STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155290	A. BUILDING 00 B. WING	10/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH HEALTHCARE CENTER	701 ARMORY RD DELPHI, IN 46923

(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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey date: October 10, 11, 12, 13, 16, and 17, 2017 Facility number: 000187 Provider number: 155290 AIM number: 100267300 Census Bed Type: SNF: 13 SNF/NF: 48 Total: 61 Census Payor Type: Medicare: 10 Medicaid: 33 Other: 18 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 24, 2017.	F 0000		
F 0154 SS=D Bldg. 00	483.10(c)(1)(2)(iii)(4)(5) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS (c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: (c)(1) The right to be fully informed in language that he or she can understand of			

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

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	his or her total health status, including but not limited to, his or her medical condition. (c)(iii) The right to be informed, in advance, of changes to the plan of care. (c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. (c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Based on interview and record review, the facility failed to inform a cognitively intact resident of changes in treatment of his pain regarding pain medications for 1 of 1 residents reviewed for notification of change in his plan of care (Resident 48). Finding includes: The record for Resident 48 was reviewed on 10/16/2017 at 9:10 a.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, abnormalities of gait and mobility, muscle weakness and major depressive disorder. Diagnoses of degenerative spondylolisthesis (is a condition in which one vertebral body slips forward on top of the vertebral body below it), lumbar	F 0154	1.Resident #48 that was cited in this survey was assessed with no adverse effects noted. Resident was made aware of changes and referred to pain management, medications have been resumed per pain clinic. 2.Social Services Director or designee will audit residents with a BIM's score of 13-15 to validate they are being notified of changes in plan of care and correct as needed. 3.Nursing staff and Social Service Director will be educated by Executive Director or Designee on Resident Rights and Notification of Change Policy. 4.Social Services Director or designee will address informed consent in Residents First Meetings upon admission and quarterly with residents who have a BIMS of 13-15. QA committee	11/16/2017

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	(lower spine) disc degeneration, lumbar canal stenosis (a narrowing of the open spaces in the lower spine) and postlaminectomy syndrome (condition characterized by chronic pain following back surgeries) were added as diagnoses on 7/11/2017. During an interview on 10/16/2017 at 11:12 a.m., Resident 48 indicated he suffered from chronic back pain. As a result of the pain, the only time he had some relief from pain was with medications and when lying down. During an interview on 10/17/2017 at 11:35 a.m., Resident 48 indicated he had been going to pain management clinic for some time now for medications to relieve pain. He was not made aware initially of the attempted gradual reduction of his pain medications. Minimum Data Set (MDS) Quarterly Reviews dated 6/15/2017 and 9/14/2017 indicated the Brief Interview of Mental Status (BIMS) of 15 indicated the resident was cogitatively intact. A care plan, started 8/17/2016 indicated the resident has, "...a lot of pain due to an automobile accident..." and requires "...strong narcotic pain meds to relieve pain...."		will review Resident First meetings 1x monthly for 2 months then quarterly. QA will monitor for any trends and make recommendations as needed until 100% is achieved.	

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	A physician's order, dated 4/24/2017, indicated, "...Dr. [name of Medical Doctor or MD] will write a script for a 30 day supply of oxycodone [a schedule II narcotic pain medication] and that will be all. Dr. [name of MD] would like pain management to follow now that Resident is no longer on Hospice. Please call and set this up b/f [before] his script runs out. A "Resident Progress Note," dated 4/24/2017 at 1:39 p.m., indicated, "...Res [resident] primary contact, [name of contact] was contacted in regards to [name of MD] orders to be followed by pain management in order to get future scripts to routine oxycodone. Left message on his voicemail...." A "Resident Progress Note," dated 4/25/2017 at 9:33 a.m., indicated, "...Drs office needs to send referral to [name of pain management doctor's] office for a pain management consult please..." A "Resident Progress Note," dated 5/1/2017 at 2:08 p.m., indicated, "Pain med [medication] reduction will begin on 5/2. [MD] goal is res [resident] will be on Norco [pain medication] TID [three times a day] by 6/1 with pain still controlled with Tylenol [pain medication] for breakthrough pain. Spoke with his			

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	son [name of son] today and went over plan and goal. Res family will be bringing in mattress they feel will be more comfortable for res. Res has h/o chronic back pain...." A physician's order, dated 5/1/2017 and discontinued 5/1/2017, indicated the resident was to receive 30 milligrams (mg) of oxycodone every 6 hours. A physician's order, dated 5/1/2017 and discontinued on 6/8/2017 indicated, "Please do not mention to res about pain med reduction per family/doctor which will start on 5/2/2017...." A physician's order, dated 5/2/2017 and discontinued 5/9/2017, indicated the resident was to receive 39 mg of oxycodone three times a day for pain for one week. A physician's order, dated 5/10/2017 and discontinued 5/16/2017, indicated the resident was to receive 30 mg of oxycodone twice a day for pain for one week. No documentation of the resident being informed of the reduction in pain medications was located. A "Resident Progress Note," dated			

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	5/11/2017 at 8:57 p.m., indicated, "...This nurse informed of resident's family requesting resident not be informed of decrease in pain medications...." A "Resident Progress Note," dated 5/31/2017 at 5:37 a.m., indicated, "...Resident yelling, screaming, crying out due to extreme back pain. Waking up all nearby residents, scaring them. Has visible tremors. Wants to know why he isn't getting all is pain meds. Writer stated that his med times were change, writer stated didn't know why. Writer does know he is on a GDR [gradual dose reduction] but is not allowed to tell resident...." During an interview on 10/17/2017 at 10:50 a.m., the Director of Health Services indicated if the resident asked staff why he wasn't getting his pain medications, the nursing staff should have told the resident why. A current policy titled, "Notification of Change in Condition" received from the Corporate Support Staff on 10/17/2017 at 12:01 p.m., indicated "...To ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with the resident's physician and if known notify the resident's legal representative			

