DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING ______ B. WING ______	C 02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

(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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to feed residents while being seated, staff member stood over the residents while feeding for 5 of 7 residents (Resident #149, #173, #159, #20, #49), and the facility allowed 1 of 7 residents to drink from a glass another resident drank from and sit in wet clothing while being fed (Resident #137). Findings included: 1. a. Review of the clinical record of Resident #149 indicated the resident was admitted to facility 10/30/2014 with diagnoses which included Dementia with behaviors. The resident's Minimum Data Set (MDS) dated 1/10/2016 indicated the resident had moderate cognitive impairment and required supervision of one person with eating. 1. b. Record review indicated Resident #173 was admitted to the facility on 9/21/2014 with diagnoses which included Aphasia and Dementia. The resident's Minimum Data Set (MDS) dated 1/8/2016 indicated the resident had severe cognitive impairment and required extensive assistance of one person for eating. A continuous dining observation was conducted shortly after entry into the facility on 2/14/2016 and revealed the following events: At 5:00 PM, 7 residents were observed seated at 4 different tables in the small 300 hall dining	F 241	Northchase Nursing and Rehabilitation Center 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 in 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. Northchase Nursing and Rehabilitation Center's 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, Britthaven 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. 1.Resident #149, #173, #159, #20, #49, and #70 will continue to be fed while staff member is seated. Resident #137 will continue to not drink from a glass that another resident drank from and will continue not to sit in wet clothing while being fed. 2.The RN supervisor, Assistant Director of Nursing, Quality Improvement Nurse, and Treatment Nurse conducted 100% round of all residents to include residents #149, #173, #159, #20, #49, # 137, and #70 during meal time to ensure residents' clothing dry, staff were in a seated position while feeding residents, and no resident's noted to be drinking from a glass that another resident drank from on 3/4/16. No concerns were identified during the audit. The Social Workers, receptionist,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE LNHA (X6) DATE 3/14/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 room. One Nursing Assistant #1 (NA) was present in the room and passed out dinner trays to each resident. The staff member stood over Resident #149 (to the left of the resident) and fed her 4 bites of food from her eating utensil. The staff member then proceeded to another table at 5:12 PM, sat down beside a male resident in the room and began feeding him. At 5:47 PM, the NA moved to Resident #173 and stood to the right side of Resident #173 and fed her several bites from her plate. On 2/17/2016, Resident #149 was approached for an interview. The resident did not respond to interview questions. Resident #173 was not interviewed due to severe cognitive impairment. On 2/17/2016 at 5:45PM, NA #1 was interviewed. The NA was asked about the dinner observation on 12/14/2016. When asked about standing over the residents when feeding them, the NA responded " I should have sat down when feeding them. I know I am not supposed to stand up when feeding them. " 2. Review of the clinical record of Resident #137 indicated the resident was admitted to the facility on 12/31/2014 following a Cerebrovascular Accident (CVA/Stroke). The resident's Minimum Data Set (MDS) dated 12/2/2015 indicated the resident had severe cognitive impairment and was totally dependent of 1 staff for feeding. A continuous dining observation was conducted shortly after entry into the facility on 2/14/2016 and revealed the following events: At 5:00 PM, 7 residents were observed seated at 4 different tables in the small 300 hall dining room. One Nursing Assistant #1 (NA) was present in the room and passed out dinner trays to each resident. At 5:10 PM, Resident #173 reached over to Resident #137 tray and took her full glass of water and started drinking it from the	F 241	bookkeeper, medical records department, scheduler, central supply, and the treatment aide conducted 100% audit of all resident's rooms to include residents who requires assistance with feeding to include #149, #173, #159, #20, #49, #70, and #137 to ensure chairs were available in the room to ensure staff member is seated while feeding the resident on 2/18/16. Chairs were placed in the room by The Social Workers, receptionist, bookkeeper, medical records department, scheduler, central supply, and the treatment aide on 2/18/16 during the audit for any identified areas of concern. 3.100% inservice was initiated by the staff development coordinator on 2/17/16 for all licensed nurses and certified nursing assistants, including NA#2, NA#3, and Nurse #2, regarding resident dignity to include being in a seated position facing resident when assisting with eating meal and ensuring that the resident is appropriately groomed, clean, and dry at meal time. NA # 1 is no longer employed at the facility. The inservice to be completed by 3/17/16. 100% inservice was initiated on 3/4/16 by the staff facilitator for all licensed nurses and certified nursing assistants including, NA#2, NA#3, and Nurse #2 regarding the need to monitor residents during meal	

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NAME OF PROVIDER OR SUPPLIER: NORTHCHASE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3015 ENTERPRISE DRIVE WILMINGTON, NC 28405	

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F 241	Continued From page 2 rim. NA#1 then walked over to the table and removed the glass from Resident #173 ' s hand and placed the glass back in front of Resident #137. At 5:25 PM, Resident #137 picked up the glass of water and began to drink it and spilled the entire contents on her shirt and pants and the floor around her wheelchair. At 5:32 PM, the NA walked over to Resident #137, sat beside her and fed her. The resident ' s shirt and pants were observed wet during the meal, and water was observed on the floor around the resident ' s wheelchair. On 2/17/2016 at 5:45PM, NA #1 was interviewed. The NA was asked about the dinner observation on 12/14/2016. When asked about giving Resident #137 the glass of water Resident #173 was drinking, she stated she remembered taking it from her hand and giving it back to Resident #137, but she didn ' t recall seeing Resident #173 drinking from the glass. When asked about Resident #137 spilling her whole glass of water on herself, the NA stated she didn ' t notice her spill it. She also stated she didn ' t notice the resident ' s wet clothes or the wet floor around her wheelchair when feeding her dinner on 2/14/2016. The NA also stated she should have changed the resident ' s wet clothes before she fed her. The Director of Nursing (DON) was interviewed on 2/17/2016. She stated her expectations were staff should be seated when feeding residents, staff should not give another resident a drink from another resident ' s hands, and staff should clean up wet residents before feeding them. 1.c. Review of the clinical record of Resident #70 indicated the resident had diagnoses which included Alzheimer ' s disease, abnormal posture, failure to thrive and muscle weakness. Review of the quarterly Minimum Data Set dated	F 241	time to ensure that no resident is drinking from a glass that another resident drank from. Inservice to be completed on 3/17/16. All new licensed nurses and certified nursing assistants will be inserviced during orientation by the staff development coordinator regarding resident dignity to include being in a seated position facing resident when assisting with eating meal, ensuring that the resident is appropriately groomed, clean, and dry at meal time, and need to monitor residents during meal time to ensure that no resident drinks from a glass that another resident drank from. 4.When feeding a resident, to include residents #149, #173, #159, #20, #49, #70, and #137 the licensed nurse or certified nursing assistant will sit facing the resident while providing assistance with eating, ensure residents' clothing dry and immediately changed for any spills, and ensure that residents. are not allowed to drink from a glass that another resident has drunk from. The Nursing Supervisor, ADON, QI Nurse, SDC, and Treatment Nurse will conduct meal observations on 10% of residents to include resident #149, #173, #159, #20, #49, #70, and #137 during all three meals utilizing a Resident Care Audit Tool 5 x week, to include weekends, x 4	

