STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355099	A. BUILDING _____ B. WING _____	05/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 05/26/15 and completed on 05/28/15, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	1)F 278-The corrective action accomplished for Residents #2, #5, #6, #7, and #9 found to have been affected by accurate coding of resident's status is that the following MDS correction was done: Item Coding Error, section M1200C (turning/repositioning), switching all 'YES' answers to 'NO' until accurate positioning assessment and evaluation User Defined Assessments (UDA's) are completed. 2) Other residents having the potential to be affected by the same practice have been identified according to the Braden Scale. Residents scoring 18 or less ~~will~~ have had ~~have a positioning assessment and evaluation UDA done at the time of their MDS~~ a modification completed per TC & DON 6/23/15 for accurate coding of turning and repositioning programs.	6/29/15

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), review of facility policy, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 5 of 9 sampled residents coded as on a turning/repositioning program (Resident #2, #5, #6, #7, and #9) and/or on nutrition or hydration interventions to manage skin problems (Resident #9). Failure to code the MDS correctly does not provide an accurate assessment of the resident's current status and needs and may affect the development of a comprehensive care plan. Findings include: The Long-Term Care Facility RAI User's Manual, October 2014, page M-38 stated, "M1200C Turning/Repositioning Program: The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [such as] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention. M1200D Nutrition or Hydration Intervention to Manage Skin Problems: The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . ."	F 278	3) Measures put into place to ensure the practice will not recur is that licensed nursing staff will be educated by DNS on 6/23/2015 on the positioning assessment and evaluation UDA tool and a positioning schedule will be obtained from the nurses and communicated to CNA's on the kiosk POC (Point of Care). 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that the MDS is accurately coded for turning and repositioning. These audits will be completed monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 278	Continued From page 2 Review of the facility policy titled "SKIN ASSESSMENT, PRESSURE ULCER PREVENTION AND DOCUMENTATION REQUIREMENTS" occurred on 05/28/15. This policy, revised May 2015, stated, ". . . PROCEDURE : . . 6. Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is recommended based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation . . . is an optional tool that may be used to help determine an individualized repositioning schedule. . . ." - Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 02/27/15, identified extensive assistance of one person for bed mobility and on a repositioning program. The resident's medical record failed to identify a repositioning program. - Review of Resident #6's medical record occurred on all days of survey. A quarterly MDS, dated 04/09/15, identified extensive assistance of one person for bed mobility and on a repositioning program. The resident's care plan, dated 06/03/14, stated "has potential for pressure ulcer development R/T decreased mobility . . ." The resident's medical record failed to identify a repositioning program as an intervention for the risk for pressure ulcers. During an interview on 05/28/15 at 8:40 a.m., an MDS nurse (#1) stated staff discontinued Resident #6's repositioning program in March 2015.	F 278		

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F 278	Continued From page 3 - Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS, dated 03/02/15, identified extensive assistance of one person required for bed mobility and transfers and on a repositioning program. The resident's current care plan stated ". . . Focus: . . . The resident has an ADL [activity of daily living] self care performance deficit R/T recent stroke E/B weakness and decreased mobility. . . . Interventions: . . . BED MOBILITY: Turn from Side to Side: Assist x [times] 2 with use of turning sheet. . . ." The resident's medical record failed to identify an individualized repositioning program. - Review of Resident #7's medical record occurred on May 27-28, 2015. A quarterly MDS, dated 02/21/15, identified extensive assistance of one person required for bed mobility and transfers and on a repositioning program. The resident's current care plan stated ". . . Focus: . . . The resident has an ADL self care performance deficit R/T CVA [cerebrovascular accident] with functional impairments to all extremities and cognitive impairment. . . . Interventions: . . . BED MOBILITY: Dependent of 2 for turning side to side using chux [sic]. . . ." The resident's medical record failed to identify an individualized repositioning program. During an interview on 05/27/15 at 4:08 p.m., Resident #7's family member shared her concerns regarding staff's failure to reposition Resident #7 in a timely manner. She explained, "He's [Resident #7] dependent on staff for repositioning and complains of his back and tailbone hurting." - Review of Resident #9's medical record	F 278		

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F 278	Continued From page 4 occurred on 05/27/15. A quarterly MDS, dated 04/10/15, identified total assistance of two people for bed mobility, on a repositioning program, and on nutrition or hydration interventions for skin problems. The current care plan stated, ". . . Focus: The resident has a stage 2 pressure ulcer to left side sacrum R/T [related to] Dementia E/B [evidenced by] immobility. . . . Interventions . . . Assist to turn/reposition at least every 2 hours or PRN [as needed]. Reposition with extensive assist of 2 and total lift. Reposition in bed with use of repositioning sling. . . ." The resident's medical record failed to identify an individualized repositioning program. A progress note, dated 04/09/15, stated, "Nutrition note: Follow-up for Pressure Ulcer . . . He is not a great eater but is on all nutrition interventions at this time for healing. He is on fortified foods, high protein supplements and a multivitamin with minerals was ordered to promote healing. . . ." The medical record lacked an individualized nutritional assessment. During an interview on the afternoon of 05/28/15, a dietary staff member (#3) confirmed the medical record lacked an individualized nutritional assessment to support the coding of the MDS.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and record review, the facility failed to ensure staff followed	F 281		