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	when:...A need to alter treatment significantly...Sample reasons to notify the physician immediately but not limited to:...Need to alter treatment significantly...Documentation of notification or notification attempts should be recorded in the resident electronic record...." A current facility policy titled, "Guidelines for Pain Observation and Management" dated 05/11/2016 and received from the Corporate Support Staff on 10/17/2017 at 12:01 p.m., indicated "...To ensure each resident's pain including its origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be observed and documented according to the needs of each individual...7. Evaluate the effectiveness of pain management interventions and modify as indicated...." 3.1-4(c)			
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the			

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	resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			

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	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on interview and record review, the facility failed to notify the physician when a change in diet order was not completed for 1 of 1 residents reviewed for notification (Residents 18). Finding includes: The record for Resident 18 was reviewed on 10/12/17 at 4:22 p.m. Diagnoses included, but were not limited to, unspecified intellectual disabilities, Alzheimer's disease, cognitive communication deficit and dysphagia (difficulty swallowing). A Registered Dietician nutrition note, dated 6/16/17, indicated a recommendation to discontinue the CCHO (consistent or controlled carbohydrate) diet and to liberalize to a regular diet to promote a stable weight. An open physician order, dated 6/14/17, indicated CCHO diet. An open physician order, dated 7/7/17, indicated diet consistency of mechanical soft, ground meat with extra gravy.	F 0157	1.Resident #18 that was cited in this survey was assessed with no adverse effects noted. Resident #18 diet Carb Controlled discontinued on 10/16/17. 2.DHS or designee will audit residents with nutritional recommendations to ensure accuracy with physician orders. Changes to be made accordingly. 3.ADHS or designee will educate nursing staff on following physician orders. 4.DHS or designee will audit nutritional recommendations for accuracy 1 time a week for 6 months. Director of Health Services or designee will report findings to the QA committee monthly for 2 months then quarterly. QA committee will monitor for any trends monthly for 6 months and make any recommendations as needed until 100% is achieved.	11/16/2017

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	A care plan, dated 7/15/16, indicated a risk of nutritional and hydration needs to support the metabolic demands. The goal included, but was not limited to, tolerate the physician ordered diet. The approaches included, but were not limited to, provide the diet as ordered by the physician. A Resident Progress notes faxed communication to the physician, dated 6/19/17, indicated the Registered Dietician had recommended discontinuing the CCHO diet and adding a regular diet. The physician responded with ok. During an interview on 10/16/17 at 1:33 p.m., the Director of Health Services (DHS) indicated the CCHO diet was not discontinued and the regular diet order was not added. She also indicated the kitchen still had the CCHO diet order. A current policy titled, "Notification of Change in Condition" received from the Corporate Support Staff on 10/17/2017 at 12:01 p.m., indicated "...To ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with the resident's physician and if known notify the resident's legal representative when:...A need to alter treatment			

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	significantly...Sample reasons to notify the physician immediately but not limited to:...Need to alter treatment significantly...Documentation of notification or notification attempts should be recorded in the resident electronic record...." 3.1-5(a)(3)			
F 0221 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for			

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	purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on interview and record review, the facility failed to remove a wanderguard (a device designed to monitor cognitively impaired individuals with wandering) for a cognitively intact resident for 1 of 1 residents reviewed for restraints (Resident 28). Finding includes: During an interview on 10/11/17 at 10:55 a.m., Resident 18 indicated he had a wanderguard on his ankle and he did not like to go to the lounge area next to the front door because the alarm would sound. The record for Resident 28 was reviewed on 10/12/17 at 10:12 a.m. Diagnoses included, but were not limited to, malignant neoplasm of the right bronchus (a main branch of the trachea leading into the lung), unspecified dementia without behavioral disturbance and recurrent depressive disorder. The Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS)	F 0221	1.Resident #28 wanderguard was assessed and removed per physician order on 10/13/17 and care plan updated for accuracy. 2.Residents with wanderguards have been reviewed by the Interdiscplinary team (IDT) for appropriateness and checked for a BIM score of 13-15, corrections made as needed. 3.Assistant Director of Health Services (ADHS) or designee will educate the nursing staff on the Guidelines for Restraint/Enabler Use policy. 4.DHS or designee will reassess residents with wanderguards 1 time per month for 2 months then quarterly. DHS or designee will report findings to the QA committee monthly x 2 months then quarterly. QA committee will monitor for any trends and make recommendations as needed until 100% is achieved.	11/16/2017

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	completed on 12/3/16 was 11 and indicated the resident was moderately impaired cognitively. The BIMS score completed on 6/13/17 was 14 and indicated the resident was intact cognitively. The BIMS score completed on 9/12/17 was 15 and indicated the resident was intact cognitively. A care plan, dated 12/2/16, indicated the resident experienced wandering. The approaches included, but were not limited to, check the placement and the function of the wanderguard on the resident's left ankle each shift and provide comfort measures when the resident begins to wander. A progress noted, dated 11/29/16, indicated the resident walked to the front door to see what the weather was like and was redirected to the outside patio next to the activity room. The resident then went outside to the walking path unassisted. The resident was wearing a coat, hat and gloves and was using his walker. A progress note, dated 12/2/16, indicated the resident was upset about the wanderguard and wanted to know when it could be removed. The resident indicated			

