STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING 00 B. WING	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This Visit was for the Investigation of Complaint IN00423380 and IN00423815. Complaint IN00423380 -- Federal/State deficiencies related to the allegations are cited at F623 and F692. Complaint IN00423815 -- Federal/State deficiencies related to the allegations are cited at F686 and F692. Survey dates: Janurary 2, 3 and 4, 2024 Facility number: 014265 Provider number: 155857 AIM number: 300029339 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type: Medicare: 0 Medicaid: 30 Other: 3 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on January 11, 2024	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the the plan of correction be considered effective January 23, 2023 to the complaint survey completed on January 4, 2024. The facility also requests that our plan of correction be considered for paper review. The facility would be happy to submit to you any additional paperwork that you would need for review.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Craig	Administrator	01/24/2024

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	resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			

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	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the			

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	facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure the transfer and discharge documents were provided and/or completed prior to a facility-initiated transfer to an area hospital for 2 of 3 residents reviewed for transfer and discharge rights. (Residents C and D) Findings include: 1. The clinical record of Resident C was reviewed on 1-2-24 at 10:46 a.m. It indicated his diagnoses included, but were not limited to, traumatic subdural hematoma, acute and chronic respiratory failure, nontraumatic subarachnoid hemorrhage, moderate protein-calorie malnutrition and cerebral infarction as a result of a pedestrian injured in traffic accident. A progress note, dated 12-9-23 at 4:02 p.m., indicated Resident C was sent to an area hospital for care, related to an elevated serum sodium level. In an interview with the Director of Nursing (DON) on 1-4-23 at 12:15 p.m., indicated she was able to locate the copies of the transfer-discharge	F 0623	F623 Notice Requirements Before Transfer/Discharge It is the practice of this facility to assure that a Transfer/Discharge Notice is provided prior to a facility-initiated transfer to hospital. The correction action taken for the residents found to be affected by the deficient practice include: Residents C and D were past transfers. Since it would not be possible to correct on these residents, please refer to systems changes and monitoring below. Other residents that have the potential to be affected have been identified by: Potentially all residents with transfers and discharges could be affected. The measures or systematic changes that have been put into	01/23/2024

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	paperwork sent with Resident C at his facility-initiated transfer to a local hospital on 12-9-23. This documentation was incomplete for the documentation as of the date of the transfer. The documentation failed to have the following information completed on the forms: -the location and address of the facility or hospital the resident was sent to. -the reason for the transfer. -the facility staff contact person name printed on the form was a staff member no longer employed by the facility. 2. The clinical record of Resident D was reviewed on 1-3-24 at 10:10 a.m. His diagnoses included, but were not limited to acute respiratory failure, congestive heart failure, metabolic encephalopathy, nontraumatic subarachnoid hemorrhage and traumatic subdural hemorrhage. He resided on the ventilator unit of the facility. In review of a progress note, dated 12-22-23 at 3:30 a.m., it indicated Resident D was unresponsive and required cardiopulmonary resuscitation (CPR). The facility contacted emergency services at 3:45 a.m., with CPR continuing until the resident was transferred by emergency services to an area hospital. In an interview with the Director of Nursing (DON) on 1-4-24 at 12:15 p.m., indicated this resident was sent out on 12-22-23 in an "emergent manner" and she was unable to locate the usual transfer/discharge paperwork sent with residents. She indicated the usual paperwork sent with a resident upon transfer to the hospital emergency room included, but was not limited to, the face sheet, physician orders and the state-mandated transfer and discharge paperwork and the bedhold policy.		place to ensure that the deficient practice does not recur include: Nurses have been inservice on how/where to print the transfer and packets have been initiated that include bed hold policy and blank transfer discharge forms. The corrective action taken to monitor performance to assure compliance through the quality assurance is: A Performance Improvement Tool has been initiated that reviews all residents discharged to the hospital to ensure that the transfer/discharge packet with bed hold is provided to facility receiving the transfer. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: January 23, 2024	

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	On 1-4-24 at 3:17 p.m., the Corporate Nurse provided a copy of a policy entitled, "Transfer or Discharge Notice," with a revision date of March, 2021, and was indicated to be the current policy utilized by the facility. This policy indicated, "Transfer and discharge includes movement of a resident from a certified bed in the facility to a non-certified bed in another part of the facility, or to a non-certified bed outside of the facility...Specifically: transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility...Residents are permitted to stay in the facility and not be transferred or discharged unless the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility...Except as specified below, the resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from the facility. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge...An immediate transfer or discharge is required for the resident's urgent medical needs..The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged; d. An explanation of the resident's rights to appeal the transfer or discharge to the state..., e. The facility bed-hold policy..." This Federal tag relates to Complaint IN00423380. 3.1-12(a)(4)(A) 3.1-12(a)(6)(A) 3.1-12(a)(8)(D)			

