MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	57ME	A. BUILDING: _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHC	501 SOUTH LOCUST STREET MCCOMB, MS 39648

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M 000	Initial Comments The State Agency (SA) conducted a State Licensure survey from 7/31/18 through 8/03/18. During the survey the SA determined the facility did not meet the licensure requirements for the State Minimum Standards for the Aged and Infirm. The SA cited M490, M620, M635, and M645.	M 000		
M 490	45.17 RESIDENTS RIGHTS RESIDENTS RIGHTS This Statute is not met as evidenced by: Level II Based on observation, resident, staff, and family interview, record review and facility policy review, the failed to ensure Resident #99 was treated with dignity and respect for one (1) of 26 residents reviewed. (Resident #99) A review of the facility's policies and procedures with a subject of "Resident Rights", dated 11/30/14, revealed the residents have the right to be treated with dignity and respect. An observation and interview on 07/31/18 at 08:31 AM with Resident #99 revealed the resident had a continuous feeding tube delivering Resident #99 stated that she did not like having the tube and she wanted to eat by mouth. Resident #99 stated she could swallow and wanted to eat. An observation and interview on 08/01/18 at 12:00 PM with Resident #99 revealed the resident sitting up in bed with her feeding pump providing feeding at 45cc/hr. The resident's roommate was	M 490	1. Root Cause Analyisis was completed 9/17/18 by Quality Assurance Performance Improvement (QAPI) Committee and based on results Resident #99 was offered and accepted a different room assignment that will maintain Residents rights and dignity. 2. A Quality Review was conducted on 9/18/18 by Director of Nursing of current Residents on "nothing by mouth" (NPO) status to ensure Residents were not in a position to watch other Residents eat food. Follow up based on findings. 3. Clinical Educator provided re-education for current facility on 9/18/18 regarding this regulation with emphasis on ensuring Residents with NPO status are not in a position to watch other Residents eat. Newly hired employees to receive education on this regulation in orientation. Resident's rights and dignity ensured by not placing Residents with orders for NPO in a position of watching other Residents eat.	9/25/18

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M 490	Continued From page 1 observed to have a lunch tray and the roommate was eating her lunch. Resident #99 stated "I wish I could eat. That lady there (pointing to roommate) eats all the time." The resident's tone became more exasperated as she stated "I have to sit and watch her eat. It be smelling so good. She eats three times a day!" The resident stated she could eat but staff wouldn't let her and say she can't swallow. The resident stated her roommate always eats in the room and no one pulls her curtain to block her view. The resident stated it made her feel like no one listens to her. A review of the resident's care plan revealed there were no interventions addressing the resident's desire to eat or interventions to keep resident from having to watch her roommate eat meals. An interview on 08/01/18 at 12:14 PM with LPN # 7, who was familiar with Resident #99 since her admission to the facility revealed the resident had been wanting to eat since she was admitted. LPN #7 stated the resident's roommate eats in the room and it was probably hard for the resident to smell the food and watch her eat. An interview on 08/02/18 at 10:16 AM with the RN Unit Manager revealed she was unaware of any interventions in place to keep Resident #99 from having to smell or watch her roommate eat but would expect staff would pull the curtain if the resident wanted them to. An interview on 08/02/18 at 10:20 AM with Resident #99's husband revealed his wife had been wanting to eat so badly and he brought food to her several times sneaking it in. He stated he got caught and was told he couldn't bring food to her because she may choke so he stopped	M 490	4.Social Worker or Unit Nurse Manager to conduct a Quality Improvement Monitoring of room assignments weekly for four weeks then monthly and as needed to ensure room assignments are appropriate to ensure Residents rights and dignity are maintained. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. Root Cause Analysis will be used by the Committee and updates made to the Performance Improvement Project (PIP) as indicated by findings.	