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F 281	Continued From page 5 and clarified physicians' orders for 1 of 9 sampled residents (Resident #9). Failure of staff to follow and/or clarify physicians' orders resulted in Resident #9 not receiving medication as ordered. Findings include: Review of the facility policy titled "ADMINISTRATION OF MEDICATION" occurred on 05/28/15. This policy, revised November 2014, stated, ". . . PROCEDURE . . . 17. If a medication is not available for 24 hours the physician/provider must be notified that the medication is not available and they must give direction for how to proceed. . . ." Review of Resident #9's medical record occurred on 05/27/15. Diagnoses included dementia. The current care plan stated, ". . . Focus: The resident has a behavior symptom R/T [related to] Dementia E/B [evidenced by] frequent spitting of food/sputum. . . ." Review of the October 2014 physicians' orders identified risperidone (Risperdal) cream ordered 10/31/14 daily at bedtime. The October and November 2014 medication administration record showed the Risperdal cream unavailable from 10/31/14 through 11/18/14 (19 days). Review of Resident #9's progress notes identified the following: * 11/02/14 at 3:48 p.m. : "spits often when up in wheel chair. given a handkerchief to use, however continues to spit on the floor, on his chair and clothing, and on the wall. . . ." * 11/12/14 at 10:40 a.m. : "DR [doctor] . . . HERE ET [and] VISITED WITH SPOUSE ABOUT RESIDENT'S STATUS. SPOUSE CONCERNED	F 281	1)F 281- Since the window of time to ensure proper notification is past for Resident #9, the corrective action accomplished regarding following and/or clarifying physician's orders is that the DNS has informed licensed nursing staff of the oversight in the nursing communication tool. Subsequently, licensed nursing staff is now aware that they need to review all physician orders daily to assure that physicians are notified within 24 hours of a medication being unavailable. 2) The facility recognizes that all residents in the facility have the potential to be affected by the same practice. Therefore, the night nurse will review all physician orders received for the past 24 hours to assure that medications have been received. Findings of no medications received will be reported to the day nurse, who will contact the pharmacy and physician as needed to receive direction on how to proceed. DNS will monitor through daily report for follow-up. 3) Measures put into place to ensure the practice will not recur is that licensed nursing staff will be educated by DNS on 6/23/2015 on the follow-up/clarification procedure listed in #2 above.	6/29/15

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F 281	Continued From page 6 ABOUT RESIDENT'S BEHAVIORS OF SPITTING AND TALKING LOUDLY. REASSURED HER THE TALKING IS NOT A PROBLEM, BUT THAT THE SPITTING IS. DR. WILL EXAMINE HIM TOMORROW." * 11/14/14 at 6:57 p.m. : "Resident constantly spitting . . ." * 11/18/14 at 2:46 p.m. : "Fax sent to Dr. [name of doctor] re: [regarding] Risperdone [sic] cream and that med has been N/A [not available] thus far. Informed that we will need to use compounding pharmacist out of [city name]. Call placed . . . they will need . . . original order or a phone in order. Awaiting return response." * 11/19/14 at 4:51 p.m. : "call from Dr. . . . discontinue Risperdone [sic] cream." Failure of the facility to notify the physician within 24 hours of the risperidone cream being unavailable resulted in Resident #9 not receiving the risperidone cream for 19 days.	F 281	4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that a fax notification has been sent to the physician within 24 hours of any medication not received or unavailable. These audits will be completed monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: PAIN 1. Based on observation, record review, review of	F 309		

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F 309	Continued From page 7 facility policy and procedure, and staff interview, the facility failed to provide the necessary care and services for 2 of 3 sampled residents (Resident #5 and #7) who experienced pain and required staff assistance to reposition. Failure to reposition residents in an appropriate and timely manner resulted in Resident #5 experiencing avoidable pain and Resident #7 experiencing discomfort. Findings include: Review of the facility policy titled "Pain Management" occurred on May 28, 2015. This policy, dated September 2012, stated, ". . . individualized approaches will be developed to address the resident's pain management needs in a holistic manner. . . ." Review of the facility policy titled "Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements" occurred on May 28, 2015. This policy, revised May 2015, stated, ". . . Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is recommended based on nutrition, hydration, incontinence, diagnoses, mobility and observation . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) with hemiplegia, dementia, and recent fall with left proximal humerus (arm) fracture. A quarterly Minimum Data Set (MDS), dated 03/02/15, identified severely impaired cognition, extensive assistance of one person required for bed	F 309	1) F 309- PAIN & UTI- The corrective action accomplished for Resident #5 related to inappropriate repositioning causing pain is that nursing staff has been instructed by the DNS since 5/27/2015 in daily report to keep resident #5 off the left side. Care plan was updated to reflect appropriate positioning of resident #5. The corrective action for Resident #7 is that nursing staff has been reminded in daily report to reposition Resident #7 according to care plan and not to chart repositioning prior to time of occurrence. In addition, regarding Resident #7's pain due to UTI, nursing staff was reminded by DNS on their communication tool on 6/8/2015 to follow the UA/UC protocol for symptoms of UTI and to follow-up in a timely manner when a physician orders a UA/UC to be done. 2) Other residents having the potential to be affected by the same practice have been identified by reviewing residents at risk for pain by reviewing pain assessments and care plans for repositioning and pain management. Residents having the potential for pain from UTI will be monitored daily by the charge nurse for appropriate follow-up with UTI treatment.	6/29/15

