STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525212	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WISCONSIN RAPIDS HEALTH SERVICES	1350 RIVER RUN DR WISCONSIN RAPIDS, WI 54494

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 0580 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews the facility did not notify the physician of significant changes in condition and the possible need to alter treatment for 1 of 7 sampled residents (R2). R2 had significant declines in his food and fluid intake, severe weight loss, and an increase in restlessness. There is no evidence the physician was consulted for these issues. By the time R2 was hosptalized on [DATE], he was severely dehydrated, had severe protein calorie malnutrition and acute on [MEDICAL CONDITION] with acute kidney injury grade 5. This is evidenced by: On 03/09/20 Surveyor received the following policy and procedure entitled from the DON (Director of Nursing). It includes the following policy statement: Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) Policy Interpretation and Implementation indicates the following: 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: .d. A significant change in the resident's physical/emotional/mental condition. e. A need to alter the resident's medical treatment significantly; f. A need to transfer the resident to a hospital/treatment center; . R2 was admitted to the facility on [DATE] following a left [MEDICAL CONDITION] and repair. R2 had [DIAGNOSES REDACTED]. R2 was his own legal decision maker. R2 chose to be full code. R2's admission weight was noted to be at 170 pounds. By 02/06/20, R2's weight had dropped to 158.6 pounds. There was no evidence the physician was consulted about R2's weight loss. Further review of R2's medical record reveals that R2's foley catheter was removed on 02/08/20 in an attempt to discontinue the catheter. On 02/09/20, R2 was sent to emergency room due to agitation. The [DIAGNOSES REDACTED]. R2 was put on [MEDICATION NAME] for the retention and [MEDICATION NAME] (antibiotic) and the recommendation to increase oral hydration. The catheter needed to be inserted due to [MEDICAL CONDITION]. R2 came back to the nursing home. Review of the Chemistry results completed at that time included the following: BUN was 33.0 (high) range (8.0-24.0), Creatinine 2.57 (high) range (0.55-1.30). These labs are indicative of dehydration and decline in kidney function. These were a decline in baseline labs from his 01/03/20 labs prior to admission. The BUN was 22 (normal) and the Creatinine was 2.09. Review of R2's meal intake records from 02/11/20 through 02/24/20 reveals that R2 refused 17 of the 39 meals offered. In addition, the record reveals that R2 ate only 0-25% of 5 meals during that time. Review of R2's fluid intake records from 02/11/20 through 02/24/20 reveals that R2's daily intake ranged from a high of 1020 cc's (cubic centimeters) on 02/12/20, to no intakes on 02/16/20 and 02/20/20. On 02/14/20, 02/15/20, 02/19/20 notes indicate that R2 only consumed 240 cc's of fluid. On 02/22/20, R2 only consumed 100 cc's of fluid. Review of R2's interdisciplinary progress notes reveal the following entries: 02/24/20 at 1:25 am nursing note: Resident exhibiting terminal restlessness. Interventions included repositioning and toileting. Offered fluids, however not accepting. Significant cognitive impairment. Foley cath patent and draining 60 cc amber colored urine via gravity bag. Mouth care performed. Medical intervention following with administration of md prescribed [MEDICATION NAME] with noted effective relief. Currently resting quietly, eyes closed. No further restlessness exhibited. Signed RN I (Agency Registered Nurse). No vitals were noted. The physician was not contacted due to the terminal restlessness and no fluid intake. R2 was full code and not on comfort measures or hospice. On 03/09/20 at 3:45 p.m., Surveyor spoke with MD H (Medical Doctor). MD H said R2 was not on comfort measures at the time of the 02/24/20 note and that he should have been contacted related to this change. MD H said the terminology terminal restlessness suggests that R2 was on comfort measures only and he was not. On 03/10/20 at 8:50 a.m., Surveyors spoke via phone to RN I. RN I said that she had never worked with R2 before 02/24/20. RN I said she recalls R2 was very thin, very restless and that R2 wasn't eating