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Healthcare Licensing and Surveys

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

(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 The following common abbreviations are used throughout this document: RN Registered Nurse MDS Minimum Data Set DON Director of Nursing CNA Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	"Preparation and/or execution of this plan of correction does not constitute 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." This plan of correction is the facility's credible allegation of compliance.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to provide a dignified dining experience for 1 of 7 sample residents (#28). The findings were: Review of the medical record for resident #28 showed s/he had diagnoses to include mental disorder, osteoarthritis and generalized weakness. Review of the weight-loss/nutrition care plan last reviewed on 9/14/12 showed s/he was unable to feed him/herself and was to receive meal assistance. The Medical Nutritional Therapy Review dated 6/14/12 revealed the resident required "maximum assist" with feeding. The following concerns were identified: Continuous observation of the evening meal on	F 241	**F241** The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Corrective Action The staff providing care for residents #28 was counseled on the need to provide a dignified dining experience. The policies and procedures for dignified dining experience were reviewed and remain current. Identification of Others Residents requiring assistance with dining are at risk.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa J. Ralph, NHA — TITLE: Administrator — (X6) DATE: 3/18/2013

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

3/21/13 The POC was accepted and reviewed with correction with Teresa Ralph Administrator Kmart State Survey

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F 241	Continued From page 1 2/20/13 from 4:35 PM through 5:48 PM showed that the resident's meal, consisting of meat loaf, ranch beans, baked zucchini and garlic bread was delivered to his/her table at 4:50 PM. The meal was left uncovered. The resident was observed watching the other diners at his/her table as they were assisted with their meals. At 5:13 PM, some diners were observed leaving the dining room and staff were observed to be clearing dishes. The resident had not yet received any assistance with his/her meal. At 5:14 PM, CNA #1 was observed re-positioning the resident's wheelchair so that s/he no longer faced into the dining room, but faced the wall. The CNA did not speak to the resident as she re-positioned the wheelchair. The CNA was observed speaking exclusively to the other diners at the table until 5:17 PM, at which time the resident was observed to receive his/her first bite of food. This was 27 minutes after the meal was delivered to the table. At 5:48 PM, the resident was wheeled out of the dining room. Interview with the administrator on 2/22/13 at 10:06 AM verified that the resident should not have to wait for assistance with his/her meal.	F 241	Systemic Changes An In-service on dignified dining experience will be held on 03/21/2013 for nursing staff. The DON/Designee will conduct random visual audits weekly on different units for 90 days to assure a dignified dining experience is being provided to all residents. If staff non-compliance is observed, an immediate corrective in-service will be conducted to ensure compliance. Monitoring: The DON/Designee will review the results of the dining observation audits with the QAPI Committee monthly X3 for input on the need to increase, decrease, or discontinue the audits.	04/08/2013
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F279 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that identified in the comprehensive assessment. are Corrective Action Resident #20's Nutritional Care Plan was implemented to reflect the resident's nutritional status, needs and preferences.	

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F 279	Continued From page 2 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive care plan that identified individual needs and preferences related to diet/nutrition for 1of 10 sample residents (#20). The findings were: Review of the medical record for resident #20 showed s/he was admitted to hospice on 1/22/13 with a terminal diagnosis of severe malnutrition. Review of the Vital Sign and Weight Flow Sheet showed the resident weighed 176 pounds on 1/9/13. Further review of the flow sheet showed the resident weighed 169 on 1/14/13 and 132.6 on 2/7/13, a weight loss of 22% in 24 days and 25% in 30 days. Review of the hospice plan of care for nutrition last reviewed on 2/6/13 showed, the resident was to be assessed for food preferences and dietary wishes. Further, small frequent meals were recommended. In addition, review of the safety measures showed the resident was at risk for aspiration and his/her head of bed needed to be elevated while eating or drinking. The following concerns were identified:	F 279	Identification of Others The nutritional care plans of Residents identified for weight loss were reviewed for a current comprehensive nutritional plan of care. Systemic Changes An In-service on completion of individualized nutritional care plans will be conducted with Dietary Manager and Registered Dietician to reflect each resident's needs and preferences, on or before date of compliance. The DON/Designee will conducted random visual audits weekly for 90 days to assure nutritional care plans are up to date. If staff non-compliance is observed, an immediate corrective in-service will be conducted to ensure compliance. Monitoring: The DON/Designee will review the results of the care plan audits with the QAPI Committee monthly X3 for input on the need to increase, decrease, or discontinue the audits.	04/08/2013

