STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555114	A. BUILDING _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD HEALTHCARE CENTER	4109 EMERALD ST TORRANCE, CA 90503

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one complaint. Complaint Incident: CA00832731. Representing the Department: HFEN 42506. The inspection was limited to the specific complaint incident investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were issued for complaint number CA00832731. See Tag F686. and F692.	F 000	**Preparation, submission 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 this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.**	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) did not develop a pressure ulcer	F 686	**Treatment / Svcs to prevent / Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)** **Corrective action:** • Resident 1 no longer resides in the facility. • Weekly skin assessment was initiated upon admission on 4/8/22 till 6/28/22. • Change of condition initiated on 5/7/22 with orders for Low air loss mattress and wound consult.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/25/23

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.

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F 686	Continued From page 1 (damaged skin or underlying tissue caused by prolonged pressure over the body's bony prominences [any area on the body where the bone is directly under the skin]) and promote wound healing. The deficient practices included failure to: 1. Monitor and assess (evaluate) to prevent from acquiring pressure ulcer when Resident 1 stayed at the facility from 04/ 2022 to 06/2022. 2. Failed to implement interventions such as repositioning, a low air loss mattress (a bed with a specialized mattress that helps relieve pressure on the residents' skin) as per physician's order dated 5/7/2022, proper hydration (ensuring the body's needs for fluids are met) and proper nutrition for pressure ulcer prevention and/or healing as indicated in the care plan, to prevent Resident 1 from developing a pressure ulcer. These deficient practices resulted in Resident 1 acquiring a stage 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia [connective tissue beneath the skin], muscle, or bone) at the coccyx (tail bone) extending to left buttocks 12 centimeters (cm a unit of length) by (x) 12 cm. Findings: During a record review of Resident 1's admission record (face sheet) , the face sheet indicated Resident 1 was admitted to the facility on 04/08/2022, with diagnoses includinghemiplegia (total or partial paralysis [inability to move] of one side of the body), dysphagia (difficulty swallowing), diabetes mellitus (dm- a condition where the body can not properly process sugar	F 686	• Resident 1 was seen by Wound specialist on 5/9/22. • Blood Works was ordered on 4/9/22. • Resident 1 was seen and evaluated by Registered Dietician on 4/14/22 with supplements to address resident condition. RD had follow up recommendation 5/19/22. • Resident 1 was seen and evaluated by speech therapy on 4/13/22 with a diet change of Pureed textured nectar thick consistency. Resident 1 with orders for 1:1 assistance at all meals on 4/14/22. • IDT notes on 4/8/22 stated that Resident 1 preferred to be in his back. **How to identify potentially affected other:** • On 5/18/23 Medical Records conducted an audit of current residents with pressure injury for completion of weekly skin assessment. No other resident	

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F 686	Continued From page 2 for energy). During a record review of the Minimum Data Set [(MDS) - a standardized assessment and care planning tool] dated 04/15/2022, MDS indicated Resident 1 was cognitively (process of acquiring knowledge and understanding through thought, experience, and the senses) intact for daily decision making and needed extensive one-to-two person physical assistancefor bed mobility (moving from one bed position to another), transfers (from one surface to another), eating, getting dressed, personal hygiene, and toilet use. The MDS indicated Resident 1 was always incontinent (lack of control over urination or bowel movements) of both bladder and bowel and it was managed with a toileting program (the identification of an incontinent person's natural voiding pattern and the development of an individualized toileting schedule, which pre-empts involuntary bladder and bowl movements). The MDS indicated Resident 1 was at risk for developing a pressure ulcer and had no pressure ulcer at the time of admission to the facility on 4/08/2022. According to the MDS Resident 1 was admitted with a burn injury to the skin for which interventions included nutrition or hydration to manage skin problems. During a record review of Resident 1's admission assessment record titled "Braden Scale for Predicting Pressure Sore Risk Original " (a tool used by a healthcare professional to assess the risk of developing a pressure ulcer) dated 04/8/2022, the record indicated Resident 1 had a score of 12 indicating a high risk for developing pressure ulcers. During a record review of Resident 1's medical	F 686	was found affected with the same deficient practice. • On 5/18/23 Medical Records conducted audit in Activity of Daily living charting which includes : weight loss , nutritional intake , skin assessment , turning and repositioning for Resident with skin issues and incontinent. No other resident was found affected with the same deficient practice. **Measures/Systemic change:** • License Nurses were given In Service and Re-education by Director of Nursing regarding Types of Pressure Injury, Prevention , Management and Post test with emphasis on documentation On 4/26/23 , 4/27/23 , 5/20/23 and 5/21/23. • License Nurses was given In service by Director of Nursing regarding documentation which include : skin assessment , pressure injury management and prevention nutritional intake , Change of condition , weight loss and gain on 5/17/23	

