record review on 12/7/22 at 11:47 AM indicated Resident 41's diagnoses included vascular dementia, psychotic disturbance, mood disturbance, anxiety, and right-side hemiplegia due to a stroke. A comprehensive MDS assessment dated 9/27/22 indicated the resident had severe cognitive impairment exhibited by a Brief Interview for Mental Status (BIMS) score of 0 on a 0-15 scale. The MDS indicated the resident required extensive staff assistance for activities of daily living (ADLs). The MDS assessment indicated the resident did not reject care. A comprehensive MDS assessment dated 10/17/22 indicated the resident required extensive staff assistance for ADLs. The BIMS score was blank on the MDS assessment. The MDS assessment indicated the resident did not reject care. Resident 41's care plan dated 11/23/2019 indicated the resident had a history of chronic reoccuring urinary tract infections. A care plan intervention initiated 4/22/2020 indicated the facility would document and notify the doctor of signs and symptoms weight loss or decreased urianry output. A progress note by NP (Nurse Practitioner) 2 dated 9/28/22 at 9:44 AM indicated the resident had an acute evaluation for increased hypomanic symptoms. NP 2 ordered blood work and a urinalysis. A progress note by RN 1 dated 9/28/22 at 10:57		**followed for 1 of 2 residents reviewed** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident care issue for Resident 41 was already addressed by the hospital on 10/06/2022. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(S) will be taken** All residents have the potential to be affected. An audit will be completed under the direction of the Director of Nursing Services or designee of all orders for Labs/Urinalysis for the past 30 days to ensure the physician orders were followed. NP/Family will be notified for any other residents noted to have been affected. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur** 1. All Nurses will be educated on the Lab and Diagnostics Policy, including notification of NP when a resident refuses a lab draw/UA to obtain further orders/direction, as well as notification of family 2. All Physician orders will be reviewed and entered daily under	

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	AM indicated NP 3 ordered a CBC, (complete blood count) a CMP, (comprehensive metabolic panel) a thyroid stimulating hormone level, (TSH) and a urinalysis with a culture and sensitivity test if indicated. The resident's physician orders did not indicate a urinalysis was to be collected. A progress note dated 9/29/22 at 9:09 PM indicated the resident refused to have her blood drawn. There was no note to indicate the NP or family had been notified. A progress note dated 10/5/22 at 3:42 PM indicated NP 2 ordered the resident to be transferred to the emergency department for altered mental status and dehydration. A progress note by NP 3 dated 10/5/22 at 5:15 PM indicated the urinalysis had not been collected due to the resident had not been urinating the last week or so. NP 3 indicated the resident's TSH was normal. NP 3 indicated no other lab results were available due to the blood sample had hemolyzed. Urinary output records did not indicate the resident had a decrease in urination. Urinary output records indicated the resident consistently urinated large amounts from 9/28/22 through 10/5/22. A progress note dated 10/6/22 at 2:25 AM indicated the resident returned from the emergency department with a new order for an antibiotic. A progress noted dated 10/6/22 at 9:19 AM indicated the resident was on antibiotic therapy for a urinary tract infection (UTI).		the supervision of the Director of Nursing or designee during Clinical meeting and entered in Matrix. 3. All Progress notes will be reviewed by the nurse manager the following day to ensure physician order was followed. This will ensure that all physician orders are logged, tracked, and addressed. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e; what quality assurance program will be put into place;** 1. The Physician Orders QAPI tool will be completed by the Medical Record Manager or designee weekly x 4 weeks, then monthly x 6 months, and then Quarterly as indicated by the Medical Records Quality Assurance Tool Calendar. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month. **By what date the systemic changes for each deficiency will be completed.** The systemic changes for each deficiency will be completed by January 6 2023	