or drinking anything. Surveyor read RN I her progress note from 02/24/20. RN I said she should not have used the term of terminal restlessness as this is not in her scope of practice. RN I was told R2 was full code, not on comfort measures. RN I said that she should have checked R2's vitals and should have called the doctor. Surveyor reviewed of R2's interdisciplinary progress notes/vitals record reveal no nurses notes or vitals for the day shift of 02/24/20. On 03/09/20 at 12:45 p.m., Surveyor spoke with the DON B (Director of Nursing). DON B said that R2 was full code at the time he went to the hospital on [DATE]. DON B said the physician should be notified of any change in condition, for instance weight loss, decline in ability to do activities of daily living, decrease in swallowing, not eating or drinking. DON B was asked why there was no note or any vitals on the 02/24/20 day shift. DON B said she thought the day shift nurse was going to update the doctor as she had told them to do that. On 03/09/20 at 1:15 p.m., Surveyor reviewed the nursing schedule for the unit on which R2 was residing on 02/24/20. The schedule reveals that RN F (Registered Nurse) was assigned to the day shift on 02/24/20. Surveyor spoke with RN F and asked RN F if she had any information for R2 on 02/24/20. RN F said she didn't know of any information related to R2's status on that day shift. Surveyor reviewed R2's interdisciplinary progress notes which included, 02/24/2020 at 17:36 (5:36 p.m.). Type communication with physician. MD notified of resident refusal to eat or drink the last 10 days. Urine from foley cath is brown. 100 cc out in 8 hours. Eyes sunken, > (greater than) 3 seconds tenting of skin. Refusing to allow VS (vital signs) or take medications. New orders to send to ER (emergency room) for eval of UTI (urinary tract infection). Signed RN E (Registered Nurse). On 03/09/20 at 9:53 a.m., Surveyor spoke with RN E via phone. RN E said R2 had resided on the unit that she usually worked and then had moved to a different unit. RN E said R2 had come into the facility following a [MEDICAL CONDITION] and repair of the fracture. RN E said R2 had a catheter for [MEDICAL CONDITION] when he came to the facility, chose to be full code, did not talk very much and did not have any visitors. RN E said when R2 first came in he would drink a lot of water and that getting R2 to eat was more of a problem. RN E said she knew that R2 had lost some weight after he was at the facility and the physician knew about the weight loss. RN E said she was assigned to work the evening shift of 02/24/20 on the unit to which R2 had been transferred . RN E said she had gotten report from the day shift nurse RN F who had said R2 wasn't eating or drinking and that he was very agitated. RN E said when she saw R2 she could tell he had had a significant change in condition from the time she had last seen R2. RN E said that R2's eyes were sunken, was very thin (rib cage sticking out hollow,) urine was brown in the catheter and she was told that R2 was not eating or drinking. RN E said she called the physician and R2 was sent to the emergency room and was admitted to the hospital in the critical care unit. Review of R2's medical record reveals that R2 was hospitalized from [DATE] to 03/05/20. Discharge [DIAGNOSES REDACTED]. Should note that in the past, patient's Creatinine has been approximately 1.44, currently 5.89 . R2's admission weight at the hospital was noted to be 134 pounds. R2 is currently at the facility on hospice comfort care and has a Court Appointed Guardian of his Person.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.**

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

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not ensure that 1 of 6 sampled residents' (R1) bowel elimination was recorded in order to assess and intervene a resident's possible constipation. The facility did not track R1's bowel movements for his entire stay until his family requested a bowel medication for his constipation. Information put into the computer prior to this was in error and did not prompt the aides to record his bowel movements. None of the staff recognized this omission or corrected it prior to the end of his stay. In addition, the facility did not address in his care plan the amount of assistance he needed and ensure his bowels were regular. This is evidenced