| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115025 | A. BUILDING _____ B. WING _____ | 03/12/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| GLENWOOD HEALTH AND REHABILITATION CENTER | 4115 GLENWOOD RD DECATUR, GA 30032 |

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

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| F 0604<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure one of 41 sampled residents (R) (R153) was properly assessed and evaluated for the use of a physical restraint. Findings include:<br>On 03/12/20 at 4:00 PM, an observation of R153 was conducted. R153 was observed sitting in the hallway outside the resident's room in a mechanical wheelchair with a lap belt fastened across R153's lap. Review of R153's Admission Record located under the Profile tab of the Electronic Health Record (EHR) documented R153 was admitted to the facility on [DATE]. The [DIAGNOSES REDACTED]. Review of R153's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/05/20, the facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of 0 out of 15 which indicated the resident has a severe cognitive impairment. In addition, the MDS Assessment documented R153 used a wheelchair under Functional Status. Review of the MDS Assessment further revealed the resident was not assessed for the use of a physical restraint as a trunk restraint in a chair or out of bed in Section P of the MDS Assessment. Review of R153's current Care Plan, with a revised date of 01/12/17, revealed R153's care plan did not address the implementation or use of a lap belt on the resident's wheelchair. In addition, there was no documentation in R153's care plan related to the use of a lap belt when the resident is out of bed or seated in a chair. Review of R153's Treatment Administration Record (TAR) for (NAME)2020 revealed R153 did not have an order for [REDACTED]. The Program Director stated R153 does not receive any therapy services at the facility. In addition, the Program Director stated R153 had not been assessed by the Therapy Services department since November 2017. On 03/12/20 at 4:13 PM, an interview was conducted with the facility's Regional Director, Therapy Services Program Manager, and the DON. The Regional Director stated the use of a lap belt on R153's wheelchair would meet the facility's definition of a restraint and should be addressed in the MDS Assessment and the resident's Care Plan. In addition, the DON reviewed the annual MDS Assessment with an ARD of 05/08/19, the Quarterly MDS Assessment with an ARD of 02/05/20, and R153's current Care Plan, dated revised 01/12/17. The DON stated R153 should have been assessed for the use of a lap belt on the resident's wheelchair and R153's Care Plan should provide guidance for the use of the lap belt. On 03/12/20 at 4:25 PM, an interview was conducted with the facility's Administrator. The Administrator stated she was aware R153 had a lap belt on the wheelchair and since R153 had not been assessed for the use of the lap belt and the resident was not able to unlatch the belt independently, the use of the lap belt met the facility's definition of a physical restraint. On 03/12/20 at 4:38 PM, an interview was conducted with MDS Coordinator 1. MDS Coordinator 1 stated there was no evidence in the Annual MDS Assessment with an ARD of 05/08/19 and the Quarterly MDS Assessment with an ARD of 02/05/20 of assessments for R153 for the use of a lap belt and the lap belt should have been indicated in the MDS Assessments as a physical restraint in Section P of the MDS Assessments. Review of the facility's policy titled, Abuse and Neglect Prohibition, dated revised 11/2019, stated, Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. In addition, the policy stated, Physical or chemical restraints that are not required to treat the resident's medical symptoms are not used for the purposes of discipline or convenience of the staff. Review of the facility's policy titled, Restraint Management, dated revised 11/2019, defined a physical restraint as, any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. In addition, the policy included examples of physical restraints and stated, using devices in conjunction with a chair, such as trays, tables, bars, or belts, that the resident cannot remove easily that prevent the resident from rising. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of 41 sampled residents (R) (R153) for the use of splints to improve the resident's alignment of the upper and lower extremities and for the use of a lap belt on mechanical wheelchair. This failure has the potential to effect other residents in the facility who have specific needs not identified and documented in the care plan for care to ensure provision of care provided as required. Findings include: On 03/10/20 at 10:15 AM, observations of R153 were conducted in the resident's room. R153 was observed awake in the bed and did not respond to questions. R153 was observed having upper and lower extremity contractures and there were no splints in place at the time of the observation.<br>Review of R153's Admission Record located under the Profile tab of the Electronic Health Record (EHR) documented R153 was admitted to the facility on [DATE]. The [DIAGNOSES REDACTED]. Review of R153's quarterly MDS, with an ARD of 02/05/20, the facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of 0 out of 15 which indicated the resident has a severe cognitive impairment. In addition, the MDS Assessment documented R153 used a wheelchair for mobility. Review of the MDS Assessment further revealed the resident was not assessed for the use of splints and the assessment documented the resident did not use a trunk restraint when in a chair. Review of R153's current Care Plan, dated revised 01/12/17, revealed R153's care plan did not address the implementation or use of splints for the resident's contractures or the use of a lap belt on the resident's wheelchair. In addition, there was no documentation in R153's Care Plan related to the use of a lap belt when the resident is out of bed or seated in a chair. Review of R153's Treatment Administration Record (TAR) for (NAME)2020 revealed R153 did not have an order for [REDACTED]. The Program Director stated R153 does not receive any services related to the use of splints for the resident's contractures and R153 has not been assessed since November 2017. Further interview of the Therapy Director provided a plan to begin 03/12/20 for R153 to begin PT for 4 weeks to achieve normal anatomical alignment with the use of knee extension splints to the right and left knee for five hours .<br>OT evaluation 3 times per week for 4 weeks for soft left elbow splint On 03/12/20 at 12:30 PM, an interview was conducted with the Registered Nurse (RN) Unit Manager. The Unit Manager stated R153 required total assistance with positioning and mobility. The Unit Manager further stated R153 did not have splints for the contractures in the resident's upper and lower extremities. On 03/12/20 at 4:00 PM, an observation of R153 was conducted. R153 was observed sitting in the hallway outside the resident's room in a mechanical wheelchair with a lap belt fastened across R153's lap. On 03/12/20 at 4:13 PM, an interview was conducted with the facility's Regional Director, Therapy Services Program Manager, and the DON. The Regional Director stated the use of a lap belt on R153's wheelchair would meet the facility's definition of a restraint and |

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 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>should be addressed in the resident's Care Plan. In addition, the DON reviewed the Annual MDS Assessment with an ADR of 05/08/19, the Quarterly MDS Assessment with an ARD of 02/05/20 and R153's current care plan, dated as revised 01/12/17. The DON stated R153 should have been assessed for the use of splints for the contractures and the lap belt should have been assessed as a physical restraint. In addition, the DON stated the care plan should address the use of the lap belt on the resident's wheelchair. On 03/12/20 at 4:25 PM, an interview was conducted with the facility's Administrator. The Administrator stated she was aware R153's care plan had not developed or implemented any interventions for the use of splints for R153's contractures and the care plan did not address the use of a lap belt on the wheelchair. On 03/12/20 at 4:30 PM, a request was made for the facility to provide a policy related to the development of comprehensive care plans. The facility failed to provide a policy. |
| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, interview, and the facility policy review the facility failed to ensure the Comprehensive Care Plan was revised and updated to include nutritional care and risk changes for seven residents (Resident (R) 1, R25, R42, R87, R143, R153 and R183) of 35 sampled residents who care plans were reviewed for nutritional risk and care needs. (Reference F692) Findings include: Review of the facility's policy titled, Medical Nutrition Therapy Assessment, revised October 2010 revealed it was the intent of the facility to Conduct a comprehensive nutritional assessment of each resident upon admission and additionally as required by state and/or federal regulation .Fundamental information of the policy stated, .Each resident will receive a comprehensive nutritional assessment upon admission, annually, and when a resident is identified as having a significant change in status. Resident will be re-addressed quarterly in conjunction with the quarterly MDS (Material Data Set) and as needed. The nutritional assessment encompasses the medical data, physical condition and examination, nutrition history, social history, and nutrient assessments .The nutritional assessment is then used in the development of the resident's individualized care plan to demonstrate the resident's needs, strengths, and priorities .Related Standards for the policy stated, .OP4 0201.00 Resident Assessment Instrument (RAI) Process Resident Care Management Systems Manual (ViaTech) was sourced. During review of the sampled residents for nutrition it was identified the Registered Dietician (RD) was not completing nutritional assessments and updating care plans timely and/or at all according to the Material Data Set (MDS) schedule and facility policy. 1. Review of R42's Admission Record undated located in the Electronic Medical Record (EMR), revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R42's current Care Plan located in the EMR revealed the RD was to evaluate and make diet change recommendations as needed. The date initiated was 01/12/18. There were no new or revised goals and/or interventions to reflect the MDS assessments for dates of 10/16/19 and 12/20/19. Review of R42's RD assessment notes located in the EMR titled, Nutrition Status Review and Nutrition Data Collection revealed the only assessments completed were for dates of 07/25/19 and 03/12/20. The 03/12/20 assessment was completed during survey after the nutrition assessment concern was identified. It was confirmed during interview with the RD, there were no other areas of the resident's hard copy chart or the EMR where nutrition assessments would be located, and he had not completed any assessments on R42 past the 07/25/19 date. 2. Review of R87's Admission Record undated located in the EMR revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R87's current Care Plan located in the EMR revealed he needed assistance with eating with a date initiated on 12/05/16 and last revised on 11/21/17. Facility was to observe intake to assure an adequate fluid intake to prevent dehydration with a date initiated on 12/05/2016. R87's diet was to be given as Ordered and to consult with the RD if problems were identified with a date initiated on 06/07/17. There was no care plan specific to nutritional care assessed by the RD. Review of R87's RD assessment notes located in the EMR titled, Nutrition Status Review and Nutrition Data Collection revealed the only assessment completed was for the date of 07/23/19. It was confirmed during interview with the RD, there were no other areas of the resident's hard copy chart or the EMR where nutrition assessments would be located, and he had not completed any assessment on R87 past the 07/23/19 date. 3. Review of R143's Admission Record undated located in the EMR revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R143's current Care Plan located in the EMR revealed the RD was to evaluate quarterly and as needed and to observe R143's caloric intake and estimate needs. The RD was to make recommendations for changes to tube feeding as needed. There were no dates to show when the care plan was initiated and/or revised in relation to RD assessments. Review of R143's RD assessment notes titled, Nutrition Status Review and Nutrition Data Collection located in the EMR revealed the last RD assessment was dated 08/29/19. There were no RD assessment notes for the 11/05/19 and the 02/04/20 MDS quarterly assessments completed. It was confirmed in interview with the RD, he had not completed any assessment on R143 past the 08/29/19 date. 4. Review of R183's Admission Record undated located in the EMR, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R183's current Care Plan revealed the RD was to evaluate the resident's nutrition needs. The RD made recommendations on 07/22/18, 10/29/18, and 12/23/19 for Nepro one can daily. However, there were no new or revised goals and/or interventions for the resident's nutritional needs. Review of R183's RD's most current note titled, Nutrition Status Review dated 12/23/19 revealed the resident had lost significant wt. of (7.5%) in one month and would recommend a supplement. However, review of the [MEDICAL TREATMENT] communication forms for the month of December 2019 revealed the resident had not had a significant wt. loss, the wt. was stable and in normal range for the resident. Interview with the RD confirmed there were no other assessment notes for R183 completed after the 12/23/19 date. Interview with the RD on 03/11/20 at 10:30 AM revealed he had not completed timely reviews on residents in correlation with the MDS Resident Instrument Assessment (RAI) 3.0 Manual and the facility policy for RD services. He stated, he had attended some of the care plan meetings and some of the nutritionally at-risk meetings but not all of them. He stated, he had three buildings in the company and had to do it all. Interview with the MDS Director on 03/11/20 revealed she stated, the MDS team would review the MDS to ensure each discipline completed their sections but would not review the resident record for completed assessment notes surrounding the findings. She stated, the MDS team typically do not review the RD's assessment findings and/or notes. She stated, the RD was responsible for updated their nutritional care plans. She stated, the RD had been advised on a few occasions to complete RD assessments on residents that were triggered for significant change in status when she seen some were not completed. She stated, she was not aware the RD had not been timely completing nutrition assessments according to the MDS schedule and facility policy. Interview with the Administrator on 03/12/20 at 1:50 PM revealed she stated, she has had some prior concerns with the performance of the RD relating to not showing up for the nutrition at risk meetings and the resident care plan meetings. She stated, she was not aware the RD assessments and care plans according to the MDS schedule and policy were not completed in a timely manner or getting completed at all.<br><br>5. On 03/10/20 at 11:06 AM, observation of R25 revealed the resident was on a continuous tube feeding. Review of R25's Admission Record located under the Profile tab of the EHR documented R25 was admitted to the facility on [DATE]. The [DIAGNOSES REDACTED]. Review of R25's Annual MDS, with an ARD of 02/26/20, revealed the facility assessed the resident to have a BIMS score of 0 out of 15 which indicated the resident has a severe cognitive impairment. In addition, the MDS Assessment documented R25's base weight was 110 pounds with no weight loss in the last six months. The MDS assessment further revealed the resident required tube feeding. Review of R25's Comprehensive Care Plan, revised date of 11/07/19, revealed R25 received all nourishment through a percutaneous endoscopic gastrostomy (PEG) tube (a tube placed in the stomach when oral intake is not adequate) and the resident did not receive any nourishment or medication orally. In addition, the care plan revealed the facility's Registered Dietician (RD) was required to evaluate R25 on a quarterly basis and as needed. R25's current Care Plan indicated the most recent revision was initiated by the RD on 04/11/19. Review of R25's Medication Administration Record [REDACTED]. On 03/11/20 at 10:40 AM, an interview was conducted with the facility's Registered Dietician (RD). The RD stated nutritional assessments were required annually and quarterly (at least every 3 months) for every resident. The RD stated R25's annual nutritional assessment was completed on 04/11/19 and he had not completed any quarterly assessments for R25 since the annual assessment on 04/11/19. 6. On 03/10/20 at 10:15 AM, observations of R153 were conducted in the resident's room. R153 was observed awake in the bed and did not respond to questions. R153 was observed having upper and lower extremity contractures. Review of R153's Admission Record located under the Profile tab of the EHR documented R153 was admitted to the facility on [DATE]. The [DIAGNOSES REDACTED]. Review |