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	he felt like he was on lock down and he didn't want to leave. He indicated he felt like he could not walk around the facility due to the alarm sounding. A progress note, dated 12/6/16, indicated the resident expressed his dislike of the wanderguard and stated he was hopeful it would be removed soon. A progress note, dated 12/20/16, indicated the resident was worried about wearing the wanderguard outside of the facility and talked about needing the wanderguard off permanently. A progress note, dated 12/22/16, indicated the resident talked about his disappointment due to still wearing the wanderguard and he felt down and had no freedom. If obsession with the wanderguard continued or caused further anxiousness, the staff would consider an anxiolytic (a medication to reduce anxiety) or psychiatric services. A progress noted, dated 12/27/16, indicated the staff spoke to the resident's son due to the resident was upset with the wanderguard. A progress note, dated 3/3/17, indicated the resident had no documented exit seeking attempts during the quarterly			

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	observation period. The Treatment Administration Record indicated a targeted behavior of exit seeking and at the end of each shift mark the frequency, how often the behavior occurred and how the resident responded to redirection. 0=did not occur. The Treatment Administration Record from 12/2/2016 through 10/11/2017 were all marked 0 which indicated the targeted behavior did not occur. During an interview on 10/12/17 at 10:54 a.m., Resident 28 indicated the wanderguard was on his left ankle and he knew he had to have someone with him before he could go outside. He indicate it was his preference not to have the wanderguard on and he hated it. During an interview on 10/12/17 at 3:49 p.m., the resident indicated he could not take off the wanderguard unless he had a pair of scissors. During an interview on 10/12/17 at 3:52 p.m., LPN 2 indicated the wanderguard had to be cut off, there was no other way to remove the device. During an interview on 10/12/17 at 1:46 p.m., the Social Services Director indicated the resident had days when he			

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	was more confused and talked a lot about wanting to go outside. She indicated the resident had an elopement risk due to a history of exit seeking. During an interview on 10/12/17 at 4:08 p.m., the Executive Director (ED) indicated the resident had a change in cognitive status at times. She indicated a less restrictive approach had not been tried and the alarm for the wanderguard did alarm before the resident reached the lobby area. During an interview on 10/12/17 at 4:37 p.m., the ED indicated she could not locate documentation on the resident's changes in cognitive status or of the resident's exhibiting exit seeking behavior. A current policy, dated 5/11/16, titled, "Guidelines for Restraint/Enabler Use," received from the Executive Director on 10/12/17 at 3:39 p.m., indicated "... To ensure completion of assessment and evaluation for appropriate and safe use of restraints...Each resident shall have an individualized nursing assessment upon admission, monthly and PRN [as needed] that shall address the need for a safety device, medical reason for use of the device and identification rather[sp] the device restricts movement, or limits the			

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	resident from doing something they could previously do...The interdisciplinary team shall:...Investigate alternatives to restraints and determine that all alternative measures have been exhausted and found to be unsuccessful...Make decisions that the device is the most appropriate for the situation...A comprehensive plan of care shall be developed that:...Includes input from the resident...The determination of whether a device is or is not a restraint is based on an individualized, assessment of the resident...The determination must include whether the resident is capable of independently removing the device...Considerations for determining whether the device is a restraint or an enabler...If a device restricts the resident from doing something they could previously do and does NOT assist the resident to function at a higher level, it is a restraint and may be used for a limited timeframe...The medical symptom for the restraint/enabler should define the reason the device is required to improve the resident's functional status...If restraints are used there must be systematic gradual restraint reduction program in place...Remember to use the least restrictive device for the least amount of time...Restraints shall be released during routine care...."			

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	3.1-3(w)			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.			

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	Based on observation, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) dental status of a resident who was edentulous (without natural teeth or teeth fragments) for 1 of 2 residents assessed for nutrition (Resident 38). Finding includes: The record for Resident 38 was reviewed on 10/12/2017 at 10:22: a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, dysphagia (swallowing problem), major depressive disorder and hypertension. During an observation and interview on 10/12/2017 at 3:11 p.m., Resident 38 was observed to be eating popcorn and did not have lower dentures in her mouth. She indicated she was unable to wear her lower dentures because they moved around and she was unable to keep them in her mouth. Review of a dental "Exam Summary" dated 12/20/2016, indicated the resident had complete upper and lower dentures. An Minimum Data Set (MDS) assessment, dated 8/7/2017, did not indicate the resident was edentulous.	F 0278	1.Resident #38 that was cited in the survey was assessed with no adverse effects noted and the MDS assessment cited was updated for accuracy. 2.Comprehensive CAA's since survey have been reviewed for accuracy on the dentoulous section L of the MDS and corrected as needed. 3.Minimum Data set Coordinator (MDSC) educated on accurately coding section L of the MDS by MDS support or designee. Nursing educated on Admission Assessment Policy by DHS or designee. 4.Assessment support nurse or designee will audit comprehensive assessments for accuracy of coding in section L of the MDS weekly times 4 weeks. Assessment nurse/designee will report findings to the QA committee. QA committee will monitor for any trends and make any recommendations as needed until 100% is achieved.	11/16/2017

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	Review of the "Resident Profile" indicated the resident "...wears upper dentures...." A "Resident Progress Note" dated 9/21/2017 at 9:41 p.m., indicated "...CRCA [Certified Resident Care Assistant] said res [resident] had dentures out, said res told her they don't fit...." During an interview on 10/13/2017 at 1:27 p.m., the MDS Coordinator indicated the resident had no natural teeth and the MDS assessment was incorrect. A current facility policy titled, "Guidelines for Admission Nursing Observation and Data Collection," dated 8/1/2016, received from Clinical Support on 10/13/2017 at 3:25 p.m., indicated "...The comprehensive head to toe observation and data collection addressess each body system and shall be initiated within 12 hours and completed within 24 hours of admission...." 3.1-31(c)(9)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous			

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	15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

