| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| GOLDEN LIVINGCENTER - DARTMOUTH | 300 PROVIDENCE ROAD CHARLOTTE, NC 28207 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>On 04/04/17 the Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section began a follow up investigation at the facility. In order for the State Survey Agency to obtain all needed staff interviews to complete the investigation the survey's exit date was extended to 04/10/17.<br>Event ID# NB8V12. | F 000 | | |
| {F 157} SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(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);<br><br>(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<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). | {F 157} | | 5/2/17 |

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

Electronically Signed | 04/26/2017

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| {F 157} | Continued From page 1<br>(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.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br>This REQUIREMENT is not met as evidenced by:<br>Based on a physician interview, nurse practitioner interview, staff interviews and review of the medical record, the facility failed to notify the physician or nurse practitioner of a significant weight gain for Resident #82, for 1 of 4 sampled residents reviewed for physician notification.<br><br>The findings included:<br><br>Resident #82 was admitted to the facility on 12/13/16. Diagnoses included severe protein calorie malnutrition, anorexia, and delusional disorder, among others. His weight on admission was 154 pounds.<br><br>Review of an annual minimum data set dated 3/3/17 revealed Resident #82 was assessed with | {F 157} | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.<br><br>F-157<br><br>Resident # 82 with significant weight gain; the resident□s RP and MD was notified of the residents weight gain and the Registered Dieticians recommendation to | |

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| {F 157} | Continued From page 2<br>impaired short term memory, intact long term memory, moderately impaired decision-making, no behaviors, supervision and the physical assistance of a staff member with meals, significant weight gain, but not on a physician prescribed weight gain regimen.<br><br>A progress note, by the nurse practitioner (NP), dated 3/7/17, assessed Resident #82 with an increase in hallucinating/delusions, based on staff interviews, regarding the resident's diagnoses of delusional disorder. The NP's plan was to increase Seroquel (antipsychotic) to 200 milligrams three times daily. There was no reference to an assessment regarding an increase in his weight.<br><br>A nutrition data quarterly assessment by the certified dietary manager (CDM) dated 3/7/17 assessed Resident #82 with a current weight of 190 pounds, ideal body weight range of 149 - 184 pounds, a significant weight gain, intact skin, received a regular, large portions diet and a plan to continue to monitor weight and intake.<br><br>A nutrition assessment dated 3/16/17 by the registered dietitian (RD) revealed Resident #82 received a regular diet with milk added at each meal for additional protein and ate approximately 96% of meals. The RD assessment indicated that Resident #82's current weight was 188 pounds, a 22.1% significant recent weight gain since admission and that his total food/fluid intake met estimated caloric needs, but not estimated protein needs. The RD's recommendation was to have nursing record his food/fluid intake and monitor weights/labs since his skin was currently intact. The goal for Resident #82 was that the resident would continue to consume adequate | {F 157} | change the whole milk to 2% milk for resident # 82.<br><br>All residents have the potential to be affected.<br><br>All residents who triggered for a significant weight loss/gain were audited in the weekly at risk meeting on 4/20/2017 by the IDT team. The residents with weight changes were assessed by the Registered Dietician and appropriate interventions were put into place. The resident□s responsible parties and Medical Providers were notified by the DON/designee of the change. The audit was completed on 4/26/2017; with all areas of non-compliance addressed immediately.<br><br>An in-service training on Notification of Changes was completed on 4/27/17 with the nursing staff by the Director of Nursing and/or designee. The Nursing staffs were re-educated to notify the RP and MD of any changes in the resident□s condition. Staffs that were not available for in-person education were called and the education was completed via telephone by the DON and/or designee.<br><br>The Director of Nursing and/or designee will audit 100% of changes in resident conditions daily events that require proper notification in the clinical startup meeting daily to ensure compliance; all areas of non-compliance will be corrected immediately. The Director of Nursing and/or designee will expand monitoring, | |

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| {F 157} | Continued From page 3<br>amounts of food to meet his nutrient needs.<br><br>Review of the facility's "Weekly Risk Management (WRM)" meeting log and a "Weight Note" written in the resident's medical record by the Assistant Director of Nursing (ADON), revealed Resident #82's weight gain was discussed during WRM meetings held on 3/3/17 and 3/16/17 with department managers to include the ADON and the RD. The plan was reweigh for accuracy and to monitor his weight weekly.<br><br>Review of Resident #82's care plan, revised on 3/20/17 by the RD, documented Resident #82 had inadequate protein energy intake and a body mass index (BMI) of 26.9% (obese) due to a recent significant weight gain of 22.1% since admission. The care plan intervention included to notify the physician of significant weight changes.<br><br>Review of Resident #8's weight history revealed the following weights:<br>· 12/13/16, 154 pounds<br>· 1/11/17, 160 pounds<br>· 2/8/17 (reweigh), 183 pounds (16% gain)<br>· 3/8/17 (reweigh), 188 pounds (18% gain)<br>· 3/29/17, 193 pounds (20% gain)<br><br>A telephone interview on 4/05/17 at 3:03 PM with the RD revealed she attended the facility's WRM meetings and that she assessed Resident #82 with a significant weight gain of 22.1% since admission to the facility. The RD stated when she assessed Resident #82 on 3/16/17, she did not have recommendations for changes to his plan of care at that time, because although he was eating less than 100% of his meals, he received additional protein from the additional milk at each meal and his skin was intact. The RD stated "I | {F 157} | interventions and corrective actions for non-compliance with notifications. Audits will be completed 5 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 6 months. Ongoing and/or expanded monitoring, interventions and additional corrective actions will be implemented as needed.<br>The results of the Director of Nursing and/or designee□s audits will be reported to the QAPI committee monthly meeting for three months and then quarterly thereafter until the QAPI committee determines compliance. Determinations will be recorded in the minutes of the QAPI.<br><br>Education<br><br>F-157 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC) (g)(14) Notification of Changes<br><br>A facility must immediately inform resident; consult with the resident□s physician; and notify, consistent with his or her authority, the resident representative(s) when there is:<br>" Accident involving the resident which results in injury and has the potential for requiring physician intervention<br>" A significant change in the residents physical, mental or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); | |

