STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145980	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DUNHAM REHAB & HEALTHCARE	**850 DUNHAM RD ST CHARLES, IL 60174**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to follow physician's orders and their policy to weigh newly admitted residents weekly; and to implement timely interventions for significant weight loss. This applies to 2 of 4 residents (R1, R2) reviewed for weight management in a sample of 12. Findings include: 1). The Face Sheet documents R2 is [AGE] years old and was admitted on [DATE], with [DIAGNOSES REDACTED]. The Minimum (MDS) data set [DATE] shows R2 has no cognitive impairment. The MDS documents R2 requires supervision (oversight, encouragement, cueing) and set up for meals. The POS (Physician's Order Sheet) dated 5/1/2020 reads: weekly weights X4 The Nursing Admission assessment dated [DATE] documents: weight 124# The first nutritional assessment in R2's medical record is dated 6/2/2020 and reads: consumes 25-75% meal intake, intake varies but overall good, no GI or swallowing issues. There were no documented weekly weights in R2's medical record. The nutritional assessment and dietary note by V21 (Registered Dietitian) dated 6/26/2020 documents weight 5/1/2020- 124#; today - 92#, =32# weight loss. Add 120ml 2 cal BID (twice daily), kitchen to adhere to food preferences. Recommend weekly weights. The dietary note dated 7/2/2020 reads weight recorded last week was 92#. No new weight recorded this week. The MAR (Medication Administration Record) for May and Jun/2020 reads: weekly weight. However, the boxes for the weights are left blank. On 8/14/2020 at 3:13 PM, V19 (Weight Management Nurse) stated the CNAs (Certified Nursing Assistants) write down the weights and give them to her. She then types them in a spread sheet. If there's a huge discrepancy (5% loss) the resident is reweighed. V19 stated the policy for new admits is to weigh them weekly X 4, then monthly. According to V19 if there's a problem with the weight, the resident is placed on weekly weights indefinitely until resolution. V19 stated she also informs the Registered Dietitian (RD) who is in the facility weekly. When asked about R2's weights, V19 stated they were supposed to be documented on the MAR. V19 Checked her spread sheet and the computerized chart and did not find weights for R2. V19 then stated she had not monitored R2's weights, and the facility had not kept up with residents' weights. The care plan dated 7/1/20 (2 months after R2's admission) reads: resident has a nutritional problem, interventions- monitor intake, administer nutritional support, and provide supplements. There were no documented interventions prior to this date. On 8/17/22 at 3:52 PM, V21 RD (Registered Dietitian) stated the policy is to visit residents 14 days after admission. V12 stated the RD is only in the facility once a week. However, if there is a concern she would come to the facility and see the resident. V21 stated R2 was admitted with a low weight. V21 stated the facility would do monthly weights so she communicated with occupational therapy department who informed her R2 was losing weight. V21 stated she asked the facility to weigh R2 weekly which did not occur. V21 added she attempted to provide R2 as much nutritional therapy as possible. V21 also stated it would be frustrating. I had to push them. I would say I need this weight by the end of the day. V21 stated if she did not get the weight by the end of the day, she would review it the following week. On 8/17/2020 at 5:05 PM, V22 (Medical Doctor) stated not weighing R2 weekly caused a delay in treatment. The problem here is they have so many binders. V22 added newly admitted residents should be weighed more frequently. V22 stated that's how you know how they are doing. Weights and protein will tell you how they will do. V22 also stated he expects the facility to follow the physician's orders and policy for weight management. V22 stated the facility is implementing a new computer system that will help better manage weights. 2). The Face Sheet documents R1 is [AGE] years old and was admitted on [DATE] with [DIAGNOSES REDACTED]. The medical record shows R1 was discharged on [DATE]. The admission notes document R1 weighs 115#. There were no other weights located in R1's medical record. The POS (Physician's Order Sheet) reads: Diet- honey thick liquid- puree, ensure three times daily. The nutritional notes dated 3/12/2020 reads: resident weights 115#. Underweight status. Start HI Cal 120ml twice daily between meals add magic cup for lunch and dinner. The resident meal intake log shows R1 consumed 0-24% of meals 03/16/2020 - 03/30/2020. The MAR (Medication Administration Record) for 03/2020 reads: weekly weights. However, the blocks for weights are left blank. The nursing notes show R1 was transferred to the hospital for an unrelated issue at 5:30 AM on 3/30/2020. The next entry at 12:22 PM (7 hours after R1 was transferred out of facility) documents the facility spoke with V23 (Nurse Practitioner) about R1's appetite. R1 did not return to the facility. On 8/14/2020 at 3:00 PM, V3 ADON (Assistant Director of Nursing) stated CNAs (Certified Nursing Assistants) are responsible for weighing residents. V3 stated nurses are to ensure weights are done. On 8/14/2020 at 3:13 PM, V19 (Weight management nurse) looked through her logs and R1's medical records and did not locate any other weight. When asked about weights and notifying RD of continued poor intake, V19 stated there were none. When asked if R1 required feeding assistance, V19 stated she guess he does given his [DIAGNOSES REDACTED]. Observe for symptoms of dehydration and malnutrition, refer to dietitian as needed. On 8/14/2020 at approximately 4:30 PM, V14 MD (Medical Doctor) stated he's not aware of R1 having weight loss. V14 stated however, keep in mind, people with [DIAGNOSES REDACTED]s don't eat. They may not do well. Just [MEDICAL CONDITION], you can feed them all the food in the world, and they will still lose weight. On 8/17/2020 at 5:05 PM, V22 (Facility's Medical Director) stated newly admitted residents should be weighed more frequently. V22 stated that's how you know how they are doing. Weights and protein will tell you how they will do. V22 also stated he expects the facility to follow the physician's orders and policy for weight management. V22 stated the facility is implementing a new computer system that will help better manage weights. The facility's weight policy reads: Guidelines: New admits and readmission will be weighed upon admission and weekly for 4 weeks prior to converting to monthly weights. Should the IDT (Intradisciplinary Team) determine the resident's weight is stable, weekly weights may be discontinued prior to 4 weeks of completion. 1). Staff will be responsible for obtaining weights for these admits and will have this information available for morning stand-up meeting. Weights will be recorded. 4). Consistent weight loss noted during the admission weight process will be brought to the attention of the MD and responsible party. 5). Weight refusals, not consistent with the resident's known preferences or expressed desires, should be documented by the attending nurse in the resident/patient's chart with notification to MD and responsible party. 7). Resident/patients who have a weight variance of 3 lbs. or more are to be re-weighed with a licensed nurse or dietetic professional in attendance for verification.

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.