STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065139	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY -- LOVELAND VILLAGE	2101 S GARFIELD AVE LOVELAND, CO 80537

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to immediately inform one (#1) of three residents reviewed out of three sample residents' representatives when there was a significant change in the resident's physical status. Specifically, the facility failed to: -Notify the resident's family when the resident was not maintaining adequate caloric and fluid intake and was losing weight. Cross-reference: F692 Failed to ensure timely interventions were implemented when the resident failed to maintain adequate caloric and fluid intake. Findings include: I. Resident #1 A. Resident status Resident #1, age 79, admitted [DATE] and discharged [DATE]. According to the May 2020 computerized physician orders [REDACTED]. The 3/17/2020 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired and unable to complete the brief interview for mental status (BIMS). Staff assessment revealed the resident had both short and long term memory problems. She required extensive assistance with all activities of daily living. The resident received a mechanically altered diet. III. Record review The nutrition care plan, initiated 6/13/18 and last revised 3/20/2020, revealed the resident had a potential for nutritional problems and had a significant weight loss. Interventions included: -Follow resident by nutritionally at risk (NAR) committee related to weight loss, initiated 12/17/19; -Weekly weight as ordered, initiate 6/13/18; -Adaptive equipment of plate guard and cups with straws needed, initiated 6/17/19; -Requires regular diet with pureed textures with mildly thickened liquids and extra gravies and sauces. Provide room water pitcher, initiated 6/13/18; and -Provide puree snacks daily related to reduced intakes, initiated 3/20/2020. The May 2020 CPO revealed the orders for a regular diet with pureed texture, mildly thick consistency fluids with extra sauces and gravies, ordered 3/16/2020. The 3/18/2020 quarterly dietitian assessment revealed the resident had a significant weight loss of greater than 10% in 180 days however the resident weight trends had stabilized in the past 30 days with improved intakes. It indicated the resident estimated calorie needs were 1,294-1,582 kilocalorie (kcal)/day with 63-79 grams (g) of protein/day and 1,701-1,890 milliliters (ml)/day of fluid. The assessment revealed the resident's labs were within normal limits based on labs completed on 1/7/2020. The 3/24/2020 care conference progress note revealed the resident's diet was changed to puree with mildly thickened liquids and the resident was self-initiating feeding well with the puree. It indicated the resident's current weight was 137.6 pounds and she was eating 70-80% of her meals. The resident's daughter attended the care conference telephonically. According to the weight summary, the resident's weight on 3/29/2020 was 141.6 pounds then decreased to 135.6 pounds on 4/19/2020 and decreased again to 129 pounds on 4/26/2020 (a 12.6 pound weight loss in 28 days). There was no documentation the family, dietitian or physician were notified of the significant weight loss. The May 2020 treatment administration record (TAR) revealed the resident was to have a weekly weight done every Thursday on night shift. On 5/7/2020 the TAR was coded (8), indicating to refer to the progress notes, which was blank. On 5/14/2020 the TAR was blank, indicating the weight was not obtained. On 5/21/2020 the TAR was coded (8) and the progress note indicated the weight was not obtained because the resident was already in bed. The 5/14/2020 physician progress notes [REDACTED]. It did not indicate any further workup would be completed and no new interventions were recommended. The 5/22/2020 nutritional status progress note revealed the resident was being followed by the nutritionally at risk (NAR) committee related to insidious (gradual but harmful) weight loss. The resident's weight on 5/11/2020 was 130.8 pounds, down 4.8 pounds or 3.5 % in 30 days, 9.4 pounds or 6.7% in 90 days and down 24.2 pounds or 15.6% in 180 days. It indicated the resident had good intake, consuming 69% of meals on average in the