STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on November 20, 2017 and completed on November 22, 2017, the sample included five (5) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review.	F 000		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F 278		12/27/17

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

Electronically Signed | 12/15/2017

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F 278	Continued From page 1 and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 1 of 17 sampled residents (Resident #9). Failure to accurately complete Section N (Medications received) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2017, Chapter 3, page's N-4 to N-6, stated, ". . . Indicate the number of days the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days . . . . Enter "0" if medication was not received by the resident during the last 7 days. . . . N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back period . . ." Review of Resident #9's medical record occurred on November 20 - 21, 2017. Diagnoses included, anxiety, neuropathy, and muscle spasms. A	F 278	1. Resident #9's MDS dated 8/8/17 was modified by the nurse manager on 12/7/17 and submitted on 12/12/17. The MDS dated 10/27/27 was modified on 12/7/17 and submitted on 12/13/17. 2. All residents of the facility using anxiolytics have the potential to be affected. 3. MDS coordinators and nurse managers were educated on 11/27/17 by the Nursing Services Administrator regarding coding medications according to the pharmacological classification as per the RAI manual. 4. A quality assurance tool has been developed, and beginning 12/18/17, all MDSs will be checked by the QAPI director or designee for proper medication classification coding. This will be done for ten (10) weeks. After that, 25 MDSs per month will be checked ongoing. The results will be discussed at the monthly QAPI meetings, with action and follow-up as necessary.	

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F 278	Continued From page 2 physician order, dated 03/29/17, stated, "Clonazepam (antianxiety) 0.5 mg (milligrams) three times a day for muscle spasms."Quarterly MDS, dated 10/27/17, and a Significant Change MDS, dated 08/08/17, showed an "0" in Section N0410B: Antianxiety. These MDSs indicated the resident did not receive antianxiety medications in the seven day look back period. The medical record showed Resident #9 received clonazepam three times a day during the seven day look back period for the MDSs dated 10/27/17 and 08/08/17. During an interview on 11/22/17 at 1:30 p.m., an administrative nurse, (#3) confirmed the MDS Section N0410B should have been coded to indicate Resident #9 received antianxiety medications all seven days of the look-back period for the MDSs dated 10/27/17 and 08/08/17.	F 278		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 309		12/27/17

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F 309	Continued From page 3 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services in a manner to maintain the highest practicable physical well-being for 1 of 1 sampled resident (Resident #9) with a leg brace. Failure to apply a leg brace as ordered by the physician placed the resident at risk for injury to the right lower leg. Findings include: Review of Resident #9's medical record occurred on November 20 -21, 2017. Diagnoses included, left above the knee amputation, peripheral artery disease, diminished vascular flow, muscle	F 309	1. Regarding Resident #9, all staff were educated to follow the routine care sheet and ensure that the resident's brace is placed when he is up in his wheelchair. (See #3 below for specific dates of education.) 2. All residents who wear a brace have the potential to be affected. 3. All CNA staff were educated on the importance of placing braces as ordered and following the routine care sheets. This was done during mandatory CNA meetings on 12/5/17 and 12/12/17. All	

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F 309	Continued From page 4 spasms, and no sensation from the waist down. A physician order, dated 04/28/17, stated, "do not wear right foot brace while in bed." Resident #9's Routine Care Sheet stated, "Brace: RLE (right lower extremity) only when up in W/C (wheelchair)." Observations on 11/20/17 are as follows: * 3:30 p.m. two CNA's (certified nurse assistants) (#1 and #2) completed Resident #9's cares, transferred the resident into his electric wheelchair and failed to apply the right lower leg brace. * 5:23 p.m. Resident #9 sat in his electric wheelchair, in his room, with no right lower leg brace in place. * 6:10 p.m. Resident #9 sat in his electric wheelchair in the coffee shop, with no right lower leg brace in place. During an interview on 11/22/17 at 1:30 p.m., an administrative nurse, (#3) stated, Resident #9 is to wear the right lower leg brace when up in his wheelchair. Failure to apply Resident #9's right lower leg brace when up in the electric wheelchair, places the resident at risk for injury to the right lower leg.	F 309	staff were also educated via email on 12/13/17. Education will also be conducted during safety huddle rounds the week of 12/12/17 through 12/18/17. The QAPI director of designee will conduct a random audit of five (5) residents on a weekly basis for ten (10) weeks, and monthly thereafter, to assess the presence and proper placement of braces. This will begin 12/18/17. Results will be discussed at the monthly QAPI meeting, with action and follow-up as necessary.	
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		12/14/17

