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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056124	A. BUILDING ______ B. WING ______	C 10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARZANA HEALTH AND REHABILITATION CENTER	5650 RESEDA BLVD TARZANA, CA 91356

(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 reflects the findings of the California Department of Public Health during an investigation of a complaint. Complaint Number: CA00691552 Representing the California Department of Public Health: Health Facilities Evaluator Nurse: 42508 The inspection was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Three deficiencies were issued for complaint number: CA00691552	F 000	***(Revised 11/17/20)*** **Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/ or executed because it is required by the provision of Health and Safety code section 1250 and 44 C.F.R. 405.1907.**	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580	"This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted" **PLAN OF CORRECTION** **F580** **Notify of Changes Injury/Decline / Room, etc)** **CFR(s): 483.10(g)(14)(i)-(v)(15)** **Corrective action for the resident affected by the deficient practice:** 1. Resident 1 No longer is at Tarzana Healthcare. 2. An in-service regarding facility's policy and procedure titled "Changes	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/17/2020

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 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of a change of condition as evidenced by: -Resident 1 had multiple days of low fluid intake, from 6/4/2020 to 6/7/2020, for one of three sampled residents (Resident 1).	F 580	in Residents Condition" was conducted by the DSD on October 23, 2020 to the Licensed Nurses. **Identification of residents having the potential to be affected by the deficient practice and corrective action taken:** The facility has identified 54 out of 116 residents, however all residents of the facility have the potential to be affected. Residents who in the last 30 days trigger for eating less than 50% for 2 meals in a day will be reviewed for accuracy in coding and potential change of condition related to poor meal and fluid intake. On 10/30/20, an audit was conducted by Unit manager to validate information in the PCC dashboard and if SBAR was done if determined information is validated and if there has been a change of condition that warrants intervention not already addressed. They will see that appropriate individuals are notified including the resident, resident's responsible party, resident's physician and other discipline as needed. Also if	

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F 580	Continued From page 2 This failure has the potential for Resident 1 to have a change of condition which may lead to acute care hospitalization for dehydration and altered nutrition. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted the resident on 12/16/2019, with diagnoses including diabetes mellitus (a condition that affects how the body processes blood sugar causing high levels of sugar in the blood) and hyperlipidemia (increased blood cholesterol levels). A review of Resident 1's Nutrition Registered Dietician Assessment, dated 12/16/2019, signed by the RD indicated Resident 1's daily fluid requirement ranged from 1400 to1680 milliliters (ml- unit of measurement) per day. A review of Resident 1's Meal Consumption Report indicated the resident's measured fluid intake during the month of 5/2020 Resident 1's fluid intake ranged from 700 to 850 milliliters per day (ml/day). On 6/4 Resident 1's total intake of fluids was 200 ml in 24 hours; on 6/5 the total was 860 ml, on 6/6 the total was 410 ml and on 6/7/2020, Resident 1 received a total of 180 ml/day. Resident 1 was consuming less than the assessed daily fluid needs (1400 to1680 ml). On 7/31/2020, at 4:40 p.m.., during an interview and concurrent record review, the Director of Nursing (DON) confirmed the fluid intake of Resident 1 from 6/4 - 6/7/2020 was low. The DON stated the licensed nurse should have documented a change of condition and notified	F 580	validated, resident's care plan will be reviewed and updated as needed. **Systemic changes to ensure the deficient practice does not recur:** On 10/12/20, 10/13/20 & 10/23/20, an inservice was conducted by the DSD (Director of Staff Development) or designee to the CNA's on monitoring and accurately reporting residents' meal and fluid intake and importance of observing for potential change of condition which would affect the residents ability to eat or drink and report this as needed to the resident's licensed nurse. Licensed nurses were in serviced by the DSD or designee on 10/12/20, 10/13/20 & 10/23/20 on monitoring of residents for change of condition during their shift and reporting to resident physician, resident's, responsible party and other disciplines as needed. If validated need for resident's care plan to be updated to reflect change and interventions being taken. CNA's will chart residents meal and fluid intake during their shift and report any resident who does not	