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M 490	Continued From page 2 bringing it. An interview with the Dietician, on 08/03/18 at 10:09 AM revealed #99 The dietician stated it would be awful if the resident wanted to eat to be watching her roommate or other people eat in front of her. The dietician stated she would expect staff to encourage the resident's roommate to eat her meals in the dining room or at least pull the curtain in the room so the resident did not have to watch her eat.	M 490		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II Based on observation, record review, staff interview and facility policy review, the facility failed to provide Resident #25's incontinent care in a manner to prevent the possible spread of infection for one of three (1 of 3) incontinent care observations. Findings include: Review of the facility's policy titled, " Perineal Care", with a revision date of 09/05/2017, revealed the Procedure included, on female residents, wash from front to back, to avoid urethral or vaginal contamination.	M 620	1. Root Cause analysis was completed by Quality Assurance Performance Improvement (QAPI) Committee and based on findings Certified Nurses Aide (CNA) #1 was re educated on 8/3/18 by Director of Clinical Services with emphasis providing perineal care in a manner to prevent spread of infection. Resident exhibited no negative outcome from perineal care provided. 2. Quality Review Observation of current CNAs was completed 9/10/18 by Clinical Educator to ensure competency of providing incontinent care in a manner to prevent the spread of infection. Follow up based on findings.	9/25/18

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M 620	Continued From page 3 An observation, on 08/02/18 at 9:00 AM, revealed Resident #25's incontinent care was provided by Certified Nursing Assistant (CAN) #1 and assisted by CNA #2. CNA #1 wiped the resident's buttocks area from back to front, instead of from front to back to prevent the possible spread of infection and/or contamination. CNA #1 wiped the area three (3) times as she was cleaning the resident. During an interview, on 08/02/2018 at 9:25 AM, CNA #1 revealed she had wiped Resident #25's bottom from back to front. CNA #1 stated, "I knew it didn't feel right, like I was doing it wrong." CNA #1 stated wiping the wrong way could cause the resident to get an infection. During an interview, on 08/02/2018 at 9:30 AM, CNA #2 confirmed CNA #1 had wiped the resident's bottom from back to front three times during her care. CNA #2 stated wiping the wrong way could cause the resident to get an infection. During an interview, with Licensed Practical Nurse (LPN) #1, on 08/02/18 at 9:35 AM, she stated not cleaned and wiped correctly from front to back, it could cause the resident to get a urinary tract infection. During an interview, on 8/2/18 at 2:50 PM, the Director of Nurses (DON), stated when providing incontinent care, the resident should be wiped from front to back to decrease the risk of an infection. An interview, on 08/03/2018 at 10:50 AM, with RN #1/Staff Development Nurse, revealed the CNA staff is given a Skills Check-Off during the new hire orientation, and at least annually. RN #1 stated she does random skills checks for the CNA staff for various reasons throughout the	M 620	3. Re-education was conducted 8/13/18 by Clinical Educator with CNAs on this regulation with emphasis on providing incontinent care in a manner to prevent the spread of infection. Incontinent care to be provided in a manner to control the spread of infection. 4. Quality Improvement Monitoring to be conducted with a random sample of two CNAS, two x weekly for four weeks then weekly for two weeks then monthly to ensure incontinent care is provided in a manner to prevent the spread of infection by Assistant Director of Nursing or Director of Nursing. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. Root Cause Analysis to be used by the Committee and updates made to the Performance Improvement Project (PIP) as indicated by findings.	

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M 620	Continued From page 4 year. RN #1 stated CNA #1 was given the Perineal Care Skills Check-Off in December of 2017. RN #1 stated CNA #1 had asked for a refresher in-service on perineal care the morning of 08/02/2018. Review of Resident #25's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2018, and the 60 Day MDS with an ARD of 03/14/2018, revealed a Basic Interview for Mental Status (BIMS) score of 99, which indicated the facility was not able to complete the interview. Further review of the MDS revealed Resident #25 was always incontinent of bowel and bladder.	M 620		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This Statute is not met as evidenced by: Level II Based observation, record review, staff and resident interview, and facility policy review, the facility failed to ensure Resident #99 received appropriate care and services to restore oral eating skills for one of four (1 of 4) residents reviewed with tube feedings. Findings include:	M 635	1. Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee and based on findings physician was notified of recommendations by therapy dated 11/17/17 for Resident #99 to advance in oral consumption. Therapy re screened Resident #99 8/9/18 for advancement in Diet. Physician orders were noted for a diagnostic barium swallow as recommended in therapy screen.	9/25/18

