STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	12/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(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 12/04/17 and completed on 12/06/17, the sample included 14 residents for review and 2 closed records for review. The sample included 1 additional resident and 2 additional closed records to verify specific concerns during the survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 2 of 14 sampled residents (Resident #2, and #5). Failure to accurately complete Section K (Swallowing/Nutritional Status) 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 User's Manual, revised October 2016, pages K-4 through K-6 stated, "K0300: Weight Loss: . . . Steps for Assessment: This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time: *At a	F 641	NCC will provide accurate assessment entry for resident's status. 1. Accurate assessments for resident #2 and #5 will be updated. Assessment dated 09/27/17 for resident #2, section K0510 is modified and updated. Assessment dated 10/05/17 for resident #5, section K0300 is modified and updated. 2. All residents will have accurate assessments. 3. Dietary manager, has been educated on tag F-641 and made the needed necessary updates and how to complete the assessments in the future without errors. NCC consulting Dietitian, has been informed of these errors and we have gone over interventions for avoiding these errors in the future. The Nutritional	1/10/18

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

Electronically Signed | 12/21/2017

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F 641	Continued From page 1 point closest to 30-days preceding the current weight. *At a point closest to 180-days preceding the current weight. . . . Coding Instructions . . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. . . . Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. Coding Tips . . . If the resident is losing a significant amount of weight, the facility should not wait for the 30 or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status. . . ." Review of Resident #5's medical record occurred on all days of survey. Recorded weights were reviewed and are as follows: * 07/05/17 - 136.0 lbs. (pounds) * 08/03/17 - 125.0 lbs. * 09/07/17 - 125.0 lbs. * 10/04/17 - 126.0 lbs. For the significant change MDS, dated 10/05/17, staff coded Section K0300 as a physician planned weight loss.	F 641	Assessment policy has been reviewed. 4. NCC will monitor residents 2 & 5, in addition to a random sample of NCC residents that their MDS assessments are completed accurately monthly X3, then quarterly by the Dietary Manager. The QA data will be reviewed by the QA committee.	

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F 641	Continued From page 2 During an interview on 12/06/17 at 10:30 a.m., a dietary staff supervisor (#4) confirmed staff should have coded an unplanned weight loss at K0300 for the 10/05/17 MDS. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dysphagia and Parkinson's disease. The MDS, dated 09/27/17, failed to identify a tube feeding. Observation on all days of survey showed Resident #2 with a percutaneous endoscopic gastrostomy (PEG) tube in place. The September 2017 Medication Administration Record (MAR) identified Resident #2 received 240 milliliters (ml) of chocolate milk via PEG tube three times per day and 480 ml of water administered via PEG tube four times per day. During an interview on 12/06/17 10:36 a.m., a dietary supervisor (#4) identified she should have coded a tube feeding on the 09/27/17 MDS.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		1/10/18

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F 657	Continued From page 3 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 6 of 14 sampled residents (Resident #1, #5, #6, #7, #9, and # 23). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #9's medical record occurred on all days of survey. The current care plan stated, "Problem: POTENTIAL FOR SKIN BREAKDOWN: Redenned [sic] area to Right ankle bone noted 10/8/17. . . . Problem: EATING . . . supplements as desired due to not eating meat. . . . Goal: To eat 80% of meals on a daily basis. . . . Approaches . . . 4 oz [ounce] Benefiber Jc [juice] Daily & [and] PRN [as needed] . . ."	F 657	Napoleon Care Center (NCC) will provide accurate careplans developed by the IDT members to direct resident care needs. 1. Accurate careplans re: resident no. 9, potential for skin breakdown will be updated as her right ankle bone redness has resolved, and a skin note will be entered. Eating section will be updated with accurate weight loss interventions and measureable goals. Resident no. 23 and resident no. 5 careplan eating section will be updated with current interventions for weight loss and measureable goals. Dietary progress notes will be completed with all dietary changes. Resident no. 20's careplan falls section will be updated with specific measureable goals. Resident no. 6's careplan smoking	