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F 580	Continued From page 3 the physician and the RD. The DON did not find documentation the licensed nurses monitored Resident 1 for signs and symptoms of dehydration The DON confirmed there was no documentation the physician was made aware of Resident 1's low fluid intake. On 8/5/2020, at 2:29 p.m., during an interview, Resident 1's attending physician (Physician 1)) stated the licensed nurses did not notify him about Resident 1's low fluid intake, and deterioration in condition before Resident 1's emergency transfer on 6/7/2020. Physician 1 further stated since he was not aware, he did not order intravenous fluid for hydration. On 8/5/2020, at 3:19 p.m., during an interview, CNA 1 stated she was assigned to the COVID-19 (Coronavirus-Infectious disease) designated unit and cared for Resident 1 from 6/4 to 6/7/2020 during the 7 a.m. to 7 p.m. shift. CNA 1 stated she assisted with feeding Resident 1 with her meals and fluids and documented Resident 1's food and fluid intake in the Meal Consumption Report and notified LVNs 1 and 2 about Resident 1's low food and fluid intake. A review of the facility's policy on Changes in Resident Condition, revised on 2/2017, indicated nursing staff, the resident, the attending physician, and the resident's legal representative are notified when changes in the resident's condition occur. A significant change in the resident's physical, mental, or psychosocial status, including a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications; or a need to alter treatment significantly.	F 580	consume at least 50% of their meal to the licensed staff. Also report any change of condition which would affect the residents' ability to eat or drink and to the resident's licensed nurse. Licensed nurses will monitor residents for change of condition during their shift and report to resident physician, resident's, responsible party and other disciplines as needed. Any issue or concern not readily resolved will be reported to the unit manager / supervisor for review and if they are unable to resolve then they will report to the Director of Nursing for resolution. Unit managers will review Monday to Friday the POC documentation in PCC and SBAR's done to validate appropriate interventions and follow up has occurred. Also, review residents who have triggered for eating <50% of meal x 2 in a day to validate appropriate interventions and follow up has occurred. Any issue or concern not readily resolved will be forwarded to the Director of Nursing for resolution.	

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F 656 F 656 SS=D	Continued From page 4 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656 F 656	**Measures that will be implemented to monitor for the continued effectiveness of the corrective action taken to see that this deficiency has been corrected and will not recur** Medical Records will audit PCC at least weekly x 4 week then bi-weekly times 3 months for residents who have been reported to have eaten 50% or less for 2 or more meals in the day. 1. Check to see if this was validated by a unit manager with a progress note to indicate action needed or not. 2. If validated was a change of condition identified. 3. If so, was an SBAR completed with parties being notified. 4. Where new orders received 5. Were orders carried out. Report to be given to Director of Nursing for follow up as needed. Findings will be reviewed during QAPI meeting for further discussion and needed action by the Director of Nursing x 3 months. QAPI committee will meet monthly and review progress and make changes as deemed necessary.	

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F 656	Continued From page 5 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a care plan for dehydration, for one of three sampled residents (Resident 1). This failure has the potential for Resident 1 not to meet sufficient oral intake needs which subsequently may lead to dehydration. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted the resident on 12/15/2019, with diagnoses including diabetes mellitus (a condition that affects how the body processes blood sugar causing high levels of sugar in the blood) and hyperlipidemia (increased blood cholesterol levels). A review of Resident 1's Nutrition Registered Dietician Assessment, dated 12/15/2019, signed by the RD indicated Resident 1's daily fluid requirement ranged from 1400 to1680 milliliters (ml- unit of measurement) per day. A review of Resident 1's Care Plan initiated on 12/15/2019 for the resident's risk for altered nutrition related to diagnoses and need for a therapeutic diet, indicated in the goals the resident would maintain consistent food intake of 50-75% and adequate body weight. The interventions included providing therapeutic diet as ordered, honoring dietary preferences, encouraging oral intake, and referring to RD as	F 656	**Completion Date** THRC will correct this deficiency no later than 11/6/20. **F656** **Develop/Implement Comprehensive Care Plan** **CFR(s): 483.21(b)(1)** **Corrective action for the resident affected by the deficient practice:** 1. Resident 1 No longer is at Tarzana Healthcare. 2.. On 10/29/20, Lead RD for HSG conducted an in-service to the RD on review of each new resident and then review residents at least quarterly and as needed. Based on his/her review will initiate a care plan which will address interventions based on review. **Identification of residents having the potential to be affected by the deficient practice and corrective action taken:** The facility has identified 54 out of 116 residents, however all residents of the facility have the potential to not	