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	resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview and record review, the facility failed to update the treatment plan to include the resident was edentulous (lacking teeth) for 1 of 1 residents reviewed for dental status (Resident 18) and for 2 of 3 residents reviewed for nutrition (Residents 38 and 77). Findings include: 1. During an observation on 10/11/17 at 9:52 a.m., Resident 18 did not show any teeth when she smiled. The record for Resident 18 was reviewed on 10/12/17 at 4:22 p.m. Diagnoses included, but were not limited to, unspecified intellectual disabilities, Alzheimer's disease, cognitive	F 0279	1.Residents #18, 38, and 77 cited in the survey were assessed with no adverse effects noted and any CAA's, Care Plans and MDS assessments in section L were updated for accuracy. 2.Comprehensive CAA's, Care Plans and MDS assessments section L since survey have been reviewed for accuracy and corrected as needed. 3.MDSC educated by home office assessment support or designee on accurately coding on the MDS section L, CAA's and Care plans that are related to dentulous and nutrition. 4.Assessment support nurse/designee will audit the MDS on nutrition and dentulous, CAA's and care plans related to dentulous and nutrition for accuracy of coding. This will be done weekly times 4 weeks. Assessment support	11/16/2017

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	communication deficit and dysphagia (difficulty swallowing). A Minimum Data Set (MDS) assessment, dated 6/21/17, indicated the resident had no natural teeth or tooth fragments and was edentulous. A Care Area Assessment (CAA) triggered from the MDS, dated 6/21/17, indicated the resident had no dentures and no natural teeth, the family was not interested in the need for teeth and there was no oral dysfunction. A care plan dated 7/18/16, indicated the resident was at risk of dysphagia and aspiration with any foods and fluids. The approaches included, but were not limited to, monitor for signs and symptoms of aspiration and provide set up help, cueing and assistance for meals. The care plan did not include the resident was edentulous and did not include approaches to implement due to the resident not having teeth. An initial Speech Therapy Plan of Care with the start of care, dated 6/15/17, indicated the resident had a complicated history of dysphagia with a definite risk of aspiration. A Speech Therapy note, dated 7/7/17,		nurse/designee will report findings to the QA committee. QA committee will monitor for any trends and make any recommendations as needed until 100% is achieved.	

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	indicated the staff was educated on the importance of oral hygiene after meals as the resident had oral thrush (a condition in which fungus accumulates on the lining of the mouth and causes creamy white lesions usually on the tongue or inner cheeks). During an interview on 10/16/17 at 1:07 p.m., the MDS coordinator indicated the resident was marked as not having teeth on the MDS assessment dated 6/21/17 and had a CAA for no teeth. She indicated if the resident did not have dentures, pain or lesions she may choose to not make a care plan. The MDS coordinator also indicated the resident had swallowing issues. 2. The record for Resident 77 was reviewed on 10/12/2017 at 9:07 a.m. Diagnoses included, but were not limited to, osteoporosis, Parkinson's disease, depression and hypertension. A "Resident Progress Note," dated 8/4/2017, "...Nutrition note: Initial Nutrition Assessment:...Chewing difficulty due to poor fitting dentures...." A care plan started 8/4/2017, indicated the resident has potential for alteration in nutritional status related to diagnoses, medications, fluid balance, diet, intake, physical activity and metabolic demands.			

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	Approaches, included and were limited to, assist with meals as needed, obtain weight as ordered/needed, offer alternate food and beverage items as needed, provide diet/supplements/medications as ordered. The care plan did not include the resident was edentulous and did not include approaches to implement because the resident wore dentures. A current policy, dated October 2016, titled, "CAA Process and Care Planning" received from the Corporate Support staff on 10/16/17 at 2:11 p.m. indicated, "...Key Tasks...Clearly states the individual's issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns... Views the resident in distinct functional areas...Provides additional clarity of potential issues and/or condition that the resident may have...Review and revise the care plan as needed...." A current facility policy titled, "Nutrition Documentation," dated 11/21/2016, received from the Executive Director on 10/12/2017 at 4:33 p.m., indicated, "...h. Indicate if diet and intake meet estimated and/or actual nutrition needs...i. Chewing/Swallowing issues...m. Information collected from the			

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	resident/resident's family/members of the IDT (interdisciplinary team) should be used to complete the assessment and writing a resident-driven plan of care...." 3.1-35(a) 3.1-35(b)(1)			
F 0280 SS=D Bldg. 00	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of			

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	the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined			

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	not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to include the resident's requests and to update the treatment plan according to the resident's current cognitive status and failed to revise the treatment plan for a resident with chronic pain after initiating a gradual dose reduction of pain medications for 2 of 12 residents reviewed for treatment plans (Resident 28 and 48). Findings include: 1. The record for Resident 28 was reviewed on 10/12/17 at 10:12 a.m. Diagnoses included, but were not limited to, malignant neoplasm of the right bronchus (a main branch of the trachea leading into the lung), unspecified dementia without behavioral disturbance and recurrent depressive disorder . A care plan dated 12/2/16 indicated the resident experienced wandering. The	F 0280	1.Resident #28 & 48 that were cited in the survey were assessed with no adverse effects noted. The Care plans and MDS assessments cited were updated for accuracy. 2.Residents since survey who are currently elopment risks with wanderguards were assessed and Bims were checked for accuracy, corrections made as needed. Residents since the survey who are cognitively intact had care plans reviewed for accuracy and corrections made as needed. 3.MDSC and Nurses educated by ADHS or designee on Resident Rights, proper care planning, and Restraints. 4.DHS/designee will audit wanderguard restraints, chemical restraints and care plans for Residents with a BIMS score between 13-15 for accuracy 2 times a week for 4 weeks then 1 time a week for 5 months. DHS/designee will report findings to the QA committee. QA committee will monitor for any	11/16/2017

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	approaches included, but were not limited to, check the placement and the function of the wanderguard on the resident's left ankle each shift. The minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) completed on 12/3/16 was 11 and indicated the resident was moderately impaired cognitively. The BIMS score completed on 6/13/17 was 14 and indicated the resident was intact cognitively. The BIMS score completed on 9/12/17 was 15 and indicated the resident was intact cognitively. A progress note, dated 3/3/17, indicated the resident had no documented exit seeking attempts during the quarterly observation period. The Treatment Administration Record indicated the target behavior of exit seeking had not occurred from 12/2/16 through 10/11/17. An Elopement Risk Review, dated 10/11/17, indicated the resident was an elopement risk due to a history of exit seeking and the select approaches included, but were not limited to, an		trends and make recommendations as needed until 100% is achieved.	

