STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675321	A. BUILDING _____ B. WING _____	05/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAITH MEMORIAL NURSING HOME	811 GARNER RD PASADENA, TX 77502

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 -** Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for 3 of 5 residents (Residents #43, #17 and #7) reviewed for nutrition. -The facility failed to ensure the Registered Dietitian's recommendations that included health shakes for Resident #43's significant weight loss of 11.4% in 90 days were communicated to the Doctor. -The facility failed to ensure the Registered Dietitian's recommendations that included supplements and health shakes for Resident #17's wound healing were communicated to the Doctor. -The facility failed to ensure the Registered Dietitian's recommendations that included large meal portions and health shakes for Resident #7's significant weight loss of 6.6% in 30 days were communicated to the Doctor. These failures could affect any resident who the Registered Dietitian made recommendations for and placed them at risk of weight loss and decline in health status. Findings include: Resident #43 Record review of Resident #43's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #43's quarterly MDS assessment dated [DATE] revealed a BIMS score of 0 - indicating severe cognitive impairment. She required extensive assistance with one person for eating. She was 62 inches tall and weighed 164 lbs. Record review of Resident #43's care plan last reviewed 5/21/20 read in part, .Focus: (Resident #43) has a potential nutritional problem (weight loss) r/t dementia not wanting to eat and needing assist at times with eating . Interventions: . RD to evaluate and make diet change recommendations PRN . Record review of Resident #43's Monthly Weight Report dated 5/30/20 revealed Resident #43 weighed 179.6 lbs in 2/2020 and 159.2 lbs in 5/2020. Record review of the Consultant Dietitian Communication to Director of Nurses and Nursing Staff sheet dated 5/8/20 and written by the Dietitian revealed Resident #43 had a significant weight loss of 11.4% in 90 days. Notes on the communication log revealed: per care team, resident eats and drinks all of the food she is given. Significant weight loss r/t unknown causes. Wt has been stable last two months. Dietitian recommendations: add sugar-free health shakes three times a day with meals. The form read, Please initiate orders and fax confirmation back to RD within 72 hours . Record review of Resident #43's condensed physician orders [REDACTED]. Observation on 5/30/20 at 5:38 p.m. of Resident #43, she was sitting in a wheelchair by her bed in her room. She was drinking an unidentified liquid from her glass. Interview on 5/30/20 at 5:40 p.m. with CNA A, she said she had assisted Resident #43 with her dinner meal and there was no sugar free health shake present. Resident #17 Record review of Resident #17's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #17's 5-day MDS assessment dated [DATE] revealed a BIMS score of 13 - indicating intact cognition. She required extensive assistance with one person for eating. She was 62 inches tall and weighed 82 lbs. Record review of Resident #17's undated care plan read in part, .Focus: (Resident #17) has nutritional problem or potential nutritional problem (weight loss) r/t needing assist while eating . Interventions: .observe/record/report to MD PRN s/sx of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss . Record review of the Consultant Dietitian Communication to Director of Nurses and Nursing Staff sheet dated 5/8/20 and written by the Dietitian revealed Resident #17 had a trauma wound to left thumb, left heel stage III, sacrum stage III, and nephrostomy tube. Resident had increased nutrient needs related to wound healing. Dietitian recommendations: add large portion to all meals, add sugar-free health shakes three times a day with meals, add liquid protein 30 mL twice a day, and add vitamin C 500 mg 1 tablet per day. Record review of Resident #17's Food and Nutrition Service Department form signed by the Dietitian on 5/8/20 revealed a recommendation to Resident #17's Doctor to add liquid protein 30 mL twice a day and vitamin C 500 mg 1 tablet per day. There was no check mark next to I agree or I disagree. There was also no doctor signature on the form. Record review of Resident #17's condensed physician orders [REDACTED]. order date 5/6/20 There were no orders for sugar free health shakes three times a day, vitamin C, or liquid protein. Observation and record review on 5/30/20 at 12:25 p.m. of Resident #17, she was sitting in her bed in her room. CNA B was assisting her with the lunch. The lunch meal contained a regular portion of smothered steak with brown gravy, greens, mashed potatoes, roll, and cheesecake bar. There was no health shake present and the meal ticket did not indicate large portion. Resident #7 Record review of Resident #7's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #7's admission MDS assessment dated [DATE] revealed a BIMS score of 14 - indicating intact cognition. He required supervision and setup help for eating. He was 70 inches tall and weighed 162 lbs. Record review of Resident #7's undated care plan read in part, .Focus: (Resident #7) has had unexplained weight loss of 5% weight change in 30 days related to terminal illness . Interventions: .give the resident supplements as ordered . if weight decline persists, contact physician and dietician immediately Record review of Resident #7's Weights and Vitals Summary dated 5/30/20 revealed Resident #7 weighed 160.6 lbs on 4/5/20 and 150 lbs on 5/4/20. There was a significant weight loss of 6.6% in 30 days. Record review of the Consultant Dietitian Communication to Director of Nurses and Nursing Staff sheet dated 5/8/20 and written by the Dietitian revealed Resident #7 had a significant weight loss of 6.6% in 30 days. Notes on the communication log revealed: Resident #7 on hospice. Per resident, wt loss possibly r/t him not wanting to eat a lot d/t him not liking the food. Resident unable to communicate likes and dislikes. Poor PO intake possibly r/t [MEDICAL CONDITION]. Dietitian recommendations: add large portions to all meals and add health shakes three times a day with meals. Record review of Resident #7's condensed physician orders [REDACTED]. Observation on 5/30/20 at 5:20 p.m. of Resident #7, he was sitting in a wheelchair by his bed in his room. He had not received a dinner tray yet. Interview on 5/30/20 at 2:18 p.m. with the DON, she said the DON, ADON, and Unit Manager were responsible for communicating Dietitian recommendations to the Doctor. They recieved the recommendations by e-mail. She said if the Doctor agreed with the recommendation, an order would be written and carried out. She said the process normally took 3 days. Continued interview and record review on 5/30/20 at 4:50 p.m., the DON said she missed the Dietitian recommendations from 5/8/20 and did not report them to the Doctor. DON showed the emails on her computer from the Dietician. She said it was important to communicate the recommendations to the Doctor, so the residents would not continue to lose weight and get sick. Telephone interview with the Dietitian on 5/30/20 at 5:12 p.m., she said the dietary recommendations for 5/8/20 were sent to the DON, Administrator, and Dietary Manager via e-mail. She said the DON at the facility instructed her to put supplement recommendations (such as vitamins and protein) on the Food and Nutrition Service Department form so the doctor could sign it and to put dietary only recommendations (such as large portions and health shakes) on the Consultant Dietitian Communication to Director of Nurses and Nursing Staff excel sheet. She said despite the different forms they were all nutritional recommendations. Record review of the facility's Consultant Dietitian Services policy dated June 2007 read in part, Guidelines .5. The Consultant Dietitian prepares a list of clinical recommendations at each visit and discusses these with the Dietary Manager and the Administrator at each visit that outlines the consultant's activities, findings, new recommendations, and progress toward previous recommendations. The Consultant Dietitian reviews the items identified on the report with the Administrator and Dietary Manager in an exit interview. 6. The Administrator and Dietary Manager acknowledge and act on the Consultant Dietitian's recommendations as evidenced by a written response to the consultant's report or notations on the original report .

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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