STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

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** The facility identified a census of 47 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to implement person-centered interventions aimed to prevent continued weight loss, and failed to ensure staff monitored and assisted when necessary to promote oral intake for Resident (R)1 who had an 11.71percent (%) weight loss in 91 days. Findings included: - R1's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R1 needed supervision of one staff member for eating and documented no weight loss noted. The Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 08/01/2020 documented R1 required more help than her baseline. The Nutritional Status CAA dated 08/01/2020 documented R1 had a weight gain in the last 30 days. The Care Plan revised 06/07/2020 directed staff to monitor, document and report to the medical director signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and appears concerned during meals. The Care Plan further directed staff to offer and encourage snacks and fluids between meals, provide supplements as ordered. It further directed staff to monitor and report to the medical director as needed for any signs and symptoms of decreased appetite, nausea or vomiting, unexpected weight loss, and complaint of stomach pain. The Care Plan revised 09/24/2019 directed staff R1 required assistance of one staff member for all transfers and set up assistance to eat. The Care Plan lacked new interventions for the significant weight loss on or after 07/01/2020. The weights under the Weights and Vital tab documented the following weights for R1: 04/01/2020 82.0 pounds (lbs) 05/01/2020 83.0 lbs 05/02/2020 82.5 lbs 06/16/2020 79.0 lbs (4.82 % weight loss in 30 days) 07/01/2020 72.4 lbs (11.71% weight loss in three months since 04/01/2020) A physician's orders [REDACTED]. It directed staff to offer flavor of choice at breakfast, lunch, and dinner related to the 4.82% weight loss in 30 days. The EMR record lacked any new intervention related to significant weight loss documented on 07/01/2020 at which point R1 had a documented 11.71 % loss in the previous 90 days. The Behavior Note dated 07/01/2020 at 01:13 PM documented the Inter Disciplinary Team (IDT) reviewed for risk management lacked documentation in reference to R1's weight loss. The IDT note dated 07/08/2020 at 01:33 PM documented R1 to have mighty shakes three times daily due to weight loss related to poor nutritional intake and R1 encouraged to come to the dining room for meals. The EMR record lacked documentation of notification to the physician, dietician, or the Durable Power of Attorney (DPOA) of R1's significant weight loss of 11.71% in the previous 90 days. The Weight Change note dated 07/13/2020 at 09:31 PM documented R1 recently demonstrated weight loss and now presented with significant weight gain. Will continue with current diet and three times a day (TID) supplement as ordered and weight to be monitored weekly for close monitoring. The progress notes lacked weight change documentation of R1's significant weight loss documented prior to 07/13/2020. On 08/31/2020 at 11:45 AM R1 laid on the fall mattress on the floor, next to a high low bed in the lowest position, under her covers with her eyes closed. R1's bedside table was approximately four feet away, parallel to the bed, raised to three feet in height with a room tray set on it. The tray contained plate covered by a lid and a glass of fluid. No staff assisted R1 to eat at that time. On 08/31/2020 at 12:05 PM Certified Medication Aid (CMA) R entered the room and asked R1 what was going on. CMA R closed the door to R1's room once entered. On 08/31/2020 at 12:10 PM CMA R removed the room tray. Observation of the tray and plate revealed a breakfast plate with eggs, toast, gravy with meat and a glass of water that had not been eaten or disturbed. On 08/31/2020 at 12:10 PM CMA R stated that R1 requested her room tray be delivered to her when it was ready and R1 requested CMA R get some medicine for an upset stomach. On 08/31/2020 at 12:33 PM Administrative Staff A entered R1's room stated he would take her lunch order. Administrative Staff A said 'Oh you are not hungry? Would you like something to drink? I can get you some water. At the conclusion of the conversation, Administrative Staff A left the room. Administrative Staff A never retuned with the water. On 08/31/2020 at 01:21 PM unidentified staff passed room trays on the hall from a cart. On 08/31/2020 at 01:40 PM R1 had not received a room tray as unidentified staff completed passing all the room trays noted on the cart. On 08/31/2020 at 01:41 PM CMA R stated R1 refused lunch from time to time. CMA R revealed she told the charge nurse about R1 not eating today. On 08/31/2020 at 01:43 PM Licensed Nurse (LN) G stated if a resident does not want to eat staff would offer something else to eat and offer something like a mighty shake or ensure. LN G stated she knew that R1 liked Dr. Pepper. When a resident does not eat or refused a few meals the physician is notified. When asked if LN G was aware that R1 had not eaten breakfast and refused lunch, she revealed that she had not heard about it until now. On 08/31/2020 at 05:00 PM Administrative Nurse D stated the facility does weekly weights and physician notification would certainly be done for weight loss. He further stated that he expected an intervention to be put in place, dietary recommendation, and physician recommendation. Administrative Nurse D further stated he expected someone prompted R1 to eat and provided education about the importance of eating when R1 refused to eat. The facility's policy Policy/Procedure - Nursing Services: Nutrition revised 07/2017 documented that significant change in the resident's condition additional nutritional interventions would be offered. It further directed that any resident weight that varied from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days would be evaluated by the Interdisciplinary Team to determine the cause of weight loss/gain, intervention required and need for further recommendations and/or referral. Family member/responsible party and attending physician would be notified. The facility failed to implement person-centered interventions aimed to prevent continued weight loss, and failed to ensure staff monitored and assisted when necessary to promote oral intake on R1 who had an 11.71 % weight loss, and required staff assistance and encouragement for eating.

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.