STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRENGER HEALTH CARE OF MISHAWAKA	60257 BODNAR BLVD MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00362924, IN00362680 and IN00362482. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy.

Complaint IN00362924 - Unsubstantiated due to lack of evidence.

Complaint IN00362680 - Unsubstantiated due to lack of evidence.

Complaint IN00362482 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F684, F686 and F692.

Survey dates: September 27, 28, 29, 30 and October 1, 2, 3, 4 & 5, 2021

Facility number: 013017
Provider number: 155804
AIM number: 201237680

Census Bed Type:
SNF/NF: 30
SNF: 16
Residential: 26
Total: 72

Census Payor Type:
Medicare: 16
Medicaid: 18
Other: 12
Total: 46

These deficiencies reflect State Findings cited in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/29/2021

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F 000	Continued From page 1 accordance with 410 IAC 16.2-3.1. Quality Review was completed on October 14, 2021.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 3 reviewed dependent residents received the necessary services to maintain personal hygiene. This failure Resident C's multiple areas of skin breakdown to go undetected until she was hospitalized with an infected wound, skin tears and multiple areas of bruising. Finding includes: On 9/27/21 at 12:39 P.M., a review of the clinical record for Resident C was conducted. The record indicated the resident was admitted on 8/19/21 and discharged to a local hospital on 9/10/21. The resident's diagnoses included, but were not limited to: Crohn's disease (a type of inflammatory bowel disease with symptoms of diarrhea and weight loss), diabetic, quadriplegia (occurs when the neck area of the spinal cord is injured) C5-C7 (area of neck involved)-incomplete (having some movement), cervical spine fusion, malnutrition, COPD (Chronic Obstructive Pulmonary Disease), and osteoporosis.	F 677		10/29/21

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F 677	Continued From page 2	F 677		

Resident C's Admission Minimum Data Set (MDS) Assessment, dated 8/26/21, indicated the Brief Interview for Mental Status (BIMS) score was 15 (normal cognition). The assessment indicated the resident required the assistance of two persons with bed mobility, toileting, and personal hygiene. The Bathing Assessment indicated bathing did not occur in the seven-day period. She also had a range of motion impairment, bilaterally, in the upper and lower extremities. The resident was occasionally incontinent of bladder and always incontinent of her bowels.

An Activities of Daily Living (ADL's) /Self-Care deficit care plan, dated 8/23/21, indicated Resident C needed assistance with transfers, toileting, bed mobility and eating as needed related to: cervical stenosis and quadriparesis. The interventions included, but were not limited to: extensive assist with toileting, bed mobility, transfers, and set up-limited assistance with eating, cervical collar on at all times, must remove for skin checks daily, prefers to be out of bed before 10:00 a.m., resident may shower and place shower cervical collar on for showers.

A care plan, dated 8/30/21, indicated the resident had a need for therapeutic recreation. She enjoyed going to the gym to exercise three times a week and doing family genealogy research. The interventions included, but were not limited to: inform of activities, important to resident to go outside-get fresh air, having window open, provide comfort and report physical complaints to the nurse.

A Therapy Department Progress Note, dated

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8/24/21 indicated someone had contacted the surgeons office to clarify the resident's restriction which were as follows: "...cervical collar is to remain on at all times. Resident may shower...."

During an interview, on 9/29/21 at 12:03 p.m., the Administrator indicated there were no shower sheets or documentation indicating the resident received a shower and/or bed bath or personal hygiene during her 24 days at the facility.

A form titled, "Elder & Dependent Adult Abuse and Neglect Part II: Medical Assessment, dated 9/10/21 at 4:00 P.M., was received from the ER-Forensic nurse. The form indicated Resident C had the following concerns labeled on a a diagram: frontal view-right lower extremity laceration with steri-strips and bruising to anterior lower extremities. The posterior view - a Stage III pressure ulcer [full-thickness skin loss]-appeared to be getting infected, a mepilex dressing over a left hip skin tear. There were 19 staples on the left iliac crest (post bone graft), a Stage II pressure ulcer [partial-thickness skinn loss] on right elbow, and Stage 1 pressure ulcer [non-blanchable, intact red skin that does not turn white when pressed] on each heel, that was nonblanchable, with redness. Bruising noted on bilateral posterior arms. These findings were photographed. The nursing note, part of the assessment, dated 9/10/21, indicated "...Large Stage 3 pressure ulcer/wound noted on buttocks as well as 19 staples. Pt [patient] also has staples in back of neck, however C-Collar not removed to assess...Pt [patient] also has a Stage 2 ulcer on right elbow and stage 1 ulcers (nonblanchable redness) on both heels as well as multiple areas of bruising on her extremities. She also has a laceration on her lower leg that looks fairly recent.

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F 677	Continued From page 4	F 677		

Pt [patient] is lethargic but responds to voice and pain...." The photos were observed and confirmed the observations of the Forensic nurse's assessment of Resident C. The dressing on the left hip/ilias was removed and presented with pressure ulcer which was infected and debrided (surgically remove damaged tissue, on 9/14/21.

A Hospital History & Physical (H&P), dated 9/19/21, indicated "...an 80-year-old lady who was my patient from 8/10 to 8/19 for lower extremity weakness and upper extremity neuropathy [a malfunction of the nerves] that found to be due to compression at the level of C3-C4 [cervical region of spinal cord] and had bilateral cervical decompression from C2-C7 by [name of physician]. Patient was discharged stable to [name of facility]...Today 9/10 she was sent from [name of facility] confused, nonresponsive. Apparently found in very poor condition covered in feces (according to the ER attending) with a pressure ulcer in sacral area...."