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M 635	Continued From page 5 Review of the facility's policy titled, "Aspects of Care", dated 11/30/14, revealed the facility would provide rehabilitation services to ensure attaining and maintain the optimal level of function of the residents. Services could have been provided by a licensed Speech Therapist and were to include screening, evaluations, and treatments. Documentation was to be ongoing and all inclusive of care given. A review of Resident # 99's Comprehensive Admission Minimum Data Set (MDS), dated 10/13/18, revealed the facility admitted the resident, on 10/06/17, with diagnoses including Aphasia, and Hemiplegia/Hemiparesis. The MDS revealed the resident was admitted to the facility with an enteral feeding tube. An observation and interview, on 07/31/18 at 8:31 AM, with Resident #99 revealed the resident had a continuous feeding tube delivering the resident's nutrition. Resident #99 stated she did not like having the tube, it had come out before, and she wanted to eat by mouth. Resident #99 stated she could eat by mouth, but "they" say she can't swallow. Resident #99 stated she can swallow, and wants to eat. When asked for clarification on who told her she couldn't swallow, she said "them people here". An observation and interview, on 08/01/18 at 12:00 PM, with Resident #99 revealed the resident was sitting up in bed with her feeding pump providing the tube feeding at 45 cubic centimeters (cc)/hr. The resident's roommate was observed to have a lunch tray, and the roommate was eating her lunch. Resident #99 stated "I wish I could eat. That lady there (pointing to roommate) eats all the time." The resident's tone became more exasperated as she stated, "I have	M 635	Diagnostic barium swallow resulted 8/23/18 with results recommending "to remain on "nothing by mouth"(NPO) status " Additional recommendation were Resident could have pleasure feedings with Speech Language Pathology to treat 5 x a week for 4 weeks to complete pleasure feedings, strengthen swallow and decrease aspiration risk. Due to max potential being met orders noted 9/7/18 to discontinue Speech Language Pathology. Recommendations made for Resident #99 to remain NPO. 2. Quality Review conducted 9/20/18 by Director of Nursing of current Residents with NPO status to ensure recommendations for advancement in oral consumption have been communicate to IDT and reported to physician. Follow up based on findings. 3. Director of Nursing has provided re-education 9/20/18 to Licensed Nurses on this regulation with emphasis following notifying physician of recommendations regarding advancement in oral consumption. Director of Rehabilitation and Director of Nursing provided re-education 9/20/18 for Licensed Nurses and therapy staff on process for communication /follow-up related to speech therapy recommendations. Newly hired employees to be educated in orientation. Speech Language Pathology recommendations to be communicated in morning meeting to Director of Nursing or	

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M 635	Continued From page 6 to sit and watch her eat. It be smelling so good. She eats three times a day!" The resident stated she could eat but staff wouldn't let her, and says she can't swallow. The resident stated her roommate always eats in the room, and no one pulls her curtain to block her view. The resident stated it made her feel like no one listens to her. An interview, on 08/01/18 at 12:14 PM, with Licensed Practical Nurse (LPN) #7, who was familiar with Resident #99 since her admission, revealed the resident has been wanting to eat since she was admitted to the facility. LPN #7 stated she thought there was an evaluation of the resident's ability to swallow done several months ago after the resident was hospitalized when her Percutaneous Endoscopic Gastrostomy (PEG) tube came out. LPN #7 stated she believed the resident was eating one meal a day, but because the resident talked a lot while eating the staff was afraid she would get choked, so efforts to have her eat were discontinued. LPN #7 stated she believed the resident could probably eat, had been caught eating when her husband snuck food into the room. LPN #7 stated the resident's roommate eats in the room, and it is probably hard for the resident to smell the food and watch her eat. A review of the Physician's Orders for Resident #99 revealed an order, dated 10/09/17 for Speech Therapy to evaluate. On 10/10/17 there was an order to start an 1800 calorie mechanical soft diet, and consult speech therapy for a deglutination study. On 11/9/17 there was an order for a Barium Swallow study. A review of the results of the Barium Swallow study, dated 11/17/17, revealed a diagnosis of Dysphagia. The report indicated the	M 635	Assistant Director of Nursing. Physician to be notified. 4. Quality Improvement Monitoring to be completed by Director of Nursing or Assistant Director of Nursing weekly x four weeks and then monthly to ensure recommendations for advancement in oral consumption for Residents with NPO status are communicated to physician. Findings to be reviewed at monthly QAPI Committee Meeting. Quality Review Schedule to be modified based on findings. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Project(PIP) as indicated.	