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	3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to conduct and document routine weekly skin assessments for 3 of 3 residents reviewed for skin concerns. (Residents C, D and E) Findings include: 1. The clinical record of Resident C was reviewed on 1-2-24 at 10:46 a.m. His diagnoses included, but were not limited to, traumatic subdural hematoma, acute and chronic respiratory failure, nontraumatic subarachnoid hemorrhage, moderate protein-calorie malnutrition and cerebral infarction as a result of a pedestrian injured in traffic accident. His most recent Minimum Data Set (MDS) assessment, dated, 11-22-23, and a Braden Scale skin assessment, dated 11-22-23, indicated he was at risk for pressure ulcers.	F 0686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer It is the practice of this facility to assure that the skin assessment of residents are conducted and documented weekly. The correction action taken for the residents found to be affected by the deficient practice include: Resident C & D - it would not be possible to correct documentation of weekly skin assessment due to residents are discharged from the facility. Resident E past skin assessments are unable to be	01/23/2024

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	A review of Resident C's physician orders indicated an order, with a start date of 11-26-23, for "Weekly skin assessment: Complete visual head to toe skin assessment every night shift every Friday for Skin monitoring; Complete Skin observation under [computer generated] assessments. Document any abnormal findings in progress notes." The facility provided documentation of skin assessments for 11-5-23, 11-14-23, 11-26-23, 12-3-23, all prior to his transfer from the facility on 12-9-23. There was a 9-day interval between the assessment of 11-5-23 and 11-14-23; a 12-day interval between the assessment of 11-14-23 and 11-26-23. The weekly assessment of 11-26-23 indicated a new stage I pressure area (described by the facility documentation as "Intact skin with non-blanchable redness of a localized area usually over a bony prominence.") was identified on that date, located to his coccyx. The assessment indicated the treatment for the new pressure area was the use of a moisture barrier cream daily and with any incontinence episodes. The following week's skin assessment on 12-3-23, did not identify any skin issues and did not address the previous week's pressure area in any manner. A review of the nursing progress notes from 11-26-23 through 12-3-23 did not address the new pressure area, with the exception of mention of the facility may use the facility's house barrier cream until the moisture barrier cream arrives from the pharmacy. A review of Resident C's care plan for "potential risk for skin impairment r/t [related to] decreased mobility. Stage I to coccyx," was initiated on 3-16-23 and most recently revised on 11-26-23. Interventions listed for this concern		corrected, however the facility is assuring that all skin assessments are being conducted and documented weekly. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. Please see system changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nurses have been in-serviced on timely conducting and documenting weekly skin assessments. CNAs have been in-serviced on notifying nurse on duty of any new skin areas found during resident care. The corrective action taken to monitor performance to assure compliance through the quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews all residents skin assessments to ensure that they are being conducted and documented weekly. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review	

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	included, but were not limited to, "Follow facility protocols for treatment of injury." Another care plan for "potential for Impaired Skin Integrity as evidenced by Braden Scale for Predicting Pressure Risk," initiated on 2-27-23, and most recently revised on 8-21-23, indicated interventions to include, but not limited to, "Evaluate skin integrity..Monitor nutritional status...Perform objective pressure ulcer risk tool such as Braden/Norton scale...Provide skin care per facility guidelines and PRN [as needed]." In an interview on 1-4-24 at 4:30 p.m., during the exit conference with the Corporate Nurse, she indicated the facility has had problems with the nurses not documenting the weekly skin assessments. "There are even [physician] orders for the weekly skin checks that says to document it under assessments, not just sign it off on the MAR's and TAR's with the vital signs." 2. The clinical record of Resident D was reviewed on 1-3-24 at 10:10 a.m. His diagnoses included, but were not limited to acute respiratory failure, congestive heart failure, metabolic encephalopathy, nontraumatic subarachnoid hemorrhage and traumatic subdural hemorrhage. He resided on the ventilator unit of the facility. A review of Resident D's progress notes indicated he was admitted to the facility on 12-11-23 from an area hospital. His nursing progress notes, dated 12-11-23 at 3:00 p.m., indicated he was admitted with "bilateral buttocks excoriation, stage 2 [pressure ulcer] to coccyx, right knee abrasion." A review of Resident D's admission Minimum Data Set assessment, dated 12-18-23, indicated he was at risk for pressure ulcers, had one stage III pressure ulcer and had moisture-associated skin		the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: January 23, 2024	

