STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 02/14/2020

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MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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
E 000	Initial Comments An unannounced recertification survey was conducted 2/9/20 through 2/14/20. The facility was found in compliance with CFR 483.73 Emergency Preparedness. Event ID - KRXF11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted 2/9/20 through 2/14/20. 1 of 4 complaint allegations was substantiated. Event ID - KRXF11.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		3/9/20

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

Electronically Signed | 03/09/2020

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F 623	Continued From page 1	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and ombudsman interview, the facility failed to provide written notification to the resident, resident's representative and the ombudsman when a resident was transferred or discharged from the facility. This was evident for 3 of 4 residents reviewed for hospitalization and discharge (Resident #51, Resident #132 and Resident #67).	F 623	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is	

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F 623	Continued From page 3 Findings included: 1. Resident #51 was admitted to the facility on December 12, 2008 with diagnoses that included pneumonia, peripheral vascular disease, and alzheimers disease with early onset. A review of the quarterly Minimum Data Set (MDS) dated January 1, 2020 for Resident #51 revealed the resident's cognition was moderately impaired. The departmental notes revealed Resident #51 was transferred to the hospital on December 13, 2019. Further review of the resident's medical record revealed no written notice of the resident's transfer was provided to the Ombudsman or resident representative. After being discharged from the hospital Resident #51 was readmitted to the facility. An interview on February 12, 2020 at 1:15 pm with the Social Worker (SW) revealed she sent the resident transfer / discharge list to the Ombudsman every 90 days. She indicated she thought this was an acceptable time frame for the list to be sent to the Ombudsman. The SW stated the facility had not been completing written notification to the resident or the resident's representatives when they were transferred or discharged. A phone interview on February 13, 2020 at 2:47 pm with the Ombudsman revealed she didn't receive the list of facility transfers / discharges monthly. She explained she received it randomly from the facility and it could be up to 3 months in between receiving the list.	F 623	submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F-623 Social Service Director and Assistant completed an audit on discharges residents for previous 45 days. Audit was completed on 2/12/2020 and Regional Ombudsman received notification on 46 residents discharged within the last 45 days. An in serviced conducted by the Facility Clinical Consultant on 2/12/2020 to the Administrator and the Social Service Director. The in service included notification of the resident or responsible representative of the transfer, the reason for the transfer in language and manner that they can understand. Notice of the transfer or discharge to a representative of the Long-term Care Ombudsman at least within 30 of transfer or discharge. The Administrator or designee will validate submission of the discharge notices to the Long Term Care Ombudsman 5X weekly	

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F 623	Continued From page 4 An interview with the Administrator on February 13, 2020 at 3:10 pm revealed the facility did not have any documentation that the resident and their responsible party were notified in writing when they were transferred to the hospital. 2. Resident #132 was admitted to the facility on November 13, 2019 with diagnoses that included diabetes mellitus, osteoarthritis and osteoporosis. The admission Minimum Data Set (MDS) assessment November 19, 2019 for Resident #132 identified her cognition was intact. Section Q of the MDS revealed question Q0400 "discharge plan" was answered, yes. A care plan dated December 12, 2019 revealed Resident #132's discharge plan stated she desired to return home or go to another facility. A social work progress note dated December 16, 2020 at 12:07 pm stated the Social Worker (SW) spoke briefly with Resident #132's family member and they decided they were not able to care for the resident at home at this time. The resident's family was now planning for the resident to remain in the facility for long term care. Resident #132's record revealed on 1/03/20 she was admitted to another facility which was the resident's choice. Further review of the medical record for Resident #132 revealed no documentation of a letter to resident, resident representative and no information to the ombudsman.	F 623	X 4 weeks then monthly X 2 months. The monthly QAPI committee consisting of Medical Directors, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Certified Dietary Manager, Activity Directors, Social Workers and Minimum Data Set Nurse and Coordinator. The committee will results of the audit tools monthly X 3 months and as needed for identification if trends, actions taken , and to determine the need for and / or frequency of continued monitoring and make recommendations of monitoring for continued compliance. The Social Workers are responsible for implementing an acceptable plan of correction	

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F 623	Continued From page 5	F 623		

An interview on February 12, 2020 at 1:15 pm with the Social Worker (SW) revealed she sent the resident transfer / discharge list to the Ombudsman every 90 days. She indicated she thought this was an acceptable time frame for the list to be sent to the Ombudsman. The SW stated the facility had not been completing written notification to the resident or the resident's representatives when they were transferred or discharged. SW stated that Resident #132 decided to be admitted to another facility on 1/3/2020.

A phone interview on February 13, 2020 at 2:47 pm with the Ombudsman revealed she didn't receive the list of facility transfers / discharges monthly. She explained she received it randomly from the facility and it could be up to 3 months in between receiving the list.

An interview with the Administrator on February 13, 2020 at 3:10 pm revealed the facility did not have any documentation that the resident and their responsible party were notified in writing when they were discharged.
3. Resident #67 was admitted to the facility on 11/13/19 and diagnoses included respiratory failure with hypoxia and end stage renal failure.