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F 657	Continued From page 4 A progress note, dated 10/09/17 at 4:31 a.m., stated, "Reddened area right ankle bone 3.0 cm [centimeters] in diameter. . . ." A skin assessment, dated 10/19/17, stated, "SKIN IN GOOD CONDITION NOTED WITH BATH TODAY." During an interview on 12/06/17 at 2:59 p.m., an administrative nurse (#1) confirmed Resident #9's ankle healed, but staff failed to update the care plan. A progress note, dated 11/13/17 at 10:41 a.m., stated, ". . . Suggest promoting more dairy and vegearian [sic] protein products like milk, peanut butter, yogurt, eggs and possible tofu. . . ." Facility staff failed to revise Resident #9's care plan to reflect the interventions mentioned in the 11/13/17 progress note and failed to develop measurable goals. - Review of Resident #23's medical record occurred on all days of survey. The current care plan stated, "Problem: EATING . . . Goal: To eat 75% of meals on a daily basis. . . . Approaches . . . supplement drink at meals BID [two times a day] . . ." Facility staff failed to revise Resident #23's care plan to reflect current weight loss interventions and failed to develop measurable goals. - Review of Resident #20's medical record occurred on all days of survey and identified falls on 10/24/17, 11/19/17, and 12/04/17. Resident #20's fall current care plan lacked specific	F 657	section will be updated with current smoking status. Resident no. 7's careplan - will not be updated as resident has died. Resident no. 1's careplan potential for skin breakdown will be updated with measureable goals and approaches to address his skin issues. 2. All residents will have accurate individualized careplans with measureable goals. 3. LTC (computer software) has been updated to include supplement intake charting. Initial education re: supplement charting occurred with CNA's and dietary staff on 12/19/17, and will be reviewed again at the January 4, 2018 mandatory meeting. Weights will be recorded weekly and monitored for 5% weight loss in 30 days, 7.5% in 90 days and 10% in 180 days. Any of these changes will be reported to residents provider. Education will be provided at mandatory Nurses/CMA/CNA meeting on 1/4/18 re: accurate careplanning and notifying careplanning staff of resident changes. Updated skin assessment policy/protocol will be provided and educated on. 4. NCC will monitor resident no. 5, 9, and 23 and a random sample for accurate dietary careplans monthly x 3, then quarterly by the dietary manager. NCC will monitor resident no. 6 and a random sample of smoking residents for accurate smoking status on their careplan monthly	

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F 657	Continued From page 5 measurable goals for the resident's falls. - Review of Resident #5's medical record occurred on all days of survey. The current care plan stated. "Problem: EATING: Wt [weight] 125 lbs. [pounds]. . . . Resident does not drink milk, will offer hot chocolate. Resident prefers Small Portions, regular diet. Goal: To eat 80% of meals on a daily basis. Approaches: DIET: Regular diet with supplements as desired. 1-1's [one to one] per CDM [certified dietary manager] and RD [registered dietician]. Monitor and record meal intakes. Weights as ordered. . . ." Review of Resident #5's weights showed the following: * 07/05/17 - 136.0 lbs. - admission weight * 08/03/17 - 125.0 lbs. * 09/07/17 - 125.0 lbs. * 10/12/17 - 126.0 lbs. * 11/09/17 - 118.0 lbs. * 11/30/17 - 117.0 lbs The above weights showed a 13.97% weight change in 5 months and a significant weight loss of 6.35% in 1 month. During an interview on 12/05/17 at 3:34 p.m., a dietary supervisor (#4) stated if Resident #5 eats 75% of a meal or less, she should receive a supplement. She said dietary staff kept track of the resident's meal intake and gave the supplement to the certified nursing assistant to administer. The supplement would be given as a snack at 10 a.m., 2 p.m., and evening. . The facility failed to identify weight loss as a problem on the care plan, identify a measurable/resident centered goal, and provide	F 657	x 3, then quarterly by social services. NCC will monitor resident no. 1 and 9 and a random sample for accurate careplanning of skin issues, interventions and measureable goals monthly x 3 then quarterly by the QA coordinator. The QA data will be reviewed by the QA committee.	