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| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>of R153's quarterly MDS, with an ARD of 02/05/20, the facility assessed the resident to have a BIMS score of 0 out of 15 which indicated the resident has a severe cognitive impairment. In addition, the MDS Assessment documented R153 required a mechanically altered diet and had a base weight of 76 pounds. Review of R153's Comprehensive Care Plan, dated revised 03/11/20, revealed the care plan addressed R153's nutritional needs because of the resident's dependence on staff for assistance with eating a mechanically altered diet, and because R153 was considered underweight. The care plan further indicated quarterly updates to the care plan were made on 08/15/18, 06/06/19, 08/19/19, and 03/11/20. R153's care plan further indicated the RD was required to evaluate and make recommendations for R153 as needed. Review of the most recent RD assessment in the EHR, dated 12/29/17, stated R153 continues to be dependent on staff for feeding and also continues to demonstrate good meal intake of 75-100%. The RD assessment further stated R153's weight is stable and no additional recommendation were needed at the time of the assessment. In addition, there were no other records of assessments by the RD in R153's record. On 03/12/20 at 12:30 PM, an interview was conducted with the Registered Nurse (RN) Unit Manager. The Unit Manager stated R153 required total assistance with eating. On 03/11/20 at 10:40 AM, an interview was conducted with the facility's RD. The RD stated nutritional assessments were required annually and quarterly (at least every 3 months) for every resident. The RD stated R153's annual and quarterly nutritional assessments had not been completed and the RD did not provide an explanation for why the assessments were not completed. In addition, the RD stated there had been no revisions to R153's Care Plan related to the resident's nutritional needs.<br><br>7. Review of R1's Admission Record, dated 03/12/20, revealed the resident was readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Review of R1's weight records in the Electronic Medical Record (EMR) revealed R1 to be losing weight monthly. 10/11/19-86lbs., 11/11/19-83lbs., 12/07/19-80lbs., 01/10/20-78lbs., 02/14/20-72lbs. Review of R1's care plan dated 06/03/19 indicated R1 has nutrition problem related to being underweight and related to need for mechanically altered texture diet. Intervention listed Registered Dietitian (RD) to evaluate and make diet change recommendations as needed. The care plan indicated R1 requires total assistance for eating his meals and drinks nectar thick liquids. Review of the meal intake logs for R1 revealed; from 02/15/20 to 03/11/20 68 meals were logged, of those two meals were refused, eight were consumed at less than 50%, 13 were consumed between 50-75%, and 47 were consumed at 75% or greater. On 03/11/20 at 12:50 PM an interview with the RD was conducted. The RD stated R1 receives a house shake (a nutritional supplement) two times per day and consumes 75% or more of most of his meals and snacks. The RD confirmed R1's weight loss of six pounds in February, a 7.69% loss which the EMR alerted him and he failed to follow up. The RD stated he should be checking/reviewing when the EMR sends the alert. He confirmed no nutritional review was performed following the EMR alert in February. The RD confirmed the last nutritional review regarding R1 was six months ago. The RD stated, I don't know why the resident lost weight. On 03/11/20 at 1:30 PM an interview with the Director of Nursing (DON) was conducted. The DON confirmed the interdisciplinary team held a meeting on 02/26/20. The DON stated the team discussed R1's care but did not specifically address R1's weight loss. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on resident/staff interviews, record review, review of facility policy and review of facility documents, it was determined the facility failed to provide care and services per professional standards for five of seven (Resident (R)34, R77, R99, R157, and R198) related to diabetic management. Specifically, staff failed to document the administration of [MED] within 60 minutes of the prescribed time, and/or following a blood glucose reading requiring [MED] coverage. This continued practice has the potential of diabetic residents receiving too little or too much [MED] and could result in the resident becoming hypo-hyperglycemic (low or high blood sugar), requiring additional medical interventions. Findings include: 1. Review of the facility form titled, Glenwood Health and Rehab Meal Schedule, undated, revealed breakfast meal servicing starting time for the Georgia Unit was at 6:55 AM and the cart was completed between 7:00 AM and 7:10 AM. Continued review of the form revealed lunch meal servicing starting time for the Georgia Unit was at 11:45 AM and the cart was completed between 11:55 AM and 12:05 PM. Further review of the form revealed supper meal servicing starting time for the Georgia Unit was at 4:50 PM and the cart was completed between 5:00 PM and 5:10 PM. Review of R34's Admission Record, undated, revealed the resident was admitted to the facility on [DATE] and then readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of R34's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/19 revealed<br>the facility assessed the resident to have a Brief Interveiw of Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Continued review of the MDS revealed the resident was assessed to have the [DIAGNOSES REDACTED]. Review of R34's Active Orders, as of 03/12/20 revealed the resident was ordered finger stick blood sugar before meals and at bedtime, [MED] [MED] solution pen injector 100 unit/ml inject per sliding scale subcutaneously before meals and at bedtime related to type 2 diabetes mellitus, [MED] solution 100 unit/ml inject 15 unit subcutaneously before meals related to type 2 diabetes mellitus without complications, and [MEDICATION NAME] Solution 100 unit/ml inject 40 unit subcutaneously in the morning related to type 2 diabetes mellitus without complications. Review of R34's Medication Administration Record [REDACTED]. Continued review of the MAR indicated [REDACTED] was not administered until 9:14 AM; on 01/15/20 the 8:00 AM dose was not administered until 9:34 AM; on 01/16/20 the 8:00 AM dose was not administered until 9:02<br>AM; on 01/17/20 the 5:30 PM dose was not administered until 7:34 PM; on 01/18/20 the 8:00 AM dose was not administered until 9:07 AM; on 01/18/20 the 12:30 PM dose was administered at 11:32 AM; on 01/20/20 the 8:00 AM dose was not administered until 9:14 AM; on 01/22/20 the 5:30 PM dose was not administered until 6:48 PM; on 01/23/20 the 8:00 AM dose was not administered until 10:02 AM; on 01/23/20 the 12:30 PM dose was administered at 11:17 AM; on 01/23/20 the 5:30 PM dose was administered at 4:34 PM; on 01/24/20 the 8:00 AM dose was not administered until 9:20 AM; on 01/27/20 the 8:00 AM dose was not administered until 9:45 AM; on 01/27/20 the 12:30 PM dose was administered at 11:39 AM; on 01/28/20 the 12:30 PM dose was administered at 11:09 AM; on 01/30/20 the 8:00 AM dose was not administered until 9:20 AM; on 01/30/20 the 12:30 PM dose was not administered until 5:38 PM; on 01/31/20 the 8:00 AM dose was not administer until 10:14 AM; and on 01/31/20 the 12:30 PM dose was administered at 11:40 AM. Further review of R34's MAR January 2020, specifically the resident's [MED], which was to be administered per the sliding scale at the scheduled times of 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM revealed the medication was not administered per the physician orders [REDACTED]. until 12:52 PM; on 01/13/20 the 4:30 PM dose was not administered until 5:36 PM; on 01/17/20 the 11:30 AM dose was not administered until 12:51 PM; on 01/25/20 the 11:30 AM dose was not administered until 4:23 PM; on 01/26/20 the 6:30 AM dose was administered at 5:37 AM; and on 01/27/20 the 4:30 PM dose was not administered until 5:40 PM. Review of R34's MAR indicated [REDACTED]. Continued review of the MAR indicated [REDACTED] not administered until 9:22 AM; on 02/20/20 at 5:30 PM the dose was not administered until 6:58 PM; on 02/21/20 the 8:00 AM dose was not administered until 9:38 AM; on 02/22/20 the 8:00 AM dose was not administered until 11:12 AM; on 02/23/20 the 8:00 AM dose was not administered until 9:33 AM; on 0[DATE] the 8:00 AM dose was not administered until 9:05 AM; on 02/25/20 the 8:00 AM dose was not administered until 9:34 AM; on 02/26/20 the 8:00 AM dose was not administered until 9:26 AM; on 02/26/20 the 5:30 PM dose was not administered until 10:58 PM; on 02/27/20 the 8:00 AM dose was not administered until 9:09 AM; on 02/28/20 the 8:00 AM dose was not administered until 9:18 AM; and on 02/29/20 the 8:00 AM dose was not administered until 1:41 PM. Further review of R34's MAR February 2020, specifically the resident's [MED], which was to be administered per the sliding scale at the scheduled times of 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM revealed the medication was not administered per the physician orders [REDACTED]. until 5:45 PM; on 02/22/20 the 9:00 PM dose was not administered until 10:08 PM; on 02/26/20 the 4:30 PM dose was not administered until 8:54 PM; on 02/27/20 the 9:00 PM dose was not administered until 10:03 PM; on 02/28/20 the 11:30 AM dose was not administered until 1:19 PM; on 02/28/20 the 4:30 PM dose was not administered until 5:44 PM; and on 02/29/20 the 9:00 PM dose was not administered until 10:17 PM. Review of R34's MAR indicated [REDACTED]. Continued review of the MAR indicated [REDACTED].