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| {F 157} | Continued From page 4<br>don't notify the physician of significant weight changes, that's up to nursing." She stated that her current plan was to continue to monitor the resident's weight status.<br><br>An interview on 4/05/17 at 3:30 PM with the Interim Director of Nursing (IDON) revealed the facility held WRM meetings, she did not attend the 3/16/17 WRM meeting, but that the ADON did attend. The IDON stated that she expected the RD to notify the physician of any significant weight changes verbally or by documentation in the physician's communication book. Review of the physician's communication book during the interview revealed there was no documentation regarding Resident #82's change in weight status.<br><br>An interview on 4/05/17 at 3:46 PM with the ADON revealed he attended the 3/16/17 WRM meeting and Resident #82's significant weight status was discussed. The ADON stated that nursing did not notify the physician or NP of the significant change in weight status for Resident #82 because the RD was present and he expected that she would have notified the physician by writing a note in physician's communication book, if there was a concern with nutrition for a resident.<br><br>A telephone interview with the physician for Resident #82 occurred on 4/5/17 at 4:15 PM. The interview revealed that he was not made aware of a significant change in weight status for Resident #82, but that he could not say whether or not his NP was advised. The physician stated that if either he or the NP were advised, documentation would be available in the physician's communication book and a corresponding progress note would be written by either the | {F 157} | " 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<br>" A decision to transfer or discharge the resident from the facility. | |

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| {F 157} | Continued From page 5<br>physician or the NP. The physician stated that if that documentation was not available, then it was likely that neither he nor the NP, were advised. The physician stated that for a 22% weight gain he would expect notification because the weight gain could likely be due to swelling/edema/fluid which would need to be assessed.<br><br>A telephone interview was conducted on 4/10/17 at 1:43 PM with the NP. The interview revealed that the NP was not advised of a significant change in weight status for Resident #82. The NP stated that typically the facility would advise of significant changes for a resident by leaving a note in the physician's communication book, but due to multiple recent changes in administration staff, Resident #82 may have been overlooked. The NP stated that she was advised that Resident #82 experienced a recent increase in hallucinations, but she could not recall whether or not she ordered an antipsychotic in response to this. The NP further stated that if she did order an antipsychotic, that could be the reason for the weight gain and she would expect notification in case an adjustment to the antipsychotic was needed. | {F 157} | | |
| {F 253} SS=D | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, a resident interview, staff interviews and review of facility records, the facility failed to secure a loose grab bar to the bathroom wall for a resident who used the | {F 253} | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an | 5/2/17 |

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| {F 253} | Continued From page 6<br>bathroom independently (Resident #95), repair a resident's door to prevent it from scaring the floor (Resident #95) and identify and repair 4 broken floor tiles (Room 317) for 2 of 7 sampled resident rooms observed.<br><br>The findings included:<br><br>1a. Resident #95 was admitted to the facility on 1/18/17. Review of an admission Minimum Data Set (MDS) assessment, dated 1/25/17, assessed Resident #95 with clear speech, understood, understands, intact cognition, required limited physical assistance of one staff person with transfers and toilet use, unsteady, but able to stabilize without staff assistance when moving from seated to standing position and moving on/off toilet. The MDS also assessed Resident #95 with 1 fall since admission and indicated that direct care staff believed Resident #95 was capable of increased independence in at least some activities of daily living.<br><br>Review of the facility's Verification of Investigation (VOI), revealed Resident #95 sustained a fall, uninjured, in his bathroom on 3/30/17, with a follow up to repair a loose grab bar in his bathroom. At the time of the fall, Resident #95 stated he fell because the grab bar in his bathroom was loose and unsteady.<br><br>An interview on 4/4/17 at 12:25 PM with the Maintenance Director revealed that he did not conduct routine facility rounds, because he had too much to do to round daily. He stated that he and the Maintenance Assistant could not be in each resident's room every day to identify needed repairs, but rather expected staff to report needed repairs via the Building Engines (computerized | {F 253} | admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.<br><br>F-253<br>Resident # 95 bathroom grab-bar and bathroom door was repaired immediately. The broken floor tile identified in RM 317 on the left side of bed-B was repaired immediately.<br><br>All Residents of the facility have the potential to be affected. The maintenance director and/or designee completed audits of all patient rooms on 4/27/17. All grab-bars, doors and tile not in compliance were repaired and/or replaced immediately.<br><br>The Executive Director and/or Maintenance Director will provide re-education to staff on the process of inputting housekeeping and maintenance issues into the facility building engines automated maintenance program software when identified by staff to keep the facility equipment and building properly maintained. The Maintenance Director was reeducated on 4/27/17 by Wanda Whipple, RN (GLC-Lead Clinical Support team) on maintaining a preventive maintenance log and conducting house wide rounds weekly to identify repairs as needed.<br><br>Facility zone rounds were implemented for department heads to assist in maintaining | |