During an interview, on 9/29/21 at 10:52 A.M., Certified Nurse Aide (CNA)/Scheduler 3 indicated she had to work as a CNA, on the unit, on 9/10/21 and she was the only CNA for the unit. She had not worked the floor for about a week. She indicated Resident C was checked and changed, before breakfast, and was only wet. Usually, the resident used her call light but that day she wasn't using it. The resident didn't eat breakfast or lunch and could not hold her sippy cup (a cup with two handles). CNA indicated she had to hold it for her. She indicated the resident was talking. She indicated after lunch she checked on the resident and she had formed stool and she cleansed the resident buttock. She

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indicated the resident did not have an open wound but had a purple area on the right side of her buttock. She indicated she did not remember seeing staples on her hip, neck or back, but resident did have a neck collar on and it was never taken off. She indicated she left at 2:00 p.m. and was not there when resident left the facility.

On 9/29/21 at 12:03 P.M. the Administrator indicated there were no shower sheets or documentation indicating the resident received a shower and/or bed bath or personal hygiene during her 24 days at the facility.

During an interview, on 10/4/21 at 10:29 A.M., the MDS Coordinator indicated could not remember if there was a specific reason the resident had not received a bed bath and/or shower during the seven-day look back period. She indicated she had not approached the CNAs regarding no documented showers or baths.

On 10/1/21 at 2:28 P.M., the Administrator provided a policy titled, "ADL's (Activities of Daily Living", dated 10/2019 and indicated the policy was the one currently used by the facility. The policy indicated "...POLICY: It is the policy of [name of facility] licensed and certified staff to provide assistance to the resident for care that they are no longer able to perform on their own. We will encourage as much self-care as the resident is able to perform and assist with the completion of tasks unable to complete. PROTOCOL: All resident will be provided assistance in the following areas as requested, needed and as indicated on the care plan *Bathing *Toileting or Incontinence Care as indicated *Dressing *Grooming *General Hygiene

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F 677	Continued From page 6 to include trimming and cleaning fingernails, shaving as desired *Oral Care and Denture Care as indicated *Transfers *Ambulation *Toenails will be trimmed by Podiatrist, staff will not trim toenails...." This Federal tag relates to complaint IN00362482. 3.1-38(a)(3)(A) 3.1-38(b)(2)	F 677		
F 684 SS=J	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 interview and record review, the facility failed to provide treatment and care in accordance with professional standards to 1 of 5 residents reviewed with post-surgical wounds. (Resident C) The immediate jeopardy began on 8/19/21, when the facility failed to assess Resident C's two post-operation incisions, with staples, at the time of admission and failed to ensure ongoing evaluations of the wounds for signs and symptoms of delayed healing or infection (e.g., observations of the wound size/depth, drainage,	F 684		10/29/21

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odor, debris/dead cells on the wound surface, etc. This caused one of the stapled areas to be covered in drainage and non-viable skin tissue (exudate and slough), with a potential of the stapled incision wounds to become separated and infected. The immediate jeopardy was removed, on 10/5/21, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm this is not immediate jeopardy.

Finding includes:

Resident C's clinical record was reviewed on 9/27/21 at 12:39 p.m. The record reflected the resident was admitted on 8/19/21 with diagnoses including, but not limited to, Crohn's disease (a type of inflammatory bowel disease with symptoms of diarrhea and weight loss), diabetes, C5-C6 incomplete quadriplegia (paralysis to upper and lower body), cervical spine fusion, malnutrition, and osteoporosis. She was discharged to a local hospital on 9/10/21.

The hospital's Operative/Procedure Report, dated 8/14/21, included the following: "...I made a skin incision over the right posterior iliac crest [right lower back] using a scalpel. I used a Bovie knife to dissect muscle and fascia [connective tissue] off the crest. I harvested bone material ...I approximated muscle and fascia with interrupted 0 Vicryl [type of suture] and performed subcutaneous closure with interrupted 2-0 Vicryl. The skin was approximated with stainless steel staples. Next, I made a midline skin incision over the spinous process of C2 [cervical/neck] down to T2 [thoracic upper back] using a scalpel ...."

The Hospital Transfer Assessment and Discharge

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orders, dated 8/19/21, did not include orders for post-surgical wound/incision care.

The Admission Assessment, dated 8/19/21, indicated the resident was admitted with skin tears to the right wrist and left forearm. There was no further documentation and/or observations regarding the two non-pressure skin tears indicating the areas were improving, closed and free of infection. There was no documentation indicating the surgical wounds with staples to her upper and lower back were observed, measured and/or assessed at admission. There was no record that physician orders were obtained for treatment to the surgical wounds.

The Admission Minimum Data Set (MDS) assessment, dated 8/26/21, indicated the Brief Interview for Mental Status (BIMS) score was 15 (normal cognition). The assessment indicated the resident required the assistance of two people for bed mobility, toileting, and personal hygiene. The resident was occasionally incontinent of bladder and always incontinent of her bowels. The assessment indicated she had a surgery which included fusion of spinal bones, surgical wounds, and skin tears. The MDS assessment documented she did not require surgical wound care.

During an interview, on 10/1/21 at 10:06 A.M., the MDS Coordinator indicated she had completed the Admission Assessment for Resident C. She indicated she had not observed the skin tears nor the surgical wounds but had assessed the resident for pain. She indicated she obtained the information about the surgical wounds from the Nurse Practitioner's (NP) assessment, on

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8/24/21, and the skin tear information from the facility's admission assessment form. She had updated the skin integrity care plan, on 9/1/21, with interventions to assess for pain with dressing changes, monitor for signs and symptoms of infection and monitor intake and ensure/encourage adequate nutrition and hydration. She provided the NP history form, dated 8/24/21, where there was a sentence which said the following: "...Patient underwent cervical spine decompression surgery on August 14...." The MDS Coordinator indicated the facility had a form to document non-pressure related skin issues. The form was not in the resident's clinical record.

Resident C's Treatment Administration Record (TAR) for August 2021, included a nursing measure/physician order, dated 8/21/21, which indicated: "Cervical incision - cleanse with normal saline and apply a dry dressing every day shift...." The first documented cervical incision cleanse was on Friday 8/27/21 (eight days after the order was written and nine days after the resident was admitted).