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F 657	Continued From page 6 pertinent information regarding supplement use as an approach/intervention. - Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, "Problem: SMOKING: Resident has a history of smoking and does not want to use a nicotine patch on admission. Resident does smoke outside in designated area. . . . Competency evaluation for independent smoking and cognitive evaluation completed by social services. . . . Res. [resident] must stop smoking in order to have knee surgery, Res. refuses. Goal: Resident will be and remain non-smoking in 90 days with safety and hygiene maintained on a daily basis. . . ." Observation showed Resident #6 smoking outside in the designated smoking area on 12/04/17 at 12:11 p.m. and at 3:56 p.m. During an interview on 12/06/17 at 9:15 a.m., a dietary supervisor (#4) and an administrative nurse (#1) confirmed Resident #6's care plan failed to address the resident's continued smoking During an interview on 12/06/17 at 2:00 p.m., an administrative nurse (#5) reviewed Resident #6's smoking care plan and confirmed the goal failed to address the resident's current smoking status. - Review of Resident #7's medical record occurred on all days of survey and identified diagnoses of alcohol dependence, anxiety disorder, personal history of urinary infections, and chronic kidney disease stage 5.	F 657		

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F 657	Continued From page 7 The current care plan stated, "Problem: ASPIRATION PNEUMONIA/TIA [transient ischemic attack]: . . . hospital for pneumonia 1/18/17, hospital for pneumonia 10/5-10/10/17. . . Goal: Resident will be free of signs & symptoms of URI [upper respiratory infection] &/or cold symptoms in 14-21 days. . . ." A progress note, dated 10/10/17 at 5:11 p.m., stated, "Hospitalized 10/05/17-10/10/17 with pneumonia left pleural effusion, acute CKD [chronic kidney disease]. Received IV [intravenous] antibiotics while hospitalized. . . ." Facility staff failed to update Resident #7's care plan goal following the hospitalization return on 10/10/17 and resolution of the treated diagnosis. The current care plan further stated, "Problem: onset 03/23/2012. Diagnosis of alcoholism with delerium [sic] tremens. Has anxiety, confusion, restlessness and some anger @ [at] times. Has hx [history] physical aggression with staff and resistant to cares. Can become verbally abusive towards staff. . . . exited building 02/11/17; attempted to exit building 04/28/17; wander guard put in place. No behaviors reported 10/16/17. Goal: Symptoms of DT's [delirium tremens] will be resolved in 1-2 weeks. . . ." The facility staff failed to provide a current and measurable goal for the problems listed in the resident's care plan. - Review of Resident #1's medical record occurred on all days of survey and identified the resident had recurrent skin issues related to incontinence. Resident #1's care plan lacked	F 657		

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F 657	Continued From page 8 specific measurable goals and approaches for the resident's skin issues.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ¿ §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including	F 676		1/10/18

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F 676	Continued From page 9 (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to maintain abilities in activities of daily living (ADL) for 1 of 2 sampled residents (Resident #28) observed during toileting. Failure to offer toileting to residents may result in a decline in ADL abilities. Findings include: Review of Resident #28's medical record occurred on all days of survey. Diagnoses included dementia. Resident #28's current care plan stated, ". . . TOILETING . . . Provide 1 assist with toileting. Occasionally needs 2 assist d/t [due to] behaviors. Provide incont. [incontinence] products and check & change every 2-3 hrs [hours] . . ." Observation on 12/05/17 at 2:21 p.m. showed two certified nursing assistants (CNAs) (#6 and #8) assisted Resident #28 out of bed using a sit-to-stand lift and checked and changed his incontinence brief. The CNAs failed to assist Resident #28 to the bathroom. During an interview on 12/06/17 at 10:27 a.m., a CNA (#7) stated Resident #28 does use the toilet, and they toilet him during the day.	F 676	Napoleon Care Center (NCC) will follow resident plan of care for ADL's to assure residents receive appropriate treatment and services to maintain or improve ADL ability. 1. Toileting and check and change will be provided to resident no. 28 every 2-3 hours while awake, and during sleeping hours resident will be checked and changed every 2-3 hours and toileted as needed. 2. All NCC residents will be provided toileting as individually careplanned. 3. Nursing staff and aides were initially educated by shift report on 12/7/17 to toilet and check and change resident no. 28 every 2-3 hours while awake, during sleeping hours to check and change resident no. 28 every 2-3 hours and toilet as needed. There is a mandatory CNA/CMA/Nursing meeting scheduled for 1/4/18 to re-educate resident no. 28 toileting careplan. 4. NCC will monitor a random sample in addition to resident no. 28 toileting plan of care being followed monthly x 3, then quarterly by QA coordinator. The QA data will be reviewed by the QA committee.	
F 684	Quality of Care	F 684		1/10/18

