STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335554	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE BRIGHTONIAN, INC	1919 ELMWOOD AVENUE ROCHESTER, NY 14620

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 observations, interviews, and record reviews conducted during the Complaint Investigation (#NY 699), it was determined that for one (Resident #1) of three residents reviewed, the facility did not provide care and services to maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible. Specifically, there was inconsistent monitoring of supplements, incorrect weights were documented, and recommendations by the Registered Dietician (RD) were not addressed. This is evidenced by the following: Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) Assessment, dated 3/20/20, included that the resident had severely impaired cognition, no swallowing issues, and required extensive assist of staff for eating. The MDS Assessment was coded for both weight loss and weight gain of 5 percent or more in the last month or 10 percent or more in the last six months, and the resident's weight was 128 pounds (lbs). The current Comprehensive Care Plan, revised on 3/20/20, included that the resident was at risk for unplanned weight change due to inability to perform Activities of Daily Living without assist, dementia, weight loss, and pocketing of food per Speech Language Therapy (SLT). The resident was on a pureed diet with thin liquids. Approaches included, but were not limited to, follow SLT recommendations as able, increase supplements, and to monitor weights monthly and as needed. On 5/4/20, the care plan was revised to include an intake study as needed, monitor weight as ordered, and provide supplements as ordered. The most recent physician orders, dated 3/20/20, included weekly weights. On 3/30/20, magic cup supplements were ordered for three times a day with meals. Review of the resident's weights, from 2/4/20 through 5/6/20, revealed the following: 2/4/20, 136 lbs; 3/20/20, 130 lbs; 3/30/20, 135 lbs; 4/6/20, 133lbs; 4/16/20, 137 lbs; 4/20/20, 156 lbs (19 lb weight gain); 4/28/20, 125 lbs (a 12 lb weight loss in 12 days); and 5/6/20, 121lbs. Review of RD progress notes revealed the following: a. On 3/23/20, the resident had a significant weight loss in one month, and a magic cup was recommended three times a day. b. On 4/6/20, the resident's weight change was insignificant and their appetite was variable. The resident needs to be encouraged to eat and drink. Supplements provided included a magic cup and mighty shakes with all meals. The RD recommended to add 2 cal HN (high calorie, high protein nutritional supplement) 2 ounces three times a day at med pass if poor intake continues. c. On 5/4/20, the resident had a significant weight loss in one month with decreased intakes. Recommendations included to increase mighty shakes to six times a day and 2 cal HN 2 ounces three times a day. Review of the Electronic Medical Record, Plan of Care History Report, and the Medication Administration Record (MAR) from 4/1/20 through 5/12/20 revealed documentation that the resident's intake varied from none to 100 percent with the majority of meal and fluid intake below 50 percent. The supplements were documented as offered on eight occasions for the month of April and nine occasions in May. The 2 cal HN supplement was not documented on the MARs. There was no additional documentation that the 2 cal HN supplement was being provided to the resident as recommended by the RD on 4/6/20 and again on 5/4/20. Review of the medical team progress notes revealed the following: a. The most recent physician note provided, dated 10/18/19, included the resident was doing well and was stable. b. On 3/20/20, the Nurse Practitioner (NP) note included that the resident had a 6 lb weight loss for one month but they did eat 100 percent of breakfast. Weekly weights were started and supplements were being given. The resident was on comfort care and continued weight loss was expected due to dementia, and to continue all supportive measures. c. On 4/29/20, the NP documented that the resident continued to lose weight with a plan to continue to offer liquids and supplements. The NP reviewed the resident's weights with the Director of Nursing and determined that some weights were inaccurate. d. On 4/30/20, the NP's note included that the resident's family had notified her of their concerns of continued weight loss. The family was told that weight loss was expected due to dementia but they would continue to offer supplements. e. On 5/11/20, the NP documented that the resident tested positive for COVID-19 (5/9/20), had been failure to thrive for approximately two weeks, and that it was no longer safe to feed her as she was unresponsive. The goal was comfort care. The facility did not provide any SLT evaluation and/or progress notes when requested by the surveyor. When interviewed on 7/1/20 at 1:50 p.m., the RD stated that when she recommends adding a supplement, she sends an e-mail to the Nurse Manager (NM) and the NP. She said if the NP agrees, an order would be written. She said the milkshakes and the magic cup would be two separate entries documented as supplements in the intake record by the aides with meals and between meals. She said the 2 cal HN would be documented by the nurses in the MARs. The RD said that she usually gets an answer back from the NM or the NP regarding her recommendations but could not remember if she received any feedback regarding the 2 cal HN recommendation for the resident. In an interview on 7/2/20 at 10:20 a.m. and at 2:45 p.m., the Registered Nurse (RN) stated that if 2 cal HN was ordered it would be documented on the MARs and followed exactly as recommended by the RD. She said it would be very unusual for the NP to disagree with the RD but if she did for any reason, she would expect it to be documented. The RN said that if there was a significant weight gain or loss in a resident's weight from one week to the next week, a reweigh was expected. When interviewed on 7/2/20 at 2:50 p.m., the Licensed Practical Nurse (LPN)/NM stated that the RD usually sends an e-mail to both the NM and the NP regarding her recommendations. She said that she could not recall receiving an e-mail from the RD regarding a recommendation for 2 cal HN. She said she has never known the NP not to follow the RD's recommendation. The LPN/NM said that the aides are supposed to document all supplements in the computer. She said if there was a significant weight gain over a week, she would expect a reweigh. (10 NYCRR 415.12(i)(j))

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