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F 279	Continued From page 3 a. Review of the weight-loss/nutrition care plan last reviewed on 2/4/13 showed the resident had a potential for weight loss. Further, review of the approaches for weight loss showed the resident was on a regular diet and food preferences were to be offered but did not show what his/her preferences were. Snacks and fortified foods were also to be offered and assistance with meals as needed. The care plan did not indicate the resident was to be offered small frequent meals and/or snacks. The care plan also failed to show the resident needed to be sitting up for meals and snacks due to the risk of aspiration. The care plan stated the head of the bed was to be elevated for meals but did not include to what degree. b. Interview with the dietician on 2/22/13 at 11:50 AM revealed he had not implemented any weight loss measures because the resident was on hospice. Further, there was no evidence to show the percentage of weight loss was unavoidable.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure the care plan was followed for 1 of 1 resident (#20) observed needing a pressure relieving mattress.	F 282	**F282** Qualified persons, in accordance with each resident's written plan of care, will provide services provided or arranged by the facility. Corrective Action All staff providing care for Resident #20 was counseled on the need to implement pressure reducing mattress as preventative measures to reduce pressure ulcers.	

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F 282	Continued From page 4 The findings were: Observation on 2/20/13 at 6:45 PM showed CNA #1 performed perineum care for resident # 20 and the resident's coccyx was redden. Review of the Braden Scale, used to determine the risk of pressure ulcer development, last dated on 1/29/13 showed the resident was at moderate risk with a score of 14. The following concerns were identified: a. An observation with the DON on 2/22/13 at 10:30 AM showed the resident's coccyx remained reddened and confirmed the resident did not have a pressure reducing mattress. b. The 1/21/13 quarterly MDS assessment showed the resident was at risk for the development of pressure ulcers. Skin and ulcer treatments included a pressure reducing device for the bed. c. The care plan for pressure ulcers last reviewed on 2/4/13 showed the resident had a stage II pressure ulcer on his/her heel. Interventions included applying a pressure reduction mattress on his/her bed. d. Interview with the DON on 2/22/13 at 10:30 AM, verified the resident did not have a pressure reducing mattress, and stated this was because the physician had not ordered the device.	F 282	Identification of Others The care plans of Residents identified at increased risk for skin breakdown were reviewed for implementation of care plan interventions. Systemic Changes An In-service on implementation of care plan interventions regarding prevention of pressure ulcers will be held on or before date of compliance with nursing staff. The DON/Designee will conducted random visual audits weekly for 90 days to assure implementation of pressure ulcers prevention interventions as stated on residents care plans. If staff non-compliance is observed, an immediate corrective in-service will be conducted to ensure compliance. Monitoring: The DON/Designee will review results of the care plan audits at the QAPI meeting Monthly X3 for input on the need to increase, decrease, or discontinue the audits.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	**F312** The facility will provide Activities of Daily Living assistant to residents needing increased assistance.	04/08/2013

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F 312	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to provide assistance with meals for 3 of 7 sample residents (#20, #28, #46) observed during meal time. Further, showers/baths were not provided twice a week as scheduled for 5 of 11 sample residents (#24, #28, #46, #66, #96) who needed bathing/hygiene assistance. The findings were: Related to meal assistance: 1. Review of the medical record for resident #20 showed s/he had diagnoses to include septic arthritis in the shoulders. The resident was placed on hospice for severe malnutrition. The following concerns were identified: a. An observation on 2/20/13 at 6:35 PM showed the resident lying in bed with his/her food tray sitting on the bedside table next to the bed. The head of the bed was elevated to less than 45 degrees. The food remained covered and the tray was above shoulder height. An interview with the resident at that time stated s/he was hungry and had not received assistance with the food tray. b. Review of the 1/21/13 quarterly MDS assessment for activities of daily living showed the resident needed extensive assistance with bed mobility. Review of the hospice plan of care dated 2/6/13 for safety measures showed the resident was at risk for aspiration and his/her head of bed was to be elevated for eating and drinking. 2. Review of the medical record for resident #28 showed s/he had diagnoses to include	F 312	Corrective Action The staff providing care for resident # 20, 28, and 46 was re-educated on the need to provide timely assistance with meals. The staff providing care for resident # 24, ~~#28~~, ~~#46~~, ~~#66~~, and ~~#96~~ was re-educated on the need to provide scheduled bathing/hygiene assistance. Identification of Others Residents requiring assistance with dining are at risk. Residents receiving assistance with bathing/hygiene are at risk. Systemic Changes An In-service on providing assistance with Activities of Daily Living including assistance with dining, bathing and hygiene will be held on or before date of compliance. The DON/Designee will conduct random visual audits weekly for 90 days to assure Residents are provided assistance with dining, in a timely manner, and bathing per schedule. If staff non-compliance is observed, an immediate corrective in-service will be conducted to ensure compliance. Monitoring The DON/Designee will review the results of the dining and bathing audits with the QAPI Committee monthly X3 for input on the need to increase, decrease, or discontinue the audits.	