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F 684 SS=D	Continued From page 10 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary services for 1 of 4 sampled residents (Resident #1) with a current skin condition. Failure to assess the cause and reassess/monitor current skin issues and treatments has the potential for further skin breakdown and resident discomfort. Findings include: Review of Resident #1's medical record occurred on all days of survey. A skin assessment, dated 09/22/17, stated, " . . . Comments: Blotchy red rashy circles to right side of lower back and buttocks. . . ." A physician order, dated 09/26/17, stated, " . . . Rash and other nonspecific skin eruption, VASELINE TWICE A DAY TO RIGHT LOW BACK AND BUTTOCKS AREA UNTIL RESOLVED . The record lacked skin assessments or reevaluation for effectivness of the treatment from the application of the Vaseline, for the months of September, October, November, and December 2017. During an interview on 12/06/17 at 04:10 p.m., an	F 684	Napoleon Care Center (NCC)will provide quality of care to all residents in accordance with professional standards of practice, the comprehensive person-centered careplan and the resident's choices. 1. Skin assessments will be provided to resident no. 1 weekly until rash has resolved, and quarterly skin assessments are completed with MDS schedule. 2. All NCC residents will have quarterly skin assessments with the MDS schedule, if they note any skin issues the nurse will initiate a weekly skin assessment until it resolves. All new skin issues that develop or skin injuries will also have weekly assessments until resolved or healed. 3. Skin assessment policy/protocol has been updated. Initial discussion occurred with nurses at our staff meeting on 12/18/17, a mandatory staff meeting on	

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F 684	Continued From page 11 administrative nurse (#1) stated the "last skin assessment for this resident was dated 09/22/17."	F 684	1/4/18 will educate staff and provide the updated policy/protocol. 4. NCC will monitor resident no. 1 and a random sample of residents for correct skin assessment completion according to our updated policy monthly x 3, then quarterly by the QA Coordinator. The QA data will be reviewed by the QA committee. The QA data will be reviewed by the QA committee.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on review of professional reference,	F 692	NCC will maintain acceptable parameters	1/10/18

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	355102	A. BUILDING _____ B. WING _____	12/06/2017

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F 692	Continued From page 12	F 692		

record review, and staff interview, the facility failed to adequately assess the nutritional status and needs, and implement appropriate interventions to restore/maintain adequate nutritional status for 3 of 3 sampled residents (Resident #5, #9, and #23) who experienced severe/significant weight loss. Failure to meet residents' nutritional needs through diet, supplements, assistance, or other interventions contributed to the residents' severe /significant weight loss.

Findings include:

The Centers for Medicare and Medicaid Services (CMS) has outlined the parameters for evaluating significance of unplanned & undesired weight loss:

Interval	Significant Loss	Severe Loss
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

- Review of Resident #5's medical record occurred on all days of survey. The record indicated an admission weight of 136 pounds (lbs) on 07/05/17. The current care plan stated, " Problem: EATING: Wt. 125.0 lbs. [pounds]. . . . Resident does not drink milk, will offer hot chocolate. Resident prefers Small Portions, regular diet. Goal: To eat 80% of meals on a daily basis. Approaches: DIET: Regular diet with supplements as desired. 1-1's [one to one] per CDM [certified dietary manager] & RD [registered dietician]. Monitor weights as ordered. Observe for food likes and dislikes. Observe for chewing/swallowing problems. Observe mobility of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.

1. Care plans for residents 5, 9, and 23, will have accurate and correct nutritional needs for diet, supplements, assistance, or interventions for severe/significant weight loss. Resident #5's care plan will reflect accurate progress notes, which will be reviewed and revised, and interventions implemented for weight loss and nutritional status, along with obtainable goals. Resident #9's care plan will reflect accurate weight loss identification, prevention, approaches, and obtainable goals. Resident #23's care plan will reflect updated progress notes, as well as weight loss identifiers, preventions, and interventions, as well as obtainable goals.