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| {F 253} | Continued From page 7<br>reporting system). The Maintenance Director stated that he reviewed Building Engines at least twice daily, around 7:00 AM and again around lunch time. He stated that he completed all repairs by the end of the day that were reported via Building Engines.<br><br>Resident #95 was interviewed on 4/4/17 at 3:20 PM and stated that the grab bar in his bathroom was unsecured to the wall when he fell in the bathroom last week and that the grab bar had been loose for a while. Resident #95 stated he reported this to a staff member and someone in the maintenance department was supposed to fix it, but the grab bar was still loose. Resident #95 stated he used the grab bars in his bathroom daily to transfer on/off the commode and used the grab bars to stabilize during his transfers.<br><br>An observation of Resident #95's bathroom occurred on 4/4/17 at 3:20 PM and revealed the left grab bar, adjacent to the commode, was unsecured to the bathroom wall, 1 of 2 screws were loose from the wall and the grab bar easily moved side to side when touched.<br><br>An interview on 4/4/17 at 3:30 PM with nurse aide (NA) #1 revealed Resident #95 used the grab bars in his bathroom to stabilize himself during transfers on/off the commode to maintain his independence. NA #1 stated she was not aware the left grab bar in his bathroom was unsecured to the wall.<br><br>An interview on 4/4/17 at 3:35 PM with Nurse #1 revealed Resident #95 used the bathroom independently, requested assistance with transfers/toileting as needed, but used the grab bars in his bathroom to stabilize during his | {F 253} | compliance. The facility zone rounds will monitor facility and resident rooms 5-times/week for 4 weeks, then 3-times/week for 4 weeks, then weekly for 3 months. The Maintenance Director and/or designee will be responsible for compliance.<br><br>The results of the monitoring will be reported to the QAPI committee monthly meeting for three months, and then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI.<br><br>Education<br>F-253 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance service necessary to maintain a sanitary, orderly, and comfortable interior;& | |

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| {F 253} | Continued From page 8 | {F 253} | | |

transfers. Nurse #1 stated she was not aware of any needed repairs for his room.

An interview occurred on 4/4/17 at 3:45 PM with the Interim Director of Nursing (IDON) and revealed Resident #95 fell in his bathroom on 3/30/17 and that his fall was discussed during the facility's Weekly Risk Management meeting. The IDON stated that the follow up to the fall included a plan to repair the loose grab bar in the resident's bathroom, the request was discussed verbally and recorded in the Building Engines. The IDON provided documentation for review dated 3/31/17 from the facility's Building Engines of the request to repair the grab bar for Resident #95. The IDON stated that an attempt to repair the grab bar was not made until Monday, 4/3/17, but that the repair was unsuccessful. The IDON stated she expected the Maintenance Director to conduct routine round/audits to identify a need for repairs, staff to report needed repairs in Building Engines and for the Maintenance Director to ensure repairs were completed timely/effectively.

Follow up observations of Resident #95's room and a follow up interview with the Maintenance Director occurred on 4/4/17 at 4:00 PM and 4/4/17 at 4:15 PM. The observations revealed the bathroom grab bar for Resident #95 was still in need of repair. The Maintenance Director stated he was not aware that the grab bar Resident #95 was in need of repair because the repair was not recorded in building engines. On 4/4/17 at 4:15 PM, the Maintenance Director further stated that the Maintenance Assistant attempted to repair the grab bar for Resident #95 on 4/3/17 after receipt of a verbal request for the repair during a morning staff meeting on 3/31/17. The Maintenance Director stated the hole in the wall was too large

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| {F 253} | Continued From page 9 | {F 253} | | |

for the screws, the initial attempt to fill in the hole was unsuccessful and now the grab bar was loose again. He also stated that he received a list of items to repair on Thursday, which he repaired, but the list did not include repairs to Resident #95's room.

An interview with the Maintenance Assistant occurred on 4/4/17 at 4:20 PM. The interview revealed that he was notified on Friday morning, 3/31/17 that the grab bar for Resident #95 was loose and needed to be repaired. He stated he attempted to make the repair, Monday, 4/3/17, but the hole in the wall was too large for the screws, he attempted to fill in the hole, using a quick drying cement, but that he did not follow up after the repair to ensure the grab bar was secured to the wall before it was used again. He stated that he just looked at the grab bar and realized the cement did not fill in the hole as he anticipated it would, so he would have to go back and repair it again.

1b. Resident #95 was admitted to the facility on 1/18/17. Review of an admission Minimum Data Set assessment, dated 1/25/17, assessed Resident #95 with clear speech, understood, understands, and intact cognition.

An interview on 4/4/17 at 12:25 PM with the Maintenance Director revealed that he did not conduct routine facility rounds, because he had too much to do to round daily. He stated that he and the Maintenance Assistant could not be in each resident's room every day to identify needed repairs, but rather expected staff to report needed repairs via the Building Engines (computerized reporting system). The Maintenance Director stated that he reviewed Building Engines at least

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| {F 253} | Continued From page 10 | {F 253} | | |

twice daily, around 7:00 AM and again around lunch time. He stated that he completed all repairs by the end of the day that were reported via Building Engines.

Resident #95 was interviewed on 4/4/17 at 3:20 PM and stated that the door to his room did not open/close easily because the door did not clear the floor, but rather got stuck. During the interview, the floor at the foot of Resident #95's bed, underneath the room door, was observed with multiple deep half circular grooves. Attempts to close the door revealed the door scraped the floor when closed approximately half way and required great force to close it.

An interview on 4/4/17 at 3:30 PM with nurse aide (NA) #1 revealed that the door to Resident #95's room was difficult to close and created grooves in the floor when opened/closed. NA #1 stated the door had been like that for a while, she did not know how long, but she had not reported this for repair.

An interview on 4/4/17 at 3:35 PM with Nurse #1 revealed she was not aware of any needed repairs for Resident #95's room.