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F 241	Continued From page 3 01/26/16 indicated Resident #70 was severely cognitively impaired and required extensive assistance with eating. Review of Resident #70 ' s Care Plan, which was last updated 02/09/16, indicated Resident #70 was unable to feed herself independently. The Care Plan indicated an intervention for staff to provide total feeding. During a dining observation on 02/14/16 at 5:30 p.m., Resident #70 was observed lying on her bed awake. Nursing Assistant (NA) #3 brought Resident #70 's dinner tray into resident 's room and placed the tray on the resident ' s over-bed table. NA #3 pointed her right index finger at resident and stated, "she's a feeder " and left the room without acknowledgement to the resident. An observation on 02/14/16 at 5:54 p.m. revealed Nurse #2 standing beside Resident #70 ' s bed feeding the resident. In an interview with NA #3 on 02/18/16 at 12:05 p.m., NA #3 stated she should not have called Resident #70 a feeder, especially in front of the resident. When asked why she left the room before setting up the dinner tray, NA #3 stated she delivered all the trays on the meal cart first and then returned to the rooms of the residents who needed to be fed. In an interview with Nurse #2 on 02/18/16 at 4:27 p.m., Nurse #2 stated she stood to feed Resident #70, because there was no chair in the resident ' s room and she wanted to feed the resident while her food was still warm. In an interview with the Director of Nursing (DON) on 02/18/16 at 2:55 p.m., the DON stated it was her expectation for nursing staff to pass meal trays to the residents who need to be fed at a time when staff were able feed them. The DON stated staff should sit when they are feeding residents.	F 241	weeks, weekly x 4 weeks then monthly x 2 months to ensure staff are sitting facing the resident while providing assistance with eating, residents' clothing dry and immediately changed for any spills, and that residents are not allowed to drink from a glass that another resident has drunk from. Any concerns will be immediately addressed by the Nursing Supervisor, ADON, QI Nurse, SDC, and Treatment Nurse with reeducation of staff during the time of the audit. The DON will review and initial the audit tool weekly x 8 weeks then monthly x 2 months to ensure compliance. The DON will compile the results of the Resident Care Audit Tool and present to the Executive Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	03/18/16

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F 241	Continued From page 4 1.d. Review of the clinical record of Resident #159 indicated the resident had diagnoses which included dysphagia, abnormal posture, dementia with Lewy bodies, and muscle weakness. Review of the quarterly Minimum Data Set dated 11/10/15 indicated Resident #159 was severely cognitively impaired and required extensive assistance with eating. During a dining observation on 02/14/16 at 5:44 p.m., Resident #159 was lying on her bed with her eyes closed. Nursing Assistant (NA) #3 brought Resident #159 ' s dinner tray into the resident ' s room and placed the tray on the resident ' s over-bed table. NA #3 left the room without setting up the tray. An observation on 02/14/16 at 5:55 p.m. revealed NA #3 standing beside Resident #159 ' s bed feeding the resident. In an interview with NA #3 on 02/18/16 at 12:05 p.m., NA #3 stated she delivered all the trays on the meal cart first and then returned to the rooms of the residents who needed to be fed. NA #3 stated she stood to feed the Resident #159, because there was not a chair in the room. NA #3 stated the room had never had a chair in it. NA #3 stated she knew she should have sat while she fed Resident #159 and stated she probably should have gotten a chair from another location. In an interview with the Director of Nursing (DON) on 02/18/16 at 2:55 p.m., the DON stated it was her expectation for nursing staff to pass meal trays to the residents who need to be fed at a time when staff were able to feed them. The DON stated staff should sit when they are feeding residents. 1.e. Resident # 49 was admitted on 3/14/2012 with diagnoses of heart failure, stroke and	F 241		

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NORTHCHASE NURSING AND REHABILITATION CENTER	3016 ENTERPRISE DRIVE WILMINGTON, NC 28405

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F 241	Continued From page 5 dementia. The annual Minimum Data Set dated 7/1/2015 assessed Resident # 49 to be severely impaired for cognition, and needed set up help for eating. Resident # 49 needed extensive assistance for all other Activities of Daily Living (ADLs). On 2/14/2016 at 5:00 PM, an observation was made of Resident # 49 in the bed, with the bed raised to a high position, and a Nursing Assistant (NA) standing at the bedside, feeding her. In an interview on 2/18/2016, an NA who works on Resident # 49 's hall and regularly provided care for Resident # 49, stated Resident # 49 was unable to feed herself a meal, the Resident did feed herself some food, but needed to be encouraged and cued. The NA stated Resident # 49 was not left alone to feed herself. On 2/19/2016 at 3:41 PM, NA # 2 stated he fed Resident # 49 on 2/14/2016 and indicated he was standing at the bedside. The NA indicated he should have been sitting down to feed Resident # 49. On 2/19/2016 at 4:15 PM, in an interview, the Director of Nursing (DON) stated residents should have been at eye level when fed. On 2/19/2016 at 4:15 PM, in an interview, the Administrator stated there should have been a chair available in each room, because staff should sit down to feed residents.	F 241	1. All commonly used personal items for resident # 25, including the water pitcher, were arranged so that they were within reach of the resident on 2/18 /16 by the medical records director and maintenance director. 2. A 100 % audit of all residents, to include resident #25, was conducted by the Nursing Supervisor on 3/7/16 to ensure residents' individual needs and personal preferences were by ensuring commonly used items were within reach to include water pitchers. All items were placed in reach per the resident's preference and special needs during the time of the audit for any identified areas of concern by the Nursing Supervisor. 100% of all staff to include licensed nursing staff, certified nursing assistants to include NA #3, housekeeping, therapy, and admissions coordinator were	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		