<br>Further review of R34's MAR indicated [REDACTED]. Interview on 03/10/20 at 10:29 AM with R34 who's room is on the Georgia Unit, revealed she did not always get her [MED] before she ate her meal. Continued interview with the resident revealed she thought that was weird because she was always instructed to take the [MED] before she ate so she could regulate her sugar levels. R34 stated her sugar was always high because of this. Interview, on 3/12/20 at 2:30 PM with the IPADON revealed when reviewing the documented administration times of R34's [MED], there were some that would be out of compliance. Continued interview revealed the fast-acting [MED] should be given within 15 minutes before or after the |

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| F 0684<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 3)<br>resident's meal and for the long acting [MED], it should be administered within an hour of the scheduled time. The ADON stated it was important the time frames be in compliance and adhered to because they(facility) want to ensure they are managing the resident's diabetes and preventing complications. Interview on 03/12/20 at 2:37 PM with LPN1 revealed when asked about the date of 03/08/20 regarding R34's scheduled dose of [MED] at 8:00 AM, the LPN stated she gave the resident the [MED] at the scheduled time but documented it given at 9:45 AM. The LPN further stated she should have documented at the time she administered it. Interview on 03/12/20 at 4:49 PM Nurse Practitioner (NP) 1 revealed she was R34's provider. Continued interview revealed the facility had showed her R34's blood glucose (bg) checks and she did find it concerning. The NP stated after reviewing the resident's glucose checks and speaking with the resident's nurses, the nurses were not following the physician's orders [REDACTED]. NP1 stated it was her expectation the nurses would have followed the physician's orders [REDACTED]. The NP also stated it was important the [MED] would be administered as order because if the resident was going to see a specialist such as a endocrinologist, it would be difficult for them to provide care because of the resident's blood glucose numbers being up and down. Interview on 03/12/20 at 7:20 PM with the DON revealed it was her expectation nurses would have followed R34's physician orders [REDACTED]. Continued interview revealed diabetic care was important to ensure there was not wide variations in blood sugars and to ensure they were stable. Interview on 03/12/20 at 7:27 PM with the Administrator revealed would have followed good standard of practice related to administering R34's [MED]. Interview on 03/12/20 at 7:32 PM with the facility's Medical Director revealed he was less concerned with R34 not getting her [MED] [MED] timely because the resident was ordered [MEDICATION NAME] also. Continued interview revealed glucose levels were irrelevant to him because the A1C was what counted. The Medical Director stated her personally did not mind that the resident's [MED] was not administered on time because he was not trying to chase the resident's numbers (blood glucose numbers) because she was on [MEDICATION NAME].<br><br>2. Review of R77's Admission Record, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R77's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/03/20, Brief Interview for Mental Status (BIMS) indicated the resident was cognitively intact. Further review of R77's MDS showed the resident received seven days of [MED] injections during the last seven days of the ARD. Review of R77's January 2020's Medication Administration Record [REDACTED]. Review of R77's MAR for January 2020 showed on 01/01/20, 01/05/20, 01/16/20, 01/17/20, 01/23/20, and 01/29/20 the resident's [MEDICATION NAME] was not documented as administered at the time the physician ordered. On the dates of 01/01/20, 01/04/20, 01/06/20, 01/08/20, 01/09/20, 01/13/20, 01/15/20, 01/16/20, 01/17/20, 01/18/20, 01/22/20, 01/23/20, and 01/27/20 the resident's [MED] [MED] was not administered as ordered. Review of R77's MAR for February 2020 showed on 02/01/20, 02/05/20, and 02/22/20 the resident's [MEDICATION NAME] was not documented as administered at the time of the physician's orders [REDACTED]. [MED] was not administered as ordered. Review of R77's MAR for (NAME)2020 showed on 03/02/20, 03/03/20, 03/04/20, 03/06/20, 03/07/20, and 03/11/20 the resident's [MEDICATION NAME] was not documented as administered as ordered. On 03/02/20, 03/04/20, 03/05/20, 03/08/20, and 03/11/20 the resident's [MED] [MED] was not administered at the time of day the physician ordered the [MED] to be administered. 3. Review of R99's Admission Record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R99's MDS with an ARD of 01/19/20, BIMS score indicated the resident was cognitively intact. Further review of the MDS did not indicate whether the resident had received any [MED] injections. Review of R99's physician's orders [REDACTED]. Review of R99's MAR for January 2020 showed on 01/31/20 the resident did not receive their [MED] [MEDICATION NAME] Pen-injector as prescribed. The resident did not require additional [MED] coverage with the [MED] [MED] for the month of January 2020. Review of R99's MAR for February 2020 showed on 02/01/20, and 02/02/20 the resident did not receive the [MED] [MEDICATION NAME] per physician's orders [REDACTED]. Review of R99's MAR for (NAME)2020 showed on 03/04/20, 03/05/20, 03/07/20, 03/08/30, and 03/10/20 revealed the resident did not have [MED] [MED] administered in the time the physician ordered. 4. Review of R157's Admission Record revealed the resident had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R157's Quarterly MDS with an ARD of 02/04/20, BIMS score indicated the resident was moderately impaired cognitively. Further review of R157's MDS showed the resident received six days of [MED] injections during the last seven days of the ARD. Review of R157's Physician order [REDACTED]. Review of R157's MAR for January 2020 revealed on 01/02/20, 01/05/20, 01/20/20, 01/21/20, 01/22/20 and, 01/24/20, the resident did not receive his [MEDICATION NAME]as ordered by the physician orders. Review of R157's MAR for February 2020 revealed on 02/03/20, 02/0420, 02/05/20, 02/07/20, 02/08/20, 02/15/20, 02/17/20, 02/20/20, and 02/21/20, the resident had not received his [MEDICATION NAME]during the time indicted per the Physician orders. Review of R157's MAR for (NAME)2020 revealed on 03/03/20, 03/03/20, 03/05/20, 03/06/20, 03/07/20, 03/08/20, and 03/10/20, the resident was not documented as receiving his [MEDICATION NAME]per the prescribed time.