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F 656	Continued From page 6 needed. A review of Resident 1's Care Plan initiated on 12/22/2020 for the resident's deficit with ADL (activities of daily living) self-care performance deficit related to physical limitations, activity intolerance, limited mobility secondary to aging process, indicated the resident required assistance to eat. A review of Resident 1's Meal Consumption Report indicated the resident's measured fluid intake during the month of 5/2020 Resident 1's fluid intake ranged from 700 to 850 milliliters per day (ml/day). On 6/4 Resident 1's total intake of fluids was 200 ml in 24 hours; on 6/5 the total was 860 ml, on 6/6 the total was 410 ml and on 6/7/2020, Resident 1 received a total of 180 ml/day. Resident 1 was consuming less than the assessed daily fluid needs (1400 to1680 ml). There was no documentation Resident 1 was monitored for signs and symptoms of dehydration. On 7/31/2020, at 1 p.m.., during an interview and concurrent record review, Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she did not update the nutritional care plan to attempt new interventions, did not notify the physician or the RD. LVN 1 stated there was no documented evidence of a care plan for dehydration risk. On 7/31/2020, at 4:40 p.m.., during an interview and concurrent record review, the Director of Nursing (DON) confirmed the fluid intake of Resident 1 from 6/4 - 6/7/2020 was low. The DON confirmed there was no documented care plan developed for Resident 1's dehydration risk. The DON stated the care plan should have been	F 656	have a care plan to address nutritional needs if resident deemed at risk. Residents will be review who trigger for: 1. Eating less than 50% for 2 meals in a day in the last 30 day. Residents will be reviewed for accuracy of documentation and review of care plan and if needed to include but not limited to interventions of a. Notify physician b. Referral to RD c. Monitoring for s/s of fluid deficit if appropriate. 2. Monthly weight loss of 5% in 30 days, 7 ½% in 90 or 10% in 180 days for care plan review to include but not limited to RD to be informed for evaluation and recommendation. Physician to be notified and follow recommendations. **Systemic changes to ensure the deficient practice does not recur:** RD were in serviced by Lead RD from HSG on 10/29/20 on review of each new resident and then review	

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F 656	Continued From page 7 developed on admission and interventions should have followed.	F 656	residents at least quarterly and as needed.	
F 692 SS=G	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 interview and record review, the facility failed to provide acceptable in quality or quantity nutrition (food for health and growth) to meet the recommended daily nutritional intake and prevent weight loss and dehydration for one of three sampled residents (Resident 1) by failing to: 1. Notify the physician of Resident 1's low fluid intake not meeting the assessed needs.	F 692	Based on his/her review will initiate a care plan which will address interventions based on review. Licensed nurses were in serviced by DSD or designee on 10/23/20 & 10/28/20 on monitoring of residents for possible change of condition during their shift in regards to residents eating less than 50% for 2 meals in a day. If change of condition is identified that involves concern with resident intake then review of care plan to see that it includes: a. Notify physician if change of condition has occurred which includes resident not meeting assessed intake needs. b. Referral to RD if change of condition has occurred which includes resident not meeting assessed intake needs. c. Monitoring for s/s of fluid deficit if appropriate. Unit managers will review residents who have triggered for eating 50% or less for 2 meals, every Monday to Friday. If change of condition is identified with a concern of lack of intake the care	

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F 692	Continued From page 8 2. Implement the plan of care on Nutrition by not referring Resident 1 to the RD for evaluation. 3. Refer Resident 1 to the Registered Dietitian (RD) for evaluation and recommendations when the resident sustained a weight loss of 10 pounds in six months and when the resident was not consuming the assessed fluid needed in a day. These deficient practices resulted in Resident 1 having a sudden change in condition, requiring transfer to General Acute Care Hospital 1 (GACH 1) on 6/7/2020 where she was diagnosed with of intravascular volume depletion (reduction in circulating volume in blood vessels), and hypernatremia (too much sodium in the blood related to dehydration). Resident 1 expired at GACH 1 two days later on 6/9/2020 due to acute renal failure (rapid loss of renal function due to damage to the kidneys). Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted the resident on 12/15/2019, with diagnoses including diabetes mellitus (a condition that affects how the body processes blood sugar causing high levels of sugar in the blood) and hyperlipidemia (increased blood cholesterol levels). A review of Resident 1's Nutrition Registered Dietician Assessment, dated 12/15/2019, signed by the RD indicated Resident 1's daily fluid requirement ranged from 1400 to1680 milliliters (ml- unit of measurement) per day. A review of Resident 1's Nutritional Data Collection form, dated 12/15/2019, electronically	F 692	plan will be reviewed to see that it includes a. Notify physician if change of condition has occurred which includes resident not meeting assessed intake needs. b. Referral to RD if change of condition has occurred which includes resident not meeting assessed intake needs c. Monitoring for s/s fluid deficit if appropriate. Unit managers or designee will review monthly weights every 1st Friday of the month and report to check that any resident with a significant weight loss of 5% in 30 days, 7 ½% in 90 days and/or 10% in 180 days has a care plan to notify the residents physician and referral to RD for evaluation and recommendations and that these interventions have been carried out. Any issue or concern will be reported to the Director of Nursing for resolution. **Measures that will be implemented to monitor for the continued effectiveness of the corrective action taken to see that this**	