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F 246	Continued From page 6 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to place a resident ' s water pitcher within reach for 1 of 3 residents reviewed for accommodation of needs. (Resident #25). Findings included: A review of the clinical record of Resident #25 indicated the resident was admitted to the facility on 03/09/15 with diagnoses which included blindness of both eyes, heart failure, muscle weakness, osteoarthritis and chronic pain. A review of Resident #25 ' s quarterly Minimum Data Set (MDS) dated 01/02/16 indicated the resident was cognitively intact and required extensive assistance with bed mobility and transfers. The MDS indicated the resident had impairment on one side in regards to functional limitation in range of motion. The MDS indicated the resident had severely impaired vision. Review of Resident #25 ' s Care Plan, last updated on 01/15/16, revealed Resident #25 ' s environment should have been adapted to ensure the resident was able to recognize objects and her own environment related to her blindness. The Care Plan indicated Resident #25 ' s commonly used items were to be within easy reach related to her visual deficit. During an observation of Resident #25 on	F 246	inserviced by the staff facilitator regarding ensuring that resident's commonly used items to include water pitchers are within reach according to special resident needs and preferences. Inservice initiated on 3/8/16 to be completed by 3/17/16. 3. When a resident is admitted to the facility the MDS Nurse will determine if the resident has any special needs or preferences related regarding placement of personal items, to include water pitchers, and update the resident care guide accordingly. 4. The RN Supervisor, Staff Facilitator, QI Nurse, Treatment Nurse, and ADON will conduct resident rounds and room observations to include resident #25 to ensure commonly used items are within resident's reach, to include water pitchers, and that special needs and preferences are being met using a QI Accommodation of Needs/ Preferences Audit	03/18/16

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F 246	Continued From page 7 02/18/16 at 3:15 p.m., Resident #25 was lying on her back in her bed. The right side of the resident ' s bed was pushed up against a wall. A 3-drawer nightstand was near the head of the bed on the left side of the bed. An over-bed table was pushed up against the left side of the bed. A Styrofoam water pitcher containing ice and water had been set on top of the 3-drawer nightstand. The water pitcher lid had no openings for a straw. There were no cups or straws observed on the nightstand or over-bed table. In an interview with Resident #25 on 02/18/16 at 3:15 p.m., Resident #25 stated she had a bad left shoulder and stated she tried not to use her left arm because of pain. When asked where her water pitcher was located, Resident #25 raised her right arm and pointed to the wall behind the headboard of her bed. When it was explained the area she pointed to was a wall, she raised her right arm and pointed towards the foot of her bed. In an interview with NA #3 on 02/18/16 at 3:35 p.m., NA #3 stated water pitchers were usually placed within the reach of the resident. When asked why Resident #25 ' s water pitcher was placed out of her reach, NA #3 did not offer an explanation. NA #3 confirmed there were no cups on Resident #25 ' s side of the room. In an interview with the Director of Nursing (DON) on 02/18/16 at 4:40 p.m., the DON stated it was her expectation nursing staff place items for Resident #25, who is blind, within her reach on her right side.	F 246	Tool 5x per week x 4 weeks then weekly x 4 weeks, then monthly x 2 months to ensure compliance. All concerns will be immediately addressed by the RN Supervisor, Staff, Facilitator, QI Nurse, Treatment Nurse, and ADON by placing commonly used items within resident's reach, reeducation of staff as needed, and/ or updating of care guide to reflect resident's preference. The DON will review and initial the audit tool weekly x 8 weeks then monthly x 2 months to ensure compliance. The DON will compile the results of the QI Accommodation of Needs/ Preferences Audit Tool and present to the Executive Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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FORM APPROVED
OMB NO. 0938-0391

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F 253	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide a safe interior by failing to clean black smudges and specks around an air vent on one of six halls in the facility. Findings included: On 2/14/2016 at 5:30 PM, during an initial tour of the facility an observation was made of the ceiling on the 300 hall near resident room 314. Around and on an air vent were black smudges and multiple small black specks on the ceiling around the air vent. Other air vents on the hall were observed to be clean. On 2/17/2016 at 10:59 AM, an observation was made of the ceiling on the 300 hall, near resident room 314. Observed were black smudges on and around the air vent and many black specks on the ceiling around the air vent. On 2/19/2016 at 3:00 PM, The Maintenance Director was interviewed, and when he looked at the ceiling he stated " its mold. " The Maintenance Director indicated he would clean it with bleach. The Maintenance Director stated he tried to check on the ceilings when he walked around and took care of any problems that he found, but he was very busy and had a lot of tasks. The Maintenance Director stated he was responsible for cleaning the heat and air vents.	F 253	1. The air vent and surrounding area near room 314 was cleaned by the maintenance director on 2/19/16. 2. 100% audit was conducted on 3/4/16 by the Activity Director of all ceiling air vents and surrounding area to include the vent near room 314 to ensure the vents and surrounding areas were clean of black smudges and black specks. The maintenance Director cleaned all areas identified with concerns on 3/7/16. 3. The maintenance director and assistant was inserviced by the administrator regarding the need to provide a safe interior by ensuring the facility is free of black smudges and specks to include around air vents and ceiling on 3/7/16. 4. The maintenance director or maintenance assistant will inspect and clean vents and the surrounding areas to include the air vent near room 314 on a weekly basis to ensure they remain free of black smudges and specks. The Activity Director will conduct an audit to ensure air vents and surrounding areas to include the air vent near room 314 are clean using a QI Air Vent Audit Tool weekly x 8 weeks then monthly x 2 months. The Activity Director will complete a work order for maintenance notification for any identified areas of concern during the audit. The administrator will review the audit tool weekly x 8 weeks then monthly x 2 months and initial. The administrator will compile the results of the QI Air Vent Audit Tool and present to the Executive QI Committee Monthly x 4 months. Trends will determine if further action or monitoring is needed.	03/18/16
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312	1.Resident #137 will continue to be fed with dry clothing. 2.100% audit of all residents, including resident # 137 was	03/18/16