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M 635	Continued From page 7	M 635		

resident wanted to start eating again, and the resident had no documented dysphagia treatment. The report indicated the resident had no difficulty with controlled straw sips of nectar to honey thick liquids and recommendation was for honey thick liquids then downgrade to nectar as the resident improved in treatment. Additional recommendations included smooth pureed textures and Speech Therapy treatment for dysphagia therapy.

A review of the resident's record revealed no documentation of a speech evaluation prior to 11/17/17. A review of the Speech Therapy documentation for Resident #99 revealed an initial evaluation, dated 11/17/17, by the contracted Speech Therapist. The Speech Therapist assessed the resident's potential for achieving goals as good, and the evaluation listed treatment approaches of evaluating swallow function, and oral function therapy. The evaluation indicated the resident was on trials to upgrade to a diet of pureed with honey thick liquids. Therapy was to be provided five times a week for one week. The evaluation indicated the resident had not had therapy previously. There was a speech therapy discharge summary indicating the resident was discharged from therapy, on 11/20/17, due to discharge to the hospital. The discharge summary indicated the resident needed continued therapy.

A review of the physician's orders revealed an order, dated 11/22/17, for the resident to be admitted to the hospital, and orders indicating a return to the facility on 11/23/17. There was no indication in the resident's medical chart that any speech therapy services were provided after the resident returned from the hospital.

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M 635	Continued From page 8 An interview, on 08/02/18 at 10:16 AM, with Registered Nurse (RN) #6/Unit Manager, revealed she was unaware of any efforts to restore eating skills for the resident as she was new to the unit. The unit manager stated she was unaware of any interventions in place to keep Resident #99 from having to smell or watch her roommate eat, but would expect staff would pull the curtain if the resident wanted them to. An interview, on 08/02/18 at 10:20 AM, with Resident #99's husband revealed he was told by the facility nurses the resident couldn't swallow. Resident #99's husband stated his wife had been wanting to eat so badly, and he brought food to her several times, sneaking it in. He stated he got caught, and was told he couldn't bring food to her because she may choke so he stopped bringing it. He stated one of the nurses told him to call the doctor to see if she could eat, but he had not been able to catch up with the doctor. He was unaware of any efforts by the facility to assist the resident to restore eating skills. An interview, on 08/02/18 at 12:41 PM, with the Therapy Supervisor confirmed Resident #99 had received therapy services to restore eating skills in November of 2017. The Therapy Supervisor stated it appeared the Speech Therapist recommended to continue working with the resident, feeding her one meal daily. The therapist no longer worked at the facility, and there were no documented services provided after November. In April 2018 an Interdisciplinary Therapy Screen (IDTS) was completed by the current contracted Speech Therapist, and he recommended Speech Therapy services in an effort to restore eating skills. The Therapy Supervisor stated that when a recommendation was made for therapy on a resident with no viable	M 635		

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M 635	Continued From page 9 billing source, she forwards a request to the Administrator of the facility for approval. If the facility approved the request, then therapy services would provide treatment for the length of time approved. The Therapy Supervisor stated she forwarded a request in April of 2018 to the facility Administrator for approval for Speech Therapy services to work with Resident #99 on restoring eating skills, but had not heard anything since the form was submitted. The Therapy Supervisor stated services could not be provided without approval for payment. Resident#99 did not have a pay source so the facility would have to pay for services. An interview, on 08/02/18 at 2:58 PM, with the current facility contracted Speech Therapist revealed he completed an assessment for the need for speech therapy on Resident # 99 in April, 2018. The Speech Therapist stated he had not assessed Resident #99 prior to that date. The Speech Therapist's recollection was that nursing staff made a referral for evaluation of the resident to see if she had the potential to start eating by mouth. He stated his screening revealed the resident had potential to start eating to the extent to supplement or perhaps replace enteral feeding. A form requesting payment for providing Speech Therapy services was submitted by his supervisor to the Administrator in April, but he had not been informed of the decision made regarding the request. A review of the "Notification of Intent to Provide Therapy Services", dated 4/12/18, indicated the current contracted Speech Therapist screened the resident, and assessed that the resident had potential for oral advancement sufficient to supplement or replace total nutrition/hydration enteral support. The notification indicated a	M 635		