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F 692	Continued From page 9 signed by the RD indicated Resident 1's usual body weight was 120 pounds. The record did not indicate the ideal body weight. A review of Resident 1's Care Plan initiated on 12/15/2019 for the resident's risk for altered nutrition related to diagnoses and need for a therapeutic diet, indicated in the goals the resident would maintain consistent food intake of 50-75% and adequate body weight. The interventions included providing therapeutic diet as ordered, honoring dietary preferences, encouraging oral intake, and referring to RD as needed. A review of Resident 1's Care Plan initiated on 12/22/2020 for the resident's deficit with ADL (activities of daily living) self-care performance deficit related to physical limitations, activity intolerance, limited mobility secondary to aging process, indicated the resident required assistance to eat. A review of Resident 1's Weights and Vitals Summary, indicated on 12/16/2019, Resident 1 weighed 123 pounds. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 12/22/2019, indicated Resident 1 weighed 123 pounds. A review of Resident 1's Care Plan initiated on 12/22/2019 for the resident's deficit with ADL (activities of daily living) self-care performance deficit related to physical limitations, activity intolerance, limited mobility secondary to aging process, indicated the resident required assistance to eat.	F 692	**deficiency has been corrected and will not recur** Medical Records will audit PCC at least weekly x 4 week then bi -weekly times 3 months for residents who have a change of condition in regards to resident eating 50% or less for 2 meals in a day and check that a care plan has interventions to: a. Notify physician if change of condition has occurred which includes resident not meeting assessed intake needs. b. Referral to RD if change of condition has occurred which includes resident not meeting assessed intake needs Medical records will audit monthly weight report x 3 months to report if residents with significant weight loss of of 5% in 30 days, 7 ½ in 90 days and 10% in 180 days have a care plan to notify physician and care plan for referral to RD. Report will be given to the Director of Nursing for review &follow up as needed. Findings will be reviewed during QAPI meeting for further discussion and needed action by the Director of Nursing x 3 months. QAPI will meet monthly and review progress and	

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F 692	Continued From page 10 A review of Resident 1's MDS, dated 3/22/2020, indicated the resident was able to understand and make decisions and did not have memory problems. Resident 1 required limited assistance with eating and extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident 1 weighed 119 pounds. A review of Resident 1's Nutrition Status Review record, dated 3/22/2020, indicated Resident 1 was re-evaluated by the RD on 3/22/2020 due to a weight loss of greater than 5% in 30 days, the most recent weight was 119 pounds. Resident 1 had a variable intake and recommended staff to encourage intake. A review of Resident 1's Weights and Vitals Summary, indicated on 6/1/2020, Resident 1 weighed 113 pounds, a weight loss of 10 pounds or 11% weight in six months. A review of Resident 1's Meal Consumption Report indicated the resident's measured fluid intake during the month of 5/2020 Resident 1's fluid intake ranged from 700 to 850 milliliters per day (ml/day). On 6/4 Resident 1's total intake of fluids was 200 ml in 24 hours; on 6/5 the total was 860 ml, on 6/6 the total was 410 ml and on 6/7/2020, Resident 1 received a total of 180 ml/day. Resident 1 was consuming less than the assessed daily fluid needs (1400 to1680 ml). There was no documentation Resident 1 was monitored for signs and symptoms of dehydration. A review of Resident 1's the Situation, Background, Assessment, Recommendation (SBAR) Communication Form and Progress	F 692	make changes as deemed necessary. **Completion Date** THRC will correct this deficiency no later than 11/6/20. **F692** **Nutrition/Hydration Status Maintenance** **CFR(s): 483.25(g)(1)-(3)** **Corrective action for the resident affected by the deficient practice:** 1. Resident 1 No longer is at Tarzana Healthcare 2. On 10/29/20, an audit was conducted by the Unit Manager and or designee to review residents who in the last 30 days trigger for eating less than 50% for 2 meals in a day, every Monday to Friday. If change of condition is identified with a concern of lack of intake will validate that d. Physician notification. e. Referral to RD. f. Monitoring for s/s fluid deficit if appropriate. g. Update of plan of care has occurred if needed. Validate data	