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F 312	Continued From page 9 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to assist a totally dependent resident with care for 1 of 1 residents (Resident #137) when facility staff fed the resident a meal while the resident ' s clothing was wet. Findings included: Review of the clinical record of Resident #137 indicated the resident was admitted to the facility on 12/31/2014 following a Cerebrovascular Accident (CVA/Stroke). The resident's Minimum Data Set (MDS) dated 12/2/2015 indicated the resident had severe cognitive impairment and was totally dependent of 1 staff for hygiene and feeding. A dinner dining observation was conducted shortly after entry into the facility on 2/14/2016 in the 300 Hall dining room observation at 5:00PM. At 5:00 PM, 7 residents were observed seated at 4 different tables in the dining room with one staff assisting all the residents. Nursing Assistant (NA) #1 passed out trays to the residents in the room. At 5:25 PM, Resident #137 picked up her glass of water and began to drink it and spilled the entire contents on the front of her shirt and pants and the floor around her wheelchair. The resident ' s shirt and pants were noticeably wet. At 5:32 PM, the NA walked over to Resident #137, sat beside and fed the resident until 5:47PM.	F 312	conducted by the RN Nursing Supervisor, Resource Nurse, Treatment Nurse, QI Nurse, and Assistant Director of Nursing on 3/4/16 to ensure all residents were clean and dry and no spills were noted on residents clothing at meal time. No problems were identified during the audit. 3.An inservice was initiated by the staff facilitator on 3/4/16 for 100% licensed nurses and certified nursing assistants regarding the need to ensure a resident is clean and dry prior to meal being served and to immediately change the resident's clothing if spills are noted. Inservice to be completed by 3/17/16. All new licensed nurses and certified nursing assistants will be inserviced during orientation regarding the need to ensure a resident is clean and dry prior to meals being served and to immediately change the resident's clothing if spills are noted. NA#1 is no longer employed at this facility. 4.Prior to assisting a resident with eating, licensed nursing staff and certified nursing assistants will ensure that the resident is clean and dry. Clothing protectors will be provided and placed on the residents by the nursing assistant or license nurse as needed. The Nursing Supervisor, ADON, QI Nurse, SDC, and Treatment Nurse will conduct meal observations on	

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F 312	Continued From page 10 The NA was interviewed on 2/17/2016 at 5:45 PM about the dinner observation on 12/14/2016. When asked about Resident #137 spilling her whole glass of water on herself, the NA stated she didn ' t notice her spill it. She also stated she didn ' t notice the resident ' s wet clothes when feeding her dinner on 2/14/2016. The NA further stated she should have changed the resident ' s wet clothing before feeding her. The Director of Nursing (DON) was interviewed following the interview with the NA on 2/17/2016 at 6:00 PM. The DON stated the expectations were staff were expected to clean up wet residents before feeding them.	F 312	10% of residents to include resident #137 during all three meals utilizing a Resident Care Audit Tool 5 x week, to include weekends, x 4 weeks, weekly x 4 weeks then monthly x 2 months to ensure residents' clothing dry and immediately changed for any spills. Any concerns will be immediately addressed by the Nursing Supervisor, ADON, QI Nurse, SDC, and Treatment Nurse with reeducation of staff during the time of the audit. The DON will review and initial the audit tool weekly x 8 weeks then monthly x 2 months to ensure compliance. The QI Nurse will compile the results of the QI Resident ADL Care Audit Tool and present to the QI Executive Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow physician orders for a follow up appointment and failed to feed a resident according to the resident ' s plan of care for 1 of 18 residents reviewed for weight loss (Resident #137), and the facility failed to	F 325	1.Resident #137 was seen by the physician on a follow up visit on 12/3/2015. Resident #137 will continue to be fed by staff following the resident's plan of care. NA #1 is no longer employed by this facility. A current weight was obtained for Resident # 169 and resident # 33 on 3/9/16 by the Restorative Aide. The physician was made aware of the missed weekly weights for resident #169 and resident #33 by the treatment nurse on 03/10/16 and updated on	03/18/16