Resident C's August 2021 TAR indicated on 8/26/21 there was a physician order to monitor for signs and symptoms of infection of the resident's cervical incision and lower back. Both were documented, as completed, on the night shift, on 8/26/21.

A TAR for August 2021 had a nursing measure/physician order, dated 8/26/21 which indicated "Lower back - Cleanse with normal saline and leave open to air every day shift every Mon, Wed, Fri...." The first documented lower back cleanse was on 8/27/21 (eight days after the

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resident was admitted).

The TAR for September 2021 indicated the cervical incision dressing change and lower back incision cleanse was completed as directed. The resident was discharged to the hospital, on 9/10/2, and there was documentation, which indicated the process of cleansing the lower back incision was completed, on 9/11, 9/13 and 9/14 and the cervical incision cleanse and dressing change was completed, on 9/13/21.

A care plan, dated 8/23/21, indicated the resident had the potential for impairment of skin integrity related to decreased functional mobility, incontinence, polyneuropathy (damaged nerves), quadriparesis, and a surgical incision to upper and lower back. There were no interventions regarding the post-surgical incisions with staples.

A Progress note, dated 8/26/21 at 4:18 P.M., indicated the resident had a new skin tear on the right lower extremity which measures 10 cm (centimeters) x 7.6 cm The area was cleanse with Normal Saline and patted dry. The note indicated the loose skin was "flapped over" with steri-strips and covered with kerlix (type of bandage) and secured with tape.

A State reported incident report, dated 8/27/21, indicated "...resident was being transferred when her legs "became jelly", she was lowered to the floor. Resident was assessed and lifted with assistance from the floor with use of gait belt due to post and cervical spine fusion. When back in bed noted skin tear to right lower extremity. Resident's skin is fragile it was contact with floor, carpeting causing friction and resulting in a skin tear. Resident denies mistreatment. No findings

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of mistreatment...." There were no other documentation signifying staff were observing the non-pressure skin tear wound for improvement or decline.

A Physician Progress Note, dated 8/27/21, indicated the Resident was seen for weakness. The assessment indicated the following: "Examination...Skin: Dressing to the cervical spine and is wearing a C-collar [cervical, immobilization collar], however, there are no incisions or staples in the thoracic or spine. Assessment: 1. Status post decompressive surgery to the cervical spine with improvement in her range of motion of her arms but still with profound weakness...." No new orders were documented after this assessment.

A form titled, "Office-Clinic Notes," dated 9/8/21, indicated the resident had been to the office to have some of her sutures and staples removed. The notes stated "...posterior neck incision clean dry intact no redness edema or drainage; sutures removed with exception of top incision, staples remain. There was no indication the Nurse Practitioner, who documented the note, observed and/or removed the lower iliac crest staples.

On 9/29/21 at 11:04 A.M., the Administrator indicated there had been no lab work completed at the facility and there was no documentation regarding the assessments of the incisions, such as, surgical wound appearance and or drainage. A Treatment Administration Record was provided, by the Administrator, which indicated nurses initialed that they had monitored the back and neck incisions for signs and symptoms of infection twice a day. Neither the TAR nor other facility documentation included assessments of

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the wounds.

During an interview, on 9/27/21 at 2:46 p.m., Licensed Practical Nurse (LPN) 2 indicated she worked on 9/10/21 and had discharged Resident C to a local Emergency Department (ED). She indicated the resident had staples in her neck and back, had a new concern on her bottom and a skin tear but she thought that had healed. The resident was having an off day, complaining of different things. When the resident had difficulty swallowing, she called the physician and the physician decided to send her to ED. She indicated she had no observations of the resident's buttock/lower back but indicated the resident did have approximately 18 staples from neck down to upper back she didn't recall if there was anything on the resident's hip.

During an interview, on 9/29/21 at 10:52 A.M., Certified Nurse Aide (CNA) 3 indicated she had to work as a CNA on the unit, on 9/10/21 and she was the only CNA for the unit. She had not worked the floor for about a week. She indicated Resident C was checked and changed before breakfast and was only wet. Usually, the resident used her call light but that day she wasn't using it. The resident didn't eat breakfast or lunch and could not hold her cup. After lunch she checked on the resident and she had formed stool and she cleansed the resident buttock. She indicated the resident did not have an open wound but had a purple area on the right side of her buttock. She indicated she did not remember seeing staples on her hip, neck or back, but the resident had a neck collar on, and it was never taken off.

During an interview, on 9/30/21 at 11:55 p.m., the ED Forensic Registered Nurse (RN) from the

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hospital Resident C was sent to, on 9/10/21, indicated she had an Abuse and Neglect form, which included an assessment and photos of Resident C's wounds. She indicated they did not have photographs of her cervical wound because they did not want to remove her C-collar.

A form titled, "Elder & Dependent Adult Abuse and Neglect Part II: Medical Assessment," received from the ED-Forensic RN and dated 9/10/21, indicated Resident C had the following concerns labeled on a diagram:

- frontal view-right lower extremity laceration with steri-strips and bruising to anterior lower extremities.
- posterior (back) view - a Stage III pressure ulcer (pressure injury with full-thickness skin loss) appeared to be getting infected,
- a mepilex dressing over a left hip skin tear,
- 19 staples from iliac crest bone graft,
- Stage II pressure ulcer (pressure injury with a shallow red base) on right elbow,
- Stage I pressure ulcer (reddened skin that does not blanch, turn white, when pressed) on each heel that was non-blanchable,
- redness with bruising noted on bilateral posterior arms.

The nursing notes, part of the assessment, dated 9/10/21, indicated "...Large Stage 3 pressure ulcer/wound noted on buttocks as well as 19 staples. Pt [patient] also has staples in back of neck, however C-Collar not removed to assess...Pt [patient] also has a Stage 2 ulcer on right elbow and stage 1 ulcers (nonblanchable redness) on both heels as well as multiple areas of bruising on her extremities. She also has a laceration on her lower leg that looks fairly recent.