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	damage (MASD). A review of the "Wound-Weekly Observation Tool," dated 12-13-23 at 8:39 p.m., for wound #1, indicated he was admitted to the facility with a stage III (described by the facility documentation as "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present, but does not obscure the depth of muscle loss. May include undermining or tunneling.") pressure area to his sacrum. A second "Wound-Weekly Observation Tool," dated 12-13-23 at 8:45 p.m., for wound #2, indicated he was admitted to the facility with MASD of the left buttock. No additional information regarding any type of skin concern to the right knee was located in the clinical record. He was transferred from the facility on 12-22-23. In an interview on 1-4-24 at 4:30 p.m., during the exit conference with the Corporate Nurse, she indicated the facility has had problems with the nurses not documenting the weekly skin assessments. "There are even [physician] orders for the weekly skin checks that says to document it under assessments, not just sign it off on the MAR's and TAR's with the vital signs." 3. The clinical record of Resident E was reviewed on 1-4-24 at 11:23 a.m. His diagnoses included, but were not limited to, acute respiratory failure, paraplegia, immune thrombocytopenia purpura, cerebral infarction, pneumonia, moderate protein-calorie malnutrition, history of a traumatic brain injury (TBI) and a history of a stage IV pressure area (described by the facility documentation as "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include[s] undermining and			

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	tunneling.") to his lower back and to sacral region. His clinical record indicated he had been readmitted to the facility on 1-2-24 after a hospitalization that began on 12-26-23. A review of Resident E's admission/re-admission nursing assessment, dated 1-2-24, indicated his skin was not intact, but did not provide any specifics of the abnormality. It did not address if there was a singular skin abnormality or additional abnormalities. Additionally, at the end portion of the skin assessment portion of the document, it indicated, "No new skin issues." A review of four (4) most recent "Wound-Weekly Observations Tool" documents, dated 12-20-23, prior to his most recent hospitalizations, identified the following wounds: -#1, a stage IV pressure area to the left ishium, measuring 6.0 centimeters (cm) by 3.5 cm by 0.6 cm, and described as worsening. -#2, a a stage IV pressure area to the right ishium, measuring 3.0 centimeters (cm) by 4.3 cm by 0.7 cm, and described as worsening. -#3,a stage IV pressure area to the sacrum, measuring 6.0 centimeters (cm) by 2.4 cm by 0.2 cm, and described as improving. -#4, a newly identified suspected deep tissue injury to the left scrotum. In an interview on 1-4-24 at 3:15 p.m., with the Director of Nursing, she indicated the current wound nurse was on vacation and unavailable to interview. On 1-4-24 at 3:17 p.m., the Corporate Nurse provided two copies of a policies entitled, "Weekly Skin Check." The first policy was undated and indicated to be the current policy utilized by the facility. It indicated, "This facility			

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	shall inspect each Resident's skin no less frequently than weekly. Area areas of the Resident's shall be inspected by C.N.A. during the provision of shower and documented at least weekly. The C.N.A. shall complete the Skin Assessment form indicating any areas of abnormality on the diagram [sic] and sign the form. The C.N.A. shall turn the completed form into the licensed nurse once completed. The licensed nurse shall review the form and indicate review with signature. Should an area of abnormality be noted the licensed nurse shall assess the area. If the area is a new or worsened the licensed nurse shall notify the physician and responsible party as applicable. The licensed nurse shall document his/her assessment and any notifications in the Resident's clinical record." The second policy entitled, "Weekly Skin Check," was undated and indicated to be the current policy utilized by the facility. It indicated, "This facility shall inspect each Resident's skin no less frequently than weekly. All areas of the Resident's skin shall be inspected by his or her nurse and documented at least weekly on the Weekly Skin Assessment. If a skin impairment has been identified the nurse shall complete the Weekly Skin Assessment form indicating any new areas of abnormality (to include measurements, appearance, drainage, etc.) and obtain a treatment order from the attending MD immediately. The nurse shall complete the Pressure (see pressure ulcer treatment and evaluation policy) or Non-Pressure form weekly to track the area of skin impairment identified. The wound care nurse, if applicable, shall review the pressure or non-pressure form and follow up with a complete assessment of the new area and address as appropriate...The Resident's plan of care and resident representative is to be updated.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