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F 325	Continued From page 11 follow physician orders and dietitian recommendations for weekly weights for 2 of 18 residents (resident # 169 and resident # 33) reviewed for weight loss. Findings included: Record review indicated Resident #137 was admitted to the facility on 12/31/2014 following a Cerebral Infarct (Stroke). The resident ' s admission diagnoses included Heart Disease, Cognitive Communication Deficits, Deep Vein Thrombosis Lower Extremity and Dementia with Lewy Bodies. The record also indicated the resident was readmitted to the facility on 03/13/2015. Review of the admission Minimum Data Set dated 3/30/2015 indicated the resident had severe cognitive impairment and required extensive assistance with eating times 1 person. The MDS also indicated the resident was 67 inches in height and weighed 194 pounds. Review of a 4/27/2015 Quality Improvement (QI) note indicated the resident was referred to restorative dining on 2/13/2015 for breakfast and lunch. The resident was placed back into the regular dining room for meals. The resident ' s diet was mechanical soft. The note also indicated the resident ' s meal intake was 25-75%. The record also indicated the resident was referred to therapy on 04/24/2015 due to not consistently putting food on spoon without spilling it, falling asleep in the middle of meals even with cueing and prompting. The resident ' s weights were reviewed from March 2015 through February 2016 and indicated the following: Review of the resident ' s clinical record indicated on 04/01/2015, the resident ' s weight was 192 pounds. Review of the resident ' s clinical record indicated	F 325	the residents' current weight status. 2.100% audit was initiated by the Treatment Nurse, QI Nurse, ADON, and RN Supervisor on 3/7/16 to review all physician's orders and clinician progress notes, to include the Registered Dietician, for past 30 days to ensure all orders, to include weekly weights, recommendations, and follow up appointments were initiated/conducted as ordered. Audit to be completed by 3/17/16. Any missed orders will be addressed by notifying the physician and completing a QI Incident Report. 100% audit was conducted of all resident care plans and care guides by the administrator and DON on 2/17/16 to ensure that special instructions for assisting a resident with eating were reflected on the resident care plan and care guide. Audit was completed on 2/26/16. Resident care plans and care guides were immediately updated by the MDS Nurse as indicated during the audit. 3.100% inservice was initiated by the staff facilitator on 3/9/16 for all licensed nursing staff, including the QI Nurse regarding the Implementation of physician's orders, to include weekly weights. Inservice to be completed by 3/17/16. All new licensed nursing staff will be inserviced by the Staff Facilitator during orientation	

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F 325	Continued From page 12 on 05/29/2015, the resident ' s weight was 186 pounds. Review of a QI (Quality Improvement) weight review on 06/25/2015 indicated the resident ' s weight was 175 pounds, a 5% change over last 30 days. The resident ' s intake was 25-75%. The resident was referred to the Registered Dietitian (RD). A progress note by the RD on 7/6/15 indicated the resident ' s weight was 175 pounds on 6/25/2015, a 6% change (11 pounds) in one month. The RD recommended to start the dietary supplement Resource 2.0, 90 cubic centimeters (cc) by mouth (PO) between meals and bedtime. Review of a Nurse Practitioner (NP) progress note on 7/13/2015 indicated the RD recommendation was not agreed by the Nurse Practitioner (NP), as " resident is within ideal body weight (IBW) at this time. " On 2/19/2016 at 3:05 PM, the NP was interviewed and stated she would not have agreed for a supplement for a resident in ideal weight parameters especially at a weight of 175. Review of the resident ' s clinical record indicated on 07/24/2015, the resident ' s weight was 165 pounds. Review of the resident ' s clinical record indicated on 8/7/2015, the resident experienced edema from middle thigh to toes in left leg. Following x-rays and laboratory work, the diuretic Lasix 10 milligrams (mg) was ordered times three days. The resident ' s clinical record indicated on 8/10/2015, the resident was evaluated by the NP who addressed swelling in left leg. The NP ordered weekly weights times 4 weeks. Review of an RD note on 8/14/2015 indicated the RD recommended to start a dietary supplement Resource 2.0 60 ml three times a day between meals.	F 325	regarding the implementation of physician's orders, to include weekly weights. A 100% inservice was initiated on 2/17/16 by the staff facilitator for all licensed nursing staff and certified nursing assistants regarding the need to review the resident care guide for special feeding instructions prior to feeding a resident. Inservice to be completed by 3/17/16. All new licensed nursing staff and CNAs will be inserviced by the staff facilitator during orientation regarding the need to review the resident care guide for special feeding instructions prior to feeding a resident. The QI Nurse was inserviced by the director of nursing on 3/9/16 regarding the need to ensure that weekly weights are being obtained as ordered by the physician. A 100% inservice was initiated for all licensed speech and occupational therapy staff by the therapy manager on 2/17/16 regarding the need to notify the MDS Nurse of any special feeding instructions for dependent residents so that the care plan and care guide can be updated to reflect the resident's needs. All new Therapy staff will be inserviced by the therapy manager during orientation regarding the need to notify the MDS Nurse of any special feeding instructions for dependent residents so that the care plan and care guide can be updated to	

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F 325	Continued From page 13 Review of physician orders indicated the supplement Resource 2.0 60 cc three times a day was ordered on 8/18/2015. Record review indicated on 8/24/2015, the resident ' s weight was 167 pounds. Review of physician orders on 8/24/2015 indicated the diuretic Lasix was ordered 10 mg three times a day for edema. Review of a QI weight review for Resident #137 indicated on 9/2/2015, the resident was removed from restorative breakfast to see if resident would eat more and be more alert. The resident ' s responsible party and facility physician were notified. The resident ' s responsible party voiced concern over the resident ' s weight loss. Milk was added to each meal tray. Review of the resident ' s plan of care indicated a plan was initiated on 9/4/2015 for " Requires assistance for eating related to cognitive deficit. Unable to feed self. Interventions included provide total feeding, feed resident slowly, without distractions. Start with liquids, offer sweets next, small bites of food with sweets on the tip of spoon. " Record review indicated on 09/30/2015, the resident ' s weight was 135 pounds. Review of the resident ' s clinical record indicated the facility physician saw the resident on 10/1/2015 and addressed the weight loss. The assessment indicated " Nursing requested evaluation of resident secondary to weight loss. She was noted to have a significant weight loss of approximately 32 pounds in the last month. On review of her cumulative weights between April and August, she had an additional 30 pound weight loss. This makes a total of approximately 60 pound weight loss in the last 6 months. Review of her chart shows she was started on Lasix 10 mg daily. She has advanced dementia.	F 325	reflect the resident's needs. 4.When a physician writes an order, to include orders for weekly weights and follow up appointments, the licensed nurse will note the order and ensure that the resident's MAR and TAR are updated as indicated and orders for follow up appointments are relayed to the scheduler to place on the appointment calendar so that arrangements can be made. All orders for weekly weights will also be relayed to the QI Nurse to be placed on the weekly weights schedule. The QI Nurse and/or ADON will review all RD recommendations monthly per protocol to ensure that all recommendations were relayed to the physician. Therapy staff will relay any special feeding needs to the MDS Nurse and the resident's care guide and care plan will be updated as appropriate to inform staff of the resident's special needs. Prior to feeding a resident, the licensed nurse or CNA will review the resident's care guide for any special feeding needs. A binder will be kept at each nurses' station with a copy of the current care guide for each resident that has special feeding needs. The CNA assigned to the dining room will take this binder to the dining room so that special feeding instructions can be reviewed by staff assigned to the dining room prior to feeding a	