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	During an interview on 12/9/22 at 11:14 AM RN 4 indicated the facility could obtain a urine sample from soiled clothing with a swab. She indicated a urine sample was not collected on 9/28/22 as ordered due to the resident had no urine output. After review of the resident's physician orders she indicated the order was not put in the computer. She indicated there was no decrease in fluid intake or output recorded in the resident's clinical record. During an interview on 12/9/22 at 1:57 PM the DON indicated she understood the rationale of 2 missed lab opportunies related to the urinalysis not ordered and the hemolyzed blood sample not redrawn the same day. She indicated it was likely NP 2 wanted to rule out physical causes for the resident's poor appetite before adjusting psyhcotrpoic medications. A current policy provided by the DON on 12/9/22 at 1:57 PM titled "Labs and Diagnostics" indicated the facility is to provide or obtain lab and diagnostic services to meet resident needs. The policy indicated the facility is responsible for the quality and timeliness of lab and diagnostic services. 3.1-37			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §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- §483.25(g)(1) Maintains acceptable			

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	155656	A. BUILDING 00 B. WING	12/12/2022

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CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN 46835

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	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. Based on interview and record review the facility failed to identify significant weight loss for 1 of 2 residents reviewed. (Resident 41) Findings include: During a record review on 12/7/22 at 11:47 AM, Resident 41's diagnoses included vascular dementia, psychotic disturbance, mood disturbance, anxiety, and right-side hemiplegia due to a stroke. A comprehensive MDS assessment dated 9/27/22 indicated the resident had severe cognitive impairment exhibited by a Brief Interview for Mental Status (BIMS) score of 0 on a 0-15 scale. The MDS indicated the resident required limited staff assistance for eating. The weight portion of the resident's MDS assessment was blank. The weight loss portion of the resident's MDS assessment indicated the resident did not have a weight loss of 5% or more in the last month or 10% in the last 6 months or it was unknown if the resident had a weight loss. The MDS assessment indicated the resident had no natural teeth or had tooth fragments. The MDS assessment indicated	F 0692	**F 692** **Based on interview and record review, the facility failed to identify significant weight loss for 1 of 2 residents reviewed** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident 41 was found to have been affected by the deficient practice. The following corrective action plan will be accomplished for this resident 1. A current weight was obtained on 12/10, 12/14, and 12/19 – resident's weight is up 4# from 12/7 2. Resident will be offered to be weighed on alternate days if she refuses the first attempt. 3. Dentist has been contacted and completed impressions for dentures 4. Resident has been referred to OT for eval to help determine	01/06/2023

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	the resident did not have a poor appetite. The MDS assessment indicated the resident did not reject care. A comprehensive MDS assessment dated 10/17/22 indicated the resident required extensive staff assistance for eating. The resident's weight on the MDS assessment was blank. The MDS assessment indicated the resident had no natural teeth or had tooth fragments. The mood portion (which included appetite) of the MDS assessment was blank. The MDS assessment indicated the resident did not reject care. The resident's weight log indicated the resident weighed 127 pounds on 5/6/22 and 6/7/2022. The weight log did not have an entry for 7/2022. The weight log indicated the resident's weight was not taken on 8/5/22. The weight log indicated the resident refused to be weighed on 9/9/22. The resident weighed 110 pounds on 10/7/22 (a 14% loss in 5 months). The resident weighed 107 pounds on 12/7/22. A progress note by NP (Nurse Practitioner) 2 on 9/28/22 at 9:44 AM indicated she was notified the resident had lacked motivation and remained in bed for the last week. She indicated the resident had been refusing medications, treatments, and care. She indicated the resident had a history of these behaviors and cycled 1 or 2 times annualy. A progress note by NP 3 on 10/5/22 at 5:15 PM indicated the resident was unable to feed herself which was new. She indicated the resident had poor fitting dentures. A progress note by the Registered Dietician (RD) dated 10/19/22 at 3:48 PM indicated the resident weighed 109 pounds. The RD indicated the root		level of assistance needed with eating **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(S) will be taken** · All residents with weight loss have the potential to be affected. · All Residents with current significant weight loss will be reviewed by Jan 6, 2023, to ensure no other residents have been affected by this deficient practice. If identified, then weight loss was addressed immediately. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur** 1. Restorative nursing will be provided re-education to ensure reweighs are offered to residents on alternate days if they refuse being weighed on the first attempt and to notify DNS/RD of refusals 2. RD/MDS will be educated on the completion and accuracy of the Swallowing/Nutritional Status portion of the MDS Assessment 3. When significant weight loss is observed, dental appointments will be completed if indicated **4.** Interdisciplinary Team members will be re-educated on the IDT baseline care plan, IDT Comprehensive Care Plan, and	