<br><br>5. Review of R198's Admission Record stated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R198's quarterly MDS, with an ARD of 02/21/20, the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. In addition, review of R198's MDS showed the resident received seven days of [MED] injections during the last seven days of the ARD. Review of R198's Active Medication Orders as of 03/09/20, included: [MED] Solution ([MED]) 100 unit/ml inject units using a sliding scale before meal and at bedtime (6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM). [MEDICATION NAME] Solution ([MED]) 100 unit/milliliters (ml) inject 76 units subcutaneous two times per day at 9:00 AM and 9:00 PM. Review of R198's MAR for January 2020 showed on 01/3/20, 01/4/20, 01/5/20, 01/6/20, 01/9/20, 01/10/20, 01/11/20, 01/12/20, 01/13/20, 01/14/20, 01/16/20, 01/19/20, 01/20/20, 01/22/20, 01/25/20, and 01/26/20 the resident's [MED] [MED] was not administered as ordered. On the dates of 01/3/20, 01/5/20, 01/6/20, 01/10/20, 01/11/20, 01/12/20, 01/20/20, 01/22/20, and 01/26/20 the resident's [MEDICATION NAME]was not documented as administered at the time the physician ordered. Review of Resident #39's February MAR indicated [REDACTED]. On the dates of 02/3/20, 02/3/20, 02/22/20, 02/23/20, 02/27/20, 02/28/20, and 02/29/20 the resident's [MEDICATION NAME]was not administered at the time of day the physician ordered the [MED] to be administered. Review of Resident 39's (NAME)MAR showed on 03/7/20 and 0[DATE]20 the resident's [MED] was not administered as ordered. Interview was conducted with the Medical Director's Physician Assistant (PA) 1 on 03/12/20 at 12:11 PM. PA 1 was asked what was her expectations related to administration and documentation of [MED]? PA 1 stated, I would expect nurses to give fast acting [MED] within 15 to 20 minutes of blood glucose and long acting [MED] as ordered. Interview was conducted with the Director of Nursing (DON) on 03/12/20 at 1:53 PM . The DON was asked what her expectations were related to nurse's [MED] administration and documentation? The DON stated, I expect nurses to document in real time when the [MED] is administered. Interview was conducted with Registered Nurse (RN)1 on 03/12/20 at 3:30 PM. RN1 was asked when he documents fast-acting and long-acting [MED]? RN1 stated, I document all medications when I give them, point click care only allows me to document in real time. Interview was conducted with Licensed Practical Nurse (LPN) 2 on 03/12/20 at 4:30 PM. LPN 2 was asked when does she document the resident's [MED] administration? LPN 2 stated, I document the [MED] right after I have given it. Telephone interview was conducted on 03/12/20 at 5:40 PM with the Consultant Pharmacist. The Consultant Pharmacist stated, it is very important for the basal [MED] such as, [MEDICATION NAME] and [MEDICATION NAME], be given at the same time every day, otherwise you would be giving more sliding scale [MED] for blood sugar coverage. This makes it very hard to manage the resident's diabetes and it is hard on their system. Review of facility policy titled Medication Administration Times revised 05/01/10, instructed facility should ensure that authorized personnel, administer medications according to times of administration as determined by facility's pharmacy committee and/or physician/prescriber . should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration .should administer medications ordered before meals approximately thirty (30) minutes before meal time, and should administer medications ordered to be given after meals no later than thirty (30) minutes after a meal has ended. Review of facility policy titled General Dose Preparation and Medication Administration revised 01/01/13, instructed staff to . verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time and, for the correct resident .administer medications within timeframes specified by facility policy. Review of the professional standards the facility indicated they followed, Lippincott Procedures-Subcutaneous Injection revised 08/16/19, revealed Subcutaneous injection delivers a drug into the adipose (fatty) tissue beneath the skin. This method allows the drug to move into the bloodstream more rapidly than with oral administration, because the drug is absorbed mainly through the capillary .verify that you're administering the medication at the proper time, in the prescribed dose, and by the correct route to reduce the |

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| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>risk of medication errors. Review of the Nurse Practice Act of Georgia, also indicated as the facility's professional standards, Practice nursing as a registered professional nurse means to practice nursing by performing .any of the following: .Providing safe and effective nursing care rendered directly or indirectly . managing and supervising the practice of nursing .administering medications and treatments as prescribed by a physician [MEDICATION NAME] medicine . Review of the Omnicare Drug Information for [MEDICATION NAME] FlexTouch ([MED] Detemir), copyright 2020, provided by the<br>facility, revealed [MED] detemir is used to control high blood sugar in people with diabetes. Controlling high blood sugar helps prevent kidney damage, [MEDICAL CONDITION], nerve problems, and loss of limbs. Proper control may also lessen the chance of a [MEDICAL CONDITION] or stroke .[MED] detemir is usually injected with the evening meal or at bedtime. If it is being given twice daily, inject as directed by your doctor, usually the first dose in the morning and second dose with the evening meal, at bedtime, or 12 hours after the morning dose. Review of the Omnicare Drug Information for [MEDICATION NAME] ([MED] [MEDICATION NAME]) revised November 2019, revealed that [MEDICATION NAME] is used to control a person blood<br>.use the medication regularly as directed by your doctor in order to get the most benefit from it .You may inject [MED] [MEDICATION NAME] once daily at any time during the day (such as before breakfast or at bedtime) but you should inject at the same time each day. Review of the Omnicare Drug Information for [MED] ([MED] [MEDICATION NAME]) revised November 2019, revealed that [MED] is used for control of high blood sugars .[MED] [MEDICATION NAME] starts working faster and lasts a shorter time than regular [MED]. Inject this medication within 15 minutes before eating a meal or immediately after a meal. Because this [MED] is a fast acting, not eating right after a dose of [MED] may also lead to low blood sugar. |
| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide enough food/fluids to maintain a resident's health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, and review of the facility's policy, the facility failed to ensure a medical nutrition therapy assessment was consistently completed to determine residents nutritional status and risk factors for eight (Resident (R) 1, R25, R42, R51, R87, R143, R153 and R183) of 35 sampled residents who were reviewed for comprehensive nutritional assessments by a registered dietician (RD). Findings include: Review of the facility's policy titled, Medical Nutrition Therapy Assessment, revised October 2010 revealed it was the intent of the facility to Conduct a comprehensive nutritional assessment of each resident upon admission and additionally as required by state and/or federal regulation .Fundamental information of the policy stated, .Each resident will receive a comprehensive nutritional assessment upon admission, annually, and when a resident is identified as having a significant change in status. Resident will be re-addressed quarterly in conjunction with the quarterly MDS (Material Data Set) and as needed. The nutritional assessment encompasses the medical data, physical condition and examination, nutrition history, social history, and nutrient assessments .The nutritional assessment is then used in the development of the resident's individualized care plan to demonstrate the resident's needs, strengths, and priorities .Related Standards for the policy stated, .OP4 0201.00 Resident Assessment Instrument (RAI) Process Resident Care Management Systems Manual (ViaTech) was sourced. Review of the facility's policy titled, Weight Management section Appendix A revised July 2017 provided by the Administrator revealed Dietician Duties were .1. Provide consultation to medical, nursing, and other professional staff of Facility regarding nutritional needs of Facility's residents. 2. Dietician shall complete nutritional assessments for Residents and assist with care plan development for Residents .Dietician shall participate in any meeting of Facility staff as reasonably requested by the Administrator or Director of Nursing including care plan meetings, quality assurance meetings, or regular morning meetings. 