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F 692	Continued From page 11 Note, dated 6/7/2020, timed at 5:30 p.m., indicated Resident 1 had change of condition including altered level of consciousness (non-responsive as usual, difficult to arouse), tachycardia (increased heart rate), and desaturation (low oxygen in blood). The blood pressure was 77/53 millimeters of mercury (mmHg - normal below 120/80 mmHg and above 90/60 mmHg), the heart rate was 121 beats per minute (bpm - normal 60 to 100 bpm), the oxygen saturation was 85% (normal above 94%). Resident 1 was transferred to GACH 1 at 5:52 p.m. via paramedics (emergency medical transportation). A review of Resident 1's GACH 1's Laboratory Results dated 6/7/2020 at 7:10 p.m., indicated Resident 1's sodium (one of the body's electrolytes, increased level can be indicative of dehydration) level was155 milliequivalents per liter (mEq/L - normal range 135 to 145 mEq/L). A review of Resident 1's GACH 1's Discharge Summary dated 6/7/2020, indicated Resident 1's primary diagnosis included pneumonia (lung infection) due to COVID-19, septic shock (life-threatening condition caused by a severe infection in blood), intravascular volume depletion (reduction in circulating volume in blood vessels), acute renal failure and hypernatremia (high sodium level in the blood). Resident 1's condition clinically declined during the duration of the stay at the hospital as she was transferred to intensive care unit (ICU) and became DNR (Do not resuscitate - allow natural death), developed cardiopulmonary arrest (the heart stopped working) and expired on 6/9/2020 at 7:40 p.m. A review of Resident 1's Certificate of Death	F 692	**Identification of residents having the potential to be affected by the deficient practice and corrective action taken:** The facility has identified 54 out of 116 residents, however all residents of the facility have the potential to have decline in meal and fluid intake and weight loss. An audit was conducted by the Unit Manager / Designee on 10/30/20 to review if the residents trigger for: 1. Eating less than 50% for 2 meals in a day In the last 30 days will be reviewed for accuracy of documentation and if found that resident is at risk or exhibiting decline due to decline in meal and fluid intake will: d. Notify physician and implement any new orders e. Referral to RD for evaluation f. Update residents plan of care for monitoring for fluid/food deficit as needed.	

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F 692	Continued From page 12 dated 8/11/2020, Indicated Resident 1's immediate cause of death was acute renal failure. On 7/31/2020, at 11:45 a.m., during an interview, the RD stated she conducts initial nutritional screening, within seven days from admission, to newly admitted residents and conducts quarterly follow up assessments. The RD stated the licensed nurses would notify her when residents have inadequate food and fluid intake and when residents have unplanned weight loss for her to reassesses the residents' nutritional needs. The RD stated Resident 1 sustained a 10-pound weight loss by 6/1/2020, had inadequate daily fluid intake for four days in 6/2020 but the licensed nursed did not inform her. On 7/31/2020, at 1 p.m.., during an interview and concurrent record review, Licensed Vocational Nurse 1 (LVN 1) stated she was assigned to Resident 1 on 6/5, 6/6, and 6/7/2020 during the 7 a.m. to 3 p.m. shift. LVN 1 stated Certified Nursing Assistant 1 (CNA 1) notified her about Resident 1's low meal and fluid consumption. LVN 1 stated she did not update the nutritional care plan to attempt new interventions, did not notify the physician or the RD. On 7/31/2020, at 4:40 p.m.., during an interview and concurrent record review, the Director of Nursing (DON) confirmed the fluid intake of Resident 1 from 6/4 - 6/7/2020 was low. The DON stated the licensed nurse should have documented a change of condition and notified the physician and the RD. The DON did not find documentation the licensed nurses monitored Resident 1 for signs and symptoms of dehydration The DON confirmed there was no documentation the physician was made aware of	F 692	2. Monthly weight loss of 5% in 30 days, 7 ½% in 90 Or 10% in 180 days will be reviewed and see appropriate intervention has occurred which would include RD informed for evaluation and recommendation along with physician being informed and orders if any have been acted upon. Review and updating of care plan for weight loss if needed. **Systemic changes to ensure the deficient practice does not recur:** RD was inserviced by Lead RD from HSG on October 29, 2020 on process for review of each new resident and then at least quarterly and as needed. Based on his/her review, RD will initiate a care plan which will identify risk any interventions which may include risk for food or fluid deficit if appropriate. Also inserviced on the process for review of monthly weights, which would include weight loss of 5% in 30 days, 7 ½ in 90 days and 10% in 190 days. All recommendations by RD will be given to the Director of Nursing for action CNA will be in serviced by DSD or Designee on accurately reporting	