past 30 days and accepted snacks occasionally between meals. It indicated the registered dietitian (RD) was going to trial interventions for weight stabilization. According to the weight summary, the resident's weight on 5/24/2020 was 121.2 pounds. A re-weigh was done on 5/25/2020 at 120.2 pounds. (This was a 10.6 pound weight loss in 14 days or 7.69% weight loss). A 5/24/2020 progress note revealed the resident was difficult to arouse and stimulate to wake up and eat meals for the last two days. A 5/25/2020 progress note revealed the resident was noted with weight loss with poor appetite, taking only bites of each meal and drinking 1-2 cups of fluid with meals. It indicated the RD and nurse practitioner (NP) were notified. There was no documentation to indicate the resident's family had been notified of the weight loss. A 5/25/2020 progress note revealed to continue pushing fluid, skin no longer flushed since early morning. The night nurse was notified to monitor the resident and push fluids when awake and report the next day, to the nurse practitioner, on how she was doing. A 5/25/2020 progress note revealed to continue pushing fluid, skin no longer flushed since early morning. The night nurse was notified to monitor the resident and push fluids when awake and report the next day, to the nurse practitioner, on how she was doing. A 5/26/2020 at 11:25 a.m. progress note revealed the resident continued to not eat or drink and appeared to be flushed. The nurse documented attempting to notify the daughter but she was unavailable. She contacted the nurse practitioner who requested emergent lab work and urinalysis. (A review of the progress notes revealed this had been the first contact with the daughter since 4/9/2020). A 5/26/2020 at 6:00 p.m. progress note revealed the resident had a change in condition and revealed signs of [MEDICAL CONDITION] and dehydration. A 5/26/2020 at 6:11 p.m. progress note revealed new orders were received to push fluids and the resident required IV fluids due to her poor intake. According to the May 2020 CPO, an order for [REDACTED]. On 5/27/2020, this intervention was added to the resident's care plan, after she was discharged to the hospital. A 5/26/2020 health status progress noted revealed the resident was not wanting to eat or drink, so the NP was notified and stat labs were ordered. The 5/26/2020 laboratory results revealed the following: -BUN (blood-urea-nitrogen) - 42mg/dL (milligrams/deciliter), normal range 5-28; -BUN/creatinine ratio - 49, normal range 10-28; -Sodium - 153 mmol/L (millimole/liter), normal range 136-145; and -Chloride 113 mmol/L, normal range 100/110. Increases in all these areas can be caused by dehydration. The 5/26/2020 verbal physician's orders [REDACTED]. Another 5/26/2020 health status progress note revealed the NP was notified of the laboratory results and ordered intravenous (IV) fluids for the resident, however, the facility did not have any sodium free fluids available, so the resident was sent to the emergency department for IV fluids and management of her high sodium. The 5/26/2020 emergency department report revealed the resident was being seen for critical high sodium of 153 mmol/L. The report indicated her admitting [DIAGNOSES REDACTED]. Her physical exam revealed her oral mucosa was dry and her weight at the hospital was 110 pounds (10 pounds less than the weight obtained at the facility). The 5/27/2020 hospital physician progress notes [REDACTED]. IV. Family interview Resident #1's family member was interviewed on 7/7/2020 at 9:00 a.m. She said her biggest regret was lack of communication. She said she had called the nursing home administrator (NHA) and had left a message wanting them to consider having her father come in to assist her mother with meals. She said she had seen her mother through the window on 5/15/2020 and her mother was covered with a blanket. She said her mother seemed very confused but she did not notice anything alarming regarding her weight. She said she saw her mother again through the window on 5/22/2020 and her mother only had on pants and a shirt and was not covered by a blanket. She said at this time she was very concerned and wanted the facility to reconsider letting her father into the facility to assist her with meals.

