STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445306	A. BUILDING _____ B. WING _____	03/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTH OF PORTLAND REHAB & WELLNESS CENT	215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148

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 facility policy review, medical record review, and interview the facility failed to notify the resident representative for 1 of 4 residents (Resident #2) reviewed for resident representative notification. The findings include: Review of facility policy, Change of Condition, revised on [DATE] showed, .The facility will evaluate and document changes in a resident's health, mental or psychosocial status in an efficient and effective manner; to relay evaluation information to physician and to document actions to include but not limited to the following: A need to alter treatment.Notify the resident's representative, consistent with his or her authority, of change and follow through completed by the facility, and document in the EMR (Electronic Medical Record). Review of facility policy, Physician Orders, revised on [DATE] showed, .Nurse receiving order is responsible for complete order documentation and communication to pharmacy.Notification to family/Power of Attorney (POA) via telephone. Review of the medical record showed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] and Annual MDS dated [DATE] showed Resident #2 scored 00 on the Brief Interview for Mental Status (BI[CONDITION]) indicating severe cognitive impairment. Further review revealed the resident required total dependence with one person physical assist with eating and had no weight loss. Review of Resident #2's Physician order [REDACTED].[MEDICATION NAME] 5 mg (milligram) twice a day. Review of Resident #2's Progress note dated 2/21/2020 showed, .Verification of order given r/t (related to) [MEDICATION NAME] 5 mg PO BID. Will continue to monitor elder's behaviors and report any further developments. During an interview on 3/18/2020 at 10:36 AM Resident #2's Power of Attorney (POA) stated the facility never contacted her related to medication changes. When she reviewed the paperwork the facility sent to the new facility her grandfather went to he had an order for [REDACTED].#1 confirmed she did not recall notifying Resident #2's POA when the resident got a new order for the medication [MEDICATION NAME] in February 2020. During further interview she confirmed she did not chart the notification to the resident's POA for the new medication [MEDICATION NAME] in the resident's medical record. During an interview on 3/19/2020 at 5:45 PM with the Director of Nursing confirmed Resident #2's POA was not notified of a medication change for [MEDICATION NAME] in February 2020.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed follow physician's orders for 2 of 4 residents (Resident #1 and #2) reviewed for physician orders. The findings include: Review of the medical record showed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment showed Resident #1 had a Brief Interview for Mental Status (BI[CONDITION]) score of 12 indicating the resident was moderately cognitively impaired. Review of Physician Order dated 2/20/20, showed, .CBC (Complete Blood Count) W/Diff (with differential); Comp (Comprehensive) Metabolic Panel, T3 (Triiodothyronine), T4 ([MEDICATION NAME]), T7 (Free [MEDICATION NAME] index), and TSH ([MEDICAL CONDITION] Stimulating Hormone). Review of the medical record showed no lab results for ordered labs on 2/20/2020. Review of the medical record showed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] and Annual MDS dated [DATE] revealed Resident #2 had a BI[CONDITION] score of 00, indicating the resident was severely cognitively impaired. Further review revealed the resident required total dependence with one person physical assist with eating and had no weight loss. Review of Resident #2's Nutrition Care Plan dated 8/13/2019 revealed, .feed elder.weigh weekly x 4 weeks; then weight monthly if weight is stable. Monitor weights for significant changes. Review of Resident #2's Physician's Orders dated August 2019 through March 2020 showed, .Monthly weight. Review of Resident #2's weight record showed no weights were documented for the months of August, September, October and December 2019, and January 2020. During an interview on 3/19/2020 at 1:04 PM with the Director of Nursing (DON) confirmed labs were not obtained for Resident #1 on 2/20/2020 for CBC with Diff, Comprehensive Metabolic Panel, T3, T4, T7, and TSH and there was no order to discontinue them. During an interview on 3/19/2020 at 4:34 PM with Registered Nurse (RN) #2 she confirmed she didn't put the lab request in the computer on 2/20/2020 for Resident #1 and the labs were not obtained. During an interview on 3/19/2020 at 5:45 PM with the Director of Nursing confirmed Resident #2's physician orders were not followed related to not obtaining Resident #2's weights monthly as ordered and not obtaining lab work as ordered.