by: R1 was admitted to the facility in December 2019 for what was initially a temporary respite stay. This was then extended to an indefinite stay. His [DIAGNOSES REDACTED]. Review of his most recent MDS (Minimum Data Set) assessment, shortly after his admission, finds he was able to express himself but had severe impairment in his attention, orientation, ability to recall new information, and both long and short term memory impairment. He had no issues with his moods however he did have disruptive verbal behaviors directed at others. He needed supervision when getting about with his walker and at times the extensive assistance of a staff member to get dressed, use the toilet, and take care of his personal hygiene. He had a catheter for retention of urine due to his enlarged prostate and was always continent of his bowels. His comprehensive plan of care states he has a catheter a goal of not having and catheter-related concerns with the staff properly caring for his catheter every shift. There is no mention of his bowels or bowel management. The plan of care for the CNAs (Certified Nursing Assistant) states they are to to monitor his urine output. This CNA care plan has no mention of his bowels either. The CAA (Care Area Assessments) and the only mention of his bowels is that he is assisted to the toilet upon rising, before and after meals, at bedtimes, with rounds at night and as he requests. The CAA states that a 3 day hourly bowel and bladder patterning is completed upon admission and then every 3 months. This was done from 12/6/19 to 12/8/19 for both his bowel and bladder elimination. The information is coded as a 2 which indicates he had no bowel movement in those 3 days. Review of the clinical record for R1 finds one Continence Evaluation dated 12/6/19. This evaluation states R1 has no history of bowel incontinence, no history of fecal impactions, is continent of of bowel, has no apparent pattern of elimination, is not on any bowel or constipation medications, and can feel when he has to defecate. Review of all of the narrative progress notes for R1 found no mention of his bowels, his bowel pattern, or if he even had one. It was not until 2/22/20 at 1:32 p.m. when RN-M (Registered Nurse) made a notation that the family had requested a medication to help his bowels. She placed a call and got a physician's orders [REDACTED]. At 8:40 p.m. she gave him a DSS ([MEDICATION NAME] Sodium) 100 mg (milligram) tablet. At 11:53 p.m. RN-I indicated that this was effective. The Head to Toe assessments have little to no information about his bowls: ~12/3/19 at 9:30 a.m. Bowel assessment: normal ~12/3/19 at 5:30 p.m. Bowel assessment (as above): Bowel sounds are present x 4. Abdomen is round, soft, and non-tender to palpation. Resident description (pain, tenderness, nausea, heartburn, indigestion) none ~12/4/19 at 9:30 a.m. As above. ~12/4/19 at 1:30 p.m. As above. ~12/4/19 at 5:30 p.m. Bowel assessment (as above): Bowel sounds are present x 4. Abdomen is soft and non-tender. Description is: none ~12/5/19 at 9:30 a.m. There is no GI (gastrointestinal) assessment. ~12/5/19 at 5:30 p.m. As above assessment on 12/3/19. ~12/6/19 at 9:30 a.m. Bowel assessment (as above): Bowel sounds are present. Resident description (as above): none ~12/6/19 at 1:30 p.m. Bowel assessment (as above): Bowel sounds are present x 4. Resident description (as above): none ~12/13/19 at 2:15 a.m. There was no GI assessment. ~12/13/19 at 4:19 a.m. There was no GI assessment. ~12/13/19 at 10:22 a.m. There was no GI assessment. ~12/14/19 at 10:40 a.m. There was no GI assessment. ~12/14/19 at 10:36 p.m. There was no GI assessment. ~12/15/19 at 3:38 a.m. There was no GI assessment. ~12/15/19 at 6:11 p.m. There was no GI assessment. ~12/16/19 at 2:32 a.m. There was no GI assessment. Review of the CNAs (Certified Nursing Assistant) charting found only 2 days in which R1's bowel pattern was completed and this was 12/4/19 to 12/6/19 with him not having a bowel movement recorded. On 3/5/19 at 10:15 a.m. Surveyor interviewed CNA-L. CNA-L stated there is a place in every resident's computer record to record the bowel movements every 2 hours and this information is there for the nurses to review and each resident has a history of this. At 11:55 a.m. Surveyor interviewed RN-F (Registered Nurse). RN-F is the consistent day shift nurse on the R1's unit. The RN stated R1 had no