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	The following information should be recorded in the resident's medical record: 1. The type of treatment and resident response. 2. The date and time would care was given. 3. The position in which the resident was placed. 4. The name and title of the individual providing the care. 5. Any change in the resident's condition. 6. All assessment data (i.e., color, size, pain, drainage, etc.) when inspecting the wound. 7. Resident tolerance of the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. Resident refusal of treatment... 10. The signature and title of the person recording the data. 11. Wounds will be measured at least weekly; documentation of this measurement will be recorded in the medical record. 12/ Update the care plan accordingly." This Federal tag relates to Complaint IN00423815. 3.1-40(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the			

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	resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to routinely monitor and document resident weights, meal intakes and the nutritional status and needs for 2 of 4 residents reviewed for nutrition. (Residents C and E) Findings include: 1. The clinical record of Resident C was reviewed on 1-2-24 at 10:46 a.m. His diagnoses included, but were not limited to, traumatic subdural hematoma, acute and chronic respiratory failure, nontraumatic subarachnoid hemorrhage, moderate protein-calorie malnutrition and cerebral infarction as a result of a pedestrian injured in traffic accident. A review of Resident C's documented weights from admission on 2-13-23, until discharge on 12-9-23, indicated his weights varied from a high of his admission weight on 2-13-23, of 182 pounds to a low of 121 pounds on 8-1-23 to his most recent weight of 151.5 pounds on 12-1-23. Resident C had admitted to the facility with a gastric feeding tube and it was discontinued in early summer and he was transitioned to an oral diet. A review of his nutrition and dietary documentation from 6-1-23, to discharge on	F 0692	F692 Nutrition/Hydration Status Maintenance It is the practice of this facility to assure that all ordered weight, meal intakes and any nutritional needs of the resident's are met. The correction action taken for the residents found to be affected by the deficient practice include: Resident C - has been discharged from the facility. Resident E - past weights, meal intakes and any missed nutritional needs are unable to be corrected, however the facility is assuring that all are being appropriately documented every shift. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. Please see system changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that	01/23/2024

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	12-9-23, indicated he had been followed closely by the facility's interdisciplinary team (IDT) for his high-risk nutrition concerns related to weight loss and multiple medical problems. An IDT note, dated 9-18-23, indicated was was being discontinued from IDT nutritional monitoring as his weight was "stable." Resident C's weights documented during/around this time were as follows: 7-3-23 142.0; 7-6-23 143.5; 7-14-23 144.5; 7-17-23 143.2; 8-1-23 121.0; 8-30-23 128.0; 9-4-23 126.0; 9-13-23 127.0. The 8-1-23 weight was a significant decline of 21 pounds or 14.7 percent (%) in less than 1 month, or 40 pounds or 28.1% in 3 months and 61 pounds or 33.5% in 6 months. Resident C's documented weights, until he was transferred to an area hospital, were as follows: 9-13-23 127.0; 10-4-23 151.0; 11-1-23 154.0 and 12-1-23 151.5. The 10-4-23 weight indicated a significant weight gain in less than one month of 24 pounds or 15.8%. The last nutritional IDT notation, dated 10-27-23, indicated Resident C had a recent significant weight gain of unspecified amount or percentage. It indicated Resident C's "Will monitor November weight for ongoing trends and adjust recommendations accordingly." There were no additional nutritional IDT notations located in his clinical record. His weights from 10-4-23 through his last documented weight on 12-1-23 remained stable. In an interview with the Director of Nursing (DON) on 1-2-24 at 2:45 p.m., she indicated she had no idea why the resident would have been dropped from IDT for weight and nutrition monitoring as his weights "had been all over the place," plus he had a new skin area at the end of November. She indicated the majority of the residents at this facility could be considered nutritionally high risk due to residents are on one		the deficient practice does not recur include: All nurses have been in-serviced on obtaining and documenting resident's weight as ordered (daily, weekly or monthly). NAR meeting are being held weekly and new dietician services have been obtained. CNAs have been in-serviced on documenting resident's meal intakes. The corrective action taken to monitor performance to assure compliance through the quality assurance is: A Performance Improvement Tool has been initiated that monitors resident's weights, meal intakes and that any nutritional needs or concerns are being monitored and documented as ordered. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: January 23, 2024	