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F 309	Continued From page 8 mobility and transfers, a repositioning program, and as-needed pain medications required for occasional, moderate pain. The resident's current care plan stated ". . . Focus: . . . The resident has an ADL [activity of daily living] self care performance deficit R/T [related to] recent stroke E/B [evidenced by] weakness and decreased mobility. . . . Interventions: . . . BED MOBILITY: Turn from Side to Side: Assist x 2 with use of turning sheet. . . ." The care plan failed to identify how staff should reposition Resident #5 with the fractured left arm. Observation showed the following: * 05/27/15 at 7:10 a.m., two certified nursing assistants (CNAs) (#9 and #10) identified Resident #5 as being incontinent. The CNAs (#9 and #10) positioned Resident #5 onto her left side. As they were providing cares, Resident #5 made the following comments, "Oh, my arm! Oh, my arm hurts! Hurry up! My arm hurts. My arm hurts. My arm hurts. My arm hurts. That hurts!" After the CNAs (#9 and #10) finished providing cares and adjusted Resident #5's clothing, they positioned her back onto her left side to place the (full body lift) sling under her. Resident #5 stated, "Ow. Ow. Ow. Ow. It hurts!" * 05/27/15 at 2:30 p.m., two CNAs (#11 and #12) transferred Resident #5 from her bed to the wheelchair using a full body lift. The CNAs (#11 and #12) positioned Resident #5 onto her left side. Resident #5 made the following comments, "Ow. My arm! My arm! It hurts! It hurts! Oh, that hurts. Oh, that hurts." During an interview on 05/28/15 at 12:00 p.m., an administrative nurse (#2) confirmed staff should	F 309	3) Measures put into place to ensure the practice will not recur is that all nursing staff will be educated by DNS on 6/23/2015 on pain management, appropriate repositioning to alleviate pain, and appropriate follow-up for UTI treatment. Definition of UTI's will be reviewed with nurses along with proper daily documentation when unable to obtain specimen. CNA's will be re-educated by DNS on proper documentation on the kiosk POC (Point of Care). 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator or designee to use audits to monitor repositioning of residents according to care plan, monitoring effectiveness of pain management and appropriate follow-up for UTI. Audits will be done monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 309	Continued From page 9 not position Resident #5 on her left side with her body weight placed on her fractured left arm. The nurse (#2) clarified this with the physical therapist, who stated, "Absolutely not." - Review of Resident #7's medical record occurred on May 27-28, 2015. Diagnoses included CVA with hemiplegia. A quarterly MDS, dated 02/21/15, identified severely impaired cognition, extensive assistance of one person required for bed mobility and transfers, a repositioning program, and scheduled medications required for pain. The resident's current care plan stated ". . . Focus: . . . The resident has an ADL self care performance deficit R/T CVA with functional impairments to all extremities and cognitive impairment. . . . Interventions: . . . The resident has potential for pressure ulcer development R/T Immobility and Incontinence. . . . BED MOBILITY: Dependent of [sic] 2 for turning side to side using chux [sic]. . . ." During an interview on 05/27/15 at 4:08 p.m., Resident #7's family member shared her concerns regarding staff's failure to reposition Resident #7 in a timely manner. She reported being present when staff "got him up from his nap at 1:30 p.m.," and stated, "It's almost 4:30 p.m., and they haven't repositioned him or toileted him." She explained, "He's [Resident #7] dependent on staff for repositioning, and complains of his back and tailbone hurting." Review of repositioning documentation showed staff repositioned Resident #7 on 05/27/15 at 2:51 p.m. This information directly conflicts with the family's observation. Resident #7's	F 309		

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repositioning documentation showed staff repositioned Resident #7 every two hours. Upon closer inspection, the documentation showed staff documented prior to Resident #7's actual scheduled repositioning times on 16 occasions in March, 18 occasions in April, and 11 occasions in May.

During an interview on 05/28/15 at 12:00 p.m., an administrative nurse (#2) confirmed staff should not document before cares have actually been completed.

URINARY TRACT INFECTION (UTI)

2. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide the necessary care and services for 1 of 7 sampled residents (Resident #7) with the diagnosis of urinary tract infection. Failure to obtain a urine sample (urinary analysis /culture (UA/UC)) in a timely manner may have resulted in Resident #7 experiencing avoidable pain/discomfort.

Findings include:

Review of the facility policy titled "Laboratory Services" occurred on May 28, 2015. This policy, dated September 2012, stated, ". . . Clinical laboratory services will be provided or obtained to meet resident needs. The center assumes the responsibility for the . . . timeliness of these services. . . ."

Review of Resident #7's medical record occurred on May 27-28, 2015. Diagnoses included cerebrovascular accident (CVA) with hemiparesis and UTI. A quarterly Minimum Data Set (MDS),