1. Review of R42's Admission Record undated located in the Electronic Medical Record (EMR), revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R42's annual MDS with an Assessment Reference Date (ARD) of 12/20/19 located in the EMR revealed R42 was severely cognitively impaired. R42 required supervision and oversight with eating. R42 was on a mechanical altered and therapeutic diet with noted weight (wt.) loss; on a physician wt. loss regimen. However, review of the physician orders [REDACTED]. loss regimen was ordered. Review of R42's Order Summary Report located in the EMR for the month of (NAME)2020, revealed the resident was ordered a regular diet with mechanical soft texture that originally started on 01/15/18 and a house supplement for wt. loss that started on 9/10/19. Monthly wt. started on 01/13/18 and then weekly wt. started on 09/13/19. There was no physician wt. loss regimen order identified. Review of R42's current Care Plan located in the EMR revealed the RD was to evaluate and make diet change recommendations as needed. The date initiated was 01/12/18. There were no new or revised goals and/or interventions to reflect the MDS assessments for dates of 10/16/19 and 12/20/19. Review of R42's RD assessment notes located in the EMR titled, Nutrition Status Review and Nutrition Data Collection revealed the only assessments completed were for dates of 07/25/19 and 03/12/20. The 03/12/20 assessment was completed during survey after the nutrition assessment concern was identified. It was confirmed during interview with the RD, there were no other areas of the resident's hard copy chart or the EMR where nutrition assessments would be located, and he had not completed any assessments on R42 past the 07/25/19 date. 2. Review of R87's Admission Record undated located in the EMR revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R87's annual MDS with an ARD of 04/20/19 located in the EMR<br>revealed R87 was severely cognitively impaired. R87 required supervision and oversight of one staff assist for eating. R87 was on a mechanically altered diet with no wt. loss recorded. Review of R87's Order Summary Report located in the EMR for the month of (NAME)2020, revealed the resident was ordered a regular diet with mechanical soft texture, regular consistency, and large portions that was originally started on 04/21/18. Review of R87's current Care Plan located in the EMR revealed he needed assistance with eating with a date initiated on 12/05/16 and last revised on 11/21/17. Facility was to observe intake to assure an adequate fluid intake to prevent dehydration with a date initiated on 12/05/2016. R87's diet was to be given as Ordered and to consult with the RD if problems were identified with a date initiated on 06/07/17. There was no care plan specific to nutritional care assessed by the RD. Review of R87's RD assessment notes located in the EMR titled, Nutrition Status Review and Nutrition Data Collection revealed the only assessment completed was for the date of 07/23/19. It was confirmed during interview with the RD, there were no other areas of the resident's hard copy chart or the EMR where nutrition assessments would be located, and he had not completed any assessment on R87 past the 07/23/19 date. 3. Review of R143's Admission Record undated located in the EMR revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R143's annual MDS with an ARD of 07/26/19 located in the EMR<br>revealed R143 was severely cognitively impaired. R143 required total dependence of staff for eating and 51 percent or more of his food was provided by a feeding tube. Review of R143's Order Summary Report located in the EMR for the month of (NAME)2020, revealed the resident received [MEDICATION NAME] 1.5 via feeding tube at a rate of 92 ml (milliliters) per hr. (hour) from 6 PM to 6 AM with water flushes at 145 ml every two hours started on 10/04/19. R143 was to have monthly wt./s started on 09/16/19. Review of R143's current Care Plan located in the EMR revealed the RD was to evaluate quarterly and as needed and to observe R143's caloric intake and estimate needs. The RD was to make recommendations for changes to tube feeding as needed. There were no dates to show when the care plan was initiated and/or revised in relation to RD assessments. Review of R143's RD assessment notes titled, Nutrition Status Review and Nutrition Data Collection revealed the last RD assessment was dated 08/29/19. There were no RD assessment notes for the 11/05/19 and the 02/04/20 MDS quarterly assessments completed. It was confirmed in interview with the RD, he had not completed any assessment on R143 past the 08/29/19 date. 4. Review of R183's Admission Record undated located in the EMR revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R183's annual MDS with an ARD of 02/11/20 located in the EMR revealed R183 was moderately cognitively impaired. R183 required supervision and oversight of one staff assist for eating. R183 was on a renal diet with wt. loss no directed by a physician. Review of R183's Order Summary Report located in the EMR for the month of (NAME)2020, revealed the resident was ordered a renal diet and was on [MEDICAL TREATMENT] with weekly wt./s. Review of R183's RD's most current note titled, Nutrition Status Review dated 12/23/19 revealed the resident had lost significant wt. of (7.5%) in one month and would recommend a supplement. However, review of the [MEDICAL TREATMENT] communication forms for the month of December 2019 revealed the resident had not had a significant<br>wt. loss, the wt. was stable and in normal range for the resident. Interview with the RD confirmed there were no other assessment notes for R183 completed after the 12/23/19 date. Interview with the RD on 03/11/20 at 10:30 AM revealed he had not completed timely reviews on residents in correlation with the MDS Resident Instrument Assessment (RAI) 3.0 Manual and the facility policy for RD services. He stated, he had attended some of the care plan meetings and some of the nutritionally at-risk meetings but not all of them. He stated, he had three buildings in the company and had to do it all. Interview with the MDS Director on 03/11/20 revealed she stated, the MDS team would review the MDS to ensure each discipline completed their sections but would not review the resident record for completed assessment notes surrounding the findings. She stated, the MDS team typically do not review the RD's assessment findings and/or notes. She stated, the RD |

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| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 5)<br>was responsible for updated their nutritional care plans. She stated, the RD had been advised on a few occasions to complete RD assessments on residents that were triggered for significant change in status when she seen some were not completed. She stated, she was not aware the RD had not been timely completing nutrition assessments according to the MDS schedule and facility policy. Interview with the Director of Nursing (DON) and the Unit Manager (UM) for the Magnolia Unit on 03/11/20 at 2:50 PM revealed they were not aware the RD had not been completing the nutritional assessments according to the MDS schedule and facility policy. The DON stated, the RD was responsible for completing an updated assessment related to annual, quarterly and change of status resident assessments. She stated, the RD was given a copy of the restorative wt. logs to input in the EMR when he completed his assessments. The UM for the Magnolia Unit revealed the nursing staff does look at the wt./s put in the computer, but they also reference the [MEDICAL TREATMENT] wt. sent from the daily [MEDICAL TREATMENT]/facility communication sheet and hospital records. The UM stated, she had no wt. concerns with any of the residents on the Magnolia Unit at the current time. Interview with the Medical Director Physician Assistant on 03/12/20 at 12:27 PM revealed she stated, she was no aware the RD nutrition assessments were not being completed timely and with the MDS schedule and facility policy. She stated, the nursing department does contact her when a resident has had a significant wt. loss or requests a supplement or diet change. She stated, many of the residents prefer outside of the facility food and the vending machine and doesn't feel the facility has a concern with excessive wt. loss. She stated, no completing the RD assessments could affect the management of resident's care with chronic diseases such as diabetes. She confirmed her residents were stable in their wt. Interview with the DON on 03/12/20 at 1:50 PM revealed she stated, she was not sure who would monitor if the RD was completing assessments or not per the MDS schedule and policy, however, she would find out. Interview with the Administrator on 03/12/20 at 1:50 PM revealed she stated, when the DON came to her to find out who would monitor the RD services, she stated, she has had some prior concerns with the performance of the RD relating to not showing up for the nutrition at risk meetings and the resident care plan meetings. She stated, she was not aware the RD assessments according to the MDS schedule and policy were not completed in a timely manner or getting completed at all. She stated, the RD was currently addressing the survey findings and updating and completing assessments and care plans.