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F 325	Continued From page 14 She is assisted with all her meals. She is documented to have usually 25% of her meals in the mornings otherwise 50-75% of her meals. She was also started on Resource supplementation three times a day last month. She appears asymptomatic. " The physician plan indicated " resident with significant weight loss. I have reviewed her medications. I will request for her to be on daily weights times 2 weeks and then weekly weights times 2 weeks. I also do not feel she would benefit from an appetite stimulant. She is documented to be eating appropriately. Her documented weight loss is not consistent with her significant weight loss. Will request complete blood count with differential, comprehensive metabolic panel and thyroid stimulating hormone tests. Certainly differential diagnosis includes possibility of malignancy. Request to follow up with resident in 2-3 weeks. " Review of the resident ' s weights indicated on 10/24/2015 134 pounds, 10/27/2015 131 pounds, 10/27/2015 131 pounds and 11/23/2015 124 pounds. An RD progress note on 11/23/2015 indicated CBW (current body weight) 131 pounds (10/27) 4 pound loss X 1 month 34 pounds in 3 months (20%) 56 pound loss X 6 months (30%) Significant weight loss X 3.6 months but stabilizing around 135 pounds X 1 month. Diet: Mechanical soft with Resource 2.0 60 milliliters (ml) three times a day PO: but mostly 25-75% of meals. Meds: Multivitamin, Lasix, Lipitor. No edema at this time. Weight loss likely complicated by diuretic use and variable PO intake. Currently receives supplementation to aid with meeting nutritional needs. Recommend Prostat 30 ml twice a day to aid with meeting nutritional needs.	F 325	resident. This binder will be reviewed periodically and updated by the MDS Nurse weekly and with any changes in resident. The QI Nurse, RN Supervisor, Treatment Nurse, and ADON will audit physicians orders and clinician progress notes daily Monday-Friday x 4 weeks then weekly x 4 weeks then monthly x 2 months using a Physician's Orders/Progress Notes audit Tool to ensure orders are being followed. Any concerns will be immediately addressed by the QI Nurse, RN Supervisor, Treatment Nurse, and ADON by notifying the physician. The QI Nurse, RN Supervisor, Treatment Nurse, and ADON will conduct audit of 10% of residents with special feeding needs to include resident #137 using a Resident Care Audit Tool 5x week, to include weekends x 4 weeks the weekly x 4 weeks then monthly x 2 months to ensure compliance with feeding resident per plan of care. Any concerns will be immediately addressed by QI Nurse, RN Supervisor, Treatment Nurse, and ADON with reeducation of staff at time of audit. The QI Nurse will audit PCC weekly x 16 weeks using A QI Weekly Weight Audit Tool to ensure that weekly weights are being obtained and recorded in PCC as per physician's orders. Anny concerns will be addressed by the QI Nurse by immediately obtaining the	

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F 325	Continued From page 15 Review of the physician visit on 12/02.2015 indicated " Right now starting Remeron (appetite stimulant) 7.5 mg at bedtime as patient felt to have some element of depression and this may also help her appetite. Discussed plan with resident ' s daughter. Patient does have advanced dementia and expected decline in overall function and weight. " The resident ' s record indicated the resident ' s weight on 12/30/2015 was 124 pounds. The resident ' s record indicated the resident ' s weight on 01/21/2016 was 124 pounds. Review of an RD note on 1/27/2016 indicated " Resident noted to refuse meds at times and likely refuses supplements as well as they are provided with medication pass. Continue plan of care and encourage PO intake. " On 2/3/2016, an RD note indicated " Significant weight loss but stabilizing x 3 months between 124-126 pounds. Continues to receive an mechanical soft diet with Resource 2.0 60 cc between meals and Prostat 30 cc BID-likely with variable PO intake of supplements as resident commonly refuses meds too. PO mostly 50-75% with recent decline to 25% for the last few days. Recommend to continue plan of care monitor weights and encourage PO intake. " A continuous dining observation was conducted during the dinner meal on 02/14/2016 in the 300 hall dining room. NA #1 was the lone staff person assisting seven residents with the meal. Resident #137 was observed seated at a table. The resident was awake and quiet and did not respond to questions. Noted on the tray of Resident #137 was a plate of food, one glass of water and one 240 cc can of ginger ale. While the NA assisted other residents, the resident picked the glass of water up and spilled the entire contents. At 5:32 PM, NA #1 walked over to	F 325	resident's weight and notification of the physician. The DON will review the Resident Care Audit Tool, Physician's Orders/Progress Notes Audit Tool and QI Weekly Weight Audit Tool weekly x 8 weeks then monthly x 2 months to ensure compliance. The QI Nurse will compile the results of the Resident Care Audit Tool, Physician's Orders/Progress Notes Audit Tool and QI Weekly Weight Audit Tool and present to the Executive QI Committee monthly x 4 months. Trends will determine the need for further action and/or change in the frequency of monitoring.	

