STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: August 7, 8, 9, 10, 11, 14, and 15, 2023 Facility number: 000010 Provider number: 155026 AIM number: 100453660 Census Bed Type: SNF/NF: 121 Residential: 34 Total: 155 Census Payor Type: Medicare: 21 Medicaid: 60 Other: 40 Total: 121 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 18, 2023.	F 0000	Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. Greenwood Village South reserves the right to challenge, in legal proceedings, all deficiencies, statements, findings and facts and conclusions that form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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

Pamela Seegers 09/03/2023

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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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview, and record review, the facility failed to provide care in a dignified manner for 1 of 1 meal observations. Residents sitting at the same table were not served at the same time and residents were not	F 0550	I. Resident 53, 86, 41 ,89, 9, 100, and 94 experienced no harm from the alleged deficient practice. It is GVS policy that residents sitting at the same dining room table be served one right after the other so	09/08/2023

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	assisted immediately after their meal was served. (Resident 53, Resident 86, Resident 41, Resident 89, Resident 9, Resident 100, Resident 94) Finding includes: During the noon meal the following was observed. On 8/7/23 at 11:55 a.m., Resident 53's food was sitting in front of him covered. Staff were not observed to be assisting Resident 53 with the food. Resident 86 was seated directly beside Resident 53. Resident 86 was observed to be eating the noon meal. At 12:04 p.m., Qualified Medication Aide (QMA) 6 was observed to assist Resident 53 with his noon meal. Resident 41 was observed to be sitting at the same table. Resident 41 was not served the noon meal until 12:06 p.m. Resident 89 was observed to be sitting at the same table. Resident 89 was not served the noon meal until 12:07 p.m. Resident 89's noon meal was observed to remain covered. Resident 9 was observed to be sitting at the same table. Resident 9 was not served the noon meal until 12:11 p.m. Resident 100 was observed to be sitting at the same table. Resident 100 was not served the noon meal until 12:12 p.m. Resident 94 was observed to be sitting at the same table. Resident 94 was not served the noon meal until 12:13 p.m. At 12:17 p.m., QMA 7 was observed to assist Resident 89 with the noon meal. On 8/9/23 at 1:09 p.m., Licensed Practical Nurse (LPN) 75 indicated during meals residents sitting at the same table should be served at the same time. On 8/11/23 at 2:50 p.m., the Corporate Nurse		that all residents sitting together can eat their meal together, providing a dignified dining experience. When all the residents at one table have been served, staff will proceed to the next dining room table and continue the same order of serving each resident at the table. Once the table is served, residents at that table will be assisted by staff if needed. II. All residents residing in the facility had the potential to be affected. The dining room tables were immediately separated to ensure staff were able to serve one table of residents before serving the next table of residents. Dogwood unit room tray cards and Oaks Dining Room tray cards were audited to ensure proper location of tray delivery for each resident. When a resident chooses an alternate location (example: room versus dining room) to have their meal served, staff will continue to accommodate this choice and ensure the meal is served in the appropriate order and timeframe. When all the residents at one table have been served, staff will proceed to the next dining room table and continue the same order of serving each resident at the table. Once the table is served, residents at that table will be assisted by staff if needed. III. The Assistance with Meals Policy has been reviewed and	

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	Consultant provided the current "Assistance with Meals" policy, revised 3/2022. The policy included, but was not limited to, Resident's who cannot feed themselves will be fed with attention to safety, comfort, and dignity. 3.1-3(a)		found to meet clinical standards. Education provided to Greenwood Village South Health Center Nursing Staff and Dining Staff on the Assistance with Meals Policy including Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. Additional systemic changes are being addressed through our quality assurance process described below. Education to be completed with all nursing staff and dining staff no later than 9/8/2023. IV. Director of Nursing or designee will: Audit meal service in each dining room, at random mealtimes, weekly for 3 months, then monthly for 9 months. Results of all audits will be brought to QAPI every month for review and discussion as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would			