<br><br>5. On 03/10/20 at 11:06 AM, observation of R25 revealed the resident was on a continuous tube feeding. Review of R25's Admission Record located under the Profile tab of the EHR documented R25 was admitted to the facility on [DATE]. The [DIAGNOSES REDACTED]. Review of R25's annual MDS, with an ARD of 02/26/20, revealed the facility assessed the resident to have a BIMS score of 0 out of 15 which indicated the resident has a severe cognitive impairment. In addition, the MDS Assessment documented R25's base weight was 110 pounds with no weight loss in the last six months. The MDS assessment further revealed the resident required tube feeding. Review of R25's Comprehensive Care Plan, dated revised 11/07/19, revealed R25 received all nourishment through a percutaneous endoscopic gastrostomy (PEG) tube (a tube placed in the stomach when oral intake is not adequate) and the resident did not receive any nourishment or medication orally. Review of R25's MAR indicated [REDACTED]. On 03/11/20 at 10:40 AM, an interview was conducted with the facility's RD. The RD stated nutritional assessments were required annually and quarterly (at least every 3 months) for every resident. The RD stated R25's annual nutritional assessment was completed on 04/11/19 and he had not completed any quarterly assessments for R25 since the annual assessment on 04/11/19. 6. Review of R51's Admission Record located under the Profile tab of the EHR documented R51 was admitted to the facility on [DATE]. The [DIAGNOSES REDACTED]. Review of R51's annual MDS, with an ARD of 07/05/19, revealed the facility assessed the resident to have a BIMS score of 12 out of 15 which indicated the resident has a moderate cognitive impairment. In addition, the MDS Assessment documented R51's base weight was 110 pounds and the resident was on a therapeutic, mechanically altered diet. Review of R51's annual assessment completed by the RD, dated 04/11/19, stated Resident's intake is highly variable. On Carbohydrate Controlled Diet (CCD) No Added Salt (NAS) diet with Puree texture and Nectar liquids .Lab data from February indicate low Na, [MEDICATION NAME], EGFR, and hemoglobin; elevated glc and HBA1C .Recommendation: add Nepro, 1 can TID (three times a day). Review of R51's laboratory results, dated 10/26/19, revealed R51's result indicated a low [MEDICATION NAME] level of 3.3 and an elevated [MEDICATION NAME] level of 3.1. Review of R51's Comprehensive Care Plan, dated revised 06/03/19, revealed R51 required a therapeutic diet and a fluid restriction due to a [DIAGNOSES REDACTED]. The Care Plan noted the resident had a weight loss related to the amputation of the resident's leg below the knee. On 03/11/20 at 10:40 AM, an interview was conducted with the facility's RD. The RD stated nutritional assessments were required annually and quarterly (at least every 3 months) for every resident. The RD stated R51's annual nutritional assessment was completed on 04/11/19 and he had not completed any quarterly assessments for R51 since the annual assessment on 04/11/19. 7. On 03/10/20 at 10:15 AM, observations of R153 were conducted in the resident's room. R153 was observed awake in the bed and did not respond to questions. R153 was observed having upper and lower extremity contractures. Review of R153's Admission Record located under the Profile tab of the EHR documented R153 was admitted to the facility on [DATE]. The [DIAGNOSES REDACTED]. Review of R153's quarterly MDS, with an ARD of 02/05/20, the facility assessed the resident to have a BIMS score of 0 out of 15 which indicated the resident has a severe cognitive impairment. Review of the most recent RD assessment in the EHR, dated 12/29/17, stated R153 continues to be dependent on staff for feeding and also continues to demonstrate good meal intake of 75-100. The assessment further stated R153's weight is stable and no additional recommendation were needed at the time of the assessment. In addition, there were no other records of assessments by the RD in R153's record. On 03/12/20 at 12:30 PM, an interview was conducted with the Registered Nurse (RN) Unit Manager. The Unit Manager stated R153 required total assistance with eating. On 03/11/20 at 10:40 AM, an interview was conducted with the facility's RD. The RD stated nutritional assessments were required annually and quarterly (at least every 3 months) for every resident. The RD stated R153's annual and quarterly nutritional assessments has not been completed and the RD did not provide an explanation for why the assessments were not completed.<br><br>8. Review of Resident (R) 1's Admission Record, dated 03/12/20, revealed the resident was readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Review of R1's weight records in the Electronic Medical Record (EMR) revealed R1 to be losing weight monthly. 10/11/19-86lbs., 11/11/19-83lbs., 12/07/19-80lbs., 01/10/20-78lbs., 02/14/20-72lbs. Review of R1's care plan dated 06/03/19 indicated R1 has nutrition problem related to being underweight and related to need for mechanically altered texture diet. Intervention listed Registered Dietitian (RD) to evaluate and make diet change recommendations as needed. Multiple observations were performed during the survey, but no meals were observed. Review of the care plan indicated R1 requires total assistance for eating his meals and drinks nectar thick liquids. There was no update to the care plan since 06/03/19. Review of the (NAME)2020 MAR for R1 revealed a water bottle of eight ounces nectar consistency four times per day documented and the House Supplement, (no ounces), two times per day. Review of the meal intake logs for R1 revealed; from 02/15/20 to 03/11/20 68 meals were logged, of those two meals were refused, eight were consumed at less than 50%, 13 were consumed between 50-75%, and 47 were consumed at 75% or greater. On 03/11/20 at 12:50 PM an interview with the RD was conducted. The RD stated R1 receives a house shake (a nutritional supplement) two times per day and consumes 75% or more of most of his meals and snacks. The RD confirmed R1's weight loss of six pounds in February, a 7.69% loss which the EMR alerted and he failed to follow up. The RD stated he should be checking/reviewing when the EMR sends the alert. He confirmed no nutritional review was performed following the EMR alert in February. The RD confirmed the last nutritional review regarding R1 was six months ago. The RD did not know why R1 lost weight. The RD stated he failed to follow up on the EMR alert and no notifications were made to the physician or interdisciplinary team. On 03/11/20 at 1:30 PM an interview with the Director of Nursing (DON) was conducted. The DON confirmed the interdisciplinary team held a meeting on 02/26/20. The DON stated the team discussed R1's care but did not specifically address R1's weight loss. |
| F 0838<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.**<br><br>Based on interview, record review and review of the annual 2019 Facility Assessment the facility failed to ensure residents received the appropriate professional Registered Dietician (RD) services as identified in their annual 2019 Facility Assessment. This had the potential to affect all eight residents reviewed for nutrition services of 35 sampled residents. Cross reference F692 Findings include: Review of the facility's annual 2019 Facility assessment dated last updated in (NAME)2019 revealed the intent of the facility assessment was to evaluate resident population to identify resources to |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115025 | A. BUILDING _____ B. WING _____ | 03/12/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| GLENWOOD HEALTH AND REHABILITATION CENTER | 4115 GLENWOOD RD DECATUR, GA 30032 |

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 0838<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 6)<br>provide person centered care and services to the residents. The overview stated: .Overview of the Assessment Tool: .Our Resident Profile: This section describes the resident population, including the number of licensed beds, census, diseases/conditions, physical and cognitive disabilities, resident acuity and ethnic, religious and cultural factors that impact care. The Services and Care We Offer Based on our Resident's Needs: This is a description of services the facility provides to meet the current resident population's needs. (The Facility Assessment is not intended to focus on individual level care plans.) Facility Resources Needed to Provide Competent Care for Our Residents: This section includes staff, staffing plan, staff education, training and competencies; physical environment and building; other resources, including agreements with vendors, health information technology resources and systems. Additionally, each facility conducts a facility-based and community-based risk assessment to ensure care is delivered competently every day and during emergencies . Review of the facility's annual 2019 Facility Assessment section, Special Treatments and Resident Care Needs; Nutrition revealed the facility would provide residents with .Tube Feeding, TPN, Supplements, Mechanically Altered Diets, and Thickened Liquids needs .Resident Support/Care Needs: individualized dietary requirements, Specialized diets, IV (intravenous) nutrition (TPN) Tube feeding Cultural or ethnic dietary needs Assistive devices Fluid monitoring or restrictions Hypodermoclysis Assessment and management of weight loss . and in the .Staff Type and Position services . Food and Nutrition Services: Registered Dietician was listed. Interview with the RD on 03/11/20 at 10:30 AM revealed he had not completed timely reviews on residents in correlation with the MDS Resident Instrument Assessment (RAI) 3.0 Manual and the facility policy for RD services. He stated, he had attended some of the care plan meetings and some of the nutritionally at-risk meetings but not all of them. He stated, he had three buildings in the company and had to do it all.