A nursing note dated 12/14/19 for Resident #67 stated an order was received from the physician to send the resident to the emergency room for evaluation. The Director of Nursing (DON) and resident ' s family were notified.

A nursing note dated 12/18/19 for Resident #67 specified the resident was readmitted from the hospital.

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A nursing note dated 12/19/19 for Resident #67 stated the resident was sent to the emergency room for evaluation of abnormal lab results. The resident ' s family was notified.

A nursing note dated 12/24/19 for Resident #67 stated the resident was readmitted from the hospital.

An admission Minimum Data Set (MDS) dated 12/31/20 for Resident #67 identified the resident ' s cognition was intact.

An interview on 2/12/20 at 12:50 pm with Resident #67 revealed he had been in and out of the hospital several times since he had been at the facility. He stated he didn ' t recall receiving any written notification from the facility about his hospitalizations.

Review of the resident transfer / discharge list for the past 3 months, provided by the Social Worker (SW), revealed Resident #67 ' s discharges were identified on the list.

An interview on 2/12/20 at 1:15 pm with Social Worker (SW) #1 revealed she sent the resident transfer / discharge list to the Ombudsman every 90 days. She indicated she thought this was an acceptable time frame for the list to be sent to the Ombudsman. SW #1 stated the facility had not been completing written notification to the resident or the resident ' s representative when they were transferred or discharged.

A phone interview on 2/13/20 at 2:47 pm with the Ombudsman revealed she didn ' t receive the list of facility transfers / discharges monthly. She explained she received it randomly from the

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F 623	Continued From page 7 facility and it could be up to 3 months in between receiving the list. An interview with the Administrator on 2/13/20 at 3:10 pm revealed the facility did not have any documentation that the resident and their responsible party were notified in writing when they were transferred to the hospital.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to accurately code the minimum data set (MDS) assessment to reflect all appliances used for urine incontinence and range of motion for 2 of 28 sampled residents whose MDS assessments were reviewed. (Resident #130 and Resident #124). Findings Included: 1. Resident #130 was admitted to the facility on 1/27/20 and diagnoses included obstructive and reflux uropathy, bladder neck obstruction and stage 4 pressure ulcer. A nursing note dated 1/27/20 for Resident #130 stated the resident had an indwelling catheter, size 18 French. A nursing note dated 1/28/20 for Resident #130 stated the resident had an indwelling catheter that was draining with dark amber urine.	F 641	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other	3/9/20

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F 641	Continued From page 8 A nursing note dated 1/29/20 for Resident #130 stated the resident had an indwelling catheter that was patent and draining amber urine. A nursing note dated 1/30/20 for Resident #130 stated the resident had an indwelling catheter that was draining well. A nursing note dated 1/31/20 for Resident #130 stated in and out catheterization was completed without difficulty. A nursing note dated 2/1/20 for Resident #130 stated external catheter had slid off. Attempted in and out catheterization with less than 100 cc ' s of urine obtained. A nursing note dated 2/2/20 for Resident #130 stated an in and out catheterization was completed twice with 600 cc ' s urine obtained with the first and 500 cc ' s urine from the second. A nursing note dated 2/2/20 for Resident #130 stated noted external catheter was off during two different checks. An admission minimum data set (MDS) dated 2/2/20 for Resident #130 revealed the resident required intermittent catheterization during the 7 day look back period. An interview on 2/13/20 at 3:13 pm with MDS Nurse #2 revealed she had completed the admission MDS dated 2/2/20 for Resident #160. MDS Nurse #2 explained she thought she only needed to code the current catheter status of the resident which had been intermittent catheterization on the day she coded the MDS.	F 641	administrative or legal proceeding. Resident number 130 Minimum Data Assessment was modified on 2/14/2020 by the Minimum Data Set Coordinator to accurately reflect external catheterization as well as intermittent catheterization. Resident number 124 Minimum Data Assessment was modified on 2/14/2020 by the Minimum Data Set Coordinator to accurately reflect the status of a resident impairment in range of motion to an extremity .On 2/17/2020 The above assessment for resident # 130 and resident # 124 were transmitted and accepted at the National Repository . On 2/14/2020 an audit was performed by the Minimum Data Set nurse and coordinator for all resident with limited range of motion of an extremity and any resident with a catheter. All residents identified had a modification of the last assessment. All assessments were transmitted and accepted on 2/17/2020 by the National Repository. On 3/4/2020 an in-service was conducted by Minimum Data Set Consultant to the Minimum Data Set nurse and Coordinator on appropriate coding on the Minimum Data Assessment. The sections identified were Section G-400 and Section H -100. An assigned Registered Nurse will audit 3 of the Minimum Data Assessments complete and submitted to the National Repository weekly X 4 weeks then 2 weekly X 8 weeks to ensure assessments were submitted accurately in catheterization and impaired range of	