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	endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for 1 of 1 random observations. A resident's call light was not within reach. (Resident 73) Finding includes: On 8/8/23 at 10:36 a.m., Resident 73 was observed to be calling out for assistance. Resident 73 indicated she needed assistance to the bathroom but did not know where her call light was. At that time, Resident 73's call light was observed to be behind the resident resting on the beside table, out of reach of Resident 73. On 8/9/23 at 10:15 a.m., Resident 73's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) Assessment, dated 7/14/23, indicated Resident 73 had mild cognitive impairment and required extensive assistance of two persons for transfers. On 8/11/23 at 2:50 p.m., the Corporate Nurse Consultant provided the current "Resident Call System" policy, dated 9/2022. The policy indicated, each resident is provided with means to call staff directly for assistance. 3.1-3(v)(1)	F 0558	I. Resident 73 experienced no harm from the alleged deficient practice. Resident 73 was immediately taken to the restroom upon being notified of the need for assistance. After being toileted, Resident 73 was returned to chair and call light was placed within reach. It is the policy of GVS that all residents have a way to directly summon staff for assistance at any time. II. All residents residing in the facility had the potential to be affected. III. The Resident Call System Policy was reviewed and found to meet clinical standards. Education provided to all Greenwood Village South nursing staff regarding making sure residents have a way to summon staff for assistance at any time by assuring the resident call light is within reach. Education will be completed with all nursing staff no later than 9/8/2023. IV. Director of nursing or designee will: Audit to verify call lights are within reach of the resident, during all three shifts and at random times, weekly for 3 months, then monthly for 9 months. Completed audits will be submitted to QAPI committee monthly for review and discussion until such time	09/08/2023

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			consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. .	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the accuracy of resident assessments for 2 of 3 residents reviewed for resident assessment. (Resident 101, Resident 98) Findings include: 1. On 8/9/23 at 11:06 a.m., Resident 101's clinical record was reviewed. A PASRR (Preadmission Screening and Resident Review) Level 2, dated 3/23/22, indicated Resident 101 had a serious mental illness. The Annual MDS (Minimum Data Set) Assessment, dated 3/9/23, indicated Resident 101 did not have a mental illness. On 8/9/23 at 1:12 p.m., the MDS Coordinator, indicated Resident 101's assessment was inaccurate. 2. On 8/9/23 at 11:11 a.m., Resident 98's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) Assessment, dated 7/7/23 indicated Resident 98 received one insulin injection during the assessment period.	F 0641	I. Resident 101 and Resident 98 experienced no harm from the alleged deficient practice. It is the policy of GVS to assure that the information captured on the MDS assessment accurately reflects the status of the resident. Resident 101 and Resident 98's assessments were immediately modified. II. All resident records that have a PASRR Level 2 indicating "Mental Illness" were audited to assure that "Mental Illness" was documented properly on the resident's MDS. All resident records that have a current physician order for "Trulicity" were audited to assure that "Trulicity" was not documented on the resident's MDS as an "insulin injection." III. The Certifying Accuracy of the Resident Assessment Policy was reviewed and found to meet clinical standards. Education provided to Greenwood Village South MDS staff regarding	09/08/2023

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	The Physician's Orders and July 2023 MAR (Medication Administration Record), lacked an order or administration of an insulin. On 8/9/23 at 1:12 p.m., the MDS Coordinator indicated she thought Trulicity (an injectable medication that increases the body's insulin production) was an insulin. On 8/11/23 at 2:50 p.m., the Corporate Nurse Consultant provided the current "Certifying Accuracy of the Resident Assessment" policy, revised 11/2019. The policy indicated the information captured on the assessment reflects the status of the resident. 3.1-31(d)		accurately documenting mental illness and insulin administration on the MDS. Additional systemic changes are being addressed through our quality assurance process described below. Education will be completed with both MDS Coordinators by 9/1/2023. IV. Director of Nursing or designee will: Audit 2 MDS assessments for accuracy, specifically related to mental illness and insulin injections, weekly for 3 months, then monthly for 9 months. Completed audits will be submitted to the QAPI committee monthly for review and discussion until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. .	
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 observation, interview and record	F 0684	I. Resident 3 experienced no harm from the alleged deficient	09/08/2023