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

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F 309	Continued From page 11 dated 02/21/15, identified severely impaired cognition, extensive assistance of one person required for toileting, and urinary/bowel incontinence. The resident's current care plan stated ". . . Focus: . . . The resident has bladder incontinence R/T [related to] impaired mobility and cognitive impairment. . . . Interventions: . . . Monitor . . . for s/s [signs/symptoms] UTI: pain . . . blood tinged urine, cloudiness, no output, . . . foul smelling urine . . . altered mental status, change in behavior, change in eating patterns. . . ." Resident #7's progress notes identified the following: * 01/30/15, "[Physician assistant] notified of resident being unresponsive and so soundly asleep he was unable to eat supper. . . . Spouse called back to nursing facility to informed [sic] this nurse that resident had ask [sic] her "Why have I got such a back ache' when she visited today; informed her we will be getting a urine on resident as soon as we are able to too, to check for possible UTI. . . . Resident was not wet when put to bed. Will attempt to get a urine in a.m. . . ." * 01/31/15, "Late entry for 01/30/15 - - [Physician assistant] called to check on residents status. Informed her resident was resting quietly and appeared to be in no distress. Informed her we would be getting a urine on resident to check for a possible infection, she stated that would be a good idea. . . . Resident incontinent of urine at 2:00 a.m. rounds, attempting to get resident to urinate in UA cup this a.m. to get urine sample, this has not been successful thus far. . . . Denies painful urination. Staff unable to obtain urine specimen this AM, states he was incontinent (medium, non-foul). Will cont. [continue] to	F 309		

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F 309	Continued From page 12 monitor and attempt to obtain urine for dipstick. . . . Resident out in solarium hollering and interrupting activity . . . Asked if having pain. Verbalized pain to left lower back, describes as dull. Repositioned in chair and received his scheduled Tylenol. Will cont. [continue] to attempt non-pharmacologic [sic] interventions for . . . pain." * 02/01/15, "Urine obtained . . . urine was yellow and slightly cloudy." * 02/02/15, "Res [Resident's] urine multistick tested positive for Leucocytes negative in all other aspects." * 02/03/15 (Tuesday), "Talked to [Physician] re [regarding]: UA done last evening, said to encourage fluids et [and] dip another UA on Thursday (02/05/15)." * 02/09/15 (Monday), "Unable to obtain urine specimen over the weekend as clinic was closed. Specimen obtained via clean catch. Dark yellow, cloudy, foul speciment [sic]. Dipstick revealed large leukocytes and trace blood. Sent to clinic for UA/UC, results pending. Will push fluids and f/u [follow up] with provider once results are obtained. Resident has had no further episodes of decreased responsiveness." Staff failed to document any attempts to obtain a urine sample on Thursday or Friday. * 02/10/15 (Tuesday), "Call from [Physician] re: UA that was sent to clinic, positive for UTI, meds [medications] reviewed, see orders rec'd [received]. . . . Initial dose of Bactrim given [seven days after the physician wrote the order for a repeat UA]." During an interview on 05/28/15 at 12:00 p.m., an administrative nurse (#2) confirmed staff should have obtained Resident #7's urine sample prior to the weekend (February 5-6, 2015) as per	F 309		

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F 309	Continued From page 13 physician's order.	F 309		6-29-15
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 6 of 6 sampled residents (Resident #4. #5, #6, #7, #8 and #9) care planned for restorative nursing services received the therapy program developed by the facility's therapy staff. Failure to provide restorative therapy (RT) services as recommended did not provide the residents the opportunity to maintain their range of motion (ROM), balance, strength, and mobility. Findings include: - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) with hemiplegia, dementia, and recent fall with fracture. The quarterly Minimum Data Set (MDS), dated 03/02/15, identified severely impaired cognition and extensive assistance required for all activities of daily living (ADL's). The current care plan stated, "FOCUS: . . . The resident has a need for restorative intervention R/T [related to]	F 318	1)F 318- Since the window of time to ensure proper correction of missed therapies is past for Residents #4, #5, #6, #7, #8 and #9, the corrective action accomplished regarding services to provide range of motion or prevent further decrease in range of motion is that the DNS has instructed CNA staff on 6/8/2015 and in daily report that all CNA's must do therapies for their assigned residents on days there may be no designated Restorative Aide on duty. 2) The facility recognizes that all residents in the facility have the potential to be affected by the same practice. Therefore, on 6/8/2015, DNS identified that all residents scheduled for restorative therapy are receiving the therapies identified in the care plan by reviewing documentation in kiosk Point of Care (POC) by the CNA's. Nursing staff were instructed in daily report on 6/8/2015 by DNS that therapies are posted at the nurses' station and if Restorative Aids are not available that day, it is the responsibility of the CNA's to complete the therapies per care plan. Charge nurse will notify nursing staff when there is no Restorative Aide on duty.	