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F 641	Continued From page 9 She added she did not realize all types of catheters needed to be coded that had been used during the look-back period. She stated the resident ' s MDS would need to be corrected to include the indwelling and external catheter, as well as the intermittent catheterization. An interview with the Administrator on 2/13/20 at 5:33 pm revealed she expected the MDS to be coded accurately and to reflect the resident ' s status during the look back period. 2. Resident #124 was admitted to the facility on 9/25/19 and diagnoses included osteoporosis, gout, pain and dementia. An observation of Resident #124 on 2/10/20 at 12:55 pm revealed 3 fingers on her right hand were shut to her palm. The resident stated she hadn ' t been able to open those fingers since she had a stroke. No device was noted to be applied to the contractures. The resident stated she had one but didn ' t wear because she was not able to roll her wheelchair when it was on. A quarterly minimum data set dated 1/27/20 for Resident #124 identified the resident had no impairment in her range of motion to either upper extremity. A care plan dated 2/6/20 for Resident #124 stated contractures of her right hand would not worsen by the next review date and to apply right hand roll which may be removed during mealtimes or whenever the resident wanted to use her right hand. An interview on 2/13/20 at 3:19 pm with MDS Nurse #1 revealed she had completed the	F 641	motion. The monthly QAPI committee consisting of Medical Directors, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Certified Dietary Manager, Activity Directors, Social Workers and Minimum Data Set Nurse and Coordinator. The committee will results of the audit tools monthly X 3 months and as needed for identification if trends, actions taken , and to determine the need for and / or frequency of continued monitoring and make recommendations of monitoring for continued compliance. The Minimum Data Set Coordinator is responsible for implementing an acceptable plan of correction	

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F 641	Continued From page 10 quarterly MDS dated 1/27/20 for Resident #124. She stated the resident did have contractures with limited range of motion to fingers on her right hand. MDS Nurse #1 added the MDS should have been coded to reflect this on section G-000 and it would need to be corrected. An interview with the Administrator on 2/13/20 at 5:33pm revealed she expected the MDS to be coded accurately and to reflect the resident ' s status during the look back period.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, and facility staff, agency nurse staff and Nurse Practitioner interviews the facility failed to transcribe an order until 2/03/20 for Resident #102 to increase Nuedexta once a day to twice a day in 1 of 5 residents reviewed for unnecessary drugs. Findings included: Resident #102 was admitted to the facility on 10/24/19 with cumulative diagnoses which included Alzheimer's disease and major depressive disorder. Review of Quarterly Minimum Data Set (MDS) dated 1/17/20 coded the resident with severe impaired cognition, inattention (difficulty focusing) and disorganized thinking.	F 658	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple	3/9/20

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F 658	Continued From page 11 Review of the physician's orders on 2/9/20 at 2 PM revealed a 1/2/20 dated order for Nuedexta 20 milligrams (mg)/10 mg by mouth daily. Nuedexta is a drug that treats involuntary outbursts of crying or laughing in people with certain neurological disorders. Review of the Nurse Practitioner's (NP) progress notes dated 1/23/20 revealed Nuedexta had been added to the plan of care for possible pseudobulbar affect (PBA) and resistant depression. The notes stated Resident #102 continued with crying spells. A recommendation was to increase Nuedexta dose to twice a day. Review of the physician's order revealed a new order dated 1/23/20 to increase Nuedexta from once a day to twice a day. Review of the Medication Administration Record (MAR) revealed the increase of Nuedexta to twice a day had not been transcribed onto the January 2020 MAR. Record review of the MAR for January 2020 revealed initials that indicated Nuedexta continued to be given once a day from 1/23/20 through 1/31/20. Review of the computerized monthly physician orders for February 2020 (reviewed by Nurse #9 on 1/29/20) revealed the same order of Nuedexta to be administered once a day. Resident 102's February 2020 MAR indicated the resident continued to receive Nuedexta once daily from 2/1/20 through 2/3/20.	F 658	Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F-658 Resident # 102 order was transcribed on 2/3/2020 as stated in 2567. A 100% audit of residents chart orders on 2/13/20 to ensure orders properly transcribed to the current medication/ treatment record. Licensed nurses education initiated on properly transcribing physician orders on 2/14/2020 by the Director of Nursing and Assistant Director of Nursing completion of in service 2/19/2020. All providers will give the nurse the written orders prior to them being placed in the residents chart. Discrepancies noted in transcription will result in immediate re-education to the licensed staff.Traanscription of orders education will be a part of the new orientation process for licensed staff inclusive of contracted staffing agency. New orders will be reviewed in Cardinal IDT to ensure they are transcribed properly 5X weekly. Completion of 24 hour check audit tool will be completed by the licensed staff and turned into the Director of Nursing or designee for review. Director of Nursing and/ or designee will monitor licensed nurse□s completion of	