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Pt [patient] is lethargic but responds to voice and pain...."

Observation of the ED's photograph of Resident C's right lower back surgical incision revealed it was located on her lower back just above her right buttocks. There were 18 intact staples. One additional staple was lying loosely on the wound. The skin on and around the wound was red. The top layer of skin at the bottom nine staples of the wound (closest to her sacrum) appeared to have sheared away with curled over edges. The tissue at the bottom four staples had a pale-yellow appearance. The upper portion of the wound was not closed and had a small gap. There was a light brown substance around seven staples in the middle of the wound and at the top perimeter of the wound.

A Consultation, dated 9/13/21, indicated there was "... an incision overlying the right iliac crest which is likely from her bone harvest utilized for her cervical fusion..."

An Operative/Procedure Report, dated 9/14/21, indicated the following findings: "...Necrotic tissue [non-viable tissue due to reduced blood supply] with foul odor and some slight amount of purulence [pus] from the sacral tissues. Similar early appearance of the left ischium. Also had a roughly 1 cm [centimeter] area at the inferior aspect of the recent right posterior hip incision that was covered in exudate [fluid which leaks out of damaged tissues] ...."

A Hospital Progress Note, dated 9/16/21, included the following: "Right lower back has a 8.5 x 2.0 x 0.1 cm incision line with some intact staples and loose staples that are falling out at

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distal aspect of incision line where there is an area of moist yellow adherent slough [non-viable yellow, tan, gray, green or brown tissue], proximal incision line has visible adherent yellow slough...Upper medial back/neck also has an incision line with staples that are intact, with dry black crusty drainage noted, no odor..."

On 10/1/21 at 11:00 A.M., the Administrator provided a policy titled, "Non-Pressure and Post-OP Skin Impairment Protocol", dated 9/202 and 9/2021 and indicated the policy was the one currently used by the facility. The policy indicated "...POLICY: It is the policy of [name of facility] that all residents admitted to and currently residing in our facility, that have acquired skin impairment that is not pressure related, such as surgical incisions and non-pressure impairment (i.e. diabetic ulcers, stasis, skin tear, etc.) will be treated in accordance with physicians orders. PROTOCOL: The facility shall ensure: 1. Admission physician orders are followed for all surgical incisions and post-op care. 2. For all other skin impairments that are not pressure related (i.e. diabetic ulcers, stasis ulcers, skin tears, etc.), the licensed nurse shall contact the physician and obtain treatment orders. 3. Notification changes shall take place per facility policy...."

The National center for Biotechnology Information (NCBI), National Institutes of Health article, "Wound Assessment," dated 2/4/06 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/, accessed 10/8/21) states the following. "The wound bed may be covered with necrotic tissue (non-viable tissue due to reduced blood supply), slough (dead tissue, usually cream or yellow in color), or eschar (dry, black, hard

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F 684	Continued From page 16 necrotic tissue) ... Since necrotic tissue can also harbor pathogenic organisms, removal of such tissue helps to prevent wound infection. Necrotic tissue and slough should be debrided with a scalpel so that the wound bed can be accurately assessed and facilitate healing. The immediate jeopardy that began, on 8/19/21, was removed, on 10/5/21, when the facility began in-servicing staff on the following: abuse/neglect policy-all staff (9/16/21 and just neglect on 10/4/21), pressure ulcer prevention, wound care & showers-nursing staff (9/29/21-9/30/21), review of wound prevention/management policy-nursing staff (10/4/21), and a full house sweep, head to toe, skin observations (completed on 9/30/21), but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all audits had not been completed for at least a week. This Federal tag relates to complaint IN00362482. 3.1-37(a)(26)	F 684		
F 686 SS=J	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	F 686		10/29/21

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F 686	Continued From page 17 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide services to prevent the development of pressure ulcers and to promote healing to 1 of 4 residents reviewed with pressure ulcers. (Resident C) An immediate jeopardy began on 9/9/21, when the facility failed to prevent the development of deep pressure injuries and/or unstageable pressure ulcers on Resident C's sacrum and buttocks, as well as Stage I and II pressure injuries to her right elbow and bilateral heels. This resulted in a procedure to debride (surgically remove damaged tissue) skin, subcutaneous tissue, and muscle at the sacrum where cultures identified an infection of Enterococcus faecalis (a bacteria found in feces). The immediate jeopardy was removed, on 10/5/21, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm this is not immediate jeopardy. A deep pressure injury is a persistent deep red, maroon or purple discoloration that does not blanch (turn white when pressed). The injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. An unstageable pressure injury is a full-thickness skin and tissue loss in which the extent of tissue damage cannot be confirmed because it is obscured by slough (non-viable yellow, tan, gray, green or brown tissue) or eschar (dead tissue that	F 686		

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is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like). A Stage I pressure injury is intact, reddened skin that does not blanch, turn white, when pressed. A Stage II pressure injury is a partial-thickness loss of skin.

Finding includes:

Resident C's clinical record was reviewed on 9/27/21 at 12:39 p.m. The record reflected the resident was admitted on 8/19/21 with diagnoses including, but not limited to, Crohn's disease (a type of inflammatory bowel disease with symptoms of diarrhea and weight loss), diabetes, C5-C6 incomplete quadriplegia (paralysis to upper and lower body), cervical spine fusion, malnutrition, chronic obstructive pulmonary disease (COPD), and osteoporosis. She was discharged to a local hospital on 9/10/21.

The Admission Minimum Data Set (MDS) Assessment, dated 8/26/21, indicated the Brief Interview for Mental Status (BIMS) score was 15 (intact cognition). The assessment indicated the resident required the assistance of two people for bed mobility, toileting, and personal hygiene. She also had a range of motion impairment, on both sides (bilaterally), in the upper and lower extremities. The resident was occasionally incontinent of bladder and always incontinent of her bowels. The assessment indicated she had a surgery which included fusion of spinal bones and a surgical wound. The assessment indicated she was at risk for developing pressure injuries and had no unhealed pressure injuries. The MDS assessment documented she was to have a pressure reducing device for her chair and bed. It indicated she was not on a turning/repositioning program and did not require nutrition or hydration

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interventions to manage skin problems. The resident's weight was 128.2 pounds.