<br>Interview with the Administrator on 03/12/20 at 1:50 PM revealed she stated, when the DON came to her to find out who would monitor the RD services, she stated, she has had some prior concerns with the performance of the RD relating to not showing up for the nutrition at risk meetings and the resident care plan meetings. She stated, she was not aware the RD assessments according to the MDS schedule and policy were not completed in a timely manner or getting completed at all. She stated, the RD was to provide resident care and services according to the MDS schedule, which required comprehensive assessments, dietary recommendations, updating care plans and attending nutrition related meetings. She stated, the RD was currently addressing the survey findings and updating and completing assessments and care plans. An additional information was obtained during Quality Assurance Process Improvement (QAPI) interview with the Administrator on 03/12/20 at 6:30 PM. She confirmed the RD had not been providing services according to the facility's annual 2019 Facility Assessment. She stated, she understood the facility was to offer according to their assessment professional RD services and according to the MDS schedule of assessments and the facility policy. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, and review of the facility's policies, the facility failed to implement and effective Infection Prevention and Control Program (IPCP) for one of one unsampled resident who was physician ordered contact isolation precautions (Resident (R) 462). Observation on 03/10/20 revealed a facility staff member in the resident's room providing care to the resident without the proper personal protective equipment (PPE) on. Additionally, the facility utilized regular equipment for the resident's meals; however, the facility failed to ensure the resident's meal equipment was properly handled when the equipment was retrieved after the meal. These failures had the potential to effect other residents and staff in the facility. Findings include: Review of the facility's Infection Prevention Manual for Long Term Care policy titled, Contact Precautions, revised 02/2018 revealed it was the intent of the facility to use contact precaution in addition to standard precaution for resident known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. Continued review of the policy, specifically section III. Gowns, revealed a gown should be donned (put on) prior to entering the room. Review of the Resident Care Equipment section of the policy revealed dedicated resident care equipment should be considered for the resident and if use of common equipment or items was unavoidable, the items should be adequately cleaned and/or disinfected before use for another resident. Further review of the policy revealed contact precautions would be considered for multi-drug resistant organisms (MDROs) and the policy included ESBL (Extended-Spectrum Beta-Lactamases) in the examples of organisms. Review of the facility's Infection Prevention Manual for Long Term Care policy titled, Fact Sheet Extended-Spectrum Beta-Lactamases (ESBLs), revised 02/2018 revealed ESBLs were organisms that secrete enzymes causing resistance to extended-spectrum (third generation) cephalosporins (e.g., [MEDICATION NAME], cefotaxime, and [MEDICATION NAME]) and monobactams (e.g., aztreonam) but did not affect [MEDICATION NAME] (e.g., [MEDICATION NAME] and [MEDICATION NAME]) or carbapenems (e.g., meropenem or imipenem). The policy also revealed a variety of bacteria could become producers of ESBLs and listed examples of K. pneumonia and E. coli. Continued review of the policy revealed the CDC (Centers for Disease Control and Prevention) recommended contact precaution but suggested that LTCFs (Long-Term Care Facilities) make a case by case decision regarding implementation or modification of contact precautions based on the individual's clinical situation and prevalence or incidence of MDRO in the facility. Review of R462's Admission Record, undated, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. coli. Review of R462's Order Summary Report, active orders as of 03/12/20, revealed the resident was ordered to remain on Contact Precautions from 03/09/20 until 03/20/20. Continued review of the Order Summary Report revealed the resident was ordered meropenem solution reconstituted 1 gm (gram) intravenously three times a day related to unspecified e. coli. Observation on 03/10/20 of room [ROOM NUMBER] revealed information on the resident's door alerting staff and visitors to see the resident's nurse before entering the room. Additionally, there was a bin with drawers outside the resident's room that contained PPE of gowns and gloves. Continued observation revealed a facility employee in the resident's room wearing gloves on her hands; however, the employee did not have a gown on and was touching the resident's bare legs and the bed linens that came into contact with the employees arms and clothing. Observation and interview with the Infection Prevention Staff Development Coordinator (IPSDC) revealed R462 was under isolation contact precautions and the employee in the room was a Resident Care Specialist (RCS) and she should be wearing a gown. The IPSDC identified the employee as RCS2 and confirmed she was not wearing a gown. The IPSDC stated it was important the RCS would be wearing a gown to prevent her (RCS) from getting sick and to prevent the spread of infection to residents and coworkers. Observation on 03/11/20 at 8:06 AM revealed R462 eating breakfast and using regular meal equipment including plate, utensils, and plastic cups. Observation on 03/11/20 at 12:09 PM revealed the resident was delivered her meal on a plastic serving tray like other residents and the tray contained regular meal equipment. Observation on 03/11/20 at 5:35 PM revealed the resident was eating her supper meal and using regular meal equipment. Observation on 03/11/20 at 5:44 PM revealed RCS3 entered R462's room with correct PPE on, gathered the residents meal items and put them on the serving tray that was on the resident's bedside table, removed gown, brought the tray with meal equipment and put the tray in the meal cart on the Georgia hall with the other residents trays. Interview on 03/11/20 at 5:50 PM with RCS3 revealed the RCS confirmed she did put R462's tray with her meal equipment in the meal cart with the other residents' trays. Continued interview revealed the tray was not covered or bagged to prevent the tray from coming into direct contact with the meal cart or other trays. RCS3 stated she had not been instructed to cover or bag the tray. Interview on 03/12/20 at 2:03 PM with the IPSDC revealed the facility did not use disposable meal equipment for resident's who are under isolation precautions. The IPSDC stated now they will be either utilizing a plastic bag to put isolation trays in and taking it directly to the kitchen. Continued interview revealed related to the meal carts being cleaned, the IPSDC stated the kitchen did take the carts outside and wash them; however, she did not know how often and what the carts were washed with. The IPSDC also stated she can see now that it is important the tray be covered with a bag to prevent cross contamination. Interview on 03/12/20 at 2:21 PM with Infection Prevention Assistant Director of Nursing (IPADON) 1 revealed she was the primary Infection Preventionist. Continued interview revealed it was her expectation anytime an employee entered R462's room they would have had both gown and gloves on to prevent the spread of infection. The IPADON stated the facility now does bag the trays of residents under isolation and walk the tray directly to the kitchen.<br>Interview on 03/12/20 at 7:21 PM with the Director of Nursing (DON) revealed it was her expectation the facility would have followed their infection control protocol to prevent the spread of infections. Interview on 03/12/20 at 7:27 PM with the Administrator revealed it was her expectation infection control guidelines would have been followed and R462's tray would have been bagged when brought out of the room. Interview on 03/12/20 at 7:32 PM with the Medical Director revealed it was his expectation the facility's infection control policy would have been followed. |