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M 635	Continued From page 10 recommendation for Speech Therapy to be provided three times a week for 30 days. The Notification had a hand written statement "Questionable due to non compliance. Family bringing in fried chicken, and items not clinically recommended." An interview with the Dietician, on 08/03/18 at 10:09 AM, revealed #99 had not had any weight loss, and the tube feeding had been meeting her nutritional goals. The Dietician stated she would recommend the resident continue tube feeding unless she was evaluated by a Speech Therapist, and worked on her swallowing. The Dietician stated she was unaware the resident had been evaluated by the Speech Therapist or findings that the resident was a candidate to restore eating skills. The Dietician stated she would expect the facility to provide those services. The Dietician stated it was awful if the resident could eat, and to be watching her roommate or other people eat in front of her. The Dietician stated she would expect staff to have the resident's roommate eat in the dining room ideally, or at least pull the curtain in the room. An interview, on 08/03/18 at 2:40 PM, with the DON, Corporate Nurse, and Administrator present regarding the facility's efforts to provide services to restore Resident #99's eating skills revealed the DON was unaware of the Speech Therapist's evaluation, and recommendation to provide therapy services. The Corporate Nurse stated there had obviously been a breakdown in communication between nursing and the therapy department. The Administrator stated she received the request for approval for speech therapy services, but did not forward it to the corporate office for approval because it was her understanding from nursing staff that the resident	M 635		

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M 635	Continued From page 11 had been non-compliant with her recommended diet. The Administrator stated the husband had brought food to the resident when the resident was supposed to be on tube feedings only. The DON confirmed the care plan for tube feeding did not include interventions to restore Resident #99's eating skills. The DON confirmed the care plan did include interventions for Speech Therapy to evaluate the resident, and she would think the facility should follow any recommendations made by the Speech Therapist, and that had not been done, so the care plan had not been followed.	M 635		
M 645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This Statute is not met as evidenced by: Level II Based on observation, record review, staff interview and facility policy review, the facility failed to ensure accurate weight monitoring for Residents #22, #26, and #129. This concern was identified for three (3) of 12 residents reviewed for weight loss/gain. Findings include: Review of the facility's policy titled, "Weighing the	M 645	1. Resident #129 was re-weighed to verify weights and reported to physician 8/6/18 by Assistant Director of Nursing. Identified staff, Certified Nurses Aid (CNA) #2, Registered Nurse (RN) #3, CNA #4 and Licensed Practical Nurse (LPN) #4 were re-educated on this regulation 8/13/18 by Director of Nursing emphasizing completing re-weights, notifying physician of significant weight change and recording significant weight	9/25/18

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	57ME	A. BUILDING: _____ B. WING _____	08/03/2018