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F 658	Continued From page 12 Continued record review of the 1/23/20 physician orders revealed the order to increase the Nuedexta was dated 2/3/20 and signed Nurse #8 as receiving this order and was transcribed onto the February 2020 MAR. On 2/4/20 Nuedexta was started to be administered twice a day to Resident #102. Interview on 2/12/20 at 11:46 AM with the NP (who ordered the increase of Nuedexta) stated due to increased crying periods, Nuedexta was increased to twice a day and attempted gradual dose reduction for antipsychotic medications were unsuccessful. Interview on 2/12/20 at 12:31 PM with Nurse #4 stated she was unsure of the frequency of Resident #102's crying episodes. A second interview on 2/12/20 at 4:08 PM with Nurse #4 (worked on 1/23/20 and 1/24/20) stated she was unsure of how the error of transcription occurred. Interview with Nursing Assistant (NA) #10 (familiar with the resident) on 2/13/20 at 3:22 PM stated the resident still cries frequently for apparent no reason. Attempts to interview Nurse #10 (worked 1/24/20), Nurse #11(worked 1/25/20), Nurse #12 (worked 1/25/20 and 1/26/20) and Nurse #8 (worked 1/27/20, 1/28/20 and 1/30/20 and transcribed the 1/23/20 order) were unsuccessful. On 2/13/20 at 2:35 PM a telephone interview was conducted with Nurse #14 stated she worked as an agency nurse on 1/30/20 and 1/31/20. A 24-hour chart check for new orders were not done. She stated she did not receive any orientation from facility to check charts for new	F 658	24 hour check s 5Xwekly for 12 weeks. Results of the audits will be presented to the monthly QAPI X3 months. The monthly QAPI committee consisting of Medical Directors, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Certified Dietary Manager, Activity Directors, Social Workers and Minimum Data Set Nurse and Coordinator. The committee will review the audit tools monthly X 3 months and as needed for identification if trends, actions taken, and to determine the need for and / or frequency of continued monitoring and make recommendations of monitoring for continued compliance. The Director of Nursing is responsible for implementing an acceptable plan of correction	

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F 658	Continued From page 13	F 658		

orders.

Interview on 2/13/19 at 4:10 PM via telephone was conducted with Nurse #15 (reviewed February 2020 computerized monthly physician orders and worked 1/28/20, 1/29/20, 2/1/20 and 2/2/20) stated she was not sure why she did not include the 1/23/20 increase in Nuedexta on the February monthly orders. Nurse #15 stated she only goes back 24 hours to review any new orders.

Interview on 2/13/20 at 5:05 PM with the Director of Nurses (DON) was conducted. The DON stated once an order was written it should immediately be transcribed onto the MAR and the night shift nurses would be responsible for checking new physician orders daily. Continued interview with the DON stated the facility provided orientation to agency nurses regarding the 24-hour new physician ordered chart checks. The DON provided an orientation packet for agency nurses that did not include the facility's procedure for transcription of orders nor chart checking of new physician orders.

Interview on 2/14/20 at 12 noon via the phone with Nurse #16 (worked 1/26/20) revealed she could not remember Resident #102. Nurse #16 stated she worked through a staffing agency for the facility and had not received orientation for the process of new orders written and was unaware of checking new orders when working the night shift.

Interview on 02/14/20 at 12:57 PM via the phone with Nurse #17 (worked 1/23/20) stated this was his first time working on Resident #102 unit. Nurse #17 stated he worked through a nurse

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F 658	Continued From page 14 agency and received an orientation regarding infection control and user ID for the computerized medical record and was unaware of checking new orders when working the night shift.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and	F 660		3/9/20

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F 660	Continued From page 15	F 660		

treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and

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F 660	Continued From page 16 to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to implement an effective discharge plan for 1 of 4 residents reviewed for discharge planning (Resident #132). Finding included: Resident #132 was admitted to the facility on November 13, 2019 with diagnoses to include; diabetes mellitus, osteoarthritis of knee and osteoporosis. A Minimum Data Set (MDS) assessment November 19, 2019 for Resident #132 identified her cognition was intact. Section Q of the MDS revealed question Q0400 "discharge plan" was answered, yes. A care plan dated December 12, 2019 revealed Resident #132's discharge plan stated she desired to return home or go to another facility. A social work progress note dated December 16, 2020 at 12:07 pm stated the Social Worker (SW) spoke briefly with Resident #132's family member and they decided they were not able to care for the resident at home at this time. The resident's family was now planning for the resident to remain in the facility for long term care. The medical record for Resident #132 revealed no documentation regarding the resident's discharge date or discharge plan. There was no recapitulation of the residents stay at the facility, no final summary of the resident's current status	F 660	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F-660 Resident # 132 was discharged on 1/3/2020 to an Assistant living facility. The facility did not perform a recapitulation on the residents stay at the facility. Social Service Director and Assistant completed an audit on discharges residents for the past 45 days. No other residents identified for recapitulation of residents stay on 2/12/2020. An in serviced conducted by the	