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F 323	Continued From page 5 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of the manufacturer's guidelines, the facility failed to properly use assistive devices during transfers for 1 of 1 (Resident #11) sampled resident who experienced a fall with injury. Failure of staff to use the correct size of sling and ensure correct placement of the sling when transferring Resident #11 resulted in a fall with significant injury. Findings include: Review of the manufacturer's guidelines titled "E/Z Way Smart Lift" occurred on 11/22/17. Pages 6-7 of the guidance stated, ". . . the back of the sling is positioned properly behind the	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 6	F 323		

patient's back and under their tailbone to provide support. (The top of the sling must reach just above the patient's shoulders and the base of the sling should be 2 inches below their tailbone.) . . . ."

Review of Resident #11's medical record occurred on all days of survey. Diagnoses included dementia. The significant change Minimum Data Set (MDS), dated 11/09/17, identified moderately impaired cognitive skills and total assistance of two or more persons for most Activities of Daily Living (ADLs). The current care plan stated, ". . . Transfers with full body mechanical lift. Leave sling in w/c [wheelchair] for safety reasons. Total assist (2) needed for transfer. . . ." The routine care sheet further identified, ". . . lg [large] sling . . ."

The progress note, dated 11/20/17 at 1:20 p.m. (on first day of survey), identified, ". . . transferring resident from wheelchair to bed via hoyer and she slid between the hoyer straps onto the floor. . . . has a 3 cm [centimeter] laceration to the left side of her cranium [head]; bruising and swelling surrounding laceration with bruising extending downward behind left ear. . . . denied pain to extremities with first assessment but later admitted to right knee discomfort. . . . cleansed laceration and applied ice pack and pillow beneath head. . . . agreeable with evaluation at ER [emergency room]. Vitals are normal. Neuro [neurological] checks initiated and normal. . . ."

The fall report, dated 11/21/17 11:08 a.m., identified, ". . . resident was lying on the floor. CNA reports . . . were transferring her [resident] from wheelchair to bed via hoyer and that she

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F 323	Continued From page 7 slid through the straps. Upon investigation, staff noted that a medium size sling was used early this AM [morning] . . . same sling remained in place until now. Resident requires a size L [large] sling. Resident was on the floor with blood on left side of cranium. . . . laceration approx. [approximately] 3 cm length and swelling surrounding the laceration at left cranium. . . . redness/bruising behind left that extends downward behind ear lobe. . . ." The investigation reported, dated 11/22/17 4:20 p.m., identified, ". . . she [resident] was seen in the emergency room. Her x-rays showed that she had sustained a fracture of the tibia. staples were applied to her laceration, which was approximately 1.25 inches in length. . . ." Based on the following information, non-compliance at F323 is considered past non-compliance. The facility addressed the corrective action accomplished for Resident #11 affected by the deficient practice by: * Incident reported to the Department of Health on 11/20/17. * Investigation completed/submitted to the Department of Health on 11/22/17. * 1 on 1 education provided immediately after incident with the day and evening shift CNAs working on Acorn Lane regarding proper use of the full body mechanical lift and the importance of ensuring staff utilize the appropriate sling size for each resident based on their assessment. The facility addressed identification of other resident having the potential to be affected by the deficient practice by:	F 323		

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F 323	Continued From page 8 * The QAPI Coordinator developed a form indicating the appropriate sling size required by each resident who utilizes a full body mechanical lift for transfers. The form is kept with the routine care sheet behind each resident's bathroom door. * A list of all residents utilizing a full body mechanical lift, along with the appropriate sling size each resident required, was placed in the Laundry and Utility rooms on each neighborhood. * All of the residents on each neighborhood were re-measured to assure the correct sling size. * Additional education was provided to the CNA staff on all neighborhoods on 11/21/17. The facility addressed measures put in place and systemic changes made to ensure the deficiency practice does not recur by: * All of the residents on each neighborhood were re-measured to assure the correct sling size. * Additional education was scheduled to be provided to CNA staff facility wide within the following week.	F 323		
F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance,	F 325		12/27/17