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F 325	Continued From page 16 Resident #137, sat beside and began feeding the resident. The resident chewed food slowly. As soon as the NA placed food in the resident ' s mouth, the NA refilled the fork and within seconds and tried to get the resident to take more while the resident was chewing. This continued until 5:47 PM. The resident repeatedly turned away from the fork when more food was offered and only took a small bite from the fork each time. When timed, the NA offered the fork 16 seconds or less each time the resident took food from the fork and continued to try to get the resident to take food while the resident was chewing. Following the meal, the NA handed the small can of ginger ale on the tray to the resident, and the resident began to drink it. At 5:47 PM, the NA moved to another resident. At 5:50 PM, Resident #137 began shaking the soda can with the straw in it and trying to get drink from it. The resident shook the can for approximately 2 minutes repeatedly sucking on the straw. The NA stood directly in front of the resident during this time. There were no other fluids observed on the tray of Resident #137. At 5:55 PM, the NA picked up the tray from the resident and returned it to the dining cart. Review of the resident ' s recorded weights indicated on 02/15/2016, the resident ' s weight was 122 pounds. A second dinner observation was conducted on 2/17/2016 and began at 5:10 PM in the 300 hall small dining room. Five residents were seated at 3 tables. Two staff members were assisting residents with their meal. NA #1 was observed seated to the right of Resident #137. Fluids observed on the resident ' s tray were an unopened carton of milk, a covered glass of water and a small unopened soda. The NA was observed offering food to the	F 325		

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F 325	Continued From page 17 resident, and the resident was taking the solid foods readily. By 5:28 PM, the resident was fed all solid foods from her tray. At 5:28 PM, the NA opened the can of soda and placed a straw in the can and gave Resident #137 the soda. At 5:31 PM, the NA stood up from the table and placed the plastic cover on the resident ' s tray which contained the unopened milk and water. During the meal observation, the NA did not offer Resident #137 the milk or the water. At 5:40 PM, NA #1 wheeled Resident #137 out of the dining room. On 2/17/2016 at 5:45 PM NA #1 was interviewed. When questioned on how she knew what care to give to specific residents, the NA reported " we just have to learn, and if it is not one of my residents, I have to ask their nurse, or I can look at the care plan. " The NA also stated she was assigned to assist Resident #137 often with the dinner meal. The NA was asked what kind of care Resident #137 required at meal time, the NA stated " I have to feed her, because she cannot feed herself. I need to make sure she gets something to drink. I have to wipe her mouth and nose. I can ' t think of anything else. " When asked the reason she did not offer Resident #137 her milk and water during her dinner meal on 2/17/2016, the NA stated " She drank all her ginger ale, and I thought that was enough. " When asked if Resident #137 was supposed to have milk on her meal trays, the NA stated she was. When asked if she observed no milk on the resident ' s tray on 2/14/2016 at dinner, the NA stated she noticed and should have contacted the kitchen. The Director of Nursing (DON) was interviewed on 02/17/2016 at 6:00 PM. The DON stated the	F 325		

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F 325	Continued From page 18 expectation was facility staff was expected to offer all the food and fluids on meal trays, and staff should know what kind of care to deliver to individual residents when assisting with a meal. The facility physician/Medical Director was interviewed on 2/18/2016 at 3:00 PM. The facility physician stated he saw the resident on 10/1/2015 to address significant weight loss. The physician stated when a resident was evaluated for weight loss, he looked at the percentages of food and fluid intake documented and supplements taken. He stated no one ever told him the resident refused the supplements, or that would have been taken into consideration. He also stated he wrote an order on 10/1/2015 to follow up with the resident in 2 to 3 weeks for weight loss and did not see her again until 12/2/2015, because the order was not put on the calendar as it should have been on his next visit. He stated he did not know why or how this was missed. He also stated he did not agree with an increase in supplements recommended by the dietician, as he was making recommendations based on what was documented being taken in by the resident. The physician also stated he was concerned on 10/1/2015 the resident might have a malignancy based on the weight loss that was reported compared to the amount of intake that was reported. He stated that is why he ordered further laboratory work to rule that out. The physician also reported Resident #137 had a diagnosis of Advanced Dementia, and some of the resident ' s weight loss probably was avoidable based on current information, but the physician also stated some weight loss for the resident at the present stage of dementia was unavoidable. On 2/18/2016 at 3:25 PM, the RD was interviewed. She stated she calculated the	F 325		

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F 325	Continued From page 19 resident ' s required caloric intake and began reviewing her in 11/2015 after a return from medical leave. She stated she made her recommendations based on staff documented percentages of the resident ' s fluid and food intake daily. She stated the resident was on supplements due to the weight loss. She also stated based on her calculations, if the resident received what was documented as well as supplements, the resident should not have continued to lose weight. She stated she recommended an increase in the amount of supplements on 12/3/2015, but the facility physician did not approve the increase. She also stated the resident ' s weight seemed stabilized now in the 120s for several week. Review of the resident ' s clinical record revealed during the weight loss period, the resident had no major medical illnesses or hospital visits associated with loss of weight. Laboratory tests were ordered and carried out frequently and reviewed with no major negative outcomes noted. Resident # 169 was admitted to the facility on 12/30/2015 with diagnoses which included displaced fracture of upper and right humerus, anemia, hypertension and lymphocytosis (increase in white blood cells). The most recent Minimum Data Set (MDS) dated 1/27/2016 indicated the resident was cognitively intact. The resident was coded as independent with eating and only required assistance with set up. The MDS listed the resident ' s diet as regular and indicated weight loss/weight gain was unknown. The resident ' s care plan dated 12/31/2015 and	F 325		

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	346119	A. BUILDING ____ B. WING ____	C 02/19/2016

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F 325	Continued From page 20 revised on 1/15/2016 indicated a focus on state of nourishment characterized by potential excess weight loss. Interventions included regular diet as ordered, refer to dietitian for evaluation/recommendations and weigh per facility protocol. The care plan goal included the resident would not experience weight loss of more than 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. A review of the resident ' s clinical record revealed the resident was on a regular diet and weights were obtained on the following dates: 12/30/2015- 181.5 pounds 01/12/2016- 161 pounds 01/15/2016- 158 pounds The Registered Dietician (RD) progress note dated 01/20/2016 indicated a 3 pound weight loss in 3 days and a 23 pound weight loss in 2 weeks. The RD note reported a significant weight loss in 2 weeks and questioned the accuracy of the 12/30/2015 weight. The RD calculated the resident ' s nutritional needs as 1800 calories, 72 grams of protein, and 2160 milliliters of fluid. The RD note reported resident had mostly moderate to good intake and no edema noted. The RD note stated to continue weekly weights to monitor with recommendations/Plan of Care: Continue POC (plan of care)-monitor weights and encourage good oral (PO) intake. Observation and interview with resident # 169 on 02/17/2016 at 1:05 PM revealed the resident in a chair in her room with the bedside table positioned in front of the chair. The resident was alert and oriented. The resident indicated although the food at the facility was palatable, and she normally did not eat everything on her plate. The resident reported staff provided encouragement at meals and offered alternatives. The resident did not remember when she was	F 325		