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

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) She said she had attended a care conference telephonically in March 2020 and they had discussed weight loss would be an issue for Resident #1. She said that staff were also aware, as it was discussed in the care conference that her father would go to the facility twice per day to assist Resident #1 with meals. She said she worked in nursing homes and trusted they would get ahold of me. She said how could a facility let that go (a big weight loss) and not contact the family? She confirmed on 5/26/2020 the nurse called her and said she had to immediately go to the hospital because they needed to start intravenous (IV) fluids to correct Resident #1's sodium levels. She said it was such a shock to hear this when she had not heard from the facility in several days. V. Staff interviews The social worker (SW), registered dietician (RD), director of nursing (DON) and the nursing home administrator (NHA) were interviewed on 7/7/2020 at 9:30 a.m. The RD said she always reviewed the meal intake and would have started other interventions if they had been significantly low. She said since the weight loss was insidious she only started the puree snack. She said she wanted staff to offer the snack at least one time per day. The RD said since September 2019 the residents spouse would come to the facility for one or two meals daily to assist Resident #1 with eating . She said when her spouse was helping her she responded very well and when he was able to come in she was more engaged. She said her normal practice was to reach out to families if nursing had not, however she assumed nursing had contacted the family in this case. The RD said, moving forward she would be making a point to ask families how frequently they would like to be contacted because making sure we have double communication is always better than not having communication. The NHA said based on the guidelines they had they would not have considered Resident #1 nearing the end of life therefore they did not consider the spouse to be an essential visitor. Licensed practical nurse (LPN) #1 was interviewed on 7/16/2020 at 1:36 p.m. She said Resident #1 had a decline during the time they had worked together in the last year and had become less active. She said Resident #1's spouse would come in and assist with both lunch and dinner until visitors were not allowed in the facility. She said the resident ate very well when her husband was assisting her with meals. LPN #1 said on 5/25/2020 Resident #1 was not eating or drinking and the NP was notified, towards the end of the day Resident #1 began to drink so the NP told the nurse to continue to monitor the resident and push fluids. She said on 5/26/2020 the resident did not accept any fluids and the NP and the family were notified. The NP ordered labs and once the results were obtained the NP ordered Resident #1 be sent to the hospital for fluids. She said she had not talked to the resident's daughter except for the day the resident went to the hospital on [DATE]. She said she had worked several days the prior week but had not talked to the daughter. She said she felt bad because she had not looked at the resident's weight the week prior to the resident going to the hospital; otherwise she would have contacted the daughter sooner.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide adequate nutritional and hydration care and services, consistent with the comprehensive assessment for one (#1) of three residents reviewed out of three sample residents. The facility failure to closely monitor for Resident #1 with a [DIAGNOSES REDACTED].#1 sustaining a 10.6 pound weight loss or 7.69% in 14 days. Subsequently, she had critical laboratory levels requiring immediate interventions and the need to be sent out to the hospital emergently. Resident #1 was admitted to the hospital with [REDACTED]. Findings include: I. Policy and procedure A. Nutrition Interventions Policy revised The Nutrition Interventions Policy and Procedure, last revised 1/19, received from Registered Dietitian (RD) on 7/7/2020 at 9:45 a.m., revealed in pertinent part, The dietitian identifies residents who are at risk and/or potential risk for nutrition-related problems due to insufficient/inappropriate intake of food. The dietitian recommends interventions to improve the resident's intake, based on resident preferences and tolerance. The dietician should determine appropriate interventions based on the identified etiology/cause of the risk factor, monitor the residents' acceptance/outcomes on a regular basis, recommend changes to foods served based on nutritional assessment and seek approval from the Medical Director for methods to increase calorie and protein intake. B. Hydration Policy and Procedure The Hydration Policy and Procedure, last revised 1/19, received from the RD on 7/7/2020 at 9:45 a.m., revealed in pertinent part, Residents will be provided with sufficient fluid to maintain proper hydration and health, including