A Weight Change Progress Note, dated 8/26/21, documented by the Dietician, indicated Resident C's weight was 116, which was a 12-pound weight loss since admission. The note indicated the Dietician would add fortified foods to her diet and recommend house supplement, four ounces, twice a day. No other weights were documented after this date.

A form titled "Braden Scale for Predicting Pressure Sore Risk", dated 8/19/21, indicated the resident was a low risk for developing a pressure ulcer. The form indicated the resident "requires minimum assistance."

A Weights and Vitals Summary form for August through September indicated the percentage of a meal eaten by the resident was documented on two days, on 8/31/21 at 9:12 a.m. and 1:26 p.m., and on 9/7/21 at 11:05 a.m. During each of these meals, it was documented, the resident ate 51% to 75% of her meal.

A care plan, dated 8/23/21, indicated the resident had the potential for impairment of skin integrity related to decreased functional mobility, incontinence, polyneuropathy (damaged nerves), quadriparesis, and surgical incision to upper and lower back.

On 9/10/21, a deep tissue injury to the buttocks was added to the care plan. The interventions included but were not limited to: "Moisture barrier after each incontinent episode, turn and reposition every two hours while in bed, minimize pressure on bony prominences, pressure

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reducing mattress to bed, monitor signs & symptoms of infection, monitor intake and ensure/encourage adequate nutrition and hydration, assess condition of skin especially over bony prominences for breakdown. Educate resident on need to reposition, assess for nutritional needs and monitor weights as ordered." Another care plan, dated 8/23/21, indicated the resident had the potential for altered respiratory status related to COPD and "...Keep HOB [head of bed] elevated at all times to help alleviate SOB [shortness of breath] while lying flat r/t [related to] COPD...."

A Therapy Department Progress Note, dated 8/24/21, indicated someone had contacted the surgeon's office to clarify the resident's restriction which were as follows: "...cervical collar is to remain on at all times. Resident may shower. No excessive bending, twisting, or lifting > 10 lbs. Office reports follow up appointment is needed in 2-3 weeks. Appointment was scheduled at this time and message left for transportation...."

The Order Summary form, for August/September, indicated the resident was being administered hydrochlorothizaide (a diuretic), 25 milligrams (mg) daily, and prednisone (steroid), 4 mg daily and tapered down to last dose on 8/26/21. The Summary indicated "...elevate the head of bed at all times while resident in bed to help alleviate SOB [shortness of breath] while lying flat. every shift related to Chronic Obstructive Pulmonary Disease...."

A form titled, "Wound Track", dated 9/9/21, indicated the resident had a facility acquired "...Unstageable Related to Suspected Deep Tissue Injury....", of the right medial buttock,

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which measured 4.5 cm [long] x 1.5 cm [wide] x 0 cm [deep]. The area was described as "...discoloration dark in color, clean, no drainage...."The form indicated nutrition was poor, family/physician were notified. Treatment ordered: "...Apply triad paste and border foam dressing daily...." The new interventions included "...low air mattress, turn and reposition Q2hrs [every 2 hours], encourage to get out of bed, pressure reducing cushion in recliner...."

The Medication Administration Record (MAR) indicated the Triad Hydrophllic Wound Dress Paste (is a sterile coating, adheres to wet skin, keeping the wound covered to facilitate healing) was applied to the coccyx, per order, at nighttime on, 9/9/21 and at lunch time on 9/10/21.

The Treatment Administration Record (TAR) indicated, on 9/9/21, to start turning and repositioning resident every two hours while in bed and document on day and night shift. There was no documentation for the night shift on 9/9/21 to indicate this task had been completed.

A Progress Note, dated 9/10/21 at 1:43 p.m., stated the following: "...Res [resident] noted change of condition. NP [nurse practitioner] evaluated, spoke with MD [medical doctor], N.O. [new order] to send to ER [emergency room]...."

The ED (Emergency Department) Notes, dated 9/10/21 at 3:01 P.M., indicated the resident was seen due to alteration in mentation, her mucous membranes are dry and is semi-comatose but does arouse some. The note indicated the resident had a "...bad breakdown on her sacral area...." She was quite dehydrated with an elevated BUN (Blood Urea Nitrogen; elevated

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levels can be due to dehydration) of 50 (normal range 8-23) with encephalopathy (disease affecting the brain).

The hospital History and Physical, dated 9/10/21, indicated resident was sent to ED in "very poor condition covered in feces" with a pressure ulcer in sacral area, which wound care was asked to evaluate.

A Consultation, dated 9/13/21, indicated the reason for the consultation was for the pressure injury. The assessment indicated the follow: "...the posterior low back was evaluated. There is a rim of erythema [redness] with central necrosis [slough or eschar] overlying the sacrum. Probably 10 cm area. There is an additional location just lateral to the left with some early changes, likely Stage II. There is also an incision overlying the right iliac crest which is likely from her bone harvest utilized for her cervical fusion..."

An Operative/Procedure Report, dated 9/14/21, indicated the following procedure was performed: "...Excisional debridement of skin, subcutaneous tissue, muscle of sacrum and left ischium. Placement of wound vac...."