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F 312	Continued From page 6 Parkinson's disease, and dementia. An observation on 2/20/13 at 6 PM showed the resident was sitting in his/her recliner with the bedside table sitting at shoulder height. The meal tray was placed on the table but was not positioned where s/he could easily reach the meal. At 6:15 PM the tray remained in the same position and the resident put on the call light. The resident requested ice cream at that time and refused the food on the tray. Review of the 11/26/12 quarterly MDS assessment for activities of daily living showed the resident needed extensive assistance for bed mobility and transfers. 3. Review of the medical record for resident #28 showed s/he had diagnoses to include osteoarthritis and generalized muscle weakness. An observation on 2/20/13 from 4:35 PM through 5:48 PM showed the resident was served his/her meal at 4:50 PM. The resident was not assisted with the meal until 5:17 PM, 27 minutes later. The resident's Medical Nutritional Therapy Review, dated 6/14/12, showed s/he needed "maximum assist" with feeding. 4. During an interview with the administrator on 2/22/13 at 10:05 AM, she acknowledged residents should not have to wait for assistance with their meals, and verified that food trays were to be placed in front of the residents within easy reach. Related to Showers/Hygiene assistance: 1. Review of facility documentation and behavior charting showed the facility failed to provide a shower for resident #96 on 18 of 25 scheduled	F 312		04/08/2013

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F 312	Continued From page 7 shower days during the period from 11/1/12 thought 1/29/13. On 4 of the resident ' s scheduled shower days, refusal or aggressive behaviors were documented. There were a total of 14 missed showers (56%) with no evidence to show why the showers were not given. 2. Review of facility electronic bath reports and behavior charting revealed resident #66 did not receive a shower on 11 of 17 scheduled showers days from 12/27/12 through 2/20/13. Behavior documentation revealed only 1 missed shower was due to resident refusal. There were a total of 10 missed showers (59%) with no evidence to show why the showers were not given. 3. Review of facility electronic bath reports reveals that the facility failed to provide a shower for resident #28 on 9 of 16 (56%) scheduled shower days during the period from 12/26/12 through 2/20/13. The facility was unable to provide any additional evidence as to why the showers were not given as scheduled. 4. Review of facility electronic bath reports reveals that the facility failed to provide a shower for resident #46 on 8 of 18 (44%) scheduled shower days during the period from 12/22/12 through 2/20/13. The facility was unable to provide any additional evidence as to why the showers were not given as scheduled. 5. Review of facility electronic bath reports reveals that the facility failed to provide a shower for resident #24 on 7 of 18 (39%) scheduled shower days during the period from 12/24/12 through 2/20/13. The facility was unable to provide any additional evidence as to why the	F 312		

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F 312	Continued From page 8 showers were not given as scheduled. Interview with the DON on 2/22/13 at 9:30 AM confirmed that there was no evidence the showers were provided. In addition, he confirmed that although the facility did not have a written shower policy, the facility expectation was that residents received 2 showers a week.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure that preventative measures were put into place to prevent the development of pressure ulcers for 1 of 7 sample residents (#20). The findings were: Observation on 2/20/13 at 6:45 PM showed CNA #1 performed perineum care for resident # 20 and the resident's coccyx was redden. Review of the Braden Scale, used to determine the risk of pressure ulcer development, last dated on 1/29/13 showed the resident was at moderate risk with a score of 14. The following concerns were identified:	F 314	**F314** Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Corrective Action Staff providing care for Resident #20 was re-educated on the need to follow interventions in place as noted on the care plan. Resident #20 was provided a pressure-relieving mattress. Identification of Others Residents identified for risk of pressure ulcers are at risk.	