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F 318	Continued From page 14 CVA and Dementia E/B [evidenced by] weakness, impaired balance, gait, and risky attempts to self transfer. . . ." Resident #5's restorative therapy documentation identified the following, "Intervention/Task: Active range of motion to RUE [right upper extremity] using the green theraband 1 x 15 reps [repetitions] as resident will tolerate daily for 3-4 days/week, Passive range of motion to RUE daily for 3-5 days/week, Walking with platform walker daily for 3-5 days/week." Review of restorative therapy documentation showed staff failed to consistently provide range of motion and failed to walk Resident #5 with the platform walker 3-5 days a week in March, April and May 2015. Observation showed staff failed to provide restorative therapy services to Resident #5 during the survey. - Review of Resident #7's medical record occurred on May 27-28, 2015. Diagnoses included CVA with hemiplegia. The quarterly MDS, dated 02/21/15, identified severely impaired cognition and extensive assistance required for all activities of daily living (ADL's). The current care plan stated, "FOCUS: . . . The resident has a need for restorative intervention R/T CVA with functional impairments to all extremities. . . ." Resident #7's restorative therapy documentation identified the following, "Intervention/Task: Passive range of motion with stretching exercises to all extremities daily for 3-5 days/week."	F 318	3) Measures put into place to ensure the practice will not recur is that the DNS will educate nursing staff on 6/23/2015 on the use of the restorative therapy log and how to document in the kiosk POC. All CNA's will watch a video on range of motion to ensure appropriate exercises are completed. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that all therapies are done according to the resident's care plan. These audits will be completed monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 318	Continued From page 15 Observation showed staff failed to provide restorative therapy services to Resident #7 during the survey. Review of Resident #7's restorative therapy documentation showed staff failed to consistently provide range of motion 3-5 days a week, as care planned, in the months of March and May 2015. - Review of Resident #6's medical record occurred on all days of survey and identified diagnoses including osteoarthritis. A quarterly MDS, dated 04/09/15, identified Resident #6 required extensive assistance with bed mobility, transfers, and walking in the room and corridor. The resident's current care plan stated, "The resident has a need for restorative intervention R/T [related to] balance and weakness." Interventions included: ". . . Walking with FWW [front wheeled walker] BID [twice a day] for 3-5 days/week. . . ." Review of Resident #6's restorative therapy documentation showed staff assisted the resident with ambulation once daily (not BID) during March, April, and May 2015. - Review of Resident #8's medical record occurred on May 27-28, 2015 and identified diagnoses including dementia with behavior disturbance. A quarterly MDS, dated 03/16/15, identified Resident #8 required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident's current care plan, stated, "The resident has a need for restorative intervention R/T past history of pain from partial tear of R) [right] shoulder rotator cuff." Interventions included: "Active range of motion to head/neck, shoulders, and elbows	F 318		

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F 318	Continued From page 16 daily for 3-4 times/week. . . . Hot packs to R) shoulder daily for 3-4 times/week. . . ." Review of Resident #8's restorative therapy documentation showed staff failed to consistently provide range of motion 3-4 days a week during April and May 2015. The record showed staff provided hot packs on four days in May 2015 (not 3-4 times a week). - Review of Resident #4's medical record occurred on all days of survey. Current diagnoses included dementia. An annual MDS, dated 03/06/15, identified limited assistance with bed mobility, supervised assistance with transfers, and independent with walking in the room and corridor. The current care plan stated, ". . . Focus: The resident has a need for restorative intervention R/T Weakness with impaired balance and limited mobility. . . . Interventions: NURSING REHAB #1: Nustep (level 3) x 10 minutes daily for 3-5 days/week. NURSING REHAB #2: Pulleys x 5 minutes daily for 3-5 days/week. . . ." Review of Resident #4's restorative therapy documentation for March, April, and May 2015 showed staff failed to consistently provide Nustep and pulley exercises 3-5 days a week. - Review of Resident #9's medical record occurred on 05/27/15. Current diagnoses included dementia and muscle weakness. A quarterly MDS, dated 04/10/15, identified total assistance with bed mobility and transfers. The current care plan stated, ". . . Focus: The resident has a need for restorative intervention R/T advanced Dementia E/B decreased mobility and risk for contractures. . . . Interventions: NURSING REHAB #1: Passive range of motion to all	F 318		

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F 318	Continued From page 17 extremities 1-2 times/day for 4-5 days/week. . . ." Review of Resident #9's restorative therapy documentation for March, April, and May 2015 showed staff failed to consistently provide passive range of motion 4-5 days/week. During an interview, on 05/28/15 at 10:00 a.m., an administrative nurse (#2) stated restorative staff are reassigned to provide resident care when needed. The nurse (#2) stated the restorative staff "try to" complete the restorative therapy when assigned to resident care.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: UNSAFE TRANSFERS: 1. Based on observation, record review, and staff interview, the facility failed to ensure staff utilized the appropriate assistive device (Stand Aid - a device used to assist residents to stand and ambulate) for 1 of 4 sampled residents (Resident #6) observed during transfers. Failure to utilize the appropriate device placed Resident #6 at risk of an injury and/or avoidable bruising during transfers.	F 323	1) F 323- UNSAFE TRANSFERS: The corrective action accomplished for Resident #6, found to have been affected by the practice that the environment remains free of accident hazards is that a stand aid device is now being used for this resident for transfers between surfaces. Nursing staff are being reminded in daily report and on their CNA assignment sheets. 2) Other residents having the potential to be affected by the same practice have been identified by the DNS checking all residents' mobilization assessments against their care plans for accuracy. All care plans were updated to reflect appropriate equipment usage by CNA's.	6/29/15

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F 323	Continued From page 18	F 323		

Findings include:

Resident #6's medical record, reviewed on all days of survey, identified diagnoses including osteoarthritis and lumbago. The resident's care plan included the following focus areas:
*11/13/13: "The resident has an ADL [Activities of Daily Living] deficit R/T [related to] cognitive impairment and limited mobility with impaired balance." Interventions included: "TOILET USE: Resident requires extensive assist x 1 to use toilet. . . . TRANSFER: Between Surfaces: Assist x 1, Stand Aid. Uses wheelchair for primary locomotion.
* 01/14/15: "The resident bruises easily and has potential for impairment of skin integrity R/T fragile skin and use of blood thinners." Interventions included: "Identify potential causative factors and eliminate/resolve where possible. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. . . ."

A Mobilization Support Data Collection Tool, dated 04/08/15, identified the resident required the Stand Aid for surface to surface transfers and the Stand Aid, gait belt, and walker for ambulation.