A hospital Progress Note, dated 9/16/21, indicated the following: "...Left buttock has a 4.5 [long] x 2.5 [wide] x 0.1 [deep] cm wound with 90% adherent yellow/gray slough, 10% red tissue wound bed, small amount of sanguineous drainage ...unstageable pressure injury. Sacrum has a 9.0 x 8.7 x 0.2 cm wound with dark purple tissue, adherent yellow slough, moist red tissue wound bed, foul odor, small amount of sanguineous drainage, this wound also appears to be unstageable pressure injury. Right lower

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back has a 8.5 x 2.0 x 0.1 cm incision line with some intact staples and loose staples that are falling out at distal aspect of incision line where there is an area of moist yellow adherent slough, proximal incision line has visible adherent yellow slough. Upper medial back/neck also has an incision line with staples that are intact, with dry black crusty drainage noted, no odor. Right heel is intact erythemic blanching skin, right dorsal foot and toes also have a few small scattered dark purple non-blanching areas that may be DTIPIs [Deep Tissue Injury Pressure Injuries] versus bruising ... Surgery consulted, and patient is post debridement on 9/14 ...Patient is growing Enterococcus faecalis and other organisms from the wound culture and Gram stain ...."

During an interview, on 9/27/21 at 2:46 P.M., Licensed Practical Nurse (LPN) 2 indicated she worked, on 9/10/21 and discharged Resident C to a local ED. She indicated the resident had staples in her neck and back, had a new concern on her bottom and a skin tear but she thought that had healed. She indicated, throughout the day, the resident was having an off day and complaining of different things. When the resident had difficulty swallowing, she called the physician and the physician decided to send her to ED. She indicated the hospital never called her back to let her know why or if they were keeping the resident. To this date, she still doesn't know if resident is still in the hospital or where she went, as no one has ever told her. She indicated she had no observations of the resident's buttock but indicated the resident did have approximately 18 staples from neck down to upper back she didn't recall if there was anything on the resident's hip.

During an interview, on 9/29/21 at 10:52 a.m.,

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Certified Nurse Aide (CNA) 3 indicated she worked as a CNA on the unit, on 9/10/21 and she was the only CNA for the unit. She had not worked the floor for about a week. She indicated Resident C was checked and changed, before breakfast, and was only wet. Usually, the resident used her call light but that day she wasn't using it. The resident didn't eat breakfast or lunch and could not hold her sippy cup (cup with two handles. The CNA had to hold it for her. She indicated the resident was talking. She indicated after lunch she checked on the resident and she had formed stool and she cleansed the resident buttock. She indicated the resident did not have an open wound but had a purple area on the right side of her buttock. She indicated she did not remember seeing staples on her hip, neck or back, but the resident did have a neck collar on and it was never taken off. She indicated she left at 2:00 P.M. and was not there when resident left the facility.

On 9/29/21 at 11:04 a.m., the Administrator indicated there had been no lab work completed, at the facility, for Resident C.

On 9/29/21 at 12:03 P.M., the Administrator indicated there were no shower sheets or documentation indicating the resident received a shower and/or bed bath during her days at the facility.

During an interview, on 10/1/21 at 10:06 a.m., the MDS Coordinator indicated she had completed the Admission Assessment for Resident C. She indicated she had not observed the skin tears nor the surgical wounds but had assessed the resident for pain. She indicated she obtained the information, about the surgical wounds, from the

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SPRENGER HEALTH CARE OF MISHAWAKA	60257 BODNAR BLVD MISHAWAKA, IN 46544

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NP's assessment, on 8/24/21 and the skin tear information from the facility's admission assessment form. She indicated she had updated the skin integrity care plan, on 9/1/21, with interventions to assess for pain with dressing changes, monitor for signs and symptoms of infection and monitor intake and ensure/encourage adequate nutrition and hydration. She provided the NP history form, dated 8/24/21, where there was a sentence which said the following: "...Patient underwent cervical spine decompression surgery on August 14...." The MDS Coordinator indicated the facility had a form to document non-pressure related skin issues, such as skin tears and incisions. The resident's clinical record did not include these forms.

During an interview, on 9/30/21 at 11:55 p.m., the ED Forensic Registered Nurse (RN) from the hospital Resident C was sent to, on 9/10/21, indicated she had an Abuse and Neglect form, which included an assessment and photos of Resident C's wounds.

A form titled, "Elder & Dependent Adult Abuse and Neglect Part II: Medical Assessment, dated 9/10/21 at 4:00 P.M., indicated Resident C had the following concerns labeled on a diagram:

- frontal view-right lower extremity laceration with steri-strips and bruising to anterior lower extremities.
- posterior (back) view - a Stage III pressure ulcer (pressure injury with full-thickness skin loss) appeared to be getting infected,
- a mepilex dressing over a left hip skin tear,
- 19 staples from iliac crest bone graft,
- Stage II pressure ulcer on right elbow,

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- Stage I pressure ulcer on each heel that was non-blanchable (skin redness that does not turn white when pressed),
- redness with bruising noted on bilateral posterior arms.

These findings were photographed. The nursing note, part of the assessment, dated 9/10/21, indicated "...Large Stage 3 pressure ulcer/wound noted on buttocks as well as 19 staples. Pt [patient] also has staples in back of neck, however C-Collar not removed to assess...Pt [patient] also has a Stage 2 ulcer on right elbow and Stage 1 ulcers (non-blanchable redness) on both heels as well as multiple areas of bruising on her extremities. She also has a laceration on her lower leg that looks fairly recent. Pt [patient] is lethargic but responds to voice and pain...." The photos were observed and confirmed the observations of the forensic nurse's assessment indicating Resident C had additional pressures wounds of the sacrum, bilateral heels and right elbow. The dressing on the left hip/medial buttock was undated, and forensic nurse indicated underneath, the dressing, was a skin tear. However, after the dressing was removed, from the area, it was documented as a pressure ulcer, Stage II.

Observation of the ED's photograph of Resident C's 20 photographs included with the 9/10/21 admitting assessment, reflected a wound to resident's sacrum with full-thickness skin loss. At least 80 percent of the wound was black or yellow. A wound to her left buttocks was covered with a dressing. The skin around the dressing was red, and there was a yellow discharge visible on the surface of the dressing. Her heels were a bright red color. There was full-thickness skin

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loss to her elbow and the inner edges of the wound had a light brown color.