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F 325	Continued From page 9 unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/20/16. Based on observation, record review, and staff interview, the facility failed to adequately monitor and provide appropriate interventions for 2 of 4 sampled residents (Resident #2 and #8) with unplanned weight loss. Failure to assess, monitor, and implement interventions for weight loss in a timely manner resulted in unplanned severe weight loss for Resident #2 and #8. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, hypertension, and a stage III pressure ulcer to the right buttock. Medications included 20 milligrams Lasix (a diuretic) daily (start date 05/28/16). Resident #2's current care plan stated, ". . . Provide and serve supplements as ordered: as determined by RD [registered dietician] or RN [registered nurse]. (7-19-17) Ensure. (9-12-17) Arginaid, Ensure. (10-18-17) Declines Arginaid. Will try Ensure & Mighty Shake as resident allows or other supplements that resident allows. . . ." Resident #2's weights included the following:	F 325	1. For identified Residents #2 and #8, their diet cards were updated by the dietitian to reflect their increased caloric needs on 12/13/17. High calorie foods will be prepared and provided at each meal. Education was provided by nurse managers on 11/24/17 to CNAs on the applicable neighborhood, Acorn Lane, on the importance of offering and assisting with snacks and supplements, for the above named residents, and all others on the neighborhood. 2. All residents at risk for unplanned weight loss have the potential to be affected. 3. High-calorie foods will be prepared and provided at mealtimes. A Nutritional Supplement Implementation Record has been created by dietitian to track the implementation of nutritional supplements. Dietitian will complete this as nutritional supplements are initiated or changed. The Nutritional Supplement Implementation Record will be reviewed by the Nutrition-At-Risk team at their weekly meetings. The dietitian will add a notation to the dietary cards and nursing	

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F 325	Continued From page 10 *05/17/17: 124.5 pounds (lbs) *06/02/17: 124.9 lbs *07/05/17: 118.6 lbs *08/02/17: 117.8 lbs *09/06/17: 115.6 lbs *10/04/17: 117.9 lbs *11/01/17: 104.8 lbs *11/20/17: 107.4 lbs *This represents a 17.1 lb weight loss over six months (13.7%, a severe weight loss). Dietary Progress Notes identified the following: *08/23/17: ". . . Res [resident] receives Liberal Geriatric DAT [diet as tolerated] with fiberbasics [juice], prunes, snacks/beverages offered TID [three times per day], nutritional supplements as determined by RD and RN. Wt 116# [pounds], BMI [body mass index] 21.9. Gradual, non-significant wt [weight] loss x past 3 months. Weight loss may be r/t [related to] resident's increased confusion, dementia. Anticipate unplanned wt loss r/t dx [diagnoses]. Meal intakes 75%. Res received diuretics. . . ." *08/25/17: ". . . Weight Warning . . . Value: 115.9 [pounds] . . . -10.0% change . . . Current wt 118#. Reviewed detailed mean intakes monitoring records. . . . Will monitor. . . ." *10/06/17: ". . . Late Entry for 9-12-17 . . . Res has unstageable area. Added Arginaid at 10 a.m. snack for skin health, in addition to continuing daily Ensure at 2:45 pm snack since 7/19/17. . . ." *10/18/17: ". . . Weight Warning . . . Value: 109.4 [pounds] . . . -10.0% change . . . Non-typical wt measure. Previous wt was 118#, which had been stable since 7/5/17. . . . Res receives supplements with snacks. Continues with Ensure at 2:45 p.m., added Mighty Shake at 10 a.m. to replace Arginaid which resident routinely refused.	F 325	will add a notation to the CNA daily assignment sheets, indicating those residents who require extra caloric intake. All CNA staff were/will be educated at mandatory CNA meetings on 12/12/17 and 12/27/17. All nursing staff were educated by email on 12/14/17. Education will also be completed with nursing staff at safety huddle rounds the week of 12/12/17 through 12/18/17. Education will be provided to the dietary department at a mandatory staff meeting on 12/21/17. 4. All residents requiring high calorie foods will be monitored weekly by the dietitian or designee. QAPI director or designee will conduct an audit of those residents identified as having unplanned weight loss to ensure snacks are offered and residents are being assisted with supplements provided, on an ongoing basis. This will be started 12/18/17. The results and any issues will be discussed at the weekly Nutrition-At-Risk meeting and the monthly QAPI meeting for action and follow-up as necessary.	