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	review, the facility failed assess a resident for polyneuropathy and the need for a topical medication treatment. The facility lacked a Physician's Order for a medicated pain cream for the treatment of leg pain and to allow the resident to keep a medicated pain cream at the bedside. The facility failed to prevent a CNA from applying a medicated pain cream to a resident. (Resident 3, CNA 2, CNA 3) Findings include: On 8/10/23 at 10:30 a.m., CNA (Certified Nurse Aide) 2 and CNA 3 were observed providing personal care to Resident 3. Resident 3's legs were observed; and no pain or skin conditions were noted while personal care was being provided. At the conclusion of the personal care, CNA 2 asked CNA 3, "Did you put the pain cream on Resident 3?" CNA 3's response was "No, not yet." At that time, CNA 2 applied Triderma Pain Relief Cream - Maximum Strength (a medicated topical cream for nerve pain) to Resident 3's legs from the hip area to the toes. During an interview at that time, CNA 2 indicated the medicated cream was used to help decrease pain in Resident 3's legs. During an interview at that time, Resident 3 indicated the cream was for her leg pains. During an observation with the DNS (Director of Nursing Services) on 8/10/23 at 10:55 a.m., a Triderma Pain Relief Cream 4 ounce jar was observed in Resident 3's unlocked top drawer of her bedside table. The jar lacked a pharmacy label that indicated the resident's name or the		practice. Medicated pain relief cream was removed from Resident 3's room, per Resident 3's permission. It is the policy of GVS to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices. II. All residents residing in the facility have the potential to be affected. CNAs involved were educated that that they cannot apply any medicated cream and that all resident requests for medicated cream application should be referred to the nurse to evaluate and address. III. The Administering Medications Policy and Certified Nursing Assistant jo descriptions were reviewed and meet clinical standards. Education provided to GVS CNAs regarding their scope of practice specific to what topical creams/lotions they can apply versus what topical creams/lotions they cannot apply. Additional systemic changes are being addressed through our quality assurance process described below. Education will be completed with all nursing staff no later than 9/8/2023. IV. Director of Nursing or designee will: Observe care provided by C.N.A.s to assure the C.N.A.s are not applying any type of medicated cream on a	

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	physician's order for the medication. During an interview at that time, Resident 3 indicated she had ordered the cream, kept it in the top drawer of her bedside table, and staff applied the cream to her legs every day. During an interview on 8/10/23 at 11:05 a.m., the Unit Manager indicated she was unaware that Resident 3 had the Triderma Pain Relief Cream in her room. The Unit Manager was also unaware that CNA 2 had applied the cream to Resident 3's legs. CNA 2 should not have applied the cream to Resident 3's legs. During an interview on 8/10/23 at 11:10 a.m., the DNS indicated it was outside of the scope of practice for a CNA to apply or administer any type of medications to a resident. Resident 3 should not have had the cream at her bedside without a Physician's Order. The facility failed to assess Resident 3 to determine if the Resident was appropriate to keep the medication at her bedside. During an interview on 8/11/23 at 2:20 p.m., the CNA Training Coordinator indicated the CNA staff were not supposed to administer or apply any type of medications to the residents. During an interview on 08/14/23 at 8:41 a.m., Resident 3 indicated she has used the cream for about 5 years. Resident 3 indicated "a while ago" she had notified the therapy department and a nurse about using the cream. The CNAs applied the cream twice a day to elevate the leg pain. During an interview on 8/14/23 at 10:12 a.m., LPN (Licensed Practical Nurse) 4 indicated it was outside the scope of practice for a CNA to apply medicated creams or ointments to any residents.		resident. This audit will consist of observation of 2 C.N.A.s per shift one time per week for a total of 6 observations per week for 3 months, then 2 C.N.A.s per shift one time per month for 9 months. Completed audits will be submitted to the QAPI committee monthly for review and discussion until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance.	