issues with his intakes and outputs or his bowels. RN-F stated she had never heard of any issues as R1 was independent in going to the toilet and the CNAs recorded this information in the computer. RN-F stated the computer system was set up to send an alert to the nurses if a resident did not have regular bowel movements so the nurse could address this with medications. RN-F stated the facility has standing orders; if no bowel movement for 3 days MOM (Milk of Magnesia) is given, then a suppository is tried if it doesn't work and as a last resort a Fleets enema is given. At 1:10 p.m. Surveyor interviewed DON-B (Director of Nursing) and was told the facility has no standing orders and no protocol as RN-F described. DON-B indicated R1's bowel pattern was pretty regular. At 1:40 p.m. Surveyor interviewed CNA-D as CNA-D is consistently the CNA on the unit R1 resided on. CNA-D stated R1 went twice a day a moderate to small amount. CNA-D stated R1 would pull his call light when he was done and staff would assist his with cares. CNA-D stated R1 may not have completely emptied his bowels but that he went every day. At 3/9/20 2:50 p.m. Surveyor interviewed RN-J. RN-J stated the facility has in place a medication regimen to address a resident's constipation should the resident's attending physician not have orders specific to that resident. RN-J stated MOM or a [MEDICATION NAME] tablet is given first if a resident has not had a bowel movement in 48 hours and a [MEDICATION NAME] suppository is given if that does not work. RN-J stated the CNAs should be keeping track of every resident's bowel movements in the POC (Point of Care) documentation system. RN-J stated she recalled on the night shift of 2/23/19 the CNAs asked her to check the computer system for R1and she discovered an error in the information being imputed into the computer and discovered the CNAs were not recording R1's bowel movements as the computer was not prompting them to do so and she then fixed the problem. At 11:45 a.m. Surveyor interviewed DON B and the DCS (Director of Clinical Services) it was at this time it was discovered that there was an unknown notation after R1's record of the tasks for the CNAs and this was going to be investigated by them. On 3/10/19 at 10:00 a.m., Surveyor interviewed RN-F and she again stated R1 would go to the bathroom by himself and then ring the staff for assistance when he was done and she did not recall and issues. At 1:45 p.m. Surveyor interviewed CNA-D. CNA-D stated she recorded R1's bowel movements each time and was certain that it popped up on the computer for her each day. CNA-D stated if it did not that the staff would recognize that and tell the nurses to fix this. At 2:00 p.m. Surveyor was told by the DCS it was discovered that the original input was incorrect and it had been put in the computer by the previous MDS nurse as set to a PRN (Pro re nata/as needed) so it never popped for the CNAs. The DCS stated she had checked the record of every other resident at the facility and only R1 was entered in error. At approximately 2:15 p.m. Surveyor interviewed CNA-K. CNA-K stated R1 was regular however she deduced this from his frequently soiled briefs. The CNA stated this was all charted in the computer on everyone and the nurses would then decide if the resident needed a laxative from the alerts. CNA-N stated she had only taken care of R1 a couple of times and that she recalled that his bowel movements were small and hardly any. Review of the clinical Alerts to the nursing staff found only alerts for 2/23/20 that states R1 had no bowel movement for 72 hours at 1:24 a.m. This coincides with RN-J's statements that on that night the CNA's noted that there have been no monitoring of his bowel movements (bowel movements) until she fixed the computer and put the CNAs' alert into the computer in order for them to record his bowel movements and thereby pop as an alert should he not have a routine bowel movement. Review of the bowel record for R1 finds the only day his bowel movement or lack of them was noted on 2/23/20 the day of his passing. Review of the narrative nursing notes for his entire stay have no notation about his bowel regimen. While staff remembered that he frequently went to the bathroom there is no record of it and the staff did not recognize that the computer was not capturing his bowels and how they were being managed.