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F 686	Continued From page 3 record titled "COMS- Skin only evaluation " dated 04/8/2022, at 5:31 p.m., the evaluation indicated Resident 1's skin check was performed, and the following skin injuries/wound(s) were identified: 1. The second- and third-degree burns (second degree: upper and inner layer of skin damaged by heat and third degree: damage to both layers of skin and damage to bones, muscles, and tendons) to a left hip measured 7.0 cm in length and 4.0 cm in width with 0.1 cm in depth and to a left hand fifth finger (pinky) and diffused ([spread] in length) burn to the middle finger. 2. Swollen (typically a result of an accumulation of fluid) left arm. During a record review of Resident1's medical record titled "COMS- Skin only evaluation " dated 4/11/2022, at 10:55 a.m., the evaluation indicated a skin check was performed and the following skin injuries/wound(s) were identified. 1. Left fourth finger skin burn measured 1.5cm in length, 2.5 cm in width and 0.1 cm in depth with serous (a clear to pale yellow watery fluid that is found in the body especially in the spaces between organs and the membranes which line or enclose them) drainage. 2. Peri wound in fragile condition. 3. Skin burn on left hip measured 3.5 cm in length, 2.1 cm inwidth and 0.1 cm in depth (second- or third-degree burn- second-degree burns involve the epidermis (outer layer of the skin) and the part of the lower layer of skin, the dermis (middle layer of the skin), third degree is full thickness of the skin)	F 686	• DON and Designee in-service all Certified Nurse Assistant regarding management , prevention of skin breakdown and documentation with emphasis on turning , repositioning , percentage of dietary intake and activity of daily living on 5/17/23, 5/20/23 and 5/24/23. • Director of Nursing In-Serviced Medical Records and Designee regarding documentation with emphasis on PCC charting that includes : skin assessment , weight loss , Change of condition , nutritional intake , positioning for incontinence and skin injury audit on 5/23/23. • The Licensed Nurses will document the status of resident's skin condition including effectiveness of current medications for skin integrity problem in the skin / wound progress notes form weekly.	

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F 686	Continued From page 4 4. Right shin scab. During a record review of Resident 1's medical record titled "COMS- Skin only evaluation " dated 04/25/2022, at 11:00 a.m., the evaluation indicated a skin check was performed and indicated the resident remained to be at risk for skin breakdown related to limited mobility, incontinence of bowel and bladder, pain, and fragile skin. During a record review of Resident1's medical record titled "change of condition evaluation " [(COC)- internal document to communicate sudden changes in a resident's condition]" dated 05/07/2022, at 18:01 p.m., (twenty-nine days after initial assessment) the COC indicated the presence of suspected deep tissue injury [(SDTI- intact or non-intact skin with deep red, maroon, purple discoloration, or blood-filled blister. This injury results from intense and/or prolonged pressure] at the coccyx extending to the left buttocks and was measured 12 cm x 12 cm. The COC further indicated that Resident 1 remains at risk for skin pressure ulcer development related to (r/t) impaired mobility, compression fracture, chronic pain, fragile skin, non-compliant with repositioning and obesity. During a record review Resident's 1 medical record titled "COMS- Skin only evaluation " dated 05/16/2022, at 1:46 p.m., (thirty-nine days since admission and 3 days after the last evaluation) the evaluation indicated Resident 1 had a Stage III (full-thickness skin loss in which fat tissue is visible) pressure ulcer to the left buttock, measured 3.0 cm in length 5.0 cm in width with an undetermined depth. The COMS evaluation	F 686	**Monitoring:** • **Medical Records Designee will audit the PCC , daily shower log , weekly weights for charting and documentation for completion weekly. Findings will be discussed in daily clinical meeting for necessary action.** • DON will review the Skin progress report , weekly weights and documentation weekly for accuracy any negative trends will be discussed and reported in the monthly QA & A meeting for further intervention and compliance.	