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	of the two specialty units of traumatic brain injury or the ventilator unit. The DON indicated she began employment at facility the latter part of December, 2023. In an interview on 1-3-24 at 9:30 a.m., with the Corporate Nurse, she indicated meal intakes documentation were not located for this resident. "The ones with nutrition or weight concerns are followed by IDT...Historically, this has been a problem for this building. We attempted to get staff to do that when the current owner took over and we have tried over the years with very little success. The staff will start out doing well, and then it falls off. To me, it is an issue with work ethics and in my opinion, you cannot get someone to do something they don't want to do or they have no desire to do." 2. The clinical record of Resident E was reviewed on 1-4-24 at 11:23 a.m. His diagnoses included, but were not limited to, acute respiratory failure, paraplegia, immune thrombocytopenia purpura, cerebral infarction, pneumonia, moderate protein-calorie malnutrition, history of a traumatic brain injury (TBI) and a history of a stage IV pressure area (described by the facility documentation as "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include[s] undermining and tunneling.") to his lower back and to sacral region. His clinical record indicated he had been readmitted to the facility on 1-2-24 after a hospitalization that began on 12-26-23. A review of his clinical record indicated Resident E had more than 6 hospitalizations from his admission in July, 2023 and until the survey exit date. A review of Resident E's weights from admission			

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	to his most recent re-admission were as follows: 7-24-23 142.0 (pounds); 7-26-23 136.0, 8-2-23 122.5, 8-20-23 129.0, 9-6-23 122.3, 9-27-23 107.0, 10-25-23 106.8, 10-27-23 106.8, 11-2-23 109.5, 11-20-23 116.5, 12-11-23 98.7, and 12-26-23 120.7. A review of Resident E's most recent readmission "Skilled Evaluation," dated 1-2-24, indicated a lack of documentation of a readmission weight, or of his most recent weight obtained by the facility. A review of the enteral feeding orders on the medication administration record (MAR) and the treatment administration record (TAR) for January, 2024 did not reflect any entries to reflect the total amounts of enteral feedings Resident E received. The Dietary Manager or Registered Dietitian (RD) had not had an opportunity to review Resident E's nutritional status since he returned to the facility on 1-2-24. In an interview with the Director of Nursing (DON) on 1-2-24 at 2:45 p.m., she indicated the majority of the residents at this facility could be considered nutritionally high risk due to residents are on one of the two specialty units of traumatic brain injury or the ventilator unit. The DON indicated she began employment at facility the latter part of December, 2023. In an interview on 1-3-24 at 9:30 a.m., with the Corporate Nurse, she indicated, "You will not find any meal intakes for the residents here. The ones with nutrition or weight concerns are followed by IDT [intradisciplinary team]. Historically, this has been a problem for this building. We attempted to get staff to do that when the current owner took over and we have tried over the years with very little success. The staff will start out doing well, and then it falls off. To me, it is an issue with work ethics and in my opinion, you cannot get			

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	someone to do something they don't want to do or they have no desire to do." On 1-4-24 at 3:17 p.m., the Corporate Nurse provided a copy of a policy entitled, "Weight Assessment and Intervention." This policy was dated September, 2008 and was indicated to be the current policy utilized by the facility. It indicated, "The multidisciplinary team with strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff will measure resident weights on admission, the, [sic] and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded in the residents' medical record. Residents that are identified to be beneath their ideal or usual body weight will be reviewed for possible needed interventions. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will immediately notify the NAR IDT, Dietary Manager or Dietitian. The resident, physician, and resident representative must also be notified. The IDT team will meet weekly as a part of the NAR program and review any resident that is showing a significant decline in weight or a significant weight loss with interventions implemented related to the weight loss. Residents with a significant weight loss will have interventions implemented and care plan will be updated. The Dietitian will review the unit Weight Record each month to follow individual weight trends over time. Negative trends will be evaluated by the NAR team whether or not the criteria for 'significant' weight change has been met. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/(usual			

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	weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe...Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the: Resident's target weight range (including rationale if different from ideal body weight); Approximate calorie, protein, and other nutrient needs compared with the resident's current intake; The relationship between current medical condition or clinical situation and recent fluctuations in weight; and Whether or to what extent stabilization or improvement can be anticipated...Care planning for weight loss or impaired nutrition will be a multidisciplinary effort...Interventions for undesirable weight loss shall be based on careful consideration of the following: Resident choice and preferences; Nutrition and hydration needs of the resident; Functional factors...Environmental factors...Chewing and swallowing abnormalities...Medications...The use of supplementation and/or feeding tubes; and End of life decisions and advance directives..." On 1-4-24 at 3:17 p.m., the Corporate Nurse provided a copy of the current contract for the nutrition services provider, which was effective as of 7-25-23. It indicated a dietitian shall be provided "Four to Eight (4-8) hours weekly and as requested...Complete nutrition assessments as identified on the dietitian referral list or Company referral; Coordinate nutrition care with nursing and dietary services..." This Federal tag relates to Complaints IN00423380 and IN00423815.			

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	3.1-46(a)(1) 3.1-46(a)(2)			