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F 314	Continued From page 9 a. An observation with the DON on 2/22/13 at 10:30 AM showed the resident's coccyx remained reddened and confirmed the resident did not have a pressure reducing mattress. b. The 1/21/13 quarterly MDS assessment showed the resident was at risk for the development of pressure ulcers. Skin and ulcer treatments included a pressure reducing device for the bed. c. The care plan for pressure ulcers last reviewed on 2/4/13 showed the resident had a stage II pressure ulcer on his/her heel. Interventions included applying a pressure reduction mattress on his/her bed. d. Interview with the DON on 2/22/13 at 10:30 AM, verified the resident did not have a pressure reducing mattress, and stated this was because the physician had not ordered the device.	F 314	Systemic Changes In-service pressure ulcer prevention will be held on or before date of compliance with nursing staff. The DON/Designee will conduct random visual audits weekly for 90 days to assure pressure relieving preventive measures are in place. If staff non-compliance is observed, an immediate corrective in-service will be conducted to ensure compliance. Monitoring: The DON/Designee will review the results of the visual ~~wound~~ audits with the QAPI Committee monthly X3 for input on the need to increase, decrease, or discontinue the audits.	04/08/2013
F 323 SS=D	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: Based on medical record review, observation, staff and family interviews, the facility failed to ensure residents were adequately monitored and interventions consistently put in place to reduce injuries from falls for 3 of 10 sample residents (#94, #66, #18). The findings were:	F 323	F323 The facility must ensure that the residents environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action Staff providing care for Residents #94, #66, #18 were counseled on the need to ensure residents are adequately monitored and interventions consistently put in place to reduce injuries from falls. Identification of Others Residents identified for increased risk of falling are at risk.	

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(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 323	Continued From page 10 1. Review of the 9/13/12 history and physical for resident #66 showed the resident had diagnoses to include dementia and osteoporosis (loss of bone mass). In addition, the resident had fractured his/her left hip fracture in July 2012. The following concerns were identified: a. Observation on 2/20/13 at 5:45 PM showed the resident sitting on the edge of the bed eating his/her meal that had been placed on the night stand. S/he was leaning over to reach the meal tray. b. Review of the 1/7/13 Side Rail Safety Review showed the resident had problems with balance and/or poor trunk control. Review of the 1/7/13 Fall Risk Evaluation showed the resident was a high risk for falls. Review of the care plan for falls last reviewed on 1/8/13 revealed the resident had poor safety awareness. c. Interview with the administrator on 1/22/13 at 10:05 AM confirmed the resident was not safe to sit on the bed eating from the meal tray on the night stand. 2. Review of the medical record for resident #18 showed s/he had diagnoses to include left below the knee amputation and dementia. Review of the 2/14/13 orthopedic consult showed the resident had fallen on 2/6/13 and sustained a right shoulder fracture and dislocation. The following concerns were identified: a. An observation on 2/20/13 at 2:50 PM showed the resident was in bed with the bed elevated. An interview with a family member at that time revealed when she entered the room the bed was elevated. She further stated she had	F 323	Systemic Changes In-service on fall prevention will be held on or before date of compliance with nursing staff. The DON/Designee will conduct random visual audits weekly for 90 days to assure fall preventive measures are in place and fall assessments and intervention are consistently in place. If staff non-compliance is observed, an immediate corrective in-service will be conducted to ensure compliance. Monitoring The DON/Designee will review results of the fall prevention audits with the QAPI Committee monthly X3 for input on the need to increase, decrease, or discontinue the audits.	04/08/2013