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F 686	Continued From page 5 also indicated Resident 1 had a Stage I (intact skin with a localized area of redness) pressure ulcer to the coccyx measured 5.0 cm in length and 5.0 cm in width. During a record review of Resident 1's medical record titled "COMS- Skin only evaluation " dated 6/6/2022 at 1:04 p.m., (sixty days since admission assessment) the evaluation indicated the following skin injuries/wound(s) were identified. 1. Left buttock unstageable (a full thickness skin and tissue loss in which the extent cannot be confirmed because the ulcer is obscured by slough [a layer of dead tissue] or eschar [hardened tissue that is brown or black in color]) pressure ulcer measured 2.5 cm in length x 6 cm in width and unable to determinedepth. 2. A Stage I pressure ulcer to the coccyx with 2.0 cm in length x 2.0 cm in width. During a record review of Resident's 1 medical record titled "COMS- Skin only evaluation " dated 6/21/2022 at 4:05 p.m., the evaluation indicated Resident 1 had a Stage IV pressure ulcer to a left buttock that measured 2.0 cm in length x 5.0 cm in width with 0.1 cm in depth and a Stage I pressure ulcer on coccyx 2.0 cm in length 2.0 by 2.0 cm in width. During a record review of Resident1's Certified Nurse assistant (CNA)'s (flow sheet documentation of ADL's the CNA assisted Resident 1 with) titled "Documentation Survey Report " for 4/2022 for bed mobility, transfer, eating, drinking and meal percentage (amount eaten by resident at each meal) of food, indicated there was no documentation for 11 of the 22 days	F 686	**Nutrition / Hydration Status Maintenance CFR(s) : 483.25 (g) (1)-(3)** **Corrective action:** • Resident 1 no longer resides in the facility. • IDT Weight Variance documented for 5/12/22 , 5/19/22 and 6/9/22. Care plan was initiated on 4/13/22 by dietary supervisor. • Upon admission on 4/8/22 , resident 1 was on mechanically altered therapeutic diet as ordered. • Resident 1 was seen and evaluated by speech therapy on 4/13/22 with a diet change of Pureed textured nectar thick consistency. Resident 1 with orders for 1:1 assistance at all meals on 4/14/22. • Resident 1 diet was upgraded to NAS CCHO Mechanically soft Regular / Thin consistency on 4/28/22. **How to identify potentially affected other:** • Medical Records designee audited current resident in the facility from 5/1/23 till 5/17/23 for significant weight loss of 5% or	

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F 686	Continued From page 6 Resident 1 had been in the facility. The dates are as follow: 04/15/2022, 04/16/2022, 04/18/2022, 04/19/2022, 04/20/2022, 04/21/2022, 04/23/2022,04/25/2022,04/29/2022,04/30/2022. During an interview with certified nursing assistant (CNA 1) on 4/6/2023 at 2:45 p.m., CNA 1 stated for total-care-residents, including Resident 1, who are not able to perform activities of daily living (ADL's) by themselves, the facility staff does all the work for them including repositioning. CNA1 stated sometimes two staff needed to assist to reposition a resident. CNA 1 stated that CNAs make sure the residents are kept clean and dry, and repositioned (when they are lying in bed) every two hours to prevent the residents from developing a pressure ulcer. CNA 1 stated that if a resident is a high risk for skin breakdown, "we must reposition the resident every two hours. " During an interview on 4/14/2023 at 2.p.m. with the Director of Staff Development (DSD), the DSD stated that CNAs were responsible and trained to document on the flow sheet every time the ADL task was completed. If the CNA did not document on the flow sheet that means the task was not done during their shift. The licensed nurses oversee the CNAs, so they need to make rounds and double check if the task was done for the day. DSD further stated that a pressure ulcer is avoidable if the CNA turns and repositions a total care (totally dependent) residents, especially those that are incontinent of both bowel and bladder because when urine or fecal material is held against the skin, the damp, acidic nature of the wastes causes the skin to become weakened	F 686	above. No other residents were identified to be affected by this practice. **Measures/Systemic change:** • Medical Records designee audited PCC compliance on 5/18/23 on emphasis on skin assessment , weight loss of 5% or more , meal intake , turning and repositioning on resident with incontinent care and with pressure injury. • License Nurses was given In service by Director of Nursing regarding documentation which include : skin assessment , nutritional intake , Change of condition , weight loss and gain on 5/17/23. • DON and Designee in-service all Certified Nurse Assistant regarding management , prevention of skin breakdown and documentation with emphasis on turning , repositioning , percentage of dietary intake and activity of daily living on 5/17/23 , 5/20/23 and 5/24/23. • Director of Nursing In-Serviced Medical Records and Designee regarding documentation with emphasis on PCC charting that includes : skin assessment , weight loss , Change of condition ,	