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F 325	Continued From page 21 last weighed. An interview with restorative nursing assistant (RNA) #1 on 02/18/2016 at 9:22 AM revealed weights were obtained upon admission and weekly for 4 weeks, and then monthly unless otherwise specified. The RNA indicated the Quality Indicator (QI) nurse supplied the names of residents that needed daily or weekly weights. The RNA reported the weights are written in weight books and recorded in the computer. A review of the weight books from 12/30/2015 to 2/18/2016 revealed weights recorded for resident # 169 on 12/30/2015, 1/12/16 and 1/15/16. The resident was listed on the weekly weight sheet for January with no weights recorded for the weeks of 1/3/16, 1/17/16 and 1/24/16. The resident was not listed on the weekly weight sheet for February. The RNA did not know why the resident was not weighed weekly in January and reported no notification of weekly weights for resident # 169 after the last week in January. An interview was conducted with facility RD on 2/18/2016 at 4:15 PM. The RD indicated the resident experienced weight loss, but the admission weight was questionable. The weekly weights had not been available for review. The RD revealed since the resident had moderate to good intake, the recommendation would have been fortified foods or some other form of altered diet to prevent further weight loss. The RD indicated the importance of completed and documented weights for dietary recommendations. The RD reported after recommendations were written, they were given to the QI nurse for follow up. An interview with the QI nurse on 2/18/2016 at 4:30 PM revealed the restorative aides were responsible for the facility weights. The QI nurse reported the printed RD recommendations and	F 325		

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F 325	Continued From page 22 medical doctor (MD) orders were reviewed in the daily clinical meeting. The QI nurse indicated when orders for weights were received, the orders were delivered to the RNAs immediately. The QI nurse indicated all new admissions were weighed upon admission and weekly for 4 weeks unless otherwise specified by the physician. The QI nurse did not know why the weekly weights for resident # 169 were not obtained. The QI nurse indicated the restorative program had been her responsibility for about a month, and the person previously responsible was no longer an employee in the facility. An interview with the facility Administrator on 2/18/2016 at 5:00 PM revealed her expectation was weekly weights to be obtained weekly and the weights documented and followed up completely. An interview with the Director of Nursing on 2/18/2016 at 5:00 PM revealed her expectation was weekly weights to be obtained weekly and the weights documented and followed up completely. The DON indicated the follow up should include dietary recommendations or physician orders for continued weight monitoring and dietary changes if needed. 3.Resident # 33 was admitted to the facility on 10/12/2010 and had cumulative diagnoses which included heart disease, hypertension and hypothyroidism. The most recent Minimum Data Set (MDS) dated 1/27/2016 indicated resident was rarely/never understood and moderately impaired for daily decision making. The resident was coded as having a feeding tube and requiring supervision with 1 person assist for eating. The MDS indicated the resident received 25% or less of	F 325		

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F 325	Continued From page 23 total calories through tube feeding. The resident ' s care plan updated on 1/28/2016 indicated a change in feeding mechanics due to unstable mental health condition, weight fluctuations with manic and depressive phases of bipolar disorder and resident fluctuated between tube feedings and oral intake. Interventions included diet as ordered, provide prescribed diet of regular mechanical soft and monitor closely during meal times, weigh per facility protocol and resident ' s weight will fluctuate with different phases of bipolar. A review of the resident ' s clinical record revealed weights were obtained on the following dates: 09/27 2015 173 pounds 10/29/2015 197 pounds 11/05/2015 191 pounds 11/20/2015 169 pounds 12/16/2015 171 pounds 12/23/2015 178 pounds 01/13/2016 178 pounds The medical record indicated an order on 10/29/2015 from the physician to increase the resident ' s diuretic (medication that helps body get rid of excess fluid) to 40 milligrams (mg) twice a day and for resident to be weighed weekly for 8 weeks. A progress note dated 11/3/2015 and signed by nurse #3 reported a weight warning for weight on 10/29/15 with follow up from MD for increased diuretic to 40mg twice a day and to weigh resident weekly for 8 weeks. An RD progress note dated 11/23/15 reported resident had a significant weight loss for 2 weeks and 1 month with an overall significant weight gain times 6 months. The progress note included a recommendation for weekly weights secondary to weight fluctuations with oral and tube feeding	F 325		

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F 325	Continued From page 24 provisions. An RD progress note dated 12/16/2015 reported the previous recommendations were approved by physician. Progress note indicated weekly weights were pending. The progress note stated for continued plan of care and to follow up with weights. Recommendation was to continue weekly weights. A Nurse Practitioner (NP) progress note dated 12/16/2015 stated resident ' s oral intake had improved for 2 weeks and resident had consumed 25% to 100% of her meals. Review of MD order dated 12/18/2015 reduced resident ' s diuretic to 40 mg daily and to continue weekly weights for 6 weeks. Resident # 33 was observed in her room on 2/17/2016 at 12:20 PM. Resident was sitting up in bed and RNA #2 was seated in a chair at bedside with resident ' s meal tray on bedside table. RNA #2 conversed with resident and encouraged resident to eat during the observation. Resident consumed approximately 35%. RNA #2 reported the amount consumed to nurse #1 and nurse #1 administered tube feeding supplement as ordered. An interview was conducted with the facility RD on 2/18/2016 at 4:05 PM. The RD indicated the weekly weights were not available in the medical record on 12/16/2015. The RD recalled making the recommendation to continue weekly weights for resident # 33. The RD stated she did not know why the weights were not obtained as ordered. The RD revealed the QI nurse received the RD recommendations and followed through with the physician orders. An interview with the QI nurse on 2/18/2016 at 4:30 PM revealed the restorative aides were responsible for the facility weights. The QI nurse reported the printed RD recommendations and	F 325		