Observation during the survey showed the following:
* 05/26/15 at 4:45 p.m.: Two Certified Nursing Assistants (CNAs) (#4 and #5) transferred Resident #6 to the bathroom using a sit-to-stand lift. When asked if the resident routinely used the lift, the CNA (#5) stated staff recently started using the sit-to-stand lift for Resident #6 following an assessment by a nurse.

3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated by DNS on 6/23/2015 regarding a) safe resident handling and b) following the care plan by reviewing the kiosk POC prior to transferring residents.

4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits for appropriate transfer of residents according to care plan. Audits will be done monthly x 1 year. Results will be reported to the QA team with corrective action implemented.

CHEMICALS:
1) The corrective action accomplished for residents found to have been affected by the practice that the environment remains free of accident hazards is that the lock on the housekeeping closet was replaced so that it stays permanently locked when the door is closed, the cupboard in the bathing room is secured to prevent exposure to chemicals and the air fresheners were removed from the utility room counter and the resident room bathroom. In addition, all resident rooms, bathrooms and utility rooms were checked by environmental services staff to ensure all chemicals were stored safely. This was accomplished on 5/28/2015.

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F 323	Continued From page 19 * 05/27/15 at 8:15 a.m.: A CNA (#6) transported Resident #6 to the tub room in a wheelchair. Once in the tub room, Resident #6 stated she needed to use the bathroom. The CNA (#6) then transferred the resident from the wheelchair to the toilet providing stand-by assistance without an assistive device. The resident held the grab bar near the toilet and was unsteady with arms visibly trembling during the transfer. The CNA then transferred Resident #6 from the toilet to the bath chair in the same manner. * 05/27/15 at 12:55 p.m.: A CNA (#7) transferred Resident #6 from her wheelchair to the toilet and then back to the wheelchair utilizing a gait belt. The resident held the grab bar during the transfers. *05/27/15 at 2:35 p.m.: A CNA (#8) transferred Resident #6 from her wheelchair to and from the toilet providing stand-by assistance and without an assistive device. The resident held the grab bar during the transfers. The resident stated, "Does anybody ever sit on the floor?" The CNA responded, "We try not to let that happen." On 05/27/15 at approximately 5:00 p.m., an administrative nurse (#2) demonstrated the use of the Stand Aid. The nurse (#2) described the Stand Aid as a non-mechanical device used to assist residents to stand, transfer, and ambulate. Once the resident is standing, they may ambulate using the Stand Aid or may choose to use a walker. The nurse stated staff are to use the Stand Aid to transfer Resident #6. During an interview on 05/28/15 at 10:00 a.m. the administrative nurse (#2) clarified use of the Stand Aid. The nurse stated staff should use the Stand Aid to get Resident #6 to a standing position. Once standing, the resident may	F 323	2) The facility recognizes that all residents in the facility have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that housekeeping staff was educated on 6/10/2015 by the environmental services supervisor on proper hazardous chemical storage. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Environmental Services Supervisor or designee to monitor by using audits that chemicals are safely stored and locked. Audits will be done monthly x 3 months. Results will be reported to the QA team with corrective action implemented.	

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F 323	Continued From page 20 ambulate using the Stand Aid or using a walker with staff assisting with a gait belt. She stated many residents don't feel comfortable walking with the Stand Aid and prefer a walker. CHEMICALS 2. Based on observation, review of product labels, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 3 of 3 days of survey (May 26-28, 2015). This practice placed residents with memory loss and/or wandering behaviors at risk of exposure to hazardous chemicals. Findings include: The facility failed to provide a policy regarding hazardous chemical storage per request. The facility identified only one resident as wandering within the facility. Review of a progress note, dated 04/19/15, identified Resident #1 (as having moderate cognitive impairments, but not as being a wanderer), "attempted to . . . remove supplies from the facility storage room. Informed her that only staff was [sic] to enter this location. . . ." On 05/26/15 at 9:30 a.m. and 5:00 p.m., 05/27/15 at 7:27 a.m. and 12:00 p.m., and 05/28/15 8:35 a.m. and 9:23 a.m., observation of the environment revealed: * An unlocked housekeeping closet containing the following chemicals: Bleach, Buckeye Star Spray Glass Cleaner, Emerel Multi-surface Cream Cleanser, Glade Air Freshener, Glance 1 Glass Cleaner, Napa Silicone Spray, Primis Light Viscosity Lube Gel,	F 323		

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F 323	Continued From page 21 Redi San RTV Hard Surface Sanitizer, SSS Emergency Clean-up, and Virex 256 1-Step Disinfectant * An unlocked cupboard in the bathing room containing the following chemicals: two Glade Air Fresheners, Virasept Disinfectant, and Virex 256 1-Step Disinfectant * A counter in the soiled utility room containing one chemical: Glade Air Freshener * A shelf in a resident's bathroom containing one chemical: Home Choice Summer Blossom Air Freshener The product labels stated the following: * Virex 256 1-Step Disinfectant: ". . . Danger, Corrosive, Causes skin and eye burns, Harmful or fatal if swallowed . . ." * Glance HC 1 Glass & Multi-Surface Cleaner: ". . . Causes sever skin burns and serious eye damage, Harmful in contact with skin. . . . Causes burns/serious damage to mouth, throat, and stomach. . . ." * Napa Silicone Spray: ". . . May cause nervous system depression. Extreme overexposure may result in unconsciousness and possibly death. . . . Headache, dizziness, nausea, and loss of coordination are indications of excessive exposure to vapors or spray mists. Redness and itching or burning sensation may indicate eye or excessive skin exposure. . . ." * Glade Air Freshener: ". . . Mild eye irritation. . . . Prolonged or repeated contact may dry skin or cause irritation. . . . Concentrating and inhaling can be harmful or fatal. . . ." * Virasept Disinfectant: ". . . Causes serious eye damage. . . ." * Bleach: ". . . Mild to moderate skin irritant. . . . Exposure to vapor or mist may irritate eyes, nose, throat, and lungs. Harmful if swallowed. May	F 323		