F 0692 **Level of harm** - 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, staff interviews, and record reviews the facility did not ensure that 2 of 7 sampled residents maintain acceptable parameters of their nutritional and hydration status to maintain their health. (R1 and R2). Since his admission to the facility on [DATE], R2 had significant declines in his food, fluid intake and weight without reassessment of his nutritional needs and/or interventions to prevent weight loss. R2 was hosptalized on [DATE] with a severe weight loss of 21.1%, severe dehydration, protein calorie malnutrition and acute on [MEDICAL CONDITION] with acute kidney injury grade 5. R1 had a decline in his appetite and a significant weight loss without reassessment and re-exploration of his nutritional needs and modalities for intervention. There is no evidence the facility staff reevaluated his diet and reviewed his hydration needs and food preferences in a timely manner. The facility has no evidence of reevaluating R1's likes and dislikes, introducing increased nutritious snacks, or attempting to make his meals as close to his usual pattern and preferences as at home. The facility immediately added a supplement rather than offering real food first as is the

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) standard of practice. This is evidenced by: Surveyor received a copy of the facility policy and procedure titled Resident/Patient Heights and Weights, The purpose of this policy is to provide consistency in the method heights and weights are obtained and recorded and to provide guidelines for the frequency of monitoring heights and weights. It is also to provide guidelines for notification and documentation of significant weight changes. The Procedure includes the following: .2. Upon day of admission, the nursing department staff will weigh resident on the appropriate scale .weekly thereafter for 4 weeks and then monthly unless otherwise ordered by the physician or recommended by the Dietitian . 5. Weekly or daily weights are recommended if any of the following are present: a. Sudden, unplanned weight loss. b. Significant unplanned weight loss in 30 days. c. Decreased meal intake for a period >48 hours. d. Gradual, unplanned weight loss over multiple months. e. Unstable [MEDICAL CONDITION] ([MEDICAL CONDITION] or significant [MEDICAL CONDITION]. f. Suspicion of fluid deficit 7. Any weight change of 5 lbs. (pounds) or greater within 30 days will be retaken within 24 hrs. (hours) for verification. Once an accurate weight is verified, the inaccurate weight should be struck out with the appropriate explanation . Example 1 R2 was admitted to the facility on [DATE] following a left [MEDICAL CONDITION] and repair. R2 had [DIAGNOSES REDACTED]. R2 was his own legal decision maker. R2 chose to be full code. R2's admission weight at the nursing home was noted to be at 170 pounds. By 02/06/20, R2's weight had dropped to 158.6 pounds. This is a 6.7% severe weight loss in 1 month. When hosptalized on [DATE] his weight was noted to be 134 pounds. This is a total loss of 36 pounds or 21.1% R2's signed physician order [REDACTED]. R2's care plan includes a problem dated 01/13/20 of The resident has nutritional problem or potential nutritional problem, Fx left femur, dementia,[MEDICAL CONDITION](fracture hypertension). The goals stated, Will accept assistance with meals as needed, Will continue to feed self and will drink fluid offered. Initiated 01/09/20. Interventions included, Diet Texture Regular. Diet Type Regular. Eating Eats in own room, Eating set up, Fluids regular thin, Hydration Screener (weekly) Provide nutritional supplement with med pass: 60 cc plus 2 Bid/Meds, Provide serve diet as ordered. Monitor intake and record every meal. RD to evaluate and make diet change recommendations prn (as needed). record weight. See tray card for specific food preferences. R2's Nutritional assessment dated [DATE] states, Nutritional Assessment/Screening Summary: Resident is a 79 y/o (year old) male with diagnosis (sic) including: s/p (status [REDACTED]. Diet order is Regular with regular texture and thin liquids. Meal intakes average 50-100%. Estimated needs are 1927-2159 kcals/day; 62-77 g protein/day. No concerns noted with chewing or swallowing. Continue with plan of care. Will continue to monitor. Signed RD G (Registered Dietician). R2's Nutritional assessment dated [DATE] indicates that R2's weight on 01/06/20 was 170 pounds. R2's usual body weight was noted to be 170 pounds. No [MEDICAL CONDITION] was present. Estimated fluid needs were noted to be 1927-2313 ml/day (milliliters). Average fluid intake was noted to be 1200-1500 cc (cubic centimeters). R2 was noted to be independent in eating assistance. The nutritional assessment identified R2 was not getting the minimum assessed amount of fluids. There were no new interventions