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 02/22/2013

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F 323	Continued From page 11 found the bed elevated during previous visits. The family member also stated the resident forgets his/her leg was amputated and has frequently attempted to get up without assistance. b. Review of the care plan for falls last reviewed on 2/8/13 showed the bed was to be placed in the low position. c. Interview with the rehabilitation manager on 2/22/13 at 9:15 AM acknowledged the resident's bed needed to be in the low position while the resident was in the bed. 3. Review of the closed medical record for resident #94 showed s/he was admitted to the facility on 12/28/12 with a history of "extensive thoracolumbosacral fusion surgery" and suffered from chronic back pain. Further, the resident was unable to maintain an erect posture for more than 30 seconds as this exacerbates her low back pain." Review of the 12/23/12 hospital admission note showed the resident complained of syncope (loss of consciousness) and falling. The following concerns were identified: a. Review of the Interdisciplinary Post Fall Review dated 12/30/12 timed 5:30 PM showed the resident fell and was found "lying on R [right] side on floor by bed, feet under bed." Predisposing diseases included "syncope and collapse." The 12/30/12 nurse's note timed at 6:30 PM revealed a bed alarm was placed and the resident was instructed to use the call light. b. Review of the medical record revealed the Nursing Admission Assessment form and the Initial Care Plan form were not completed. Interview with the DON on 2/22/13 at 10:35 AM confirmed the forms in the chart were not completed. The facility was unable to show any documentation the resident was provided	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 12 education at the time of admission regarding safety. c. Review of the falls management policy, revised August 2012, revealed the "facility will take a proactive approach for new residents admitted and will consider all residents to be at risk for falls until reviewed by IDT [Interdisciplinary Team]. A falls care plan will be initiated upon admission for each resident."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff and resident interviews, the facility failed to ensure residents were provided the nutritional support and services needed for 1 of 7 sample residents (#20). The findings were: Review of the medical record for resident #20 showed s/he was admitted to hospice on 1/22/13 with a terminal diagnosis of severe malnutrition. Review of the 1/21/13 quarterly MDS assessment for activities of daily living showed the resident	F 325	**F325** The facility will maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrations that this is not possible. Corrective Action Staff providing care for Resident #20 was counseled on the need to provide a therapeutic diet and to maintain acceptable parameters of nutritional status; unless Resident's clinical condition deteriorates preventing maintaining acceptable parameters. Identification of Others Residents identified with weight loss are at risk.	

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F 325	Continued From page 13 needed extensive assistance with bed mobility. Review of the hospice plan of care for musculoskeletal showed the resident was unable to lift his/her upper arm off the bed for more than 2-3 seconds due to physical deterioration. Review of the hospice plan of care for nutrition last reviewed on 2/6/13 showed the resident was to be assessed for food preferences and dietary wishes. Further, the resident was to receive small, frequent meals. Review of the facility's weight-loss/nutrition care plan last reviewed on 2/4/13 showed the resident had a potential for weight loss and was on a regular diet and food preferences were to be offered. The following concerns were identified: a. The care plan failed to show what his/her preferences were. Further, it showed snacks and fortified foods were to be offered and assistance with meals provided as needed. b. An observation on 2/20/13 at 6:35 PM showed the resident was lying in bed with his/her food tray sitting on the bedside table next to the bed. The head of the bed was elevated to less than 45 degrees. The food remained covered and the tray was above shoulder height. An interview with the resident at that time stated s/he was hungry and had not received assistance with the food tray. Further, the resident revealed s/he had lost weight. c. Review of the Vital Sign and Weight Flow Sheet showed the resident weighed 176 pounds on 1/9/13. Further review of the flow sheet showed the resident weighed 169 on 1/14/13 and 132.6 on 2/7/13, a weight loss of 22% in 24 days and 25% in 30 days. The Medical Nutrition Therapy Review dated 2/9/13 only showed the resident was on hospice and his/her weight	F 325	Systemic Changes An In-service on providing nutritional parameters and therapeutic diets will be conducted with nursing and dietary staff on or before date of compliance. The DON/Designee will conduct random visual audits weekly for 90 days to ensure nutritional parameters and therapeutic diets, and any other nutritional support services as needed, are followed. If staff non-compliance is observed, an immediate corrective in-service will be conducted to ensure compliance. Monitoring: The DON/Designee will review the results of nutritional audits will be shared with the QAPI Committee monthly X3 for input on the need to increase, decrease, or discontinue the audits.	04/08/2013

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F 325	Continued From page 14 continued to decline. There were no specific interventions recommended for the weight loss. d. Review of the hospice plan of care dated 2/6/13 for safety measures showed the resident was at risk for aspiration. The head of his/her bed was supposed to be elevated for eating and drinking. The facility's nutrition/weight loss care plan did not show the resident needed to be sitting up for meals and snacks due to the risk of aspiration. The care plan only stated the head of the bed was supposed to be elevated for meals but did not indicate the degree of elevation or state the reason. e. Interview with the dietician on 2/22/13 at 11:50 AM revealed he did not implement any weight loss measures because the resident was on hospice. Further, there was no documentation to show the percentage of weight loss was unavoidable. f. Interview with the administrator on 2/22/13 at 10:05 AM, verified the resident needed to be assisted to a sitting position and the food tray placed in front of him/her.	F 325		