fluids served at mealtimes and between meals, offered consistent with care plan, preference and choice. Risk factors for dehydration will be identified. Risk factors may include cognition/dementia, fluid loss or restriction, functional impairments, refusal to consume food/beverages, or other factors. If hydration status is poor on thickened liquids, consult with family/SLP (speech/language therapist)/physician on balancing the risks for aspiration against the potential benefits of better hydration. The dietitian will be notified of all significant changes in hydration status for accurate assessment of fluid needs and recommended interventions. Additional fluids are offered between meals throughout the day. Resident's identified at risk for dehydration include those with conditions such as weight loss, poor meal intakes and pressure injuries. These residents may have their fluid intake monitored by nursing, have interventions documented on the care plan, be added to Nutrition Alert, and offer additional fluids during medication pass or between meals. II. Resident #1 A. Resident status Resident #1, age 79, admitted [DATE] and discharged [DATE] to the hospital. According to the May 2020 computerized physician orders [REDACTED]. The 3/17/2020 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired and unable to complete the brief interview for mental status (BIMS). Staff assessment revealed the resident had both short and long term memory problems. She required extensive assistance with all activities of daily living. The resident received a mechanically altered diet. No rejection of care documented. III. Record review The nutrition care plan, initiated 6/13/18 and last revised 3/20/2020 (new interventions were not added until after the resident was sent out to the hospital-see May 2020 CPO), revealed the resident had a potential for nutritional problems and had a significant weight loss. Interventions included: -Follow resident by nutritionally at risk (NAR) committee related to weight loss, initiated 12/17/19; -Weekly weight as ordered, initiate 6/13/18; -Adaptive equipment of plate guard and cups with straws needed, initiated 6/17/19; -Requires regular diet with pureed textures with mildly thickened liquids and extra gravies and sauces. Provide room water pitcher, initiated 6/13/18; and, -Provide puree snacks daily related to reduced intakes, initiated 3/20/2020. The May 2020 CPO revealed the orders for a regular diet with pureed texture, mildly thick consistency fluids with extra sauces and gravies, ordered 3/16/2020. The 3/18/2020 quarterly dietitian assessment revealed the resident had a significant weight loss of greater than 10% in 180 days, however, the resident weight trends had stabilized in the past 30 days with improved intakes. It indicated the resident estimated calorie needs were 1,294-1,582 kilocalorie (kcal)/day with 63-79 grams (g) of protein/day and 1,701-1,890 milliliters (ml)/day of fluid. The assessment revealed the resident's labs were within normal limits based on labs completed on 1/7/2020. The 3/24/2020 care conference progress note revealed the resident's diet was changed to puree with mildly thickened liquids and the resident was self-initiating eating well with the puree. The daughter attended the care conference telephonically. It indicated the resident's current weight was 137.6 pounds and she was eating 70-80% of her meals. According to the weight summary, the resident's weight on 3/29/2020 was 141.6 pounds then decreased to 135.6 pounds on 4/19/2020 and decreased again to 129 pounds on 4/26/2020 (a 12.6 pound weight loss in 28 days). -There was no documentation the family, dietitian or physician were notified of the significant weight loss. The May 2020 treatment administration record (TAR) revealed the resident was to have a weekly weight done every Thursday on night shift. On 5/7/2020 the TAR was coded (8), indicating to refer to the progress notes, which was blank. On 5/14/2020 the TAR was blank, indicating the weight was not obtained (no documentation was found in the progress). On 5/21/2020 the TAR was coded (8) and the progress note indicated the weight was not obtained because the resident was already in bed. The 5/14/2020 physician progress notes [REDACTED]. -It did not indicate any further work-up would be completed and no new interventions were recommended. The 5/22/2020 nutritional status progress note revealed the resident was being followed by the nutritionally at risk (NAR) committee related to insidious (gradual but harmful) weight loss. The resident's weight on 5/11/2020 was 130.8 pounds, down 4.8 pounds or 3.5 % in 30 days, 9.4 pounds or 6.7% in 90 days and down 24.2 pounds or 15.6% in 180 days. It indicated the resident had good intake, consuming 69% of meals on average in the past 30 days and accepted snacks occasionally between meals. It indicated the registered dietitian (RD) was going to trial interventions for weight stabilization-the trial interventions were not documented. According to the weight summary, the resident's weight