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	During an interview on 8/14/23 at 10:14 a.m., CNA 5 indicated CNAs were not supposed to apply any medicated creams to residents. During an interview on 8/14/23 at 10:14 a.m., CNA 8 indicated CNAs were not allowed to apply any medicated creams to residents. On 8/09/23 at 2:11 p.m., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, pain, polyneuropathy (nerve damage affecting many nerves in different parts of the body), and osteoarthritis. A Physician's Order and a nursing measure, effective 2/4/22 with no end date, indicated nursing staff were to assess and record Resident 3's pain level every shift. A review of the August Medication Administration Record (MAR) report indicated Resident 3 was without any pain during that time frame. A Physician's Order and a nursing measure, effective 2/4/22 with no end date, indicated nursing staff were to assess and record Resident 3's skin condition weekly. A review of the August MAR report indicated Resident 3 was without any skin conditions during that time frame. The Quarterly MDS (Minimum Data Set) Assessment, dated 6/21/23, indicated Resident 3 was cognitively intact. The clinical record lacked a Physician's Order for Triderma Pain Relief Cream - Maximum Strength (cream).			

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	The clinical record lacked an assessment for Triderma Pain Relief Cream - Maximum Strength (cream) to be kept at Resident 3's bedside. On 8/11/23 at 9:08 a.m., the Corporate Nurse Consultant provided a copy of CNA 2's Job Description. A review of the document indicated, "...The Nurses Aide assists the licensed nursing staff by performing routine nursing duties and activities of daily living...assists residents with dressing, grooming, eating, bathing, positioning, turning, toileting, and exercising...Successful completion of a State approved geriatric nursing assistant training program...I understand the information contained in the Job Description..." The document was signed by CNA 2 on 6/27/23. On 8/11/23 at 9:08 a.m., the Corporate Nurse Consultant provided a copy of CNA 3's Job Description. A review of the document indicated, "...Nurse Aides assist the licensed nursing staff by performing routine nursing duties and activities of daily living...assists residents with dressing, grooming, eating, bathing, positioning, turning, toileting, and exercising...Successful completion of a State approved geriatric nursing assistant training program...I understand the information contained in the Job Description..." The document was signed by CNA 3 on 1/15/19. On 8/10/23 at 11:44 a.m., the DNS provided a copy of the Administering Medications policy, dated December 2022, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so...Medications must be administered in accordance with the orders...topical medications used in treatments must be recorded on the			

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	resident's treatment record...shall reevaluate ...examine the individual ...determine if there is a clinical reason for ...the medication ..." On 8/10/23 at 11:44 a.m., the DNS provided a copy of the Administering Topical Medications policy, dated October 2010, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...this procedure is to provide guidelines for the safe administration of topical medications...verify that there is a physician's medication order...follow the medication administration guidelines in the policy entitled Administering Medications...assess the area for broken skin, drainage, debris, rashes, allergic reaction or signs of infection ..." 3.1-37(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing			

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	155026	A. BUILDING 00 B. WING	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

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	data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily posted nurse staffing reflected the actual hours worked by staff, as indicated by facility policy for 3 of 7 days during the survey period. Findings include: On 8/7/23 at 9:30 a.m., observed the daily posted nursing hours. The posted nursing hours did not indicate actual worked hours. On 8/8/23 at 8:54 a.m., observed the same. On 8/9/23 at 8:50 a.m., observed the same. On 8/9/23 at 11:30 a.m., the Director of Nursing (DON) indicated the facility posted the shifts daily, and indicated the posting of facility hours had not included the actual working hours.	F 0732	I. No residents were affected by the alleged deficient practice. The facility added specific shift times to the posting during the survey immediately upon surveyor notification that “actual hours worked” was defined by CMS as specific shift times, not just total hours worked by each staff person for the shift. It is the policy of GVS to assure that the posted nursing staff information is updated daily with the facility name, current date and hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. II. As stated above, daily staff posting was changed to reflect specific hours of staff during the	09/08/2023

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	On 8/9/23 at 11:30 a.m., the DON provided a policy titled Posting Direct Care Daily Staffing Numbers, dated August 2022, and indicted it was the current policy being used by the facility. A review of the policy indicated, "Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. ...g. The actual time worked during that shift for each category and type of nursing staff."		survey. III. The Posting Direct Care Staffing Numbers Policy was reviewed and found to meet clinical standards. Education provided to Greenwood Village Pavilion Staffing Coordinator and designee on including specific shift times on the daily nursing staff posting. Additional systemic changes are being addressed through our quality assurance process described below. IV. Director of Nursing or designee will: Audit daily nursing staff posting to ensure specific hours are listed on staff posting completed every day, including weekends, for one month, then one time weekly for 2 months, then one time monthly for 9 months. Completed audits will be submitted to QAPI committee monthly for review and discussion until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. .	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.	R 0000	Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts	