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F 686	Continued From page 7 and susceptible to cracking and peeling. DSD further stated that during scheduled shower days CNAs are responsible for checking the skin by observing the resident's skin for any new changes in skin such as redness, rash, skin tear, laceration, etcetera (etc.). The skin check form is then reviewed by either the treatment nurse or the charge nurse in case of any skin changes that needed to be addressed. DSD also stated direct care staff in collaboration with Licensed Vocational Nurse (LVN)'s and CNAs, and dietary staff ensure that residents are getting proper nutrition, treatment, and to prevent Residents from developing or worsening of pressure ulcers. During a record review of Resident 1's interdisciplinary team [(IDT) a coordinated group of experts from several different fields who work together toward a common resident goal) progress notes dated 6/23/2022, IDT progress notes indicated Resident 1 remained to be at risk for skin breakdown related to comorbidities (the condition of having two or more diseases at the same time) and that Resident 1 preferred to lay on his back most of the time. IDT recommendations included repositioning Resident 1 every two hours and as needed, instruct resident to call for assistance for adult brief change in a timely manner. During a review of Resident 1's care plan (C/P) titled "Resident has deep tissue pressure injury (DTPI) at coccyx area extending to left buttock " , initiated on 5/7/2022, the C/P indicated a goal for Resident 1 was to have intact skin, free of redness, blisters, or discoloration by revision date 5/9/2022 and 7/12/2022. The C/P interventions included for facility nursing staff to follow policies and protocol for the prevention and treatment of	F 686	nutritional intake , positioning for incontinence and skin injury audit on 5/23/23. **Monitoring:** • **Medical Records Designee will audit the PCC , daily shower log , weekly weights for charting and documentation for completion weekly. Findings will be discussed in daily clinical meeting for necessary action.** • DON will review the Skin progress report , weekly weights and documentation weekly for accuracy any negative trends will be discussed and reported in the monthly QA & A meeting for further intervention and compliance. Completion Date : 5/25/23	

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F 686	Continued From page 8 skin breakdown. If the resident refuses treatment, confer with the resident, IDT, and family to determine why and try alternative methods to gain compliance, document alternate methods applied, monitor nutritional status, and monitor intake and record. The resident needs extensive assistance to turn/ reposition at least every two hours, more often as needed or requested (documented by facility staff on the ADL flowsheet). During an interview with LVN 2 on 4/6/2023 at 3:15 pm., LVN 2 stated it was important to prevent pressure ulcers because it decreased the quality of life of the residents. Staff should assist residents, who are unable to turn, to change position while in bed every two hours. During a concurrent interview and record review with the Director of Nursing (DON) on 4/6/2023 at 3:50 p.m., the DON stated Resident 1 was admitted to the facility on 4/8/2023 with clear, intact skin. DON stated Resident 1 did not have any pressure ulcers at the time of admission and on discharge had a Stage IV pressure ulcer. During an interview with Registered Nurse (RN 1) on 4/14/2023 at 1:27 pm., RN 1 stated, "we need to check frequently on incontinent residents to make sure they do not stay wet or soiled for a long time, and reposition them every two hours, and keep them dry and clean, and observe skin condition changes. " RN1 stated CNA's documentation on the flow sheet, indicate the necessary care was provided. RN 1 stated that when there is no documentation on the flow sheet, that means those tasks were not performed.	F 686		