on 5/24/2020 was 121.2 pounds. A re-weigh was done on 5/25/2020 at 120.2 pounds. (This was a 10.6 pound weight loss in 13 days). A 5/24/2020 progress note revealed the resident was difficult to arouse and stimulate to wake up and eat meals for the last two days. A 5/25/2020 progress note revealed the resident was noted with weight loss with poor appetite, taking only bites of each meal and drinking 1-2 cups of fluid with meals. It indicated the RD and nurse practitioner (NP) were notified. -There was no documentation to indicate the resident's family had been notified of the weight loss. A 5/25/2020 progress note revealed to continue pushing fluid, skin no longer flushed since early morning. The night nurse was notified to monitor the resident and push fluids when awake and report the next

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) day, to the nurse practitioner, on how she was doing. A 5/26/2020 at 11:25 a.m. progress note revealed the resident continued to not eat or drink and appeared to be flushed. The nurse documented attempting to notify the daughter but she was unavailable. She contacted the nurse practitioner who requested emergent lab work and urinalysis. (A review of the progress notes revealed this had been the first contact with the daughter since 4/9/2020). A 5/26/2020 at 6:00 p.m. progress note revealed the resident had a change in condition and revealed signs of [MEDICAL CONDITION] and dehydration. A 5/26/2020 at 6:11 p.m. progress note revealed new orders were received to push fluids and the resident required IV fluids due to her poor intake. According to the May 2020 CPO, an order for [REDACTED]. -On 5/27/2020, this intervention was added to the resident's care plan, after she was discharged to the hospital. The May 2020 food and fluid intake report documented the following: -5/1/2020-5/26/2020: Resident #1 received less than 1700 ml of fluid a day except on 5/2/2020 when she received 2310 ml. -5/1/2020-5/26/2020: Resident #1 received less than 1294 kcal/day except on 5/2/2020 when she received 2310 kcal and on 5/18/2020 when she received 1400 kcal. For the month of May 2020, Resident #1 received less than the recommended amount of fluid and calories per day that was estimated by the RD on 3/18/2020 (see quarterly dietitian assessment above). A 5/26/2020 health status progress noted revealed the resident was not wanting to eat or drink, so the NP was notified and stat labs were ordered. The 5/26/2020 laboratory results revealed the following: -BUN (blood-urea-nitrogen) - 42mg/dL (milligrams/deciliter), normal range 5-28; -BUN/creatinine ratio - 49, normal range 10-28; -Sodium - 153 mmol/L (millimole/liter), normal range 136-145; and -Chloride 113 mmol/L, normal range 100/110. The 5/26/2020 verbal physician's orders [REDACTED]. Another 5/26/2020 health status progress note revealed the NP was notified of the laboratory results and ordered intravenous (IV) fluids for the resident, however, the facility did not have any sodium free fluids available, so the resident was sent to the emergency department for IV fluids and management of her high sodium. The 5/26/2020 emergency department report revealed the resident was being seen for critical high sodium of 153 mmol/L. The report indicated her admitting [DIAGNOSES REDACTED]. Her physical exam revealed her oral mucosa was dry and her weight at the hospital was 110 pounds (10 pounds less than the weight obtained at the facility on 5/25/2020). The 5/27/2020 hospital physician progress notes [REDACTED]. She had not been on hospice or palliative care while residing at the facility. IV. Family interview Resident #1's family member was interviewed on 7/7/2020 at 9:00 a.m. She said her biggest regret was lack of communication. She said she had called the nursing home administrator (NHA) and had left a message wanting them to consider having her father come in to assist her mother with meals. She said she had seen her mother through the window on 5/15/2020 and her mother was covered with a blanket. She said her mother seemed very confused. She said she saw her mother again through the window on 5/22/2020 and her mother only had on pants and a shirt and was not covered by a blanket. She said at this time she was very concerned and wanted the facility to reconsider letting her father into the facility to assist her with meals. She said she had attended a care conference telephonically in March 2020 and they had discussed weight loss would be an issue for Resident #1. She said that staff were also aware, as it was discussed in the care conference that her father would go to the facility twice per day to assist Resident #1 with meals until all visitors could no longer come to the facility as a result of COVID-19. She said she worked in nursing homes and trusted they would get a hold of me. She said how could a facility let that go (a big weight loss) and not contact the family? She confirmed on 5/26/2020 the nurse called her and said she had to immediately go to the hospital because they needed to start intravenous (IV) fluids to correct Resident #1's sodium levels. V. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 7/2/2020 at 10:18 a.m. She said that Resident #1 had started declining in the last few weeks and had gone from regular texture to pureed food. She said Resident #1's spouse would come in every day to help assist her with meals and when the resident started declining her spouse would stay longer to help her with eating until visitors were no longer allowed because of COVID-19. CNA #2 was interviewed on 7/2/2020 at 10:26 p.m. She said that Resident #1's spouse came in daily to assist with two or three meals until visitors were no longer allowed. She said she remembered the day she went to the hospital because the resident was so lethargic. Resident #1's medical doctor (MD) was interviewed on 7/2/2020 at 10:44 p.m. He confirmed that the resident had a decline and prior to visitor restrictions the resident's family would come every day and provide assistance. The social worker (SW), registered dietician (RD), director of nursing (DON) and the nursing home administrator (NHA) were interviewed on 7/7/2020 at 9:30 a.m. The RD said on 3/16/2020 the resident was ordered nectar thick liquids (NTL) and she added pureed snacks to the care plan which included pudding, jello and pureed fruit. She confirmed this was the first intervention she had added when the resident started losing weight. Both the DON and the RD confirmed offering pureed snacks was not on the kardex (CNA communication about the resident from the care plan). She said if snacks would have been a physician's orders [REDACTED]. The RD said she always reviewed the meal intake and would have started other interventions if the meal intakes had been significantly low. She said since the weight loss was insidious she only started the puree snack. She said she wanted staff to offer the snack at least one time per day. She said there had been no other labs completed for the resident since January 2020 (see 3/18/2020 dietitian assessment above). The RD said the resident's last dietary assessment was completed in March 2020. She and the DON indicated that fluid intake was documented based on fluid intake at meals and nursing staff were encouraged to chart fluid intake between meals. The RD said she looked at fluid intake regularly; primarily when completing a resident's quarterly MDS assessment. The RD said it was standard for the dietary staff, during meals, to offer two fluids, usually one was water and then something else. She said although the amount of fluid the resident consumed was low, both she and the DON agreed that they would also rely on nursing staff to provide fluids throughout the day and this was not being documented. The RD said that she would take the average of what a resident was eating to determine whether an intervention should be implemented. She said from 5/6/2020 until 5/21/2020 the average for Resident #1 was 69% which was close to 70%. She said if it had been less than 70% she would have implemented other interventions. The RD said since September 2019 the resident's spouse would come to the facility for one or two meals daily to assist her with eating . She said when her spouse was helping Resident #1 she responded very well and when he was able to come in she was more engaged. She said her normal practice was to reach out to families about the residents status if nursing had not, however she assumed nursing had contacted the family in this case. The RD said, moving forward she would be making a point to ask families how frequently they would like to be contacted because making sure we have double communication is always better than not having communication. The RD confirmed there was a significant decrease in meal intake from 5/21/2020 until 5/24/2020 and the Mighty Shake (dietary supplement) was started 5/25/2020. The RD said the May 2020 NAR meeting had been the first time Resident #1's weight loss had been discussed; although the care plan indicated she should have been reviewed in NAR as of 12/17/19. The NHA said based on the guidelines they had they would not have considered Resident #1 nearing end of life therefore they did not consider the spouse to be an essential visitor. Licensed practical nurse (LPN) #1 was interviewed on 7/16/2020 at 1:36 p.m. She said Resident #1 had a decline during the time they had worked together in the last year and had become less active. She said Resident #1's spouse would come in and assist with both lunch and dinner until visitors were not allowed in the facility. She said the resident ate very well when her husband was assisting her with meals. LPN #1 said on 5/25/2020 Resident #1 was not eating or drinking and the NP was notified, towards the end of the day Resident #1 began to drink so the NP told the nurse to continue to monitor the resident and push fluids. She said on 5/26/2020 the resident did not accept any fluids and the NP and the family were notified. The NP ordered labs and once the results were obtained the NP ordered Resident #1 be sent to the hospital for fluids.