Resident C's Operative/ Procedure Report, dated 9/14/21, had a description of the procedure which indicated a "cautery [burning a part of the body to remove it] was used to dissect around the obviously demarcated [boundary] area of necrotic tissue overlying the sacrum. This is a full-thickness skin and subcutaneous dissection which did include some muscle. The dimension of the sacral portion is 10 x 15 cm. This is taken down to the bone but not including the bone. There is some foul odor and minimal amount of purulence [pus]. This was sampled with a swab ...."

A Progress Note, from the hospital, dated 9/16/21, indicated the following: " ...Reviewed the Gram stains [a method of staining used to differentiate bacteria] as well as culture from wound. Still growing some Enterococcus faecalis, few gram-negative's and a few gram-positive's ...."

On 9/28/21 at 3:24 P.M., the Administrator provided a policy titled, "Wound Prevention & Management Policy, dated 10/2014, 9/2019 and 8/2021 and indicated the policy was the one currently used by the facility. The policy indicated "...Facility comprehensive assessment will consist of: 1. A complete body skin check on admission by a nurse...A Wound Assessment will be documented on discovery of the wound then weekly thereafter until the wound heals...Weekly skin checks will be performed by licensed nurse...CNAs will monitor skin during care for signs of breakdown and notify nurse in charge of that resident...."

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F 686	Continued From page 28 The immediate jeopardy that began, on 8/19/21, was removed, on 10/5/21, when the facility began in-servicing staff on the following: abuse/neglect policy-all staff (9/16/21 and just neglect on 10/4/21), pressure ulcer prevention, wound care & showers-nursing staff (9/29/21-9/30/21), review of wound prevention/management policy-nursing staff (10/4/21), and a full house sweep, head to toe, skin observations (completed on 9/30/21), but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all audits had not been completed for at least a week. This Federal tag relates to complaint IN00362482.	F 686		
F 692 SS=G	3.1-40(a)(1) 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- §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;	F 692		10/29/21

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§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to 1 of 4 resident reviewed for weight loss maintained acceptable parameters of nutritional and hydration status. This failure resulted in a significant weight loss, development of a pressure wound, slow healing incisions and hospitalization with decreased dehydration with encephalopathy (decreased mentation) and additional pressure ulcers discovered upon her arrival at the Emergency Department. (Resident C)

Finding includes:

On 9/27/21 at 12:39 p.m., a review of the clinical record for Resident C was conducted. The record indicated the resident was admitted on 8/19/21 and discharged to a local hospital on 9/10/21. The resident's diagnoses included, but were not limited to: Crohn's disease (a type of inflammatory bowel disease with symptoms of diarrhea and weight loss), diabetic, quadriplegia (occurs when the neck area of the spinal cord is injured) C5-C7 (area of neck involved)-incomplete (having some movement), cervical spine fusion, malnutrition, COPD (Chronic Obstructive Pulmonary Disease) and osteoporosis.

The Admission Assessment, dated 8/19/21, indicated the resident was admitted with a skin tear to the right wrist and left forearm. The

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assessment indicated the resident had no pressure wounds and had her own teeth. The resident's weight was 128.2 using scale in a weight chair.

A care plan, dated, 8/20/21 and revised on 8/23/21, indicated the resident was at risk for decreased nutritional status, malnutrition, and dehydration due to abnormal labs, advanced age, decreased mobility, inadequate oral intake, multiple medications, and specific food preferences. The interventions included, but were not limited to: Adaptive devices: two-handled cup with scoop lid to place straw for beverages and soup, assist with meals; feed resident as needed, resident likes fruits veggies (pears, peaches, green beans specifically), carrots, mashed potatoes and gravy, baked potatoes, peanut butter, smoothies, protein foods, dessert after dinner, monitor oral intakes, monitor weight per protocol, offer/encourage increased oral fluid between meals, fortified foods, and provide supplements as ordered.

Another care plan, dated 8/20/21, indicated the resident had the potential for a fluid volume deficit related to the use of a diuretic. The interventions included, but were not limited to: electrolytes within normal limits, skin turgor normal, mucous membranes moist, no acute change in mental status, good oral care twice a day and Dietitian to determine fluid needs

A Nutrition/Dietician Progress Note, dated 8/24/21, indicated the resident's weight at admission was 128.2 and her intake of meals and supplements was not adequate to meet her needs. The resident had reported a 6-pound weight loss in the last 90 days and indicated she

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had always been "slender" due to 40-year history of Crohn's disease. Resident denied oral supplement use, stated she took protein powder at home and would ask son to bring protein bars. Resident was educated on the importance of protein needs for rehabilitation. She had no alterations to skin related to pressure. The hospital labs were reviewed and reflected low total protein and magnesium levels. Supplements added were a multi-vitamin, magnesium, potassium and vitamin D. Medications include; steroid use that may affect appetite/weight, and (hydrochlorothiazide) a diuretic.

The Admission Minimum Data Set (MDS) Assessment, dated 8/26/21, indicated the Brief Interview for Mental Status (BIMS) score was 15 (normal cognition). The assessment indicated the resident required supervision/oversight/encouragement of one person with eating and her range of motion was impaired in both upper and lower extremities. The resident weighed 116 pounds and had a weight loss of 5 % in the last month and was not on a physician prescribed weight-loss regimen. The assessment indicated she had a surgery which included fusion of spinal bones with a surgical wound.

A Weight Change Progress Note, dated 8/26/21 at 2:02 P.M., documented by the Dietician, indicated the resident's weight was 116 (used chair weigh scale), which was a 12-pound weight loss since admission. The resident had specific food preferences and limited meal intake that may have contributed to her weight loss. Note indicated Dietician would add fortified foods to the resident's diet and recommend house supplement, 4 ounces, twice a day. No other

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weights were documented after this date.

A Progress Note, dated 8/26/21 at 5:18 P.M., indicated the facility had conducted a care plan meeting with the resident and the resident's son. The note indicated the resident's weight was stable, appetite was fair and there were no dietary concerns.