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F 686	Continued From page 9 During an interview with LVN 3 on 4/14/2023 at 1:35 pm., LVN 3 stated causes of pressure ulcers includedpoor nutritional intake, infrequent or lack of repositioning and lack of good peri/incontinence care. These tasks should be done and documented under ADL care flowsheet. The documentation is important because if it is not documented it was not done. During the review of the facility's policy and procedure (P/P) titled "Pressure Injury Prevention," revised September 1, 2020, the P/P indicated, the purpose was to provide interventions for Residents identified as high risk for developing pressure injuries. The nursing staff will implement interventions identified in care plan which include repositioning and turning, monitoring food and fluid intake. Nursing staff will observe for any signs of potential or active pressure injury daily while providing care. Preventive interventions may be documented on ADL flow sheets ... or ADL documentation records.	F 686		
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	F 692		

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F 692	Continued From page 10 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 interview and record review, the facility failed to prevent significant weight loss as per the resident's plan of care (CP summery of a resident's health conditions, specific care needs and current treatments and projected health goals) and the facility's policy and procedure (P&P) for one of three sampled residents (Resident 1) by failing to: a. Assist Resident 1 with every meal as specified in his care plan. b. Ensure a resident centered care plan was updated and implemented to address Resident 1's significant weight loss of 30 pounds (lbs. a measure unit of weight) within three months (April 2022 - June 2022) c. Maintain an acceptable parameter of nutritional status through consistently monitoring intake, evaluation of weight and diet as per policy and procedure. As a result, Resident 1 had insidious (gradual unintended weight loss over time), and unplanned weight loss leading to a severe weight loss of 14.6% in three months (April 2022 through June 2022) due to lack of continuous monitoring and	F 692		

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interventions.

Findings:

During a record review of Resident 1's admission record (face sheet), the face sheet indicated Resident 1 was admitted to the facility on 04/8/2022, with diagnoses that included hemiplegia (total or partial paralysis [inability to move] of one side of the body), dysphagia (difficulty swallowing), diabetes mellitus (dm- a condition where the body can not properly process sugar for energy).

During a record review of the Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 04/15/2022, MDS indicated Resident 1 was cognitively intact (process of acquiring knowledge and understanding through thought, experience, and the senses) in daily decision making and needed extensive one to two person assistance with bed mobility (moving from one bed position to another), transfer (from one surface to another), eating, getting dressed, personal hygiene, and toilet use. The MDS indicated Resident 1 was always incontinent (lack of control over urination or bowel movements) of both bladder and bowel and was managed with a toileting program (the identification of an incontinent person's natural voiding pattern and the development of an individualized toileting schedule, which pre-empts involuntary bladder and bowl movements). According to the MDS Resident 1 was admitted with a burn injury on the skin for which interventions included nutrition or hydration to manage skin problems.

Further review of the MDS dated 4/15/2023 indicted Resident 1 had a therapeutic (a meal

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plan that controls the intake of certain foods or nutrients as part of treatment of a disease) diet and required pureed (food consistency does not need chewing) texture of food and thickened (thicker consistency liquids that makes it less likely that individuals with dysphagia would choke while they are drinking) liquids.

During a review of Resident 1's medical record, a document titled, "Nutritional Risk Assessment " dated 4/14/2022 at 2:20 pm, the assessment indicated Resident 1 had had a 5.9% weight loss (Resident lost 13 lbs. in one month during his stay at the facility he was transferred from) a score of 185.8 which indicated Resident 1 was a high risk for weight loss. The nutritional intervention measures included supplements (items added to a diet to enhance nutritional value), bedtime snacks and 1:1 assistance with all meals.