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F 692	Continued From page 13 Resident 1's low fluid intake. On 8/3/2020, at 10:01 a.m., during an interview, the DON confirmed there was no documented care plan developed for Resident 1's dehydration risk. The DON stated the care plan should have been developed on admission and interventions should have followed. On 8/6/2020, at 2:29 p.m., during an interview, Resident 1's attending physician (Physician 1)) stated the licensed nurses did not notify him about Resident 1's weight loss, low fluid intake, and deterioration in condition before Resident 1's emergency transfer on 6/7/2020. Physician 1 further stated since he was not aware, he did not order intravenous fluid for hydration. On 8/5/2020, at 3:19 p.m., during an interview, CNA 1 stated she was assigned to the COVID-19 (coronavirus-contagious disease) designated unit and cared for Resident 1 from 6/4 to 6/7/2020 during the 7 a.m. to 7 p.m. shift. CNA 1 stated she assisted with feeding Resident 1 with her meals and fluids and documented Resident 1's food and fluid intake in the Meal Consumption Report and notified LVNs 1 and 2 about Resident 1's low food and fluid intake. CNA 1 stated Resident 1 did not have nutritional supplement drinks ordered. A review of the facility's policy on Hydration Management dated 7/2017, indicated residents are provided with sufficient fluid intake to maintain proper hydration and nutritional status. Residents' hydration will be monitored on a regular basis. Sufficient fluid means the amount of fluid needed to prevent dehydration and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's	F 692	of food and fluid intake and informing the licensed staff of residents who don't consume 50% of meal and or fluids for the meals served on shift. Licensed nurses were in serviced by DSD or designee on 10/23/20 & 10/28/20 on monitoring of residents for possible change of condition during their shift in regards to residents eating less than 50% for 2 meals in a day. If change of condition is identified: a. Notify physician b. Referral to RD c. Monitoring for s/s of fluid deficit if appropriate. d. Update plan of care if needed. Licensed staff will monitor residents for possible change of condition during their shift in regards to residents eating less than 50% for 2 meals in a day. If change of condition is identified a. Notify physician b. Referral to RD c. Monitoring for s/s of fluid deficit if appropriate. d. Update plan of care if needed. Unit managers will review residents	

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F 692	Continued From page 14 condition fluctuates (e.g., increase fluids if resident has fever or diarrhea). A general guideline for determining baseline daily fluid needs is to multiply the resident's body in kilograms times 30 ml, except for residents with renal or cardiac distress. A review of the facility's policy on Changes in Resident Condition, revised on 2/2017, indicated nursing staff, the resident, the attending physician, and the resident's legal representative are notified when changes in the resident's condition occur. A significant change in the resident's physical, mental, or psychosocial status, including a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications; or a need to alter treatment significantly. The SBAR Communication Form and the Progress Note are used to assess and document changes in condition in an efficient and effective manner; provide assessment information to the physician and provide clear comprehensive documentation. Changes in the resident's status that affect the problems/goals or approaches on his or her care plan, are documented as revisions and communicated to the interdisciplinary caregivers.	F 692	who have triggered for eating 50% or less for 2 meals every Monday to Friday. If change of condition is identified with a concern of lack of intake will validate that h. Physician notification. i. Referral to RD. j. Monitoring for s/s fluid deficit if appropriate. k. Update of plan of care has occurred if needed. Unit managers or designee will review monthly weight report to check that any resident with a significant weight loss of 5% in 30 days, 7 ½% in 90 days and/or 10% in 180 days has a care plan to notify the residents physician and referral to RD for evaluation and recommendations and that these interventions have been carried out. Any issue or concern will be reported to the Director of Nursing for resolution. **Measures that will be implemented to monitor for the continued effectiveness of the corrective action taken to see that this deficiency has been corrected and will not recur**	

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