added to ensure proper fluid intake. A physician's orders [REDACTED]. On 02/06/20, R2's weight had dropped to 158.6 pounds. The facility's charting system sent an automated weight warning to DM C (Dietary Manager). On 03/05/20 at 12:45 p.m., Surveyor spoke with DM C. DM C said that when R2 had the weight loss from 170 to 158.6 pounds noted on 02/06/2020, she had repeatedly asked for a reweigh. DM C said that she could not get the nursing staff to reweigh R2. On 03/09/20 at 10:27 a.m., Surveyor spoke with RD G (Registered Dietician). RD G said the facility policy is to get weekly weights for 4 weeks upon admission. RD G said they will get a reweigh of weight with a 5 pound change up or down. RD G said R2 had a 11.4 pound weight loss between 01/06/20 and 02/06/20 and they were requesting a reweigh. RD G said they had started plus 2 med pass supplement twice a day on 02/04/20. RD G said she had sent emails to DM C and the DON requesting the reweigh for R2. RD G said they did not get the reweigh. RD G provided Surveyor with R2's weights which included 01/06/20 of 170 pounds and 02/06/20 of 158.6 pounds noted a month later. No reweighs were obtained. RD G provided surveyor with emails requesting a reweigh for R2 sent to DM C (02/11/20) and DON (02/17/20 and 02/26/20). DM C's progress note in R2's medical record states, 02/20/2020 weight change note. Note text: Weight warning: Value: 158.6. Vital Dated 02/06/2020 at 10:42 a.m MDS: -5.0% change over 30 day(s) (6.7%, 11.4). -3.0% change from last weight (6.7%, 11.4). -3.0% change over 30 days (6.7%, 11.4) have asked many times for a re weight on him, Will continue to monitor him, care plan reviewed and updated. Signed DM C. On 03/09/20 at 12:45 p.m., Surveyor spoke with DON B. DON B said DM C will ask for reweighs if she sees any discrepancy in weights. DON B said she had been asked by both DM C and RD G for a reweigh for R2 because of the decline in R2's weight from 170 pounds on 01/06/20 down to 158.6 pounds on 02/06/20. DON B said she had asked the nursing staff repeatedly to reweigh R2, and they never did. DON B said R2 was admitted downstairs and eventually moved upstairs. DON B said that over time, R2 was eating and drinking less and then wouldn't get out of bed. DON B said R2 had a catheter for [MEDICAL CONDITION] and it was removed for a short period of time and had to be put back in due to retention. R2 then developed a urinary tract infection and was placed on an antibiotic. DON B said when a resident is treated for [REDACTED]. DON B said the nurses have to follow the intakes to determine if the resident is eating and drinking enough based on their food and fluid intake needs. The medical record reveals R2 was sent to the emergency roiagnom on [DATE] for agitation. He was diagnosed with [REDACTED]. R2 was put on [MEDICATION NAME] for the retention and [MEDICATION NAME] (antibiotic) and the recommendation to increase oral hydration. R2 came back to the nursing home. Review of the Chemistry results completed at that time included the following: BUN was 33.0 (high) range (8.0-24.0), Creatinine 2.57 (high) range (0.55-1.30) and Glucose 133 (high) 70-100. These labs are indicative of dehydration and decline in kidney function. These were a decline in baseline labs from his 01/03/20 labs prior to admission. The BUN was 22 (normal), Glucose 110 (high) and the Creatinine was 2.09. Surveyor review of R2's medical record reveals a Hydration Risk Eval and assessment dated [DATE]. The finding indicate that risk factors were present. Section B Hydration assessment does not mention the elevated BUN, Creatinine and Glucose. The summary indicated to encourage fluid intake. There is no indication the facility implemented any interventions to increase R2's fluid intakes. Surveyor review of R2's medical record reveals a physician progress notes [REDACTED]. R2's meal intake records from 02/11/20 through 02/24/20 indicates R2 refused 17 of the 39 meals offered and had 5 meals where intake was 0-25%. Fluid intake records for 14 days from 02/11/20 through 02/24/20 reveals that R2's highest fluid intake for 24 hours was 1020 cc's. All other intakes were below this amount including 240 cc's on 3 days, 100 cc's 1 day, and no fluids for 2 days. R2 was not meeting his recommended fluid needs of 1927-2313 cc's per day or even his average fluid intake of 1200-1500 cc's per day. On 03/05/20 at 1:45 p.m., Surveyor spoke with CNA D (Certified Nursing Assistant). CNA D said they record all meal intakes and fluid intakes for all residents in Point Click Care (charting system). CNA D said R2 was not eating or drinking very well and he would refuse to allow them to feed him. A nursing progress note dated 02/20/20 states, Dr. (MD H) updated that resident has had a significant weight change in the past month. No new orders. Another note on 02/20/2020 indicates the physician had decreased