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F 325	Continued From page 11 . . ." *10/26/17: ". . . Weight Warning . . . Value: 109.2 [pounds] . . . -10.0% change . . . Reviewed wt and meal intakes with nurse managers for Nutrition-at-Risk. . . . Res receives pureed diet, small portions, nutritional supplements, high calorie, high protein menu items. Res receives diuretics per MD. Anticipate weight loss. . . ." *11/02/17: ". . . Weight warning . . . Value 104.8 [pounds] . . . -10.0% change . . . Will explore acceptance of adding protein powder to food items at meals. Will monitor. . . ." *11/15/17: ". . . Continued wt loss. Res on Hospice. . . ." *Resident #2's medical record failed to identify if protein powder was implemented, and identified Resident #2 was not on Hospice. The current snack list included with the 10:00 a.m. snack pass failed to identify a snack/supplement (such as a Mighty Shake) for Resident #2. During an interview on 11/22/17, a certified nursing assistant (CNA) (#5) confirmed Resident #2 did not have a specific snack/supplement for 10:00 a.m. The CNA stated he would offer the resident a snack if she was awake, but she is usually sleeping during this time. When asked for the snack/supplement intake records for September 1-November 21, 2017, a dietary staff member (#6) provided records beginning 10/20/17, and identified this as the date staff began documenting snack/supplement intakes. Review of intake records from October 21, 2017 through November 21, 2017 identified the following regarding the 10:00 a.m. snack: *No intakes recorded on 16 of 32 days, "Not	F 325		

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	355082	A. BUILDING _____ B. WING _____	11/22/2017

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AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

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applicable" or "not available" documented on 6 of 32 days, and "refused" documented on 8 of 32 days.

Observations during the survey identified the following:
*11/20/17 at 3:15 p.m.: Resident #2 asleep in bed, with a glass of chocolate Ensure on the bedside table.
*11/20/17 at 4:33 p.m.: A CNA (#4) checked and changed Resident #2's brief in bed, but failed to offer the Ensure on the bedside table.
*11/20/17 at 5:32 p.m.: Two CNAs (#4 and #7) assisted Resident #2 out of bed, into her wheelchair, and to the dining room for dinner, but failed to offer the Ensure on the bedside table.
*11/20/17 at 5:45 p.m.: Staff served Resident #2 dinner, which included pureed hotdish, pureed beans, pureed bread, 8 ounces (oz) water, 4 oz juice, and 8 oz hot chocolate (mixed with water).
*11/21/17 at 9:21 a.m.: Resident #2 ate breakfast in the dining room, which included egg bake, hot cereal, 8 oz 2% milk, and 4 oz juice.
*11/21/17 at 12:06 p.m.: Resident #2 ate lunch in the dining room, which included pureed chicken, pureed potato salad, pureed pasta, 4 oz 2% milk, 8 oz water, and 4 oz juice.
*11/21/17 at 8:48 a.m.: Resident #2 ate breakfast in the dining room, which included pureed pancakes with syrup, pureed sausage, 8 oz 2% milk, and 4 oz juice.
*The above meal observations identified staff served Resident #2 a pureed diet from the regular menu and did not include additional high calorie/high protein menu items.