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M 645	Continued From page 12 Resident", with a revision date of 09/05/17, revealed: When there is a significant variance from the previous recorded weight the scale should be re-balanced and the resident re-weighed and a licensed nurse to validate. Resident # 22 An interview, on 07/31/18 at 12:34 PM, revealed Resident #22 stated he thinks he is losing weight. On 7/31/18 at 12:54 PM, and observation revealed Resident #22's lunch tray was tray in front of him on the overbed table. The tray was covered, and the resident stated he was not going to eat. Review of Resident #22's Weight History revealed the following weights: 02/01/18 (Admission) - 173,20 pounds (#), 02/12/18 - No weight, 03/06/18 - 209.8#, 04/04/18 - 145.60#, 04/18/18 - 114,00#, 05/04/18 - 140.20, 05/23/18 - 143.20, 06/08/18 - 130.8#, 06/15/18 - 102.60, 06/27/18 - 133.40#, 07/02/18 - 133.40#, 07/17/18 - 130.00#. Review of the weights revealed there was weight losses and/or gains of five(5)# or more, and no re-weight documented. Review of Resident #22's Physician Orders revealed orders for a No Added Salt/ No Concentrated Sweets (NAS/NCS) Mechanical soft diet The physician also ordered Ensure with meals, and four (4) ounces (oz) med pass three times a day (TID). The record review indicated the Registered Dietician (RD) had tried multiple interventions such as supplements and appetite stimulants in the past. Review of a printed record of weights received from Medical Records revealed, on 7/2/18 the	M 645	results. 2. Quality Review conducted 8/15/18 by Assistant Director of Nursing of current Residents weights to ensure appropriate reweights are obtained, notification of physician of significant weight changes and consistent documentation of weights. Follow up based on findings. 3. Re-education was conducted with current Licensed Nurses and CNA 9/18/18 by Clinical Educator on this regulation with emphasis on re-weights notification of physician of significant weight changes and consistent documentation of weights. Newly hired licensed Nurses and CNA's to receive education in orientation. Residents with five or more pound weight change to be reweighed with verified significant weight changes reported to physician. Weights will be recorded consistently and reviewed during morning clinical meeting. 4. Quality Improvement Monitoring to be conducted by the Director of Nursing or Assistant Director of Nursing weekly x4 weeks then every two weeks times four weeks, then monthly to ensure appropriate re-weights are obtained, consistent weights are documented and physician is notified of significant weight change. Findings to reviewed at monthly QAPI Committee Meeting. Quality Review schedule will be modified based on findings. Root Cause Analysis (RCA) will	

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M 645	Continued From page 13 resident had a weight of 133.4#, and on 7/17/18 the resident had a weight of 130#, which would calculate to be an 8% weight loss in three months, and a 29% weight loss since admission. On 8/2/18 at 9:34 AM, an interview with Certified Nurse Assistant (CNA) #2 revealed she had been doing the monthly weights since July. CNA #2 reported the resident's primary CNA for the day recorded the weekly weights. CNA #2 stated if there was a reweight needed, she would do it. When asked about the weight discrepancies of 5 pounds or greater, CNA #2 reported the resident should be reweighed. CNA #2 reported when she weighed residents she did not have a copy of the last weight to know if there was a weight gain or loss. CNA #2 reported she turns the weights in to the Director of Nurses (DON) office when she completed them. CNA #2 stated the list of re-weights are left on each unit for her each week, and they come from the DON. CNA #2 reported she does not report any weight losses to anyone, that she just weighs them and turns in the list to the DON. On 8/2/18 at 10:45 AM, Registered Nurse (RN) #3/Unit Manager reported the facility's scales had just been recalibrated, and CNA #4 was put in charge of weights. RN #3 reported the Assistant Director of Nursing (ADON) was in charge of the weights, and she brought a list each week of weights with any discrepancies to the unit for the CNA to re weigh the residents. RN #3 verified it is expected that the Physician be notified if there is a five (5)# discrepancy in the weight. RN #3 reported they had been having trouble with the scales and had recently had them calibrated, and the facility had implemented a Performance Improvement Plan (PIP) on the accuracy of the weights. RN #3 reported there is a committee	M 645	be used by the Committee and updates made to the Performance Improvement Project (PIP) as indicated.	

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M 645	Continued From page 14 that meets each week on the residents who are at risk or losing weight, and the DON keeps up with this information. On 8/2/18 at 4:21 PM, the DON revealed the Restorative Aide has been placed in charge of monthly and weekly weights since July. The DON reported they have put a weekly weight review meeting in place. The DON reported she would expect that the unit manager would report a five (5)# weight gain/loss to the physician, and document it in the nurses notes. The DON reported if there is a discrepancy in weight identified in the weekly weight meetings, then they are placed on weekly weights until they are stabilized. On 8/3/18 at 10:54 AM, an interview revealed DON reported that Maintenance calibrates the scales. On 8/3/18 at 9:45 AM, an interview with Licensed Practical Nurse (LPN)#2 revealed weight loss is discussed in the Interdisciplinary Team (IDT) meeting weekly if there is a discrepancy. The LPN reported it could be four to five days from the time the weight is done until the time of the meeting before the discrepancy is noticed. LPN #2 reported the CNA does not have a copy of the last weight when they are weighing residents to be able to notify the nurse if there is a discrepancy. On 8/3/18 at 10:22 AM, an interview with the Registered Dietician (RD) revealed, "the scales have been messed up since I have been here". The RD reported she has been working here since February. The RD reported they have a weekly weight meeting, and look at the residents with weight loss or significant weight changes, but	M 645		