2. All residents will have accurate and correct nutritional needs met to maintain weights and updated care plans.

3. Supplements have been put into our charting system (LTC), for better record keeping. Initial education on supplement charting was done on 12/19/2017, with supplement charting education mandatory meeting to be held January 4th. Weights will be taken weekly on residents. Weights will be assessed, documented, and reviewed weekly. Any weights with

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F 692	Continued From page 13 limitations for eating and drinking. Medicate with Multivitamin as ordered. Independent after set up help some of the time. May need 1 assist at times d/t [due to] res. [resident] mood/affect & willingness to participate. Resident [sic] is needing Non-slip mat at table under plate. Using sippy cup and divider plate. . . ." Physician orders identified regular diet, supplements as desired and small portions per resident request. Review of the resident's weights identified the following: * 07/05/17 - 136 lbs. * 08/03/17 - 125 lbs. * 09/07/17 - 125 lbs. * 10/12/17 - 126 lbs. * 11/09/17 - 118 lbs. The weights identified a 13.97% weight loss in 4 months and 6.35% in 1 month. Review of Resident #8's dietary progress notes identified the following: * 07/20/17 at 3:45 p.m.: ". . . She is offered her meals in her room and since this, her intakes have improved dramatically. She is currently eating 64% of her meals . . . She receives supplement drink or hi calorie ice cream when her intakes are under 50%. Will continue with current plan of care." * 10/12/17 at 2:51 p.m.: "Resident's weight is 125 lbs and she is eating 80% of her meals. . . . Resident is still on regular diet and regular texture. . . . Resident sits at an assist [sic] tabe [sic] and is supervision assist. Some days may need more help. Will continue with curent [sic] plan of care."	F 692	gains or losses of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days will be discussed with the provider (per weight loss policy) and documented. Progress notes and care plan will be updated accurately and regularly with any needed dietary changes, notes, or concerns. Residents will be offered proper nutritional needs, supplements, or any other needed interventions to prevent weight loss (per Nutrition Care Policy). Residents dietary care plan goals will be person centered and obtainable. The Nutritional Assessment; Resident Quarterly Review; and Minimum Data Set, Resident Assessment Instrument policies have been reviewed. 4. NCC will monitor residents 5,9, and 23, in addition to a random sample of NCC residents for accurate nutritional needs for diet, supplements, assistance, or interventions for severe/significant weight loss in their care plans monthly X3, then quarterly by the Dietary Manager. The QA data will be reviewed by the QA committee.	

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The dietary progress notes identified staff failed to review, revise, and implement interventions to promote nutritional status and prevent severe weight loss. The facility implemented measures in July and failed to modify or try new interventions to address Resident #5's nutritional needs and help maintain/prevent weight loss.

During an interview on 12/06/17 at 9:15 a.m., an administrative dietary staff member (#4) stated that Resident #5 receives a supplement after meals for a snack if she eats 75% or less of her meals. The administrative dietary staff member (#4) also confirmed that no other interventions for weight loss have been trialed since July 2017.

- Review of Resident #9's medical record occurred on all days of survey. A significant change Minimum Data Set (MDS), dated 10/14/17, identified Resident #9 experienced weight loss. The current care plan stated, "EATING . . . wt [weight] 126 10/26/17 . . . Does not eat meat . . . Refusing protein supplement . . . Approaches . . . supplements as desired due to not eating meat. . . ."

Review of Resident #9's weights identified the following:
*09/29/17: 139 lbs
*10/26/17: 126 lbs
The weights identified a 9.3% weight loss in one month.

Review of Resident #9's "Nutritional Assessments" showed the following:
*09/21/17: ". . . Weight . . . 139 lbs . . . Supplement Foods: Refuses protein supplements