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F 660	Continued From page 17 or medications. During an interview with Social Worker (SW) #1 on February 12, 2020 at 3:15pm she revealed she was the SW for Resident #132. She stated Resident #132 was placed at the facility for therapy and planned on a short-term stay. She added Resident #132 was her own representative. The SW indicated she never completed a discharge summary; just the FL-2. The SW indicated she was unaware that she needed to have a discharge plan for Resident #132. The SW revealed during this interview that Resident #132 went to another facility on 1/3/2020 which was the resident's choice. During an interview with the Administrator on February 12, 2020 at 4:30 pm revealed she would need to read more on this regulation; however, her expectation was that Social Workers would have discharge plans for each resident per the regulations.	F 660	Administrator on 2/12/2020 to the Social Worker Director, Social Worker Assistance ,and the Director of Nursing pertaining to the recapitulation of a residents stay in the facility. The Administrator or designee will validate submission of the discharge notices for recapitulation 5X weekly X 4 weeks then monthly X 2 months. The monthly QAPI committee consisting of Medical Directors, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Certified Dietary Manager, Activity Directors, Social Workers and Minimum Data Set Nurse and Coordinator. The committee will review the discharged audit tool monthly X 3 months and as needed for identification if trends, actions taken, and to determine the need for and / or frequency of continued monitoring and make recommendations of monitoring for continued compliance. The Social Workers are responsible for implementing an acceptable plan of correction	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		3/9/20

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F 684	Continued From page 18 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to have a resident's condition assessed by a licensed medical professional before staff moved the resident after the resident experienced two falls for 1 of 5 sampled residents reviewed for accidents (Resident # 46). The findings included: Resident # 46 was admitted to facility on 9/27/16 with a history of dementia with behavioral disturbances. Resident #46's quarterly Minimum Data Set (MDS) assessment dated 12/24/19 revealed Resident #46 had moderate cognitive impairment and required extensive with 1-person assistance with bed mobility, transfers, and required staff assistance to stabilize with transfers from bed to chair. He had impaired range of motion of bilateral lower extremities and a history of falls. Resident #46's fall care plan, which was in place on 02/05/20, revealed the resident was at risk for falls. Care plan interventions included: assist during transfer and mobility. An Incident report, completed by the Director of Nursing (DON), for an incident that was noted to have occurred on 2/5/20 at 2:50 AM, specified Nursing Assistant (NA) #2 reported Resident #46 slid from bed, noted to be sitting with his back against the bed; resident unable to give description; Immediate action: resident was	F 684	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F 684 On 2/5/2020 resident #46 slid to the floor and was placed back in bed by NA #2 without licensed nurse notification or assessment. On 2/5/2020 an in service was conducted by the Director of Nursing and Staff Facilitator to all nursing staff of the process of responsibility when a resident falls, completion of in-service for licensed	

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F 684	Continued From page 19 placed back in bed; no injury observed at time of incident. An Incident report, completed by the DON, for an incident that was noted to have occurred on 2/5/20 at 3:45 AM, specified Nurse #1 was called to Resident #46's room by NA #2. The resident was noted to be bleeding profusely from small wound to right forehead and his ear. Emergency Medical Services (EMS) was contacted. On 2/11/20 at 2:45 PM an interview was conducted with NA #2. The NA stated on 02/05/20 at about 2:50 AM he went into Resident #46's room and the resident had slid to the floor. The resident was in a sitting position on the floor with his back to the bed. NA #2 stated he left the resident's room to get the nurse and the nurse told him to get the resident up, and she would come down to the resident's room after she finished documenting. The NA stated he went back to Resident #46's room and he did not see any injuries on the resident, so he picked Resident #46 up from the floor and put the resident back in bed by himself. NA #2 stated Resident #46 was not assessed by a nurse for possible injuries before he transferred the resident from the floor to his bed. He stated on 2/05/20 at 3:45 AM while he was in Resident #46's bathroom, he heard a noise in the resident's room, and he saw Resident #46 on the floor face down. NA #2 explained the resident still had his eyeglasses on, which had broken, and he saw blood coming from a cut on the resident's forehead. NA #2 stated he used a towel to apply pressure to the resident's forehead and picked Resident #46 up and put him in bed by himself before the resident was assessed by a nurse. The NA stated he pulled the room's call light out	F 684	staff on 2/9/2020.. All resident require an assessment from a licensed staff member before returned to upright chair or bed position. New hired licensed staff and contracted licensed staff will be educated with orientation. Falls audit tool utilized daily X 5 days in Cardinal IDT to ensure any resident with a fall has been assessed by a licensed staff member before transferred into another position. The interdisciplinary team will monitor tools daily X 5 days weekly for 12 weeks to ensure all residents were assessed by an licensed staff member before they were places in chair/or bed. Audit tools will be utilized X 12 weeks for licensed staff members to assess resident before transferred . The monthly QAPI committee consisting of Medical Directors, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Certified Dietary Manager, Activity Directors, Social Workers and Minimum Data Set Nurse and Coordinator. The committee will review the falls audit tool monthly X 3 months and as needed for identification if trends, actions taken, and to determine the need for and / or frequency of continued monitoring and make recommendations of monitoring for continued compliance. The Director of Nursing is responsible for implementing an acceptable plan of correction	