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F 323	Continued From page 22 cause nausea and vomiting if swallowed. . . ." * Emerel Multi-Surface Cream Cleanser: ". . . Moderately irritating to the eyes. Moderately irritating to the skin. . . . May cause irritation to mouth, throat, and stomach. . . ." * Redi San RTU Hard Surface Sanitizer: ". . . Moderately irritating to eyes. . . ." * Primis Light Viscosity Lube Gel: ". . . May cause mild eye irritation if product comes into contact with eyes. . . . May cause mild skin irritation. . . . Ingestion can cause mild irritation to the digestive tract or case a laxative effect. . . ." * SSS Emergency Clean-up: ". . . May cause slight eye irritation. Keep out of reach of children. . . ." * Buckeye Star Spray Glass Cleaner: ". . . May cause eye irritation. . . ." * Home Choice Summer Blossom Air Freshener: ". . . Keep out of reach of children. . . ." During an interview on 05/28/15 at 8:35 a.m., a managerial maintenance staff member (#13) confirmed he expected chemicals to be kept locked and out of reach of the residents.	F 323		
F 325 SS=E	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.	F 325		

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F 325	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on review of facility policy and record review, the facility failed to assess and implement interventions to prevent weight loss and maintain nutritional status for 3 of 4 sampled residents (Resident #2, #3, and #9) with weight loss. Failure to initiate timely and effective interventions and modify the interventions as needed may have contributed to significant weight loss for Resident #3 and severe weight loss for Resident #2 and #9. Findings include: Review of the facility policy "Dietary Documentation" occurred on 05/28/15. The policy, revised June, 2013, stated, ". . . NUTRITION ASSESSMENT AND OTHER DIETARY DOCUMENTATION . . . 1. . . . a. Dietitian Assessment: The registered dietitian (RD) completes a nutrition assessment for each resident upon admission . . . If the center uses the services of a consultant dietitian, the nutrition assessment is completed during the next scheduled visit. However, the dietitian is notified by the DDS [Director of Dietary Services] if a newly admitted resident is nutritionally-at-risk so that appropriate arrangements can be made. b. The Dietitian Assessment is completed annually, with significant change in nutrition, with decline in MNA-SF [Mini Nutritional Assessment-Short Form] score and upon hospital return. The registered dietitian oversees provision of nutrition services to all residents and completes additional assessments as warranted. c. The RD will document monthly on all residents determined to	F 325	1)F 325-The corrective action accomplished for Residents #2, #3, and #9 related to maintaining nutrition status unless unavoidable is that on 6/4/2015, the dietician (LRD) completed dietician assessments per GSS policy for Residents #2, #3 and #9. In addition, follow-up on the dietician assessments was completed by the dietary manager on 6/4/2015. 2) Other residents having the potential to be affected by the same practice have been identified by the dietary manager on 6/4/2015 by completing dietary assessments, Mini Nutritional Assessment and the PCC (Point Click Care) weight summary report to determine the need for an individualized nutritional plan for each resident. The needs of each resident identified are being addressed at the monthly nutritional risk committee meetings. 3) Measures put into place to ensure the practice will not recur is that the dietician (LRD) was educated by the dietary manager on 6/4/2015 regarding GSS's policy on dietician assessments including when the assessments are to be completed. The dietary manager will review any interactions or visits with residents that have a bearing on maintaining or improving the resident's nutritional status with the LRD at each monthly meeting.	6/29/15