During a record review of the weights summary for the month of April- June 2022, the summary indicated that Resident 1's weight was as follows:

a. 4/9/2022- 205 pounds(lbs.)

b. 5/5/2022-197 pounds (3.9% weight loss from 4/9/2022)

c. 5/26/2022-189 pounds (7.8% significant weight loss from 4/9/2022)

d. 6/4/2022-184 pounds

e. 6/9/2022-183 pounds (10.7 % significant weight loss from 4/9/2022 significant weight loss)

f. 6/25/2022-178 pounds (13.2% significant

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F 692	Continued From page 13 weight loss, 27 lbs. difference from 4/9/2022) g. 6/30/2022-175 pounds (14.6% significant weight loss, 30 pounds difference from 4/9/2022) During a record review of Resident's 1 care plan titled "Nutritional Status related to (R/T) medical condition " dated 5/12/2022, the care plan indicated Resident 1 with recent weight loss of 8.0 lbs. in 30 days R/T poor oral intake. Resident 1's CP interventions included to determine Resident 1's ability to chew and swallow. Educate Resident 1 regarding nutritional needs and requirements. During a record review of Resident 1's care plan titled "Resident has weight loss of 14 lbs. in 1 month," initiated on 06/09/2022, the care plan indicated a goal that Resident 1 would not have significant weight loss of 5% or more per month. The care plan interventions indicated for facility staff to monitor and record food intake at each meal, observe and report signs and symptoms (S/S) of altered fluid status. During a record review of Resident's 1 Certified Nurse assistant (CNA) flow sheet titled "documentation Survey Report " for 04/2022 for eating, drinking and meal percentage of food there was no documentation of the percentage of meals eaten by Resident 1, for the dates of 4/11/2022-4/21/2022 and 4/25/2022 thru 4/31/2022. During a record review of Resident's 1 Certified Nurse assistant (CNA) flow sheet titled "Documentation Survey Report " for 05/2022, for bed mobility, transfer, eating, drinking and meal percentage of food eaten, there was no	F 692		

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F 692	Continued From page 14 documentation of the percentage of meals eaten by Resident 1, noted for the following dates. a. 5/7/2022, 5/8/2022, 5/10/2022, 5/11/2022, 5/13/2022, 5/22/2022-5/24/2022, 5/26/2022-5/28/2022, 5/30/2022 and 5/31/2022. During a record review of Resident's 1 Certified Nurse assistant (CNA) flow sheet titled "Documentation Survey Report " for 6/2022, for bed mobility, transfer, eating, drinking and meal percentage of food there was no documentation noted for the following dates. A. No documentation of Resident 1 eating on the ADL flowsheet on 6/1/2022 for breakfast, lunch, and dinner and 6/4/2022 thru 6/6/2022 dinner was not documented, B. No documentation on 6/7/2022 for breakfast and lunch. C. No documentation on 6/8/2022 for breakfast, lunch, and dinner. D. No documentation 6/10/2022 thru 6/12/2022, 6/14/2022, 6/16/2022, 6/21/2022, 6/24/2022 thru 6/26/2022, 6/28/2022 and 6/30/2022 for breakfast and lunch. During a record review of Physician's Order (PO's) summary dated 4/14/2022, the PO's indicated to provide Resident 1 with 1:1 assistance at all times with meals. During a record review of PO's summary dated 4/28/2022 at 2:25 p.m., the PO's diet order indicated no added salt (NAS), and Controlled carbohydrate (CCHO a meal plan prescribed for	F 692		

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patients with diabetes mellitus) diet, Mechanical soft (food consistency for people that have problems chewing and swallowing) texture, regular / thin consistency liquids, related to dysphagia, oropharyngeal (swallowing problems occurring in the mouth and/or the throat) phase.

During a record review of the speech therapist's (therapists that work to prevent, assess, diagnose, and treat speech, cognitive-communication, and swallowing issues) progress report titled "date of service from 4/13/2022 to 4/19/2022- dysphagia therapy " , the progress report indicated that on 4/19/2022 Resident 1 had moderate-severe dysphagia and diet consisted of Pureed Nectar Thick Liquid (NTL - fluids that are thicker than water, fall slowly from a spoon, and are sipped through a straw or from a cup to make swallowing easier).