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	alarm device on the resident. During an interview on 10/12/17 at 10:54 a.m., Resident 28 indicated it was his preference not to have the wanderguard and he hated it. During an interview on 10/12/17, the Social Services Director indicated the resident had an elopement risk due to a history of exit seeking. During an interview on 10/12/17 at 4:37 p.m., the Executive Director indicated there was no documentation of the resident displaying exit seeking behaviors. 2. The record for Resident 48 was reviewed on 10/16/2017 at 9:10:07 AM. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, abnormalities of gait and mobility, muscle weakness and major depressive disorder. Diagnoses of degenerative spondylolisthesis (is a condition in which one vertebral body slips forward on top of the vertebral body below it), lumbar (lower spine) disc degeneration, lumbar canal stenosis (a narrowing of the open spaces in the lower spine) and postlaminectomy syndrome (condition characterized by chronic pain following back surgeries) were added as diagnoses on 7/11/2017.			

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During an interview on 10/16/2017 at 11:12 a.m., Resident 48 indicated he suffered from chronic back pain. As a result of the pain, the only time he had some relief from pain was with medications and when lying down.

During an interview on 10/17/2017 at 11:35 a.m., Resident 48 indicated he had been going to pain management clinic for some time now for medications to relieve pain. He was not made aware initially of the attempted gradual reduction of his pain medications.

Minimum Data Set (MDS) Quarterly Reviews, dated 6/15/2017 and 9/14/2017, indicated the Brief Interview of Mental Status (BIMS) of 15 indicated the resident was cogitatively intact.

A care plan, started 8/17/2016, indicated the resident has "...a lot of pain due to an automobile accident..." and requires "...strong narcotic pain meds to relieve pain...." Approaches, started on 8/17/2016, included "...Please ask me to rate my pain using the pain scale of 0-10 with 10 being the worst pain. Then medicate me appropriately. Notify my Dr. [doctor] if my pain doesn't seem to be relieved with pain meds [medications] as ordered. I require strong narcotic pain

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	reliever at least every 6 hours. Medicate me prior to therapy...." On 6/29/2017 an approach indicated family would bring a mattress from home for the resident's comfort. A "Resident Progress Note," dated 5/1/2017 at 2:08 p.m., indicated "Pain med [medication] reduction will begin on 5/2. [MD] goal is res [resident] will be on Norco [pain medication] TID [three times a day] by 6/1 with pain still controlled with Tylenol [pain medication] for breakthrough pain. Spoke with his son [name of son] today and went over plan and goal. Res family will be bringing in mattress they feel will be more comfortable for res. Res has h/o chronic back pain...." No other interventions, including nonpharmacological interventions were implemented after the gradual dose reduction of the resident's pain medication began on 5/2/2017. A physician's order, dated 5/1/2017 and discontinued on 6/8/2017, indicated "Please do not mention to res about pain med reduction per family/doctor which will start on 5/2/2017...." A current policy, dated 5/11/16, titled, "Guidelines for Restraint/Enabler Use"			

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	received from the Executive Director on 10/12/17 at 3:39 p.m., indicated "... A comprehensive plan of care shall be developed that:...Includes input from the resident...Is based on informed choice with the risks and benefits explained...Addresses medical symptoms...Is evaluated and revised as necessary, at least quarterly...." A current policy, dated October 2016, titled, "CAA Process and Care Planning" received from the Corporate Support staff on 10/16/17 at 2:11 p.m. indicated, "...Key Tasks...Clearly states the individual's issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns... Views the resident in distinct functional areas...Provides additional clarity of potential issues and/or condition that the resident may have...Review and revise the care plan as needed...." 3.1-3(n)(3) 3.1-35(d)(2)(B)			
F 0325 SS=G Bldg. 00	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (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; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to reassess interventions, implement new interventions and follow physician and registered dietitian recommendations which resulted in a significant weight loss for 2 of 3 residents reviewed for nutrition (Residents 38 and 77). Resident 38 had a 26 pound (lb) weight loss in 180 days, which is a significant weight loss. Findings include: 1. The record for Resident 38 was reviewed on 10/12/2017 at 10:22: a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, dysphagia (swallowing problem), major depressive disorder and hypertension.	F 0325	1.Resident's #38 & #77 that were cited in this survey were assessed with no adverse effects noted. Dietician assessed resident #38 & #77 with new dietary recommendations on 10/31/17. Tray Cards and physician orders reviewed and updated. 2.Residents who have had a significant weight change will be added to the Clinical At Risk meeting (CAR) by Director of Health Services (DHS). Interdisciplinary Team (IDT) will assess residents for intervention success with this meeting and add new interventions as needed. IDT to include consultation with the Registered Dietician and Speech Therapist for these Residents. Current residents will be reviewed to ensure weekly weights are in place if ordered, physician orders are accurate and tray card	11/16/2017