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 medical record review and interview, the facility failed to obtain and verify weights for 1 of 4 residents (Resident #2) reviewed for nutrition. The findings include: Review of the medical record showed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] and Annual MDS dated [DATE] showed Resident #2 scored 00 on the Brief Interview for Mental Status (BI[CONDITION]) indicating severe cognitive impairment. Further review revealed the resident required total dependence with one person physical assist with eating and had no weight loss. Review of Resident #2's Nutrition Care Plan dated 8/13/2019 showed, .feed elder.weigh weekly x 4 weeks; then weight monthly if weight is stable. Monitor weights for significant changes. Review of Resident #2's physician's orders [REDACTED].Monthly weight. Review of Resident #2's weight report showed no weights were documented for the months of August, September, October and December 2019, and January 2020. Review of Resident #2's weight report showed the resident weight on [DATE] was 160.2 pounds, November 1, 2019 was 164.8 pounds, February 11, 2020 was 133.0 pounds, February 26, 2020 was 126.0 pounds, and February 26, 2020 was 122.1 pounds. Review of Resident #2's Registered Dietician assessment dated [DATE] showed, .most recent height 67 inches, most recent weight 164.8.date of most recent weight 11/1/2019.he had gained from 140's in early summer to 160's in August and November, no recent weight.He is often combative with staff and care and has not been weighed in 3 months. P (plan): Continue with current POC (Plan of Care) and monitor. Review of Resident #2's Nutrition Risk assessment dated [DATE] showed, .most recent weight 2/11/2020 133.0 pounds.significant weight variance 3 months 19.3%, 6 months 18.7%.Resident noted with significant weight loss.He is at low end of IWR (Ideal Weight Range): 133-163, BMI (Body Mass Index): 20.83. P: Recommend to add magic cups BID (twice a day) on lunch and supper trays for 580 calories 18 GMs (grams) protein. Recommend to add to weekly weights. Continue to monitor.

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) During an interview on 3/19/2010 at 5:06 PM with the Registered Dietician confirmed she did an annual nutrition assessment for Resident #2 on February 5, 2020 and she noted the resident's most recent weight was November 2019 and she asked the staff to get a current weight on the resident. During further interview she stated the staff had not notified her that weights were not being obtained for the resident or asked her for any recommendations for the resident. During an interview on 3/19/2020 at 5:45 PM with the Director of Nursing confirmed Resident #2's weights were not obtained or monitored since August 2019.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to maintain a complete and accurate medical record for 1 of 4 residents (#2) reviewed. The findings include: Review of the medical record showed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] and Annual MDS dated [DATE] showed Resident #2 scored 00 on the Brief Interview for Mental Status (BI[CONDITION]) indicating severe cognitive impairment. Further review revealed the resident required total dependence with one person physical assist with eating and had no weight loss. Review of Resident #2's Nutrition Care Plan dated 8/13/2019 showed, .feed elder.weigh weekly x 4 weeks; then weight monthly if weight is stable. Monitor weights for significant changes. Review of Resident #2's physician's orders [REDACTED].Monthly weight. Review of Resident #2's weight record showed no weights were documented for the months of August, September, October and December 2019, and January 2020. Review of Resident #2's Vital Sign report for food intake dated August 1, 2019 through March 6, 2020 revealed no meal intake documentation for 56 meals. Review of Resident #2's weight report showed the resident weight on [DATE] was 160.2 pounds, November 1, 2019 was 164.8 pounds, February 11, 2020 was 133.0 pounds, February 26, 2020 was 126.0 pounds, and February 26, 2020 was 122.1 pounds. During an interview on 3/19/2020 at 5:45 PM with the Director of Nursing confirmed Resident #2 medical record was incomplete related to meal intakes or weights not being documented.