STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **106116**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARDMOOR OAKS HEALTHCARE AND REHABILITATION CENTE	**9035 BRYAN DAIRY RD LARGO, FL 33777**

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 0692 **Level of harm -** Minimal harm or potential for 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, interviews, and policy review the facility did not ensure appropriate and timely interventions were implemented for weight loss for one resident (#3) related to obtaining an order for [REDACTED].#3 was admitted to the facility with a [DIAGNOSES REDACTED]. A review of the MDS (Minimum Data Set) assessment dated [DATE] indicated Resident #3 was on a mechanically altered diet. A review of Resident #3's weight record reflected the following: 4/7/20 134 lbs. 5/15/20 133 lbs. 6/12/20 130 lbs. 7/14/20 121 lbs. 7/21/20 120 lbs. 8/11/20 123 lbs 9/15/20 117 lbs. 9/25/20 111 lbs. Upon review of the 9/15/20 dietary note the following was found: RD (registered dietician) to rec (request) MD to assess for appetite stimulant. Review of another dietary note in the record dated 9/29/20 reflected RD to have MD assess for appetite stimulant r/t (related to) poor intake and weight loss. Review of the ADL (Activities of Daily Living) Meal intake percentages record for the month of August showed there was no documentation of the percentages of intake for the following dates and meals: 8/6/20 dinner meal, 8/7/20 lunch and dinner, 8/8/20 no documentation of any meal, 8/9/20 no documentation of any meals, 8/10/20 and 8/11/20 no documentation for the dinner meals, 8/14/20, 8/15/20, and 8/16/20 no documentation for any meals. 8/17/20 no dinner meal documentation. 8/18/20 no documentation for lunch or dinner. 8/19/20 and 8/.20/20 no dinner meal documentation. 8/21/20 no documentation for any meals. Review of the September 2020 ADL meal eating percentages reflected the following: no documentation of any meals on 9/8/20, 9/12/20, 9/13/20, 9/15/20, 9/16/20, 9/17/20, 9/18/20, 9/19/20, 9/21/20, 9/22/20, 9/24/20, 9/25/20, 9/26/20, 9/27/20 , and 9/28/20. The lunch and dinner meals were not documented on 9/7/20. The dinner meals wasn't documented on 9/9/20, 9/11/20, and 9/14/20. There was no documentation for lurch or dinner on 9/.23/20. Resident #4 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the 8/17/20 MDS assessment in the medical record reflected that Resident #4 weighted 210 pounds. A review of the weight record reflected two weights were taken and were as follows: 8/28/20 184 lbs. 9/25/20 186 lbs. No weight was documented upon Resident #4's admission on 8/10/20. A review of the 8/17/20 nutrition evaluation in the medical record reflected a weight of 210 pounds. Resident #1 was admitted to the facility with a [DIAGNOSES REDACTED]. A review of the weight record for Resident #1 reflected the following: 2/7/20 155 lbs. 3/10/20 147 lbs. 4/7/20 139 lbs. 4/17/20 135 lbs. 5/1/20 129 lbs. 5/12/20 133 lbs. 5/22/20 120 lbs. 6/12/20 126 lbs. 6/19/20 127 lbs. 6/26/20 128 lbs. 7/21/20 126 lbs. 8/11/20 138 lbs. 9/15/20 135 lbs. Review of the last care plan review dated 9/23/20 reflected a Focus, The resident has nutritional problem or potential nutritional problem r/t therapeutic diet, diuretic in use, expect weight fluctuations, Hx (history) of significant weight changes. Interventions included Provide, serve diet as ordered. Monitor intake and record Q (every) meal. Review of the September 2020 ADL eating meal percentage record reflected the following: There was no documentation of meal intake percentages on 9/1/20, 9/2/20, 9/4/20, 9/5/20, 9/6/20, 9/7/20, 9/8/20, 9/10/20, 9/11/20, 9/12/20, 9/13/20, 9/14/20, 9/15/20, 9/18/20, 9/19/20, 9/20/20, 9/21/20, 9/22/20, 9/23/20, and 9/24/20. Further review revealed no documentation for the dinner meal on 9/3, and 9/17, and no documentation of the lunch or dinner meals on 9/9/20 and 9/16/20. On 9/29/20 at 10:28 a.m. an interview was conducted with the RD and CDM (certified dietary manager). The RD said she talks to CNAs (certified nursing assistants) to verify how much the resident is eating. She said she also goes and sees at lunch how much they ate. Also when the trays come back dietary will let me know if they are not eating. If they are alert and oriented she will interview them. If they are not interviewable we will talk to family and see what some of their favorite foods are. She might talk to the doctor about getting an appetite stimulant. Sometimes she asks the CNAs what they are eating, and we may put it on the tray more often if it's food they accept better than some other foods. The nurses are to be charting the percent consumed. I don't see where the doctor okayed the stimulant yet, so I will contact him myself today and we will talk to the family about possible tube feeding. She was on an appetite stimulant at one point. It was discontinued. She is starting to trend down again. She didn't want the med pass. We are reapproaching the appetite stimulant. Her family used to come in and feed her. We have a call out to the family about coming in as a care giver to feed her. For staff she either refuses or eats very little. Yes, there would be an admission weight. We had a weight from the 3008, but that was stricken out because that was incorrect. I requested a weight upon admission. The weight nurse has been on the floor a lot lately. When she is able to get them she gives it to me, and I put them in the computer. The RD didn't have an answer as to why there wasn't a weight for Resident #4 after she was admitted . I was told the weight on the 3008 was wrong. When they gave me the first weight, they told me that was her first weight in-house, so I put it in. The staff could put the weight in. They have just always given them to me and told me to put the weight in. Since COVID has been happening they have had people out and they have been pulling the restorative aid to the floor. Yes, staff should be documenting meal percentages after every meal. The RD confirmed the meal percentages weren't being documented for Resident #3. Yes, we have discussed it and the unit managers try and stay on top of them. I know at one time they didn't have the pads they use and had to go look for them. That's why I usually go to the CNAs and ask how much they're eating so that way I know. The CDM said every now and then I look at the percentages. The staff will keep the tray and the ticket and notify me they are not eating. On 9/29/20 at 11:54 a.m. an interview was conducted with the Director of Nurses (DON). She said she asked the restorative aid about the weight and she said she got it and put it in. The DON said she put Resident #4's weight in this morning. The restorative aid checked her weight book and it was 184. The RD should go by the weights that we get here. She communicates with the restorative aids. The DON agreed they should get a weight on admission and put it in the record. She confirmed the RD should have confirmed there was an admission weight. The DON said she doesn't know if the doctor declined the appetite stimulant or not. She said she doesn't know if the doctor was notified about the appetite stimulant, she is researching it. Usually we talk with the physician and the family. The staff should be recording the meal percentages. We identified that last week The staff were not documenting ADLs (activities of daily living) and meal percentages. We are bringing it to QA (Quality assurance). We will work on a plan and educate the staff. It was actually that and the weights. Review of the policy, Weighing the Resident, dated 9/5/17, revealed the following: Policy: Residents of the facility shall be weighed upon admission and monthly and as needed unless ordered otherwise by the physician.

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