Staff provided a copy of a November 2017 Dietary Department Communication Meeting

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minutes. The minutes stated, ". . . Resident with Unplanned Weight Loss & Poor Intakes: . . . [Resident #2] . . . For those in dining room, encourage the CNA's to take an extra margarine for the vegetable, potato, brown sugar for sweet potatoes & squash. Servers: brown sugar for hot cereal, squash, etc. Add gravy over pureed & ground meats. Pureed bread. . . ." Resident #2's care plan and tray card failed to identify these additional interventions. Observation failed to identify the use of extra margarine, gravy, or brown sugar. During an interview on the afternoon of 11/22/17, a dietary staff member (#6) stated Resident #2 does not like gravy.

Failure to consistently implement existing weight loss interventions, monitor and evaluate their effectiveness in a timely manner, and modify interventions as needed resulted in severe weight loss for Resident #2 and may contribute to delayed healing of a stage III pressure ulcer.
- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia without behavioral disturbance and anemia. The current care plan stated ". . . provide and serve supplements as ordered: as determined by RD or RN. (10-12-17) Magic Cup (1-1-17) [sic] Declines [Magic Cup was discontinued on 11-1-17] (11-3-17) Mighty Shake . . . weekly wts [weights] or PRN [as needed]. . . ."

Review of Resident #8's weight record identified the following:
09/26/17 - 137 lbs.
10/03/17 - 135.7 lbs.
10/11/17 - 131.8 lbs.
10/16/17 - 136.6 lbs.

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F 325	Continued From page 14 10/17/17 - 136.4 lbs. 10/24/17 - 132.4 lbs. 11/02/17 - 127.1 lbs. 11/03/17 - 128.2 lbs. 11/08/17 - 128 lbs. 11/14/17 - 126.2 lbs. 11/21/17 - 124.7 lbs. This represents a 12.3 lb. weight loss over approximately two months (9% weight loss). The Dietary Progress Notes showed the following: * 10/12/17 4:08 p.m. - "Dietary staff concerned with resident's meal intakes. Visited with resident about appetite and meals. . . . resident ate 75% [percent] of meal. . . . add magic cup at 2:45 pm [afternoon] snack. . . ." * 10/19/17 4:12 p.m. - ". . . Current wt 136# [pounds]. Not significant wt change. . . . offered snacks and beverages TID [three time per day], including Magic Cup and Ice cream. Recent hx [history] of wt loss may be r/t [related to] dx [diagnosis], recent illness. . . ."[10-11-17 Right Hip Fracture] * 10/19/17 5:38 p.m. - ". . . Res [resident] receives Magic Cup. Was receiving ice cream will remove . . ." * 10/31/17 10:31 a.m. - ". . . Nutrition interventions: regular diet, nectar thick liquids, in assisted room, nutritional supplements, high calorie/protein foods, small portions. Weight loss may be r/t declining health, dx, possible GI [gastrointestinal] bleed. . . " * 11/02/17 4:13 p.m. - ". . . not attempting to eat. . . . offered menu alternatives but resident decline. Meal intakes at noon were recorded as 0-25%. Resident has been provided with Magic Cup	F 325		

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supplement at 2:45 pm snack. Res routinely declined and sent back to kitchen. . . ."
* 11/03/17 5:14 p.m. - "added Mighty Shake to 2:45 PM snack. . . ."
* 11/03/17 5:31 p.m. - ". . . unplanned wt loss > [greater than] 5% x [times] 30 days. Anticipate weight loss r/t dx."
* 11/10/17 2:55 p.m. - ". . . Meal intakes: 50%. Wt loss may be r/t dx, decline in status. Nutrition interventions: regular diet, nectar thick liquids, small portions, Mighty shakes, eggs at breakfast. Offered favorite foods, menu alternatives, snacks TID. . . ."
* 11/14/17 4:10 p.m. - ". . . wt 126 #, >5% wt loss x 30 days. Anticipate unplanned wt loss r/t dx."
* 11/15/17 2:31 p.m. - ". . . weight loss x past 6 months d/t [due to] decline in health, dx. Res eats on assisted side. Observed resident in dining room. Res stares at plate without attempting to feed self. Staff assist. Meal intakes vary, 0-75%. . . ."
* 11/20/17 2:49 p.m. - "Detailed meal intakes: Breakfast: 23% x 1 days, 50 % x 1, 75% x 2 days. Noon: <25% x 1, 25 x 1, 50% x 1. Supper: < [less than] 25% x 1, 25 x 2. Snacks refused 100% x 4 days TID."
* 11/20/17 6:23 p.m. - "Observed resident in dining room for supper. Res not eating, not interested in meal. Offer resident alternative selections, favorite foods. Res declined. Family came in for a visit."