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F 692	Continued From page 15 . . ." *10/13/17: ". . . Weight . . . 130 . . . Supplement Foods: Protein Supplements, Refuses most often . . ." *10/25/17: ". . . Weight . . . 126 . . . Supplement Foods: Nutritional Supplement BID [twice a day] . . ." The assessments failed to identify the severe weight loss and/or any changes in the approach for this problem. A nutrition risk assessment, dated 11/13/17, identified the following ". . . WEIGHT STATUS . . . NO/LOW RISK . . . NO WEIGHT CHANGE . . . wt [weight] 128 . . . Recent illness with hospitalization. . . . was ill so higher protein might be helpful but she refuses supplements and does not likye [sic] meat. Suggest extra dairy or milk products like milk, yogurt, cheese, peanut butter, eggs and possibly tofu. . . ." The assessment did not identify the resident's previous weight of 139 lbs. A dietary progress note, dated 11/13/17 at 10:41 a.m., stated, "Readmission, Nutrition Risk Assessment, Moderate Risk with 6 points mostly due to poor oral and fluid intake which is reportedly improving since readmission. She does not like supplements even though she [sic] they would be recommended. Suggest promoting more dairy and vegearian [sic] protein products like milk, peanut butter, yogurt, eggs, and possibly tofu." The progress note contradicts the nutrition risk assessment completed on the same day regarding the resident's risk for weight loss. During an interview on 12/06/17 at 2:47 p.m. a dietary staff member (#4) stated currently	F 692		

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Resident #9 does not receive any supplements because the resident refused them. The dietary staff member (#4) stated Resident #9 likes mashed potatoes and eats them everyday at lunch and dinner. She confirmed they did not offer Resident #9 fortified mashed potatoes.

- Review of Resident #23's medical record occurred on all days of survey. An annual MDS, dated 10/30/17, identified Resident #23 experienced weight loss. Physician's orders showed Remeron 15 milligrams (mg) started on 11/17/17 and increased to 30 mg on 11/21/17 to increase appetite. The current care plan stated, "EATING . . . Wt 135 . . . 8 oz [ounce] resource supplement drink at meals BID [twice a day], 8 oz. Supplement Qd [daily] at 10am snack, if under 75% intake at noon, resident will get 8 oz. supplement drink at 3. . . ."

Review of Resident #23's weights identified the following:
*08/28/17: 141
*09/25/17: 139
*10/25/17: 135
*11/29/17: 133
The weights identified a 5.6% weight loss in three months.

Review of the dietary progress notes identified the following:
*08/03/17 at 11:52 a.m.: "CARE PLAN REVIEW: Resident's thirrd [sic] quarter care plan was held today with resident and daughter-in-law . . . present. Residents weight is 138 lbs and her meal intake is 17%. She is receiving nutritional supplements at meals and is doing well with them. She gave me some suggestions that she

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F 692	Continued From page 17 does and does not like. I will pass them along to dietary staff to ensure she is receiving what she likes. . . ." * 10/18/17 at 9:43 a.m.: "Annual Nutrition Risk Assessment. Low risk with 5 points. She has been eating poorly with 37% reported meal intake. She is getting protein supplements TID [three times a day] and PRN [as needed] which should be continued." * 11/06/17 at 1:38 p.m.: "CARE PLAN REVIEW: Residents Annual care plan review was held today. Residents daughter-in-law . . . was present. Resients [sic] weight is decreasing and is curently [sic] at 133 lbs. She is only eating 23% of her meals. Resident is receiving supplementental [sic] drink at all meals (TID) and is also recieveing [sic] supplemental resource drink at 3pm for a snack. She also gets another one at mroning [sic] snack if her breakfast intake is under 75%. Will try to offer some hi calorie cookies and ice cream to get her intakes up and more nutritional value in her diet. Residet [sic] states she just has no appetite. . . ." A nutrition risk assessment dated 10/18/17 stated, ". . . WEIGHT STATUS . . . NO/LOW RISK . . . NO WEIGHT CHANGE . . . wt 139# . . . supplements TID & PRN. . . ." Review of Resident #23's December 01-05, 2017 meal and snack intake documentation showed intakes of 0% for nine out of fifteen meals. The facility failed to recognize and make the necessary changes/interventions to prevent the resident's continued weight loss. During an interview on 12/06/17 at 9:13 a.m., two managerial staff members (#1 and #4) stated	F 692		