R2's Tylenol and [MEDICATION NAME] doses at night and R2 is completed with the antibiotic for a urinary tract infection. The notes do not mention that the physician was informed of the decrease in food and fluid intakes. Review of R2's interdisciplinary progress notes reveal the following entries: 02/24/2020 at 01:25 am nursing note: Resident exhibiting terminal restlessness. Interventions included repositioning and toileting. Offered fluids, however not accepting. Significant cognitive impairment. Foley cath patent and draining 60 cc amber colored urine via gravity bag. Mouth care performed. Medical intervention following with administration of md prescribed [MEDICATION NAME] with noted effective relief. Currently resting quietly, eyes closed. No further restlessness exhibited. Signed RN I (Agency Registered Nurse). On 03/10/20 at 8:50 a.m., Surveyors spoke via phone to RN I. RN I said she had never worked with R2 before 02/24/20. RN I recalled R2 was very thin, very restless, and was told R2 wasn't eating or drinking anything. R2's interdisciplinary progress notes includes, 02/24/2020 at 17:36 (5:36 p.m.). Type communication with physician. MD notified of resident refusal to eat or drink the last 10 days. Urine from foley cath (catheter) is brown. 100 cc out in 8 hours. Eyes sunken, > 3 (greater than) seconds tenting of skin. Refusing to allow VS (vital signs) or take medications. New orders to send to ER (emergency room) for eval of UTI (urinary tract infection). Signed RN E. On 03/09/20 at 9:53 a.m., Surveyor spoke with RN E via phone. RN E said R2 had come to the facility following a [MEDICAL CONDITION] and resided on the unit she usually worked and then moved to a different unit. RN E said R2 had a catheter for [MEDICAL CONDITION] when he came to the facility. RN E said that R2 did not talk very much and did not have any visitors. RN E said when R2 was first admitted , he would drink a lot of water and that getting R2 to eat was more of a problem. RN E said she knew that R2 had lost some weight after he was at the facility and the physician knew about the weight loss. RN E said that R2 was full code. RN E said she was assigned to work the unit where R2 resided on the evening shift on 02/24/20. RN E said she had gotten report from the day shift nurse, RN F who had said R2 wasn't eating or drinking and that he was very agitated. RN E said when she saw R2 she could tell he had had a significant change in condition from the time she last saw him. RN E said R2's eyes were sunken, was very thin (rib cage sticking out hollow), urine was brown in the catheter and she was told R2 was not eating or drinking. RN E said she called the physician and they sent R2 into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525212	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WISCONSIN RAPIDS HEALTH SERVICES	1350 RIVER RUN DR WISCONSIN RAPIDS, WI 54494

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 -** Actual harm **Residents Affected -** Few	(continued... from page 3) emergency roiagnom on [DATE] and R2 was admitted to the critical care unit at the hospital. R2 was hospitalized from [DATE] to 03/05/20. Discharge [DIAGNOSES REDACTED]. Should note that in the past, patient's Creatinine has been approximately 1.44, currently 5.89 (elevated creatinine levels is indicative of kidney impairment) . R2's admission weight at the hospital was noted to be 134 pounds. R2's weight loss since admission (01/06/20) was a total of 36 pounds, or 21.1% weight loss. From 01/06/20 through 02/24/20, there were no new interventions to address R2's declining food and fluid intakes or to increase fluids when R2 was started on an antibiotic for a urinary tract infection. Review of R2's medical record and interview with staff reveals that R2 came back from the hospital on [DATE] with hospice services. Example 2: R1 was admitted to the facility in December 2019 for what was initially a short term respite stay, which was then extended to a long term stay. R1's [DIAGNOSES REDACTED]. Review of his most recent MDS (Minimum Data Set) assessment, shortly after his admission, finds he was able to express himself but had severe impairment in his attention, orientation, ability to recall new information, and both long and short term memory impairment. He had no issues with his moods however he did have disruptive verbal behaviors directed at others. He needed supervision when getting about with his walker and at times the extensive assistance of a staff member to get dressed, use the toilet, and take care of his personal hygiene. He was independent in his ability to eat and drink with the staff just setting him up. The CAAs (Care Area Assessment) indicated that R1 had a BMI (Body Mass Index) that was too low. R1 passed away on 2/23/20 from [MEDICAL CONDITION] and heart failure. R1's plan of care states he has a nutritional problem