STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115612	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WARNER ROBINS REHABILITATION CENTER	**1601 ELBERTA ROAD WARNER ROBINS, GA 31088**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to implement a care plan intervention to provide supplements as ordered for weight loss for one resident (R) (#5) from a total sample of 12 residents. Findings include: R#5 had a care plan for at risk for nutrition/dehydration related to history of poor intake and a history of weight loss. It was revised on 6/29/20 to reflect a 5% weight loss due to a recent hospital stay. On 7/23/20 a revision noted the resident continued to have weight loss. The care plan had an intervention to provide supplements as ordered. The resident had a physician's orders [REDACTED]. During observations of the resident's lunch trays on 8/5/20 at 12:45 p.m., 8/6/20 at 12:10 p.m. and 8/10/20 at 12:40 p.m., the resident was not served a homemade strawberry milkshake as ordered. Cross refer to F692.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to provide a thorough initial assessment of a pressure ulcer for one resident (R) (#7) from a total sample of three residents. Findings include: The facility had a pressure ulcer policy. The Pressure Ulcer and Skin Care Management policy dated 4/25/17 revealed that the licensed nurse documents the evaluation or presence of skin concerns. R#7 was admitted to the facility on [DATE] with the following but not limited to Diagnoses: [REDACTED]. The Weekly Pressure Ulcer QA & A Log dated 6/18/2020 documented that R#7 had a facility acquired area to the right buttock measuring 1.5 cm x 3.5 cm x 0.2 cm. The notes revealed that the treatment was a [MEDICATION NAME] dressing. However, the nurse's notes failed to describe the stage of the wound. On 6/25/2020 it was documented that R#7 had a facility acquired area to the right buttock measuring 1.5 cm x 3.0 cm x 0.2 cm. The notes revealed that the treatment was a [MEDICATION NAME] dressing. However, the nurse's notes failed to describe the stage of the wound. On 7/2/2020 it was documented that R#7 had a facility acquired stage 3 area to the sacrum measuring 6.0 cm x 6.0 cm x 0.1 cm. The notes revealed that the treatment was Santyl. Nursing Progress Notes dated 6/18/2020 and 6/25/2020 stated the resident has a facility acquired pressure ulcer to the right buttocks and the wound care physician would visit the resident on a weekly basis. However, a thorough description of the pressure ulcer was not documented until the wound care physician's consultation on 7/1/2020. Wound Care Physician Notes dated 7/1/2020 documented that the patient presents with an area on his sacrum. At the request of the referring physician, a thorough wound care assessment and evaluation was performed today. The wound measured 6 cm x 6 cm x 0.1 cm, with light serous drainage, surface area 36 cm, and 100% granulation tissue. The note further stated that the wound was in an [MEDICAL CONDITION] stage and is unable to progress to a healing phase because of the presence of biofilm. During an interview with the Interim Director of Nursing on 8/11/2020 at 4:38 p.m. she stated the treatment nurse does not stage wounds, the facility waits on the wound care physician to come every week and he does that. During an interview with the Administrator on 8/12/2020 at 8:45 a.m. she confirmed that the treatment nurse doesn't stage wounds, that the facility does not do that, they wait on the wound care physician to do it and he comes every Wednesday. During an interview with the Wound Care Physician on 8/12/2020 at 9:20 a.m. he confirmed that he makes rounds every week with the treatment nurse to see new patients. He also confirmed the first visit for R#7 was on 7/1/2020, then the resident went to the hospital. He further stated that R#7 developed the area on the sacrum, and the measurements are deceptive, because the wound was a cluster of two small open areas. The whole wound was open when I saw him the first time with denuded skin that looked like a moisture problem, sloughing off when it was wiped away. The policy here is that the facility wants me to stage wounds, however, there needs to be a description of the wound bed. He further stated that he reserved [MEDICATION NAME] dressings for stage two wounds.