During a record review of Resident's 1 Certified Nurse assistant (CNA) flow sheet (documentation of ADL's the CNA assisted Resident 1 with) titled "documentation Survey Report " for 4/2022 for meal percentage of food (amount eaten by resident at each meal), indicated no documentation for 10 of the 22 days. The dates are as follows:

a. 04/15/2022, 04/16/2022, 0 4/18/2022, 04/19/2022, 04/20/2022, 04/21/2022, 04/23/2022, 04/25/2022, 04/29/2022, 04/30/2022.

During an interview with Licensed Vocational Nurse (LVN) 3 on 4/14/2023 at 1:35 pm., LVN 3 stated documentation was important because if a task was not documented as having been done, then it didn't happen. LVN 3 stated the records of care given to Resident 1 for example in

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April/20223, did not indicate Resident 1 received assistance with his meals, and how much he ate, because nothing was documented for 10 of 22 days in April 2022.

During a record review of Resident 1's interdisciplinary team (IDT- a coordinated group of experts from different fields who work together toward a common resident goal) IDT progress notes - weight variance (weight gain or loss) and nutritional condition, dated 5/17/2022 at 17:33 p.m., the notes indicated "of note patient has episode of less than 50% intake that contribute to weight loss " .

During an interview with the director of dietary services (DDS) on 4/19/2023 at 9:53 a.m., the DDS stated Resident 1 was on high protein (nutritional suplement that performs most of the work within the human body including rebuilding of the body's tissues and organs) diet with supplements for weight loss and pressure ulcer (damaged skin or underlying tissue caused by prolonged pressure over the body's bony prominences [any area on the body where the bone is directly under the skin]) healing. DDS stated he recommended assistance with all meals as Resident 1 had verbalized that he could not see, Resident 1 wore glasses at that time. DDS stated from 5/19/2022 to 6/9/2022 per Dietary consultant resident had lost 14 pounds, 7.11% which is considered a significant weight loss. DDS stated CNAs go around, give supplements, and document the resident's intake, if the food was consumed or not. DDS stated, in general, if not documented, I would assume it was not done.

During a record review of the Registered Dietician

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(a specialty that ensures residents receive food that's appropriate for them, whatever special needs or restrictions they may have) notes (RDN) for Resident 1's weight and skin check dated 6/9/2022, the RDN indicated weight 183 lbs. down 7.1% x 1-month, significant weight loss possibly related to pressure injuries. RD suggested pro heal (a medical food developed for the dietary management of wounds and conditions requiring supplemental protein) sugar free twice a day and discontinued assistance with meals, check HgbA1c.

During an interview with Registered Nurse (RN) on 4/14/2023 at 1:27 pm., RN stated that in the ADL flow sheet, we can verify care is provided when we look at the ADL flow sheet for toilet use, eating and skin observations. When there is no documentation in the flow sheet, that means the activity of daily living was not performed, RN stated it was important to ensure residents are consuming adequate nutrition and documenting how much they ate and drank, this helps to plan the care accordingly.

During a concurrent interview and record review with the Director of Nursing (DON) on 4/6/2023 at 3:50 p.m., DON stated Resident 1 was admitted to the facility on 4/8/2023, with an initial weight of 205 pounds and on 6/20/2023 his weight was 175 pounds. Resident 1 lost 30 pounds in 3 months which is a significant weight loss. DON stated IDT and care plan was initiated but if the interventions did not work and Resident 1 was still losing weight, we need to make sure that CNAs are assisting the resident with meals properly. DON further stated that documentation is important, and during IDT meeting we should have reviewed all care areas to properly address the concern of

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F 692	Continued From page 18 weight loss. During a record review of an undated Certified Nursing assistant (CNA) job description, the description indicated general duties and responsibilities included assist in preparing residents for meals, serve nourishment in accordance with established facility procedures, feed residents who cannot feed themselves and chart required information every shift. During a review of the facility's policy and procedure (P&P) dated 04/2022 titled " evaluation of weight and Nutritional Status " avoidable the resident did not maintain acceptable parameters of nutritional status and that the facility did not do one or more of the following, evaluate the resident's clinical condition and nutritional risk factors, define and implement interventions that are consistent with resident needs, residents goals and recognized standards of practice, monitor and evaluate the impact of interventions or revise the interventions as appropriate.	F 692		