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	On 10/16/2017 at 8:12 a.m., Resident 38 was observed in the restorative dining room eating biscuits and gravy on a regular plate with a small glass of milk. The resident was not observed to be cued to take a bite or swallow. The resident was not observed to have a fortified shake at breakfast. The following weights were recorded for Resident 38: 1) On 4/3/2017, the resident weighed 151 pounds (lbs). 2) On 5/5/2017, the resident weighed 148.7 lbs. 3) On 6/7/2017, the resident weighed 141.4 lbs. 4) On 7/7/2017, the resident weighed 136.2 lbs. 5) On 8/2/2017, the resident weighed 131.8 lbs. 6) On 9/6/2017, the resident weighed 128.6 lbs. 7) On 10/1/2017, the resident weighed 125.2 lbs. No other weights were located for the resident. A care plan, started 6/25/2016 and last reviewed/revised on 8/23/2017, identified Resident 38 had difficulty feeding herself related to her dementia and weakened		information is accurate during the daily Clinical Care Meeting (CCM) and changes will be made accordingly. 3.Nursing, Dietary staff and meal managers will be educated by Dining Service support or designee on the process to ensure that tray card information is executed. Nursing staff to be educated on Guidelines for weight tracking and Nutrition documentation by clinical support or designee. Nursing staff to be educated by DHS or designee on specific resident interventions related to cueing, assisting, and swallowing. 4.The dining room will be audited to ensure tray card interventions are followed through with, the audits will be completed by the meal managers or designee for 2x a week for 4 weeks, then 1x a week for 5 months then Quarterly in QAA x2. Meal intake will be monitored by DHS or designee in CCM 5x per week for residents at risk for weight loss as identified in CAR for 6 months. ED or designee will audit that CAR is being completed weekly x 6 months and in QA quarterly or until 100% compliance is achieved.	

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	physical condition. The goal was for the resident to have adequate nourishment at meals with our without assistance of staff. Approaches were to "...provide meals and set up and assist as needed, may sit in restorative for additional assistance, therapy consult prn [as needed] ST [speech therapy] has recommended eating foods in separate bowls to help with self feeding...." A care plan, started 6/22/2016 and last reviewed/revised on 8/23/2017, identified Resident 38 had some swallowing deficits and took a long time to eat meals. The goal was for the resident to have the safest and least restrictive diet and not demonstrate any choking or aspiration. Two approaches were implemented. The most recent approach started 7/31/2017, indicated the resident was to, "...sit in restorative dining for additional assist...." The second approach, started 6/22/2016, indicated the daughter had agreed to speech therapy, diet per speech therapy recommendations and provide food in separate bowls. If able keep distractions at a minimum while eating. Daughter is ok with her eating in room to take as long as she wants...." A care plan, started 5/13/2016 and last reviewed/revised on 8/11/2017, identified Resident 38 would like to meet her			

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	nutritional and hydration needs to support her overall metabolic demands. The identified goal was to "...Maintain my weight at a healthy range...without any unwarranted significant weight changes, tolerate my physician ordered diet, have my personal food and dining preferences met; maintain my skin integrity...." Approaches were to obtain "...weight as ordered/needed offer alternate food and beverage items as needed...assist with meals as needed...diet/supplements/medications as ordered...." A current physician order, dated 3/7/2017, indicated Resident 38 was to receive Med pass 120 milliliters (mLs) by mouth 3 times a day between meals to promote healing. A "Resident Progress Note" dated 5/2/2017 at 11:53 a.m., indicated, "...Resident is taking hours to eat, seems distracted, chewing and chewing foods but forgetting to swallow...." A physician order, dated 5/3/2017 and discontinued 6/12/2017, indicated speech therapy for dysphagia (a swallowing problem) and cognitive linguistic evaluation was completed and the resident began speech therapy skilled services 3 times a week for 60 days to			

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	treat cognitive linguistic deficits including problem solving and recall and dysphagia deficits. The least restrictive diet level was to be determined during this therapy. A current physician order, dated 6/1/2017, indicated Resident 38 was to have pureed meat and a mechanical soft diet for all other foods. Each food item was to be served in an individual bowl. A "Resident Progress Note" written by the Registered Dietitian (RD) dated 6/09/2017 at 10:58 a.m., indicated "...No edema noted. Res [resident] on Mech [mechanical] soft diet with puree meat. Res on Med Pass 120 ml [milliliters] TID [three times a day]. PO [by mouth] intake 35-55% which is decreased for res. Will add fortified shake with meals to help promote stable weight. A current physician order dated 6/12/2017, indicated Resident 38 was to receive a fortified shake with meals to promote stable weight. Review of the "Therapist Progress and Discharge Summary," dated 6/12/2017, indicated the while chewing the resident had "minimal impairment (10-25% impairment; risk for trace aspiration...)..." and "...mild impairment (25-50%			

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	impairment; risk for aspiration on liquids...)...SLP [speech language pathologist] recommends all puree foods, but POA [power of attorney] requests only puree meats and all other foods be served mechanical soft...The pt [patient] is very distracted in the dining room and requires max cues from SLP to take another bite, alternate solids and liquids, and to swallow...the pt demonstrates increased meal consumption provided assistance to feed and cues to consume solids...." A "Resident Progress Note...Quarterly Progress Note" written by the RD, dated 6/20/2017 at 8:31 a.m., indicated "...Res feeds self in DR [dining room]. No chewing or swallowing problems noted...Nutritional status is stable. Will continue to monitor...." A "Resident Progress Note," regarding nutrition, dated 7/7/2017 at 5:23 p.m., indicated "...Sig [significant] loss in 90d [90 days]. Res on puree meat, other foods mech [mechanical] soft, fortified shakes with meals. Res does not like puree meat. PO intake 30-35%. Res on Med Pass 120 ml [milliliters] TID. Current interventions provide ample calories for wt [weight] support. Will inquire if diet consistency can be upgraded to increase intake. Will			

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	continue to monitor...." A "Resident Progress Note" written by the Social Services Director on 7/28/2017 at 10:34 a.m., indicated the resident's family was contacted regarding the residents decline in "...being able to eat by herself and it is taking her longer to complete each meal. Often, resident doesn't eat much at all...." A "Resident Progress Note-Sig [Significant] Change Nutrition Assessment" written by the RD dated 8/4/2017 at 10:19 a.m., indicated "...Res having increased difficulty with self feeding. Family agreed to RDR [restorative dining room] with increased assistance at meals. Res has had sig wt loss in 180d. Res has fort [fortified] shakes at meals and Med Pass between meals which provide ample calories for wt maintenance. Will monitor intakes in RDR and weights for weight improvement...Monitoring and Evaluation: Monitor weight, labs, and physical parameters to evaluate that diet and intake meet actual nutrition needs and resident goals...." On 8/7/2017 at 10:20 a.m., Resident 38 was identified to have a stage III (full thickness tissue loss) pressure ulcer to her left ankle.			