A Weights and Vitals Summary form for August 2021 through September 2021 indicated the percentage (%) of a meal, eaten by the resident was documented on 2 days, on 8/31/21 at 9:12 A.M. & 13:26 P.M., and on 9/7/21 at 11:05 a.m. During each of these meals, it was documented, the resident ate 51-75% of her meal. There was no other documented meal intake for Resident C. The weights recorded were as follows: 8/20/21 - 128.2 (weight chair), 8/26/21 - 116 (weight chair) and reweigh 8/26 - 116.2 (weight chair). There were no other documented weights on the form.

A form titled, "Elder & Dependent Adult Abuse and Neglect Part II: Medical Assessment, dated 9/10/21 at 4:00 P.M., was received from the ER-Forensic nurse. The form indicated Resident C had the following concerns labeled on a diagram: frontal view-right lower extremity laceration with steri-strips and bruising to anterior lower extremities. The posterior view - a Stage III pressure ulcer-appeared to be getting infected, a mepilex dressing over a left hip skin tear. There were 19 staples on the left iliac crest (post bone graft), a Stage II pressure ulcer on right elbow, and Stage 1 pressure ulcer on each heel, that was nonblanchable, with redness. Bruising noted on bilateral posterior arms. These findings were photographed. The nursing note, part of the assessment, dated 9/10/21, indicated "...Large

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Stage 3 pressure ulcer/wound noted on buttocks as well as 19 staples. Pt [patient] also has staples in back of neck, however C-Collar not removed to assess...Pt [patient] also has a Stage 2 ulcer on right elbow and stage 1 ulcers (nonblanchable redness) on both heels as well as multiple areas of bruising on her extremities. She also has a laceration on her lower leg that looks fairly recent. Pt [patient] is lethargic but responds to voice and pain...." The photos were observed and confirmed the observations of the Forensic nurse's assessment of Resident C. The dressing on the left hip/ilias was removed and presented with pressure ulcer which was infected and debrided, on 9/14/21.

A Hospital History & Physical (H&P), dated 9/19/21, indicated "...an 80-year-old lady who was my patient from 8/10 to 8/19 for lower extremity weakness and upper extremity neuropathy [a malfunction of the nerves] that found to be due to compression at the level of C3-C4 [cervical region of spinal cord] and had bilateral cervical decompression from C2-C7 by [name of physician]. Patient was discharged stable to [name of facility]...Today 9/10 she was sent from [name of facility] confused, nonresponsive. Apparently found in very poor condition covered in feces (according to the ER attending) with a pressure ulcer in sacral area...." The H&P indicated the residents blood work, at admission was a low albumin of 2.1 (low levels may indicate malnutrition) and a high BUN (Blood Urea Nitrogen) level of 50 (higher than normal levels indicate a kidney problem/dehydration) normal level is between 8-23.

A Hospital Progress Note, dated 9/16/21, indicated the resident was growing Enterococcus

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faecalis [found in fecal matter and other organisms in her wound cultures of her ducubitus ulcers.

During an interview, on 9/28/21 at 3:36 P.M., the Regional Director/RN indicated there was no documentation reflecting the resident was receiving adequate fluids, as the resident was not a physician ordered I&O (input & output) monitoring.

During an interview, on 10/1/21 at 12:42 P.M., the Dietician indicated when Resident C had the weight loss, she provided her recommendations, for the physician, by completing a referral form with a summary of her findings, such as weight loss. This form was provided to the Administrator, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) to communicate her findings with the physician and she assumed the nurses were responsible to make the notification to the physician.

During an interview, on 10/1/21 at 3:25 PM the DON indicated the summary of the Dietitian's notes were forwarded to her and the ADON and indicated it would be her or the ADON who would contact the Medical Doctor (MD) and/or family of the weight loss. She indicated she did not not think there was any documentation she had notified the MD. She indicated the facility had a weekly "focus" meeting to discuss weight loss. She doesn't remember if the resident was part of the focus.

During an interview, on 10/2/21 at 11:50 A.M., the Director of Nursing (DON) indicated the facility had a nutrition at risk form called "Focus" and residents were added to this list, by the Dietician,

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when they have a significant weight loss and/or wounds. The Dietician would send a list of residents who should be placed on weekly weights. This list went to the Medical Records Certified Nurse Aide (CNA) 4. The DON indicated, on 8/23/21, Resident C was added to the weekly weight list. The DON indicated the resident was on the Focus form and the Nutrition Recommendation form for 8/26/21, indicating the resident had a weight loss of 12.2 pounds in less than 30 days. The resident was on the weekly weight list again, on 8/29/21, however she was never weighed weekly as directed by the weekly weight list. The DON indicated she had no record of the physician and/or Nurse Practitioner were notified of the resident's weight loss. A weight list for the following week was requested but never provided.

On 9/30/21 at 11:29 A.M., the Administrator provided a policy titled, "Weight Change Policy," dated 3/2014 and indicated the policy was the one currently used by the facility. The policy indicated "...POLICY: It is the policy of [name of the facility] to ensure weights are obtained as ordered and are monitored appropriately. PROTOCOL: The facility shall ensure the following: 1. Notify the physician and resident representative of significant wight gains or losses of 5% in 30 days, 7.5% in 3 months or 10% in 180 days since the last documented weight. a. Re-weights will be obtained to verify weight. b. Documentation of notification will be noted in the resident's clinical record...3. Intake of food will be documented in the resident's clinical record by the STNA [State Tested Nursing Assistant]. 4. Weekly weights will be obtained as recommended by RD [Registered Dietician and/or physician...."

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F 692	Continued From page 36 On 9/30/21 at 11:29 A.M., the Administrator provided a policy titled, "Hydration Policy", dated 7/2011 and revised on 1/2021 and indicated the policy was the one currently used by the facility. The policy indicated "...POLICY: To ensure that residents have access to fluids throughout the day as needed and as requested by the residents unless ordered or restricted by the physician...." This Federal tag relates to complaint IN00362482. 3.1-46(a)(1) 3.1-46(2)(b)	F 692		