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	cause of weight change was the resident had new trouble feeding herself. The RD indicated the resident's usual body weight was 130 pounds. A progress note by the RD on 10/26/22 at 4:12 PM indicated the resident frequently refused to be weighed. A progress note by the RD on 11/9/22 at 5:00 PM indicated the resident weighed 106 pounds. She indicated the root cause for the resident's weight loss was trouble feeding self, bipolar cycling, and the resident's daughter had been visiting less. The resident's care plan dated 12/8/2020 did not indicate the resident had trouble feeding herself, but indicated the resident utilized a denture/bridge or partial upper and lower. The care plan interventions indicated the facility would ensure the dental device fit properly, ensure the device was present before meals, and obtain a dental consult as needed. A care plan intervention dated 4/22/2020 indicated the facility would document and notify the physician of signs and symptoms of weight loss. A care plan dated 11/19/2019 indicated the resident is at risk for depression and the resident had cycles of refusing to get out of bed when feeling down. A copy of the comprehensive MDS assessment dated 10/27/22 was provided by the Director of Nursing (DON) on 12/9/22 at 1:57 PM. The weight portion of the MDS assessment indicated the resident weighed 110 pounds. During an interview on 12/9/22 at 3:58 PM the RD (Registered Dietician) indicated she had not been		IDT Weight Review Policies including updating the plan of care when a resident has a change in need for assistance. **5.** Interdisciplinary Team members will identify residents with weight loss to monitor these residents by Nutrition At Risk program and notify the physician and family as applicable. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e; what quality assurance program will be put into place;** 1. The Significant Weight Change/Nutritional Risk QAPI tool will be completed by the Director of Nursing or Designee weekly x 4 weeks, then monthly x 6 months, then every quarter as indicated thereafter by the Director of Nursing/Nurse Management Team QAPI Calendar. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month. **By what date the systemic changes for each deficiency will be completed.** The systemic changes will be completed by Jan 06 2023	

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	aware of the resident's weight loss due to the resident's refusal to be weighed on previous months. She indicated the resident's appearance did not indicate weight loss. She indicated the staff thought the resident's poor meal intake was due to the resident's cycling. She indicated the resident has manic cycling episodes She indicated she was unaware if residents were offered to be weighed on alternate days if they refused the first attempt. She indicated she was unaware of the resident's dental status. She indicated she was unaware of the resident being assessed to see if her dentures still fit after losing a significant amount of weight. During an interview on 12/12/22 at 10:22 AM RN 4 indicated she was unsure of the facility protocol related to resident's refusal to be weighed. She indicated the restorative department was responsible for obtaining residents weights, then the weights went to the MDS nurse. She indicated the facility did not have a policy for refusal of weights. During an interview on 12/12/22 at 10:39 AM the RD indicated all residents were weighed monthly prior to the 7th day of each month unless a problem was identified. She indicated she was aware of Resident 41's refusal to be weighed for 3 months. She indicated she was not made aware of the resident not eating well. She indicated the resident did not appear to have lost weight. She indicated she was not aware of the resident's care plan intervention for proper denture fit and for dentures to be in the resident's mouth before each meal. During an interview on 12/12/22 at 11:49 AM the DON indicated there had been no assessment to ensure the resident's dentures still fit. She			

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	indicated a dental consult had not been scheduled. 3.1-46			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or			