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	A "Resident Progress Note" dated 8/9/2017 at 11:30 a.m., indicated "...Resident continues to loose [sic] weight r/t [related to] current intake less than 50% of meals...Resident does not like pureed meats. Resident has order for fortified shakes with meals and medpass [Med Pass] TID...." A "Resident Progress Note- Nutrition-Sig Change assessment" written by the RD dated 8/11/2017 at 1:13 p.m., indicated "...Res on Mech soft diet with puree meat and fortified shakes with meals, po [by mouth] intake 40-60%. No chewing or swallowing problems noted. Res also on 2 cal supplement 120 ml TID-takes >75%. Res has Pressure area to ankle. Meds [medications] reviewed. Current interventions provide adequate protein for healing. Will monitor progress...." A "Resident Progress Note" dated 9/11/2017 at 2:51 p.m., indicated "...Residents weight is down 3.2# [pounds]/30 days and 7.6#/60 days. Resident pureed diet started in 6/17. Resident already has orders for fortified shakes with meals...." A "Resident Progress Note-Nutrition" written by the RD on 9/13/2017 at 2:48			

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	p.m., indicated "...fortified shakes with meals...Will continue fortified foods and supplement and encourage po intake. Will continue to monitor...." A "Resident Progress Note" dated 9/21/2017 at 9:41 p.m., indicated "...CRCA [Certified Resident Care Assistant] said res had dentures out, said res told her they don't fit...." A "Resident Progress Note-Nutrition" dated 10/6/2017 at 10:46 a.m., indicated "...Res on puree meant, other foods mech soft, fortified shakes with meals. Res does not like puree meat. PO intake 40-70%. Res on Med Pass 120 ml TID. Current interventions provide ample calories for wt support. Will continue fortified foods and supplements and encourage po intake. Will continue to monitor...." The tray card on 10/16/2017 for Resident 38 indicated the resident should have been served in individual bowls. The diet was listed as regular, fortified, mechanical soft. There was no mention of fortified shakes with meals on the tray card. Review of the resident's profile indicated the resident was to be in the restorative dining room for "...cues and			

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	encouragement...." Review of the Med Pass supplement intake report indicated from June 2017 through October 13, 2017 no supplement intake was recorded. Review of the "Meals and Fluids Detailed Entry Report" for Resident 38 from 3/17/2017 through 8/20/2017 indicated the following: 1) No dinner intake was recorded for 3/18/2017. 2) No lunch intake was recorded for 3/19/2017. 3) No dinner intake was recorded for 3/21/2017. 4) No lunch intake was recorded for 3/30/3017. 5) 2 different lunch intakes were recorded on 3/31/2017. 6) 2 different breakfast intakes were recorded on 4/14/2017. 7) No lunch intake was recorded for 4/15/2017. 8) No breakfast intake was recorded for 4/21/2017. 9) No dinner intake was recorded for 5/4/2017. 10) No dinner intake was recorded for 5/5/2017. 11) No dinner intake was recorded for 5/8/2017. 12) No lunch intake was recorded for			

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	5/12/2017. 13) No dinner intake was recorded for 5/17/2107. 14) No lunch intake was recorded for 5/27/2017. 15) No breakfast or lunch intakes were recorded for 5/29/2017. 16) No breakfast intake was recorded for 6/6/2017. 17) No breakfast intake was recorded for 6/10/2017. 18) No lunch or dinner intakes were recorded for 6/16/2017. 19) 2 different dinner intakes were recorded for 7/4/2017. 20) No dinner intake was recorded for 7/10/2017. 21) 2 different breakfast intakes were recorded on 7/12/2017. 22) No lunch intake was recorded for 7/14/2017. 23) No breakfast intake was recorded and 2 different lunch intakes were recorded for 7/17/2017. 24) No lunch intake was recorded for 8/12/2017. 25) 2 different breakfast intakes were recorded for 8/16/2017. 26) No breakfast intake was recorded for 8/19/2017. During an interview on 10/13/2017 at 11:56 a.m., the SLP indicated she was unaware the resident was eating in the			

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	restorative dining room and that staff should have been trained on giving her cues, feeding techniques, and strategies to assist her. Additionally, the resident's food should be served in separate bowls. During an interview on 10/13/2017 at 1:55 p.m., the Social Services Director indicated she was unaware the resident was having problems with her dentures. During an interview on 10/13/2017 at 2:06 p.m., the Assistant Director of Health Services (ADHS) indicated the computer tracking software was a critical communication tool and nursing staff was trained on how to complete the documentation accurately and completely. During an interview on 10/13/2017 at 2:39 p.m., the RD indicated poorly fitting dentures should be considered as a reason the resident lost weight. The resident was getting Med Pass between meals and should have received fortified shakes and foods at meals. No additional interventions have been considered since those interventions should provide the needed calories for the resident. During an interview on 10/13/2017 at 2:44 p.m., LPN 3 indicated if the supplemental intake is blank the			

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	supplement was not charted as given. During an interview on 10/13/2017 at 2:46 p.m., the Assistant Director of Health Services indicated the CRCA's should have cued the resident to eat and at the time the resident moved to the restorative dining room, the staff was not trained on techniques to cue the resident. During an interview on 10/13/2017 at 3:29 p.m., the Director of Health Services indicated residents with nutritional problems should be weighed. During an interview on 10/16/2017 at 8:20 a.m., CRCA 1 indicated the resident was drinking regular milk and eating off a regular plate. 2. The record for Resident 77 was reviewed 10/12/2017 9:07:45 AM. Diagnoses included, but were not limited to, osteoporosis, Parkinson's disease, depression and hypertension. The following weights were recorded for the resident: 1) On 8/1/2017, the resident weighed 82.8 pounds (lbs). 2) On 8/18/2017, the resident weighed 77 lbs (which is a 7.2% loss). 3) On 8/23/2017, the resident weighed 77.2 lbs.			