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F 325	Continued From page 24 be at nutrition risk in the PN [progress notes] - Nutritional Status. The documentation will include a summary of progress toward the care plan goals and if nutritional interventions have been effective. If the nutritional interventions have not been effective, describe the new goals and interventions to be added to the care plan. . . ." - Resident #3's medical record, reviewed on all days of survey, identified diagnoses including dementia and neoplasm (cancer) of the forehead and neck. An admission Minimum Data Set (MDS), dated 11/13/14, identified the resident as independent with eating and weighed 213 pounds (#). A quarterly MDS, dated 04/29/15 showed the resident weighed 185 # and had experienced a 5 percent (%) weight loss in the last month or 10% in the last 6 months, and not on a physician prescribed weight-loss regimen. Review of weight records showed Resident #3 experienced a gradual weight loss since his admission, weighing 188.5 # on 04/09/15 - an 11.5 % weight loss in 5 months. The record failed to identify dietary notes, assessments, or interventions attempted during the 5 month period. A dietary manager's note, dated 05/05/15 at 8:14 a.m. stated, "Resident is 185# . . . Intakes are 85% on Dysphagia III regular liquids. Adaptive equipment of lipped edge plate. Resident is encouraged to drink 16-24 oz [ounces] of liquid at each meal due to history of UTI. Weight loss of 10% over last 180 days gradual. No concern at this time will monitor and refer to LDR [Licensed Registered Dietitian]." The dietary manager failed to consult with the dietitian or implement interventions at that time. A dietitian's note, dated 05/15/15 at 11:38 a.m.,	F 325	4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Dietary manager or designee to monitor by using audits that dietician assessments are completed per GSS policy, that nutritional risk committee meetings are held monthly and that appropriate interventions are in place. Audits will be completed monthly x 3 months then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 325	Continued From page 25 stated, "[Resident #3] has experienced a significant weight loss which is significant in the past 6 months. Current weight is 186.5# . . . He has diagnosis of dementia and has hx [history] of having many UTI's which often brings on increased confusion. He may need more nutrition during these UTI's which is why I recommend supplements of choice up to 3 x [times]/day to promote weight gain and overall nutritional status. Follow-up." The record showed Resident #3 continued to lose weight, weighing 181.5 # on 05/21/15 - a 13.2% weight loss in 6 months. The record lacked evidence of follow-up by the dietary manager or dietitian and lacked evidence staff performed a nutrition assessment, as identified in the facility policy, when the resident experienced continued weight loss. Failure to promptly address Resident #3's significant weight loss placed the resident at nutritional risk and may have contributed to additional weight loss. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, Alzheimer's disease, and psychosis. A quarterly MDS, dated 02/27/15, identified extensive assistance for eating, weighed 121 pounds, and had experienced a 5% weight loss in the last month or 10% in the last 6 months, and not on a physician prescribed weight-loss regimen. The current care plan stated, ". . . Focus: The resident has a potential nutritional problem due to low intakes and dementia. . . . Interventions: Weigh weekly or as needed to monitor weight loss. Eating: Adaptive equipment: K-CUP with straw is needed for all	F 325		

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F 325	Continued From page 26 beverages. Resident needs to be seated at assist table. Resident needs constant redirection to eat and drink. Adaptive equipment to include cup with lid and straw. Monitor and record intake at each meal. . . ." Review of weight records showed Resident #2 experienced a severe weight loss from December 2014 to January 2015, weighing 118.5 # on 01/21/15 - a 7.8 % weight loss in 30 days. Review of the progress notes identified the following: * 01/14/15 at 1:56 p.m. : "Resident continues to refuse Health shake." A progress note dated 01/15/15 at 8:39 a.m. stated, "Changed health shake schedule. Resident refusing to drink them. Will schedule 2x day to encourage her to try again (decreased from 3 times a day). . . ." * 03/02/15 at 2:25 p.m. : "Resident is 120.5#, 60" BMI of 23.5. Intakes are 20% on regular no restriction diet. Resident refuses supplements, Resident is seated at maximum assist table for meals. Needs constant encouragement and sometimes assistance to eat meals. Adaptive equipment is K cup with straw." * 03/02/15 at 2:27 p.m. : "Resident supplements have been d/c [discontinued]. Refuses to accept. Does not like them. Resident placed on fortified diet to supplement extra calories due to low intakes. Ice cream, whole milk, cookies, soda are some of the interventions in place. The record failed to identify assessments or interventions attempted until 40 days later. A dietitian's note, dated 05/15/15 at 12:24 p.m., stated, "[Resident #2] has had a sign [significant] weight loss - she has lost 10% in the past six months. Current weight is 113.5# and BMI is	F 325		

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F 325	Continued From page 27 22.2. She has become more active as she is now using a merry walker. She is already on a high calorie, fortified meal plan but she is not that great of an eater for meals. Recommend to try supplements TID [three times a day] to help regain lost weight. Follow-up." A dietary manager's note, dated 05/27/15 at 8:28 a.m., stated, "Residents weight down 10% in 180 days. Resident refuses to drink supplements. Offer foods of choice PRN. Fortified diet in place. Cookies, ice cream and whole milk. Will continue to monitor intakes and weight. Will refer to LDR next visit." The record showed Resident #2 continued to lose weight, weighing 112.5 # on 05/27/15 - a 12.1% weight loss in six months. The record lacked evidence staff initiated interventions promptly and performed a nutrition assessment, as identified in the facility policy, when the resident experienced severe weight loss. Failure to promptly address Resident #2's severe weight loss and update the care plan to reflect current interventions placed the resident at nutritional risk and may have contributed to additional weight loss. - Review of Resident #9's medical record occurred on 05/27/15. Diagnoses included dementia and dysphagia. A quarterly MDS, dated 04/10/15, identified total assistance with eating, weighed 121#, and had experienced a 5% weight loss in the last month or 10% in the last 6 months, and not on a physician prescribed weight-loss regimen. Review of weight records showed Resident #9	F 325		

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F 325	Continued From page 28 experienced a severe weight loss, weighing 116.5 # on 05/07/15 - a 12.1% weight loss in six months. A dietary manager's note, dated 05/06/15 at 4:11 p.m. stated, "Resident weight is -5% over last 30 days. Intakes down. Fortified diet and juice supplements per DR order. Resident refuses to open mouth. Will continue to monitor and refer to LDR" A dietitian's note, dated 05/15/15 at 11:52 a.m. stated, "[Resident #9] continues to gradually lose weight. Current weight is 116# and BMI is low at 18.2. His weight loss is unavoidable and expected due to his progression of his Alzheimer's disease. We will continue with current plan of care for [Resident #9]. Follow-up." The record lacked evidence staff performed a nutrition assessment, as identified in the facility policy, when the resident experienced severe weight loss. Failure to perform a nutritional assessment placed Resident #9 at nutritional risk and may have contributed to additional weight loss.	F 325		