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	damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to ensure dental services were provided for 1 of 3 residents reviewed (Resident B). Findings include: During an observation on 12/6/22 at 10:50 AM, Resident B indicated she was missing bottom teeth and her partial denture plate had been missing for a long time. Resident B indicated she had some trouble chewing but believed that she had enough to eat with what is available. She indicated she wished she had her partial denture plate so she could eat anything she wanted. During an interview on 12/6/22 at 2:46 PM, Resident B's family member indicated her partial denture plate had been missing for several months. The family member indicated they had several conversations with the facility about the lost dentures, the facility responded they were "following up', but the family never received a clear answer on what the facility's plan was. During a record review on 12/7/22 at 10:27 AM, a Minimum Data Set dated 11/29/22 indicated Resident B had diagnoses including	F 0791	**F 791** **Based on observation, interview and record review, the facility failed to ensure dental services were provided for 1 of 3 residents reviewed (Resident B)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Corrective action was taken for Resident B by making a dental consult appointment on 12/14/2022 where the measurements were taken for the upper partial dentures. An Oral Status and Swallowing Disorder Screening Observation Assessment was completed with no concerns noted. No adverse outcomes noted from deficient practice. **How other residents having the potential to be affected by the same deficient practice will be**	01/06/2023

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	non-Alzheimer's dementia, hypertension, and hyperlipidemia. A progress note dated 10/3/22 at 3:32 PM written by Nurse Practitioner (NP) 3 indicated Resident B was upset about her dentures being lost. The progress note also indicated the findings were discussed with nursing. A Concern/Grievance form dated 10/26/22 indicated in Section I, Resident B's son reported her dentures had been missing for more than a month. Section II of the grievance form, a department head follow-up note dated 10/27/22, indicated the dentures were located the following day and staff offered to lock them in the nurse's cart. Resident B declined the offer and the dentures were missing again. Section III of the grievance form, follow up communication with the individual filing the report, dated 10/4/22, indicated the Social Enrichment Director called the Resident B's son, explained the resident refused to have her dentures locked up and they were lost again. An additional note in this section, also dated 10/4/22 indicated there were no further issues. No explanation of date discrepancies was received by the time of exit. Additional notes attached to the grievance form indicated the subject was reviewed on 11/18/22 during a care plan meeting. Additional notes indicated dental offices were contacted regarding quotes for denture replacement on 11/21/22, 11/28/22, and 12/2/22. Documents titled Oral Status and Swallowing Disorder Screening forms dated 11/14/22 and 11/22/22 were reviewed. The checklist style form had no check marks, notes, or any other indication a screening had been completed. No signature or date was on either form to indicate completion.		**identified and what corrective action(S) will be taken** All residents have the potential to be affected. A list of Residents with dental issues will be identified by Social Services Director/ designee and ensure that dental assessment / dental services will be scheduled if needed. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur** 1. IDT re-education on the Oral Status and Swallowing Disorder Screening form in Matrix and Dental Services / Missing Dentures Policy will be completed by Jan 6, 2023 2. IDT will identify any resident with an identified need for dental services. The identified resident will have a dental referral completed as indicated. IDT will follow up to ensure that the dental referral was made and completed by 01/06/2023 by Social Services Director or designee. 3. IDT re-education regarding the Resident Concerns and Grievance Policy will be completed **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e; what quality**	

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	During an interview on 12/8/22 at 10:50 AM, the Director of Nursing indicated she did not know why the Oral Status and Swallowing Disorder screening forms were not completed. A care plan dated 10/5/21 indicated Resident B had dentures, she should have had a dental consult as indicated and should have been observed for decreased ability to chew food. A current policy titled Resident Concerns and Grievances, last revised 1/19, indicated actions should be taken to resolve the complaint within 72 hours of the time the concern was received. No records regarding oral screening to determine ability to effectively chew without the missing dentures were available for review at the time of exit. No records regarding contact with a dental office about missing dentures prior to 11/21/22 were available for review at the time of exit. 3.1-24(a)(3)		**assurance program will be put into place.** 1. The Dental Services QAPI tool will be completed by the Social Services Director or Designee weekly x 4 weeks, and monthly for 6 months and then every quarter as indicated by the Social Services QAPI Calendar. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month. **By what date the systemic changes for each deficiency will be completed.** The systemic changes will be completed by January 06 2023	