Review of Resident #8's November supplement intakes identified the following:
* refused supplement - 44 times
* consumed supplement 0-25% - 8 times
* consumed supplement 26-50% - 1 time
* consumed supplement 51-75% - 1 time

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F 325	Continued From page 16 * consumed supplement 76-100% - 1 time Staff provided a copy of a November 2017 Dietary Department Communication Meeting minutes. The minutes stated, ". . . Resident with Unplanned Weight Loss & Poor Intakes: . . . [Resident #8] . . . For those in dining room, encourage the CNA's to take an extra margarine for the vegetable, potato, brown sugar for sweet potatoes & squash. Servers: brown sugar for hot cereal, squash, etc. Add gravy over pureed & ground meats. . . . ." Resident #8's care plan and tray card failed to identify these additional interventions, however the tray card identified resident disliked squash and no cereal for breakfast. Observation failed to identify the use of extra margarine and gravy. Failure to consistently implement existing weight loss interventions, monitor and evaluate their effectiveness in a timely manner, and modify interventions as needed resulted in severe weight loss for Resident #8.	F 325		
F 328 SS=D	TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such	F 328		12/27/17

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F 328	Continued From page 17 appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive	F 328		

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F 328	Continued From page 18 person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility standing orders, review of facility policy, and resident and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled residents (Resident #16) with physician's orders for oxygen. Failure to clarify oxygen orders may result in complications related to inadequate or excessive oxygen levels. Findings include: Review of the facility's standing orders occurred on 11/22/17. The orders included, ". . . DYSPNEA . . . Oxygen per nasal cannula or mask for comfort. Residents with COPD [chronic obstructive pulmonary disease] 2 liter/minute per nasal cannula maximum. Notify physician after initiating, and get physician's order and specifics. . . ." Review of the facility policy titled "Oxygen Protocol" occurred on 11/22/17. This policy, dated September 2014, stated, ". . . In spontaneously breathing hypoxemic residents with COPD, oxygen administration may lead to an increased carbon dioxide level, thus putting the resident at risk for respiratory depression. Oxygen liter flow should never be increased over 2 liters/minute without a physician's order, except in case of serious emergency. . . ." Review of Resident #16's medical record occurred on 11/22/17. Diagnoses included	F 328	1. Resident #16's oxygen orders were clarified on 11/27/17 by nursing staff, and parameters were set by the attending physician. 2. All residents who use oxygen have the potential to be affected. 3. All residents who have oxygen orders were checked by the QAPI director or designee to ensure that parameters have been specified by the physician. All nurses were educated via email on 12/13/17, and will also be educated during safety huddle rounds the week of 12/12/17 through 12/18/17. Further education with the nurses will take place at the mandatory monthly nurses meeting on 12/21/17. 4. The QAPI director or designee will check all new admissions on oxygen, as well as any existing residents who receive new orders for oxygen to ensure that all residents have parameters designated by the physician, beginning 12/18/17 and ongoing. Any issues will be discussed at the monthly Quality Assurance meeting with action and follow-up as necessary.	

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F 328	Continued From page 19 COPD. Current physician's orders identified, ". . . Oxygen Therapy qhs [every night] PRN [as needed] for COPD . . ." Nurses' notes and Respiratory Monitoring Records identified Resident #16 wore oxygen via nasal cannula at 1.5-2.5 liters continuously. Observation on 11/22/17 at 9:47 a.m. showed Resident #16 wore oxygen via nasal cannula. Resident #16 stated she wears the nasal cannula oxygen daily at 2.5 liters/minute. During an interview on the afternoon of 11/22/17, a supervisory nurse (#3) stated staff should have clarified the oxygen order.	F 328		