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F 684	Continued From page 20 of the wall and yelled for the Nurse to come into the room. The NA stated Nurse #1 came into the room at that time a took over care of Resident #46. NA #2 explained he did not inform Nurse #1 that he transferred Resident #46 off the floor to his bed because the resident was bleeding. NA #2 stated he had received training on the importance of not moving a resident, who experienced a fall, until the resident was assessed by a nurse. On 2/11/20 at 5:33 PM an interview was conducted with Nurse #1. She stated on 02/05/20 at around 2:45 AM she did not instruct NA #2 to get Resident #46 off the floor. Nurse #1 explained, NA #2 had not informed her that he found the resident on the floor at this time. She also stated on 02/05/20 at 3:45 AM when NA #2 called her to the resident's room Resident #46 was in bed and was bleeding from the cut on his forehead. Nurse #1 stated she was not aware NA #2 had transferred Resident #46 from the floor to his bed before she arrived at the resident's room. During an interview on 2/12/20 at 3:48 PM with Administrator, she stated NA #2 had been in serviced on not moving a resident, who experienced a fall, until the resident was assessed by a nurse.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		3/16/20

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F 689	Continued From page 21 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and physician interview the facility failed to prevent an accident by leaving an agitated and dependent resident unsupervised on a bed that was in an elevated position and the resident fell off the bed onto the floor. This was evident for 1 of 5 sampled residents reviewed for accidents (Resident #46). As a result of the unsupervised fall Resident #46 hit his head on the floor and was observed by staff bleeding from a small wound to his forehead. The resident was transported to the hospital by Emergency Medical Services (EMS) for evaluation and treatment. At the hospital Resident #46 was diagnosed with a facial laceration which was repaired with a surgical skin glue. Findings Included: Resident #46 was admitted to facility on 9/27/16 with a history of dementia with behavioral disturbances. A fall risk evaluation dated 12/1/19 for Resident #46 identified the resident was at risk for falls. Resident #46's quarterly Minimum Data Set (MDS) assessment dated 12/24/19 revealed Resident #46 had moderate cognitive impairment and required extensive with 1-person assistance with bed mobility, transfers, and required staff assistance to stabilize with transfers from bed to chair. He had impaired range of motion of bilateral lower extremities and a history of falls.	F 689	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F 689 On 2/5/2020 NA #2 was following plan of care for resident #46 to address agitation during early hours of morning care. Resident # 46 sustained a fall resulting in a small wound to the right forehead. First aid was immediately administered on site by nursing staff. Resident sent to hospital for agitation and first aid per physician order.	

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(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 689	Continued From page 22 Resident #46's care guide, that was in place when he fell on 2/05/20, specified Resident #46 had a Hi-low bed and the bed was to be returned to lowest position after giving care . Resident #46's care plan, that was in place when he fell on 2/05/20, revealed he was at risk for falls. Care plan interventions included: assist during transfer and mobility, place shoes in wheelchair seat when in bed to reduce anxious behavior and provide frequent staff observation of resident. The care plan goal was Resident #46 would not sustain serious injury through next review. Resident #46's care plan, that was in place when the resident fell on 02/05/20, also revealed he exhibited inappropriate behaviors including; being resistive to treatment and medications and refusing to go to bed. Care plan interventions included: allow for flexibility in activities of daily living routine to accommodate resident's mood, if resident refuses care, leave resident and return in 5-10 minutes. The care plan goal specified Resident #46 would accept care through next review. An Incident report, completed by the Director of Nursing (DON), for an incident that occurred on 2/5/20 at 2:50 AM, specified Nursing Assistant (NA) #2 reported Resident #46 slid from bed, noted to be sitting with his back against the bed; resident unable to give description; Immediate action: resident was placed back in bed; no injury observed at time of incident. An Incident report, completed by Nurse #1, for an incident that occurred on 2/5/20 at 3:45 AM, specified Nurse #1 was called to Resident #46's	F 689	On 2/6/2020 all residents rooms were reviewed by Interdisciplinary team for beds in the proper position per plan of care and completed on 2/6/2020 with no negative outcome identified. Staff facilitator, Director of Nursing, and Assistance Director of Nursing initiated on 2/5/20 education with all nursing staff included bed positioning care of agitated residents. Education completed by the staff facilitator on 2/8/20 New hired staff are educated in orientation on bed positioning and care of agitated residents Beginning 2/5/2020 the Staff facilitator initiated education to licensed and certified staff on the care of agitation residents and completion of in service of care of agitated staff on 2/9/2020. On 2/5/2020 License staff was educated on the usage of the audit tool titled Fall Monitoring and Review by the Staff facilitator. No licensed staff were permitted to work until education completed. Beginning 2/5/2020 licensed staff began utilizing the Fall Monitoring and Review audit tool to monitor the position of the residents proper bed during and after care. The licensed staff will complete the audit tool on 25 residents X 1week then 10 residents X 7 weeks and return to the Director of Nursing for review and intervention if needed.	