An interview occurred on 4/4/17 at 3:45 PM with the Interim Director of Nursing (IDON) and revealed she expected the Maintenance Director to conduct routine round/audits to identify a need for repairs, staff to report needed repairs in Building Engines (computerized reporting system) and for the Maintenance Director to ensure repairs were completed timely/effectively.

Follow up observations of Resident #95's room and a follow up interview with the Maintenance

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| {F 253} | Continued From page 11 | {F 253} | | |

Director occurred on 4/4/17 at 4:00 PM and 4/4/17 at 4:15 PM. The observations revealed the room door for Resident #95 was still in need of repair. The Maintenance Director stated that several rooms had doors that scraped the floor because the building settled over time and he had not had an opportunity to address this issue yet. He also stated that he received a list of items to repair on Thursday, 3/30/17 which he repaired, but the list did not include repairs to Resident #95's room.

2. An observation occurred on 4/4/17 at 10:32 AM of room 317. The floor next to the left side of bed B, across from the window revealed 4 of the floor tiles were broken/jagged which left a space of approximately 12 inches x 6 inches void of floor tiles.

An interview on 4/4/17 at 12:25 PM with the Maintenance Director revealed that he did not conduct routine facility rounds, because he had too much to do to round daily. He stated that he and the Maintenance Assistant could not be in each resident's room every day to identify needed repairs, but rather expected staff to report needed repairs via the Building Engines (computerized reporting system). The Maintenance Director stated that he reviewed Building Engines at least twice daily, around 7:00 AM and again around lunch time. He stated that he completed all repairs by the end of the day that were reported via Building Engines.

An interview occurred on 4/4/17 at 3:45 PM with the Interim Director of Nursing and revealed she expected the Maintenance Director to conduct routine round/audits to identify a need for repairs, staff to report needed repairs in Building Engines

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| {F 253} | Continued From page 12<br>and for the Maintenance Director to ensure repairs were completed timely/effectively.<br><br>Follow up observations of room 317 and a follow up interview with the Maintenance Director occurred on 4/4/17 at 4:00 PM and 4/4/17 at 4:15 PM. The observations revealed the floor tiles (room 317) were still in need of repair. The Maintenance Director stated he was not aware that the floor tiles (room 317) were in need of repair because the repairs were not recorded in Building Engines. On 4/4/17 at 4:15 PM, the Maintenance Director further stated that he received a list of items to repair on Thursday, 4/3/17 which included floor tiles in room 317, which he repaired. The Maintenance Director also stated that he assumed the tiles that were currently broken in that room must have just occurred, but when he repaired the tiles in that room, he did not look to see if other repairs were needed. | {F 253} | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited | F 323 | | 5/2/17 |

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| F 323 | Continued From page 13<br>to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews and medical record review, the facility failed to secure a grab bar to the wall in the bathroom to prevent a fall and as a fall intervention after a fall for 1 of 3 sampled residents reviewed with a history of falls. (Resident #95)<br><br>The findings included:<br><br>Resident #95 was admitted to the facility on 1/18/17. Diagnoses included Parkinson's disease, chronic congestive heart failure and glaucoma, among others.<br><br>Review of an admission Minimum Data Set (MDS) assessment, dated 1/25/17, assessed Resident #95 with clear speech, understood, understands, intact cognition, required limited physical assistance of one staff person with transfers and toilet use, unsteady, but able to stabilize without staff assistance when moving from seated to standing position and moving on/off toilet. The MDS also assessed Resident #95 with 1 fall since admission and indicated that direct care staff believed Resident #95 was | F 323 | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.<br><br>F-323<br>Resident # 95 bathroom grab-bar was repaired immediately.<br><br>All Residents of the facility have the potential to be affected if a grab-bar is installed in their bathroom. The maintenance director and/or designee completed an audit of resident rooms on 4/27/2017. All grab-bars not in compliance were repaired and/or replaced immediately.<br><br>The Executive Director and/or Maintenance Director will provide reeducation to staff on the process of | |

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| F 323 | Continued From page 14<br>capable of increased independence in at least some activities of daily living.<br><br>Review of Resident #95's care plan, revised 3/3/017, revealed he was at risk for falls related to a history of falls, new environment, weakness, unsteadiness and Parkinson's disease. Care plan goals included to increase/maintain his current level of physical functioning. Interventions included for staff to ensure adaptive equipment was secure.<br><br>Review of the facility's Verification of Investigation (VOI) dated 3/30/17 at 04:43 AM and a nurse's note dated 3/30/17 at 06:37 AM, both written by Nurse #2, revealed Resident #95 sustained a fall, uninjured, in his bathroom on 3/30/17, with a follow up to repair a loose grab bar in his bathroom. The VOI documented that at the time of the fall, Resident #95 stated he fell because the grab bar in his bathroom was loose and unsteady.<br><br>An observation of Resident #95's bathroom occurred on 4/4/17 at 3:20 PM and revealed the left grab bar, adjacent to the commode, was unsecured to the bathroom wall, 1 of 2 screws were loose from the wall and the grab bar easily moved side to side when touched.<br><br>Resident #95 was interviewed on 4/4/17 at 3:20 PM and stated that the grab bar in his bathroom was unsecured to the wall when he fell in the bathroom last week and that the grab bar had been loose for a while. Resident #95 stated he reported this to a staff member and someone in the maintenance department was supposed to fix it, but the grab bar was still loose. Resident #95 stated he used the grab bars in his bathroom | F 323 | inputting housekeeping and maintenance issues, (work orders and preventive maintenance tasks); into the facility building engines automated maintenance program software when identified by staff to keep the facility equipment and building properly maintained.<br><br>The Maintenance Director and/or designee will audit for life safety concerns 5-times/week for 4 weeks, then 3-times/week for 4 weeks, then weekly for 3 months. The Executive Director will conduct audits for life safety concerns 3 times a week for 4 weeks, then weekly for 3 months. Identified repairs will be corrected at that time.<br><br>Facility zone rounds were implemented for department heads to assist in maintaining compliance. The facility zone rounds will monitor facility and resident room□s 5-times/week for 4 weeks, then 3-times/week for 4 weeks, then weekly for 3 months. The Maintenance Director and/or designee will be responsible for compliance.<br><br>The results of the monitoring will be reported to the QAPI committee monthly meeting for three months, and then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitoring, interventions and additional corrective actions needed to ensure compliance. Determinations will be recorded in the minutes of the QAPI. | |