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M 645	Continued From page 15 "it doesn't seem to be getting any better." The RD reported, "every week they have a plan to fix the scales and the next week it seems that there are more and more discrepancies with the scales, and they never seem to get corrected." The RD reported it is hard for her to make an accurate assessment for the residents due to inaccurate weights, and she is afraid there will be a negative outcome. The RD stated she is concerned that she may order/recommend a supplement/diet that could possibly have a negative affect for a resident. On 08/03/18 at 12:29 PM, an interview with the Maintenance Director revealed he calibrates the scales monthly. He reported he does not have a log e records the results each time he calibrates it. He reported he has not had any training and hasn't looked at a policy, but knows that there is one. He reported he uses a 50 pound weight the manufacture sent him to calibrate the scales with, and has pictures on his phone dated to prove when he did it, and the scale is calibrated correctly. He reported he has witnessed a few CNAs using the scales, and from what he saw they subtracted the weight that was written on the side of the wheelchair from what the scales said, and did not weigh the wheelchair separately. He reported the stand up scales is probably five to six years old, and the wheelchair scale and lift scales are older than that, but he is not sure how old they are. Review of the Face Sheet revealed Resident #22 was admitted by the facility, on 02/01/18, with the included diagnoese, Diabetes Type Two, Schizophrenia, Major Depression, and Generalized Edema. Resident #26	M 645		

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M 645	Continued From page 16 A review of Resident #26's Weight Record revealed an admission weight, on 2/02/2018, of 148.4# (pounds). Further review of the Weight Record revealed the following weights: 2/20/2018- 149.7#, 2/27/2018-155.8#, 3/5/2018-156.2#, 4/4/2018-144#, 6/15/2018-146.2#, 7/10/2018-129.2#, 7/17/2018-137.2#. Resident #26 had a 7.30 % wt loss in 5 months. These weights document a greater than or less than five (5)# weight loss or gain, and no indication of a re-weigh to validate an accurate weight. Interview, on 08/02/2018 at 4:21 PM, with the Director Of Nurses (DON) revealed Restorative had been placed in charge of monthly and weekly weights since July. The DON reported they have put weekly weight review meetings in place. The DON reported that she expected the Unit Managers to report a five pound (5 lb) weight gain/loss to the physician, and document it in the Nurses Notes. The DON reported if there is a discrepancy with the weights in the weekly weight meetings those residents are placed on weekly weights until they are stabilized. The DON confirmed the facility failed to have a consistent weight procedure, and the facility also failed to follow the Comprehensive Care Plan by inconsistent weights being recorded. A review of the Face Sheet revealed the facility admitted Resident #26, on 02/02/2018, with diagnoses which included Alzheimer's Disease, Depression, Schizophrenia and Hypertension. A review of Resident #26's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2018, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the facility	M 645		

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M 645	Continued From page 17 was unable to complete the interview. Review of the Face Sheet revealed Resident #26 was admitted by the facility, on 02/02/18. with the included diagnoses, Alzheimer's Disease, Psychosis, Major Depression, Gastro-Esophageal Reflux Disease (GERD), and Schizophrenia. Resident #129 On 07/31/18 at 12:47 PM, an observation revealed Resident # 129 was feeding herself with no difficulty. Resident appeared well nourished. Resident stated "the food is very good." A review of the resident's weights revealed a 15# weight gain from 5/4/2018 to 6/15/2018, then a 16# weight loss from 6/15/2018 to 7/2/2018. Review of the weight record revealed no re-weights were documented. Review of the Face Sheet revealed Resident #129 was admitted by the facility, on 12/27/17, with diagnoses including Cognitive Communication Deficit, Chronic Obstructive Pulmonary Disease (COPD), and Dememtia Without Behavior Distrubance.	M 645		