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F 689	Continued From page 23 room by NA #2. The resident was noted to be bleeding from small wound to right forehead and his ear. Emergency Medical Services (EMS) was contacted. Immediate action taken was pressure applied to bleeding. Resident was prepared for transfer. Resident sent to hospital for evaluation via EMS. Administrator, Director of Nursing (DON), responsible representative notified. On 2/11/20 at 2:45 PM an interview was conducted with NA #2. NA #2 stated on 02/05/20 at about 2:50 AM he went into Resident #46's room and the resident had slid to the floor and was in a sitting position with his back to the bed, which was in low position. The NA stated he left the room to get the nurse and the nurse told him to get the resident up, and she would be down after she finished documenting. NA #2 stated he went back to the residents' room and Resident #46 was still in the same position on the floor and he did not see any injuries. The NA stated he picked Resident #46 up and put him back in the bed. He stated Resident #46 was yelling at him, being combative, and attempting to get out of bed. NA #2 stated he proceeded to gather materials to give the resident a bath. He stated he elevated the resident's bed and proceeded to wash Resident #46. NA #2 said he turned the resident over towards his left side to wash his back side and then left Resident #46 unsupervised on the elevated bed when he went to the bathroom to freshen the water, he was using to wash the resident. NA #2 explained while he was in the bathroom, he heard a noise, went out of the bathroom and saw Resident #46 face down on the floor. He stated the resident still had his eyeglasses on, which had broken and saw blood coming from a cut on the resident's forehead. NA#2 stated he used a towel to apply	F 689	Fall and Behavior monitoring tool reviewed daily 5X weekly during Cardinal IDT for review of residents plan of care related to falls by the interdisciplinary team. The Fall Monitoring Review tool will be taken to the monthly QAPI meeting for review and discussion by the Director of Nursing to assure continued compliance monthly X2 months. QAPI committee consist of Medical Directors, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Certified Dietary Manager, Activity Directors, Social Workers and Minimum Data Set Nurse and Coordinator.	

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F 689	Continued From page 24	F 689		

pressure to the resident's forehead cut and picked the resident up and put him in the bed. The NA stated he pulled the room's call light out of the wall and yelled for the nurse to come into the room. NA #2 stated Nurse #1 came into the room and told him to leave because the resident was agitated with him and she applied pressure to the resident's forehead cut and the resident was combative with the nurse as well. NA #2 stated he was aware he should have informed the nurse when resident was combative and usually would, but on this occasion he did not inform the nurse about the resident becoming combative when he was attempting to provide care.

On 2/11/20 at 5:33 PM an interview was conducted with Nurse #1. Nurse #1 stated on 02/05/20 NA #2 called her to Resident #46's room and she observed the resident in bed bleeding from his forehead. She stated she called 911 and applied pressure to residents' forehead. Nurse #1 stated NA #2 informed her that the resident was combative and fell on the floor. She stated she was unaware that earlier in the shift NA #2 found Resident #46 on the floor before this fall occurred and she did not instruct NA #2 to pick Resident #46 up from the floor. Nurse #1 stated EMS arrived and took over the care of Resident #46 and the resident was combative with them as well.

Resident #46's hospital records dated 2/5/20 revealed diagnoses of facial laceration. Facial laceration repaired with a surgical glue.

On 2/11/20 at 3:10 PM, NA #2 demonstrated the height of Resident #46's bed, which NA #2 had raised to provide care, on 2/05/20 when the resident fell from the bed. The height of the bed

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F 689	Continued From page 25 was measured as 2 feet and 4 inches. NA #2 stated it could have possibly been a little higher than measured. .On 2/13/20 at10:37 AM, NA #3 was interviewed. NA #3 stated Resident #46 attempted to be independent and he was at risk for falls. She stated the interventions in place to try to minimize Resident #46's falls included to keep his bed in a low position. An interview was conducted on 2/12/20 at 2:59 PM with Physician #2. MD #2 stated she evaluated Resident #46 after he returned from the hospital following his fall on 02/05/20. She specified, she did a skin assessment, which revealed no other injuries except for the laceration to right forehead. The MD stated the resident had no recollection of what happened when she evaluated him. An interview was conducted on 2/13/20 at 3:08 PM with the DON. She stated an investigation was completed of Resident #46's fall on 02/05/20. The DON stated, it was determined the resident's fall was caused by the resident being agitated and not because the staff member left the resident's bed elevated. The DON believed NA #2 was in a hurry trying to get the resident ready because the resident was agitated and was trying to get out of bed. On 2/13/20 at 3:43 PM an interview occurred with the Administrator. She stated the facility did not believe the height of the resident's bed was a contributing factor for the laceration.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		3/9/20

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F 692	Continued From page 26 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to identify, assess and implement interventions for a resident who experienced a 5.8% significant weight loss in one month and a 9.6 % weight loss in 3 months. This was evident for 1 of 7 residents reviewed for nutrition (Resident #2). Findings Included: Resident #2 was admitted to the facility on 11/1/19 and diagnosis included cerebral vascular accident, dementia and diabetes. Review of the physician ' s orders for Resident #2	F 692	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it	