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| F 323 | Continued From page 15<br>daily to transfer on/off the commode and used the grab bars to stabilize during his transfers.<br><br>An interview on 4/4/17 at 3:30 PM with nurse aide (NA) #1 revealed Resident #95 used the grab bars in his bathroom to stabilize himself during transfers on/off the commode to maintain his independence, but that she was not aware that it was not secured to the wall.<br><br>An interview on 4/4/17 at 3:35 PM with Nurse #1 revealed Resident #95 used the bathroom independently, requested assistance with transfers/toileting as needed, but used the grab bars in his bathroom to stabilize during his transfers. Nurse #1 stated she was not aware of any needed repairs for his room.<br><br>An interview occurred on 4/4/17 at 3:45 PM with the Interim Director of Nursing (IDON) and revealed Resident #95 fell in his bathroom on 3/30/17 and the that the fall was discussed during the facility's 3/31/17 Weekly Risk Management meeting. The IDON stated that the follow up to the fall included a plan to repair the loose grab bar in the resident's bathroom, the request was discussed verbally and recorded in the Building Engines (computerized repair system). The IDON provided documentation for review dated 3/31/17 of the request to repair the grab bar for Resident #95 from the facility's Building Engines. The IDON stated that an attempt to repair the grab bar was not made until Monday, 4/3/17, but that the repair was unsuccessful. The IDON stated she expected the Maintenance Director to conduct routine round/audits to identify a need for repairs and to ensure repairs were completed timely/effectively. | F 323 | Education<br><br>F-323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS<br><br>(d) the facility must ensure that (1) the resident environment remains free from accident hazards as is possible. | |

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| F 323 | Continued From page 16 | F 323 | | |

Follow up observations of Resident #95's room and an interview with the Maintenance Director occurred on 4/4/17 at 4:00 PM and 4/4/17 at 4:15 PM. The observations revealed the bathroom grab bar was still in need of repair. The Maintenance Director stated he was not aware that the grab bar was in need of repair because the repair was not recorded in Building Engines. On 4/4/17 at 4:15 PM, the Maintenance Director further stated that the Maintenance Assistant attempted to repair the grab bar on 4/3/17 after receipt of a verbal request for the repair during a morning staff meeting on 3/31/17. The Maintenance Director stated that the hole in the wall was too large for the screws, and the attempt to fill in the hole was unsuccessful and now the grab bar was loose again.

An interview with the Maintenance Assistant occurred on 4/4/17 at 4:20 PM. The interview revealed that he was notified on Friday morning, 3/31/17 that the grab bar for Resident #95 was loose and needed to be repaired. He stated he attempted to make the repair on Monday, 4/3/17, but the hole in the wall was too large for the screws, he attempted to fill in the hole, using a quick drying cement, but that he did not follow up after the repair to ensure the grab bar was secured to the wall before it was used again. He stated that he just looked at the grab bar and realized the cement did not fill in the hole as he anticipated it would, so he would have to go back and repair it again.

A telephone interview on 4/4/17 at 4:36 PM with Nurse #2 revealed Resident #95 fell in his bathroom during a transfer from the commode to his wheel chair during the 11:00 PM - 7:00 AM shift on 3/30/17. Nurse #2 stated that she

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| F 323 | Continued From page 17<br>assessed him after the fall on 3/30/17 and observed the left grab bar in his bathroom was not secure to the wall, but "shaky" when moved. Nurse #2 stated she assessed him without injury after the fall and that the resident stated he felt the loose/unsteady grab bar was the reason for his fall. Nurse #2 stated she documented on the facility's VOI that the follow up would be to repair the loose grab bar. Nurse #2 stated she was not aware that the grab bar was loose prior to Resident #95's fall on 3/30/17, but confirmed that the resident used the grab bars in his bathroom to transfer independently.<br><br>A telephone interview on 4/5/17 at 10:11 AM with NA #2 revealed she was the assigned NA for Resident #95 when he fell on the 11:00 PM - 7:00 AM shift on 3/3/017 and that she was also his assigned NA on the same shift on 3/31/17. NA #2 stated that the grab bar in his bathroom was loose before the fall on 3/30/17, but that she was not certain how long it had been loose and that she did not report the need for a repair. NA #2 further revealed that Resident #95 used the grab bars in his bathroom to transfer independently on/off the commode and continued to do so on 3/30/17 and 3/31/17. | F 323 | | |
| F 490 SS=D | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by: | F 490 | | 5/2/17 |