or the potential for one due to his dementia and reflux. Included in his goals for his care is that he will continue to eat by himself, have no GI (gastrointestinal) complaints, will drink what is offered him and will eat over 75% for 2 of his 3 meals. There is a target date of 12/18/19 however his care plan was not revised or updated since mid-December. Interventions for his care includes he has a regular diet and eats independently in the dining room with staff setting him up. Staff are to record how much he eats and drinks, record on a weekly basis how his hydration is, get his weight daily, report GI complaints to the nurse, and the RD (Registered Dietician) is to evaluate this and make changes to his diet as needed. Review of his physician orders [REDACTED]. ~ 2/22/20 Plus 2 120 cc (cubic centimeters) twice a day with med pass on 1/28/20 and then increased on 2/22/20 to 3 times a day at the family's request. ~ [MEDICATION NAME] 40 mg (milligram) tablet, a diuretic since his admission. ~ [MEDICATION NAME] 25 mg tablet, also a diuretic since his admission. ~ [MEDICATION NAME] DHA (docosahexaenoic) 200 mg Capsule, a multivitamin with fish oil since his admission. The facility has evidence of just one Hydration Risk Eval and assessment dated [DATE] that indicates R1 is at risk for dehydration. The facility's assessment indicates he is at risk for dehydration and indicates staff will schedule additional screens weekly or daily however none were done. This is especially imperative as R1 takes 2 diuretics every day for his [MEDICAL CONDITION]. According to the New Dinning Practice Standards published by the Pioneer Network in August of 2011 and endorsed by numerous dietary, geriatric health, long-term care professionals and the medical directors' association, the concept of real food first is the standard of geriatric care. Of note is that the facility has only 2 documented weights for his entire stay: ~ 12/4/19 - 168# (pounds) ~ 1/22/20 - 156# This is a 12 pound or 7.14% weight loss in 7 weeks. R1's mean average intake from December 2019 through the first 10 days of February 2020 calculated to approximately 51% to 75%. From 2/11/20 to 2/22/20 he ate 51% to 75% only 5 meals, 26% to 50% 3 times, 0 to 25% 11 times and refused his meal entirely 13 times for a average of approximately 0 to 25%. Despite the decline in R1's intakes, there were no change in approaches to increase R1's intake. There was no increase in monitoring his weight, no evidence that his food preferences were reevaluated, that any lab work was discussed with his physician, any review of how his increasing anxiety was interfering with his intakes and exploring ways to increase his calories. The only change being the family's request for an increase in his supplement on 2/22/20. Review of the interdisciplinary notes found only 3 narrative notes by RD G and DM C: The first initial note by RD-G on 12/6/19 reviewed his diagnoses, his calorie and protein needs, and that he is eating 50% to 75%. The next note was made by DM-C on 1/28/20 in which she notes a warning that he had a weight loss of 7.6% and 12.8# to 156# in a month, his intakes were down to 25% to 75%. Plus 2 120 ccs was added 3 times a day with his meds. The order was just for the supplement 2 times a day. There is no notation about getting additional weights, reviewing his food preferences, and/or how and when he would like his food prepared. The only intervention was the introduction of his supplement. The next note is RD-G on 1/31/20 that again noted the weight loss, that a supplement was added, his average intakes, and the fact that he had no [MEDICAL CONDITION]. RD-G stated the plan of care was to be continued. There were no notations by the nursing staff about how his eating, nutrition, and/or hydration with the exception of a brief mention in some head to toe assessments that ended on 12/16/19. On 3/9/20 at 8:58 a.m. Surveyor interviewed RD-G. RD-G stated the facility's usual first course of action when a resident is losing weight and not eating is to add the supplement Plus 2 to be given when residents are getting their medications. The RD stated, I like to do the Plus 2 first at the med pass because there is usually good documentation that it's being given and that way it does not get in the way of the meals. She reiterated the facility's policies however did not know why the weights were not obtained per the policy. RD-G stated she would talk to DM-C or DON-B if weights were missing however she has 6 facilities she covers and did not recall if that had been done for R1 in particular. RD stated she relies on DM-C for day to day assessments of the residents. On 3/10/20 at 2:30 p.m. Surveyor interviewed DM-C. DM-C stated she will request from nursing on a sticky note any missing weights she needs and did not know why R1's weight was only checked once since his admission.