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	155290	A. BUILDING 00 B. WING	10/17/2017

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	4) On 8/28/2017, the resident weighed 75.6 lbs. Documentation was provided by the ADHS on 10/13/2017 at 3:03 p.m., the Assistant Director of Health Services (ADHS) indicated at that time the information was from a "Weight Record" and not from the resident's electronic medical chart. 5) On 9/6/2017, the resident weighed 74.8 lbs. 6) On 9/10/2017, the resident weighed 79.6 lbs. 7) On 10/1/2017, the resident weighed 79.8 lbs. A care plan dated 8/4/2017, indicated the resident had the potential for altered nutrition. Approaches included, but were not limited to "...Obtain weight as ordered/needed...." A "Resident Progress Note" dated 8/7/2017 at 11:54 p.m., indicated a wound was found on the resident's buttocks, the medical doctor (MD) was notified and treatment orders were received. A "Resident Progress Note" dated 8/9/2017 at 12:03 p.m., indicated the wound is a stage II pressure ulcer. A "Resident Progress Note" dated 8/21/2017 at 5:26 p.m., indicated			

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	"Resident weight down 5.8 [lbs]/2 weeks. Resident already has order for 90 ml med pass BID [twice a day]. Will continue to monitor weekly...." A "Resident Progress Note" dated 8/23/2017 at 3:25 p.m., indicated "Nutrition note: wt [weight]: 77# [pounds] wt down since admission. although wt is stable with July wt at other facility 79#. Res eats ave [average] 82% at meals. 90 mL 2.0 cal supplement BID started. no new interventions. will ask for wkly [weekly] weights x4 or until stable...." No weekly weights were located for this resident. A physician's order for Med Pass three times a day to promote stable weight was started on 8/28/2017 and discontinued on 9/1/2017 and restarted on 9/1/2017. During an interview with the ADHS and RD on 10/13/2017 at 2:06 p.m., the RD indicated weekly weights should have been done for the resident. A current facility policy titled "Guidelines for Weight Tracking" dated 5/15/2016, received from Clinical Support on 10/12/2017 at 3:08 p.m., indicated the purpose of the policy was to			

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	"...ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration...Procedures...2. Unless otherwise indicated or ordered by the physician the resident have their weight taken and recorded monthly...6. The weight should be recorded in the individual resident medical record...." A current facility policy titled, "Nutrition Documentation" dated 11/21/2016, received from the Executive Director on 10/12/2017 at 4:33 p.m., indicated "...h. Indicate if diet and intake meet estimated and/or actual nutrition needs...i. Chewing/Swallowing issues...m. Information collected from the resident/resident's family/members of the IDT should be used to complete the assessment and writing a resident-driven plan of care...." 3.1-46(a)(1)			
F 0371 SS=D Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or			

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	regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, record review and interview, the facility failed to ensure opened food was labeled and dated and expired food removed from the reach in refrigerator and the dry storage area. This deficient practice had the potential to affect 61 of 61 residents who received food from the kitchen. Findings include: During a tour of the kitchen area on 10/10/17 at 10:02 a.m., the following items were observed: Dry Storage Area: A package of yellow cake mix was found opened and sealed with no opened date.	F 0371	1.No Adverse affects have been noted 2.Residents residing at the facility have the potential to be affected by the alleged deficient practice. All food in the refrigerators, freezer and open in the kitchen area that was found to be expired, open, and unlabled or uncovered was disposed of on 10/10/17 3.The Director of Food Services (DFS) or designee will inservice all of the dietary staff on the proper storage and dating of food and expired foods as well. Audits will be completed by the DFS or designee for proper food storage, labeling and dating and expired foods in the open kitchen area, dry storage, refrigerator and	11/16/2017

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	Reach In Refrigerator: A container of French onion dip was found with a used by date of 10/7/17. An opened package of turkey breast lunch meat was found with an expiration date of 10/9/17. An opened package of ham lunch meat was found with an expiration date of 10/8/17. During an interview with the Dietary Manager and the Regional Manager on 10/12/17 at 2:30 p.m., the Dietary Manager indicated the expectation was to remove expired items in the morning but removal did not happen the morning of the review. A current policy titled, "Food Labeling and Dating Policy", dated 5/31/16, obtained from Corporate Clinical Support on 10/13/17 at 2:46 p.m., indicated "... Policy: Any food product removed from its original container, has a broken seal, and has been processed in any way must have a label. Purpose: To have food product properly labeled and dated. Procedures: Any food product removed from its original container, has a broken seal, and has been processed in any way must have a label. 1. Item Name 2. Date and time the food was labeled		freezer. The audits will be conducted 4 times a week for 1 month, then 3 times a week for one month, then weekly times 4 months. 4.Results of the audits will be brought to the monthly Quality Assurance meetings. The QAA committee will review for trends x 6 months or until 100% compliance is achieved.	

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	3. Use BY date 4. Initials of the person labeling the item 5. Securely cover the food item 6. The same label will be used at all times and in all areas. GFS item code number 708471...." 3.1-21(i)(3)			