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| F 490 | Continued From page 18<br>Based on observations, resident interviews, interviews with the physician and nurse practitioner, staff interviews and review of medical and facility records, the facility's administration failed to implement a system for communication to the physician or nurse practitioner when 1 of 4 sampled residents (Resident #82) experienced a significant change in weight status and failed to utilize resources effectively to identify and maintain repairs in bathrooms and resident rooms (Resident #95 and room 317) for 2 of 7 sampled resident rooms observed.<br>The findings included:<br><br>This tag is cross referred to:<br><br>1. F 157 Notification of Changes: Based on a physician interview, nurse practitioner interview, staff interviews and review of the medical record, the facility failed to notify the physician or nurse practitioner of a significant weight gain for Resident #82, for 1 of 4 sampled residents reviewed for physician notification.<br><br>During an interview on 4/5/17 at 4:57 PM with the Interim Administrator and the Interim Director of Nursing (IDON), the Interim Administrator stated that it was not the facility's typical practice to notify the physician/nurse practitioner of all items discussed during Weekly Risk Management (WRM) meetings, particularly if no changes were made to a resident's plan of care. The IDON stated that the Registered Dietitian attended the WRM meeting held on 3/16/17 and had no recommendations for Resident #82 as it related to the resident's significant weight gain. The IDON stated this was the reason the physician or nurse practitioner were not notified of the resident's significant change in weight status. | F 490 | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.<br><br>F-490<br>All residents have the potential to be affected.<br><br>The Executive Director and Director of Nursing received education on the proper supervision of resources for effective and efficient administration. Corporate Clinical & Operational support team provided education in their area of expertise. Education was completed on 4/26 & 4/27 2017.<br><br>An AD-HOC QAPI meeting was completed on 4/27/17 addressing 2567 citations.<br><br>The Executive Director and Director of Nursing, under the direction of Clinical & Operational Support Team and/or designee will validate the proper administration of resources through the QAPI process. The direction, monitoring and support will take place through in person and via conference call to ensure compliance.<br><br>The QAPI committee will begin meeting, at least, monthly and/or as needed, to | |

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| F 490 | Continued From page 19<br><br>This tag is cross referred to:<br><br>2. F253 Housekeeping and Maintenance Services: Based on observations, a resident interview, staff interviews and review of facility records, the facility failed to secure a loose grab bar to the bathroom wall for a resident who used the bathroom independently (Resident #95), repair a resident's door to prevent it from scaring the floor (Resident #95) and identify and repair 4 broken floor tiles (Room 317) for 2 of 7 sampled resident rooms observed.<br><br>During an interview on 4/5/17 at 4:57 PM with the Interim Administrator and the Interim Director of Nursing (IDON), the Interim Administrator stated he met with the head of each department on Thursday, 3/30/17 and discussed the status of auditing/monitoring tools to ensure monitoring was ongoing. He expressed that he attributed the ongoing maintenance repair needs to a lack of administrative oversight/auditing and the need to coordinate/outsource repair services. The Interim Administrator stated that there was no attempt to repair the grab bar for Resident #95 until Monday, 4/3/17, which was not timely enough. The IDON stated that the facility met for Weekly Risk Management (WRM) meetings and discussed Resident #95's fall and the need to repair the grab bar during the WRM meeting of 3/16/17. The IDON stated that an attempt to repair the grab bar was not made until Monday, 4/3/17 and the facility's next follow up to see if the intervention was implemented would not have occurred until Friday, 4/7/17. The IDON stated that if the Maintenance Director was not conducting rounds, the facility may not have identified that the grab bar was not repaired until, | F 490 | address all identified areas in respect to the proper administration of resources for the purpose of implementing appropriate plans of action to correct identified deficiencies.<br><br>QAPI meetings will be scheduled for the 3rd Wednesday of each month at 11:00 a.m.<br><br>All plans of action initiated through QAPI will be monitored, for the purpose of updating, revising and/or amending as needed ensuring compliance and correction. Monitoring will continue for three months and then randomly thereafter. All documentation of monitoring will be brought to QAPI for evaluation.<br><br>Education<br><br>F 490 □Facility Administrated Effectively<br><br>F490 ¿483.75 Administration A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. | |

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| F 490 | Continued From page 20<br>Friday, 4/7/17 at the next WRM meeting. | F 490 | | |
| {F 520} SS=D | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. | {F 520} | | 5/2/17 |

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| {F 520} | Continued From page 21<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interviews, physician/nurse practitioner interviews, staff interviews and review of medical and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May 2016. This was for 1 recited deficiency that was originally cited April 2016 on a Recertification/Complaint survey and subsequently recited on the facility's current Recertification/Complaint survey and a Revisit/Complaint survey. The deficiency was in the area of housekeeping and maintenance services. The facility's QAA also failed to maintain implemented procedures and monitor these interventions that the committee put into place in March 2017. This was for 1 recited deficiency that was originally cited in February 2017 on a Recertification/Complaint survey and subsequently recited on the facility's current Revisit/Complaint survey. The deficiency was in the area of notification of changes. The continued failure of the facility during 3 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.<br><br>Findings included:<br><br>This tag is cross referred to:<br><br>1a. F 157 Notify of Changes: Based on a | {F 520} | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.<br><br>F-520<br>All residents have the potential to be affected.<br><br>The Executive Director and Director of Nursing received education on the QAPI process by the Corporate Clinical Support Team, education was completed on 4/26/17.<br><br>An AD-HOC QAPI meeting was completed on 4/27/17 addressing 2567 citations.<br><br>The QAPI committee will begin meeting, at least, monthly and/or as needed, to address all identified areas in respect to quality assessment and assurance activities for the purpose of implement appropriate plans of action to correct identified deficiencies. | |