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	Survey dates: August 7, 8, 9, 10, 11, 14, and 15, 2023 Facility number: 000010 Residential Census: 34 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.		alleged in this statement of deficiencies and Plan of Correction. Greenwood Village South reserves the right to challenge, in legal proceedings, all deficiencies, statements, findings and facts and conclusions that form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure physician orders for daily weights were obtained and documented in the clinical record, for 1 of 7 residents, reviewed for weights. (Resident 12) Finding includes: On 8/14/23 at 2:00 p.m., Resident 12's clinical record was reviewed. Resident 12 was admitted to the facility on 4/13/23. Resident 12's weight at the time of admission was 177 pounds. On 8/14/23, Resident 12's weight was 192 pounds.	R 0349	I. Resident 12 experienced no harm from the alleged deficient practice. It is the policy of GVS to maintain clinical records on each resident related to daily weights. II. Four other residents with daily weight orders had the potential to be affected. An audit of those four resident records was completed and ensured the task of daily weight was added to the order. III. The Medication Orders and Weight Assessment and Intervention Policies were reviewed and found to meet clinical standards. Education provided to	09/08/2023

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	Diagnosis included, but were not limited to, diabetes and hypertension. Physician Orders included, but were not limited to, "daily weight, once a day, notify MD [Medical Doctor] for a gain of 3 lbs [pounds] in 24 hours or 5 lbs in 1 week, start date: 4/13/23; end date: open ended [no end date]." The Counseling Evaluation Report, dated 6/27/23, indicated Resident 12 was mildly cognitively impaired. The MAR (Medication Administration Record), dated 4/15/23 to 5/15/23, indicated daily weights were obtained as indicated by the staff's initials for each date. The MAR lacked a specific weight measurement for each date. The MAR, dated 5/16/23 to 6/15/23, indicated the same as above. The MAR, dated 6/16/23 to 7/14/23, indicated the same as above. The MAR, dated 7/15/23 to 8/14/23, indicated the same as above. The Vitals Report, dated 4/13/23 to 8/14/23, indicated the following: -April lacked documented weights for 16 of 18 days; -May lacked documented weights for 26 of 31 days; -June lacked documented weights for 16 of 30 days;		Greenwood Village South Director of Resident Services and to Residential nursing staff regarding the importance of ensuring daily weight was obtained and documented per each resident with a daily weight order. Additional systemic changes are being addressed through our quality assurance process described below. This education with the AL Director and all AL nursing staff will be completed by 9/8/2023. IV. Director of Nursing or designee will: Audit resident records with an order for daily weights daily (Monday through Friday. Weekend weights will be reviewed on Monday) for one month, then weekly for 2 months, then monthly for 9 months. Completed audits will be submitted to QAPI committee monthly for review and discussion until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance.	

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	-July lacked documented weights for 20 of 31 days; and -August lacked documented weights for 10 of 14 days. During an interview on 8/15/23 at 9:35 a.m., Licensed Practical Nurse 2 indicated when Resident 12 was malnourished at the time of admission and has steadily gained weight. At the time of admission, Resident 12's Physician had ordered daily weights. The daily weights were to be documented in the clinical record. However; not all daily weights were obtained or recorded in the clinical record. During an interview on 8/15/23 at 9:45 a.m., the DNS (Director of Nursing Services) indicated Resident 12 was supposed to have daily weights taken and recorded in the clinical record. The clinical record lacked documentation that daily weights were obtained and recorded. On 8/15/23 at 10:20 a.m., Resident 12 indicated staff weighed him "maybe every week or so...definitely not on a daily basis." On 8/15/23 at 9:51 a.m., the DNS provided a copy of the Medication Orders policy, dated January 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders...each resident must be under the care of a Licensed Physician...when recording orders...specify the type...frequency..." On 8/15/23 at 9:51 a.m., the DNS provided a copy of the Weight Assessment and Intervention			

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	policy, dated September 2008, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents...weights will be recorded in each...individual's medical record...."			