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F 692	Continued From page 27 revealed an order for a no added salt (NAS), no concentrated sweets (NCS), ground meat diet. An admission minimum data set (MDS) assessment dated 11/7/19 for Resident #2 identified he required supervision one person assist with eating, received a therapeutic, mechanically altered diet and weight was 253 pounds (lbs.). His cognition was moderately impaired. A care plan dated 11/8/19 for Resident #2 revealed his state of nourishment was less than body requirements characterized by weight loss, inadequate intake, decreased intake related to being on a mechanically altered, therapeutic diet and difficult chewing / swallowing. A goal stated the resident would maintain or gain weight. Interventions included to serve diet as ordered, weigh per facility protocol, set-up meal tray and encourage consumption of meal. A physician note dated 1/2/20 for Resident #2 identified the resident had mild edema to his lower extremities that was stable. There was no information documented regarding the resident ' s weight. The weight record for Resident #2 revealed the following weights: 11/6/19 - 253.9 pounds (lbs.), 12/9/19 - 246 lbs., 1/6/20 - 231.5 lbs. and 2/5/20 - 222.3 lbs. The resident had lost 5.8% of his body weight in one month (December 2019 to January 2020) and showed continued significant weight loss of 9.6% in three months (November 2019 to February 2020). A dietary progress note, written by the Dietary Manager, dated 1/28/20 for Resident #2 stated the resident continued with a ground therapeutic	F 692	constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F-692 Resident # 2 was assessed on 2/14/2020 by the Certified Dietary Manager and dietary supplements were ordered to increase caloric intake by 600 calories. On 2/14/20 the Registered Dietician reviewed resident #2 alleged weight loss without additional nutritional interventions. On 2/14/2020 an in service was conducted by the Corporate Consulting Dietician to the Certified Dietary Manager to manually calculate weights to capture any significant weight changes. A 100% audit of all residents was conducted by the Certified Dietary Manager on 2/17/2020 any identified residents received a dietary supplement and reviewed by the Corporate Consulting Dietician. Weight audit tool utilized daily X 5 days in Cardinal IDT to ensure any resident with significant weight lost with appropriate nutritional intervention. The interdisciplinary team will monitor tools daily X 5 days weekly for 12 weeks to ensure all residents nutritional needs are met and weight lost identified .	

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F 692	Continued From page 28 diet and had a 64% meal intake in his seven day look back period. The resident was independent with most meals with tray set-up. He continued to receive prostat (a high protein supplement) to help promote wound healing. Resident ' s current weight was 231.5 lbs., was stable for 3 months and hadn ' t triggered a weight loss. The dietary progress note did not specify any new interventions staff were to implement to address the resident ' s continued weight loss. An observation of Resident #2 on 2/12/20 at 12:45 pm revealed the resident was sitting up in bed eating his lunch. The resident ' s right arm/hand was observed to be shaking when feeding himself, but he was able to consume a bowl of chili without spilling it. He consumed the bowl of chili, but nothing else was consumed on his meal tray. An observation of Resident #2 on 2/13/20 at 9:30 am revealed the resident was sitting up in bed and consumed a bowl of cold cereal. His right arm/hand was shaking, but he was able to consume the cereal with a regular spoon without spilling. The resident did not eat any other foods on his breakfast tray except for the cereal. An interview on 2/13/20 at 9:37 am with Nursing Assistant (NA) #1 revealed she was familiar with Resident #3 and provided care for him. She stated the resident was able to feed himself after the staff set-up his tray. She explained the resident received weighted utensils, but he often refused to use them and wanted regular silverware. NA #1 stated the resident ate very little; usually around 25% of his meal and she had never seen him eat more than 50% of his meal. She explained the resident would tell the staff to	F 692	The monthly QAPI committee consisting of Medical Directors, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Certified Dietary Manager, Activity Directors, Social Workers and Minimum Data Set Nurse and Coordinator. The committee will review the weight audit tool monthly X 3 months and as needed for identification if trends, actions taken, and to determine the need for and / or frequency of continued monitoring and make recommendations of monitoring for continued compliance. The Certified Dietary Manager is responsible for implementing an acceptable plan of correction	

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F 692	Continued From page 29	F 692		

leave his meal tray so he could eat more, but he wouldn ' t eat more even if they left his tray.

An interview on 2/13/20 at 11:01 am with the Dietary Manager (DM) revealed nursing would obtain the monthly weights for residents and she typically received the weights by the 4th or 5th of the month. She explained the electronic medical record system the facility used would identify if a resident had a significant weight loss. The DM stated the system had not identified a significant weight loss for Resident #2 for December 2019 to January 2020 and she didn ' t know why this was missed. She indicated the resident ' s meal intake record completed by the NAs showed the resident consumed 75 to 100% of his meals and he received about 200 calories a day from his protein supplement. The DM stated she should have identified the resident had a significant weight loss when she assessed the resident on 1/28/20 and he needed to be re-assessed for his continued weight loss. The DM confirmed no interventions were implemented by the facility to address the resident ' s significant weight loss.

An interview on 2/13/20 at 5:29 pm with the Administrator revealed the DM reviewed the resident ' s weights monthly and would adjust the resident ' s supplements as needed. She stated Resident #2 should have been referred to the Registered Dietitian for his weight loss.