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| {F 520} | Continued From page 22<br>physician interview, nurse practitioner interview, staff interviews and review of the medical record, the facility failed to notify the physician or nurse practitioner of a significant weight gain for Resident #82, for 1 of 4 sampled residents reviewed for physician notification.<br><br>During a Recertification/Complaint survey of February 16, 2017, the facility was cited for failure to notify the healthcare power of attorney when a resident received occupational therapy utilizing a hand splint and a guardian of a resident's discharge. On the current Revisit/Complaint survey of April 10, 2017, the facility was cited for failure to notify the physician/nurse practitioner of significant change in weight status.<br><br>1b. F 253 Housekeeping and Maintenance Services: Based on observations, a resident interview, staff interviews and review of facility records, the facility failed to secure a loose grab bar to the bathroom wall for a resident who used the bathroom independently (Resident #95), repair a resident's door to prevent it from scaring the floor (Resident #95) and identify and repair 4 broken floor tiles (Room 317) for 2 of 7 sampled resident rooms observed.<br><br>During a Recertification/Complaint survey of April 29, 2016, the facility was cited for failure to replace broken floor tiles, repairs holes in the wall/bathroom door, repair a leaking commode and replace missing wall outlet covers. On the current Recertification/Complaint of February 16, 2017 the facility was cited for failure to repair a commode, bathroom faucets, over the bed table, wardrobe door, broken floor tiles, door frames and replace a missing drawer. On the subsequent Revisit/Complaint survey of April 10, 2017, the | {F 520} | QAPI will be held monthly, on the 3rd Wednesday at 11:00 AM.<br><br>All plans of action initiated through QAPI will be monitored, for the purpose of updating, revising and/or amending as ensuring compliance and correction. Monitoring will continue for three months and then randomly thereafter. All documentation of monitoring will be brought to QAPI for evaluation.<br><br>The Executive Director and Director of Nursing, under the direction of corporate Clinical Support Team and/or designee, will ensure the QAPI committee addresses all identified areas in respect to quality assessment and assurance activities for the purpose of implementing appropriate plans of action to correct identified deficiencies. The direction and monitoring of QAPI will take place through in person and via conference call to ensure compliance.<br><br>Education<br><br>F-520 483.75(g)(1)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance Facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>" DNS<br>" Medical Director | |

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| {F 520} | Continued From page 23<br>facility was cited for failure to repair a grab bar, floor tiles and a resident's room door.<br><br>The Interim Administrator and Interim Director of Nursing (IDON) were interviewed on 04/05/17 at 4:57 PM. The Interim Administrator stated that he was made aware of the deficiencies cited during the facility's February 2017 Recertification/Complaint survey on Thursday, March 30, 2017. The Interim Administrator stated he met with the head of each department and discussed the status of auditing/monitoring tools to ensure monitoring was ongoing. He stated that he attributed the ongoing maintenance repair needs to administrative oversight due to a lack of auditing. He also stated that it was not the facility's typical practice to notify the physician/nurse practitioner of all items discussed during Weekly Risk Management (WRM) meetings, particularly if no changes were made to a resident's plan of care. The IDON stated that the Registered Dietitian was present during the 3/16/17 WRM meeting, but did not see a need to recommend a change to the plan of care for Resident #95 related to the significant weight status. | {F 520} | " At least three other members of the facilities staff, at lest one of who must be the administrator, owner, a board member or other individual in a leadership role;<br>(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies: | |

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| F 000 | INITIAL COMMENTS<br><br>On 04/04/17 the Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section began a complaint investigation at the facility. In order for the State Survey Agency to obtain all needed staff interviews to complete the investigation the survey's exit date was extended to 04/10/17.<br>Event ID# W7TB11. | F 000 | | |
| F 157 SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(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);<br><br>(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<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). | F 157 | | 5/2/17 |

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

Electronically Signed | 04/26/2017

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| F 157 | Continued From page 1<br>(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.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br>This REQUIREMENT is not met as evidenced by:<br>Based on a physician interview, nurse practitioner interview, staff interviews and review of the medical record, the facility failed to notify the physician or nurse practitioner of a significant weight gain for Resident #82, for 1 of 4 sampled residents reviewed for physician notification.<br><br>The findings included:<br><br>Resident #82 was admitted to the facility on 12/13/16. Diagnoses included severe protein calorie malnutrition, anorexia, and delusional disorder, among others. His weight on admission was 154 pounds.<br><br>Review of an annual minimum data set dated 3/3/17 revealed Resident #82 was assessed with | F 157 | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.<br><br>F-157<br><br>Resident # 82 with significant weight gain; the resident's RP and MD was notified of the residents weight gain and the Registered Dieticians recommendation to | |

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| F 157 | Continued From page 2<br>impaired short term memory, intact long term memory, moderately impaired decision-making, no behaviors, supervision and the physical assistance of a staff member with meals, significant weight gain, but not on a physician prescribed weight gain regimen.<br><br>A progress note, by the nurse practitioner (NP), dated 3/7/17, assessed Resident #82 with an increase in hallucinating/delusions, based on staff interviews, regarding the resident's diagnoses of delusional disorder. The NP's plan was to increase Seroquel (antipsychotic) to 200 milligrams three times daily. There was no reference to an assessment regarding an increase in his weight.<br><br>A nutrition data quarterly assessment by the certified dietary manager (CDM) dated 3/7/17 assessed Resident #82 with a current weight of 190 pounds, ideal body weight range of 149 - 184 pounds, a significant weight gain, intact skin, received a regular, large portions diet and a plan to continue to monitor weight and intake.<br><br>A nutrition assessment dated 3/16/17 by the registered dietitian (RD) revealed Resident #82 received a regular diet with milk added at each meal for additional protein and ate approximately 96% of meals. The RD assessment indicated that Resident #82's current weight was 188 pounds, a 22.1% significant recent weight gain since admission and that his total food/fluid intake met estimated caloric needs, but not estimated protein needs. The RD's recommendation was to have nursing record his food/fluid intake and monitor weights/labs since his skin was currently intact. The goal for Resident #82 was that the resident would continue to consume adequate | F 157 | change the whole milk to 2% milk for resident # 82.<br><br>All residents have the potential to be affected.<br><br>All residents who triggered for a significant weight loss/gain were audited in the weekly at risk meeting on 4/20/2017 by the IDT team. The residents with weight changes were assessed by the Registered Dietician and appropriate interventions were put into place. The resident's responsible parties and Medical Providers were notified by the DON/designee of the change. The audit was completed on 4/26/2017; with all areas of non-compliance addressed immediately.<br><br>An in-service training on Notification of Changes was completed on 4/27/17 with the nursing staff by the Director of Nursing and/or designee. The Nursing staffs were re-educated to notify the RP and MD of any changes in the resident's condition. Staffs that were not available for in-person education were called and the education was completed via telephone by the DON and/or designee.<br><br>The Director of Nursing and/or designee will audit 100% of changes in resident conditions daily events that require proper notification in the clinical startup meeting daily to ensure compliance; all areas of non-compliance will be corrected immediately. The Director of Nursing and/or designee will expand monitoring, | |