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F 692	Continued From page 18 other interventions had been tried, but were not documented and confirmed Resident #23 continued to lose weight.	F 692		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and facility policy review, the facility failed to ensure a medication error rate of less than 5 percent on 1 of 2 days of medication administration (12/04/17) for 2 of 12 residents (Resident #11 and #23) observed during medication pass. Twelve medication errors occurred, resulting in a 36% error rate. Failure to ensure staff correctly administered medications per physicians' orders may result in reduced efficacy or in residents experiencing adverse health effects. Findings include: Review of the facility policy titled "Medication Administration Guidelines" occurred on 12/06/2017. This policy, dated August 2012, stated, ". . . Medications will be administered in a timely manner. Consider the condition of the resident and type of medication . . . Medications may be given up to one hour before and one hour after the designated time . . . Medication administration times may vary to meet individual resident needs."	F 759	Napoleon Care Center will be free of medication error rate of greater than 5%. 1. Resident no. 11 and 23 will receive their medications as scheduled and ordered by their provider. 2. All residents will receive their medications as scheduled and ordered by their providers. 3. Education provided to med aides on 12/19/17 and 12/21/17 re: holding medication with sleeping residents and not reporting to the nurse. Medication administration policy has been updated and will educate and provide a copy at mandatory Nurses/CMA/CNA meeting on 1/4/18. 4. NCC will monitor resident no. 11 and 23 in addition a random sample of residents to assure medications are administered with less than 5% error rate and that policy was followed with any	1/10/18

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F 759	Continued From page 19 Observation during the medication pass on 12/04/17 at 12:15 p.m., showed a Medication Assistant II (MA II) (#2) charted, "Not Administered (N)" (12:00 p.m. scheduled medications) for Resident #11 and #23 due to "Resident sleeping." The MA II (#2) failed to notify the nurse or reattempt medication administration. Review of Resident #11's December 1-6, 2017 electronic medication administration record (eMAR) showed the MA II (#2) documented the following: * 12/04/17 at 12:21 p.m. - MiraLax Powder 17 grams (GM) daily for constipation. Not Administered (N) Reason: Resident asleep (also held 12/01/17 and 12/05/17) * 12/04/17 at 12:21 p.m. - Dilantin 100 milligram (MG) capsule take 2 capsules (200 MG) by mouth (PO) twice daily for epilepsy. (N) Reason: Resident asleep (also held 12/01/17 and 12/05/17) * 12/04/17 at 12:21 p.m. - Seroquel 50 MG tablet PO three times per day for Alzheimer's disease. (N) Reason: Resident asleep (also held 12/01/17 and 12/05/17 at noon) * 12/04/17 at 12:21 p.m. - Tylenol 325 MG tablet 2 tablets (650 MG) PO three times a day for cervical disc degeneration. (N) Reason: Resident asleep (also held 12/01/17 and 12/0517 at noon) * 12/04/17 at 12:21 p.m. - Senna 8.6 MG tablet one tablet PO three times daily for constipation. (N) Reason: Resident asleep (also held 12/01/17 and 12/05/17 at noon) Review of Resident #23's December 1-6, 2017 eMAR showed the following: * 12/04/17 at 12:15 p.m. - Aspirin Enteric Coated	F 759	medication refusals monthly x 3, then quarterly by QA Coordinator. The QA data will be reviewed by the QA committee.	

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F 759	Continued From page 20 (EC) 81 MG tablet take 2 tablets (162 MG) PO daily for unspecified atrial fibrillation. (N) Reason: Resident asleep (also held 12/01/17) * 12/04/17 at 12:15 p.m. - Diltiazem 24 hour Extended Release 180 MG capsule PO daily for essential (primary) hypertension. (N) Reason: Resident asleep (also held 12/01/17) *12/04/17 at 12:15 p.m. - Cymbalta 60 MG capsule PO daily for other recurrent depressive disorders. (N) Reason: Resident asleep (also held 12/01/17) *12/04/17 at 12:15 p.m. - Lasix 20 MG tablet PO daily for heart failure. (N) Reason: Resident asleep (also held 12/01/17) *12/04/17 at 12:15 p.m. - Senna 8.6 MG tablet 2 tablets PO daily for constipation. (N) Reason: Resident asleep (also held 12/01/17) The MA II (#2) failed to administer Resident #11 and #23's medications per physician orders and failed to report this error to a nurse. Failure to administer the medications as ordered and scheduled may result in non-therapeutic and adverse consequences to the residents' health.	F 759		