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 observation, record review and staff interview, the facility failed to serve one resident (R) (#5) a strawberry milkshake as ordered by the physician from a total sample of 12 residents. Findings include: R#5 was admitted to the facility on [DATE] and had the following but not limited to Diagnoses: [REDACTED]. Review of the resident's weight record revealed the had an 8.3% weight loss in two months from 96 pounds on 6/6/20 to 88 pounds on 8/7/20. The resident had a physician's orders [REDACTED]. During observations of the resident's lunch trays on 8/5/20 at 12:45 p.m., 8/6/20 at 12:10 p.m. and 8/10/20 at 12:40 p.m., the resident was not served a homemade strawberry milkshake as ordered. During an observation of the resident's lunch tray with the Administrator on 8/10/20 at 1:15 p.m., she confirmed the resident was not served the milkshake. She stated they did make homemade milkshakes there because they had nutritional supplements that were ready to serve available. During a subsequent interview with the Administrator on 8/10/20 at 1:30 p.m., she stated she called the Registered Dietician who stated that she and the previous Dietary Manager decided they would try some homemade milkshakes for the resident. She also stated the Registered Dietician told her she meant to discontinue the milkshake when the resident returned from the hospital on [DATE] because the resident did not need the milkshake. Review of a list of residents who were reviewed by the Registered Dietician on 7/23/20 noted that R#5 was receiving a strawberry milkshake with lunch trays. However, during an interview with the Dietary Manager on 8/10/20 at 3:29 p.m., she stated she has been the Dietary Manager since 12/2019 and they have never made homemade milkshakes. She also stated after receiving the list of supplements from the Registered Dietician on 7/23/20, she did not ensure R#5 was receiving the homemade strawberry milkshakes. Although the resident had not received the homemade milkshake as ordered, he was receiving an appetite stimulant since 7/13/20, fortified foods with all meals since 5/21/20, and Readycare 2.0 90 milliliters twice a day since July 2020.
F 0803 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview, review of facility menus, it was determined the facility failed to follow the approved menu for 79 residents receiving an oral diet. The facility census was 88 residents. Findings include: A review of the 8/5/2020 posted daily menu revealed cubed steak, white rice, lima beans cornbread w/butter and fruit. Beef steak was substituted. No butter or other condiments were noted on the meal trays or serving carts available for residents. The Week at a Glance menu stated Wednesday 8/5/2020 lunch meal would be cube steak, french fries, french green bean medley. A review of the 8/6/2020 posted daily menu revealed lunch as fried chicken, potato salad, mixed vegetables, cornbread w/butter, and

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

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F 0803 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) chocolate pudding. The dessert served was lemon pie. No butter was available on the trays. A review of the 8/10/2020 posted daily menu revealed cubed steak, white rice, buttered zucchini, dinner roll w/ butter, and carrot cake w/frosting. No butter was served with the trays, the cake did not have frosting. Record review revealed the Week at a Glance menu stated Monday 8/10/2020 lunch meal would be lemon herb fish with paprika rice, zucchini medley, bread or roll & butter or margarine, carrot cake, milk, beverage of choice. The observed meal that was served was cube steak, white rice w/gravy, zucchini medley (cauliflower mix), carrot cake, dinner roll. An interview on 8/10/2020 at 2:03 p.m. with the Dietary Manager revealed that she doesn't always get the food that she orders, she stated for example I might get a substitute if I order fish and we are supposed to serve fish but if they are out, they might send me something else. She confirmed the menu's had been changed and that sometimes the posted daily menu doesn't match what is being served because she writes that menu to look good, meaning that the cake with frosting on the posted daily menu wasn't actually served with frosting. An interview on 8/11/2020 with the Administrator confirmed that sometimes the facility doesn't get what they order, further stating that if 50 buildings are all ordering the same thing, they may not get it or they may not get a substitute that's why she has always ordered hamburger steaks to make sure the residents have something to eat if an order doesn't come in or a substitute isn't sent. An observation on 8/12/2020 at 1:50 p.m. of the posted daily menu revealed the same menu as the day before, the Administrator revealed the Dietary Manager is out today and confirmed the daily posted menu had not been updated.