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| F 157 | Continued From page 3<br>amounts of food to meet his nutrient needs.<br><br>Review of the facility's "Weekly Risk Management (WRM)" meeting log and a "Weight Note" written in the resident's medical record by the Assistant Director of Nursing (ADON), revealed Resident #82's weight gain was discussed during WRM meetings held on 3/3/17 and 3/16/17 with department managers to include the ADON and the RD. The plan was reweigh for accuracy and to monitor his weight weekly.<br><br>Review of Resident #82's care plan, revised on 3/20/17 by the RD, documented Resident #82 had inadequate protein energy intake and a body mass index (BMI) of 26.9% (obese) due to a recent significant weight gain of 22.1% since admission. The care plan intervention included to notify the physician of significant weight changes.<br><br>Review of Resident #8's weight history revealed the following weights:<br>· 12/13/16, 154 pounds<br>· 1/11/17, 160 pounds<br>· 2/8/17 (reweigh), 183 pounds (16% gain)<br>· 3/8/17 (reweigh), 188 pounds (18% gain)<br>· 3/29/17, 193 pounds (20% gain)<br><br>A telephone interview on 4/05/17 at 3:03 PM with the RD revealed she attended the facility's WRM meetings and that she assessed Resident #82 with a significant weight gain of 22.1% since admission to the facility. The RD stated when she assessed Resident #82 on 3/16/17, she did not have recommendations for changes to his plan of care at that time, because although he was eating less than 100% of his meals, he received additional protein from the additional milk at each meal and his skin was intact. The RD stated "I | F 157 | interventions and corrective actions for non-compliance with notifications. Audits will be completed 5 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 6 months. Ongoing and/or expanded monitoring, interventions and additional corrective actions will be implemented as needed.<br>The results of the Director of Nursing and/or designee's audits will be reported to the QAPI committee monthly meeting for three months and then quarterly thereafter until the QAPI committee determines compliance. Determinations will be recorded in the minutes of the QAPI.<br><br>Education<br><br>F-157 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC) (g)(14) Notification of Changes<br><br>A facility must immediately inform resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:<br>• Accident involving the resident which results in injury and has the potential for requiring physician intervention<br>• A significant change in the residents physical, mental or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); | |

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| F 157 | Continued From page 4<br>don't notify the physician of significant weight changes, that's up to nursing." She stated that her current plan was to continue to monitor the resident's weight status.<br><br>An interview on 4/05/17 at 3:30 PM with the Interim Director of Nursing (IDON) revealed the facility held WRM meetings, she did not attend the 3/16/17 WRM meeting, but that the ADON did attend. The IDON stated that she expected the RD to notify the physician of any significant weight changes verbally or by documentation in the physician's communication book. Review of the physician's communication book during the interview revealed there was no documentation regarding Resident #82's change in weight status.<br><br>An interview on 4/05/17 at 3:46 PM with the ADON revealed he attended the 3/16/17 WRM meeting and Resident #82's significant weight status was discussed. The ADON stated that nursing did not notify the physician or NP of the significant change in weight status for Resident #82 because the RD was present and he expected that she would have notified the physician by writing a note in physician's communication book, if there was a concern with nutrition for a resident.<br><br>A telephone interview with the physician for Resident #82 occurred on 4/5/17 at 4:15 PM. The interview revealed that he was not made aware of a significant change in weight status for Resident #82, but that he could not say whether or not his NP was advised. The physician stated that if either he or the NP were advised, documentation would be available in the physician's communication book and a corresponding progress note would be written by either the | F 157 | • 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<br>• A decision to transfer or discharge the resident from the facility. | |

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physician or the NP. The physician stated that if that documentation was not available, then it was likely that neither he nor the NP, were advised. The physician stated that for a 22% weight gain he would expect notification because the weight gain could likely be due to swelling/edema/fluid which would need to be assessed.

A telephone interview was conducted on 4/10/17 at 1:43 PM with the NP. The interview revealed that the NP was not advised of a significant change in weight status for Resident #82. The NP stated that typically the facility would advise of significant changes for a resident by leaving a note in the physician's communication book, but due to multiple recent changes in administration staff, Resident #82 may have been overlooked. The NP stated that she was advised that Resident #82 experienced a recent increase in hallucinations, but she could not recall whether or not she ordered an antipsychotic in response to this. The NP further stated that if she did order an antipsychotic, that could be the reason for the weight gain and she would expect notification in case an adjustment to the antipsychotic was needed.