| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **415059** | A. BUILDING _____ B. WING _____ | **06/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **ORCHARD VIEW MANOR** | **135 TRIPPS LANE EAST PROVIDENCE, RI 02915** |

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) |
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F 0686

**Level of harm -** 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 record review, and staff interview, it has been determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent infections from developing for 1 of 3 residents who have actual pressure ulcers (ID # 1). Findings are as follows: A review of the facility's policy titled, Prevention and Management of Pressure Injuries, states in part: Residents with pressure injuries .are identified, assessed and provided appropriate treatment to encourage healing or maintain skin integrity .ongoing monitoring and evaluations are provided to ensure optimal resident outcomes . Assessment: Ulcer/Risk Factors . 5. Pressure injuries are assessed and documented on at least weekly and with a significant change in the wound until it is resolved. Pressure ulcer assessment includes: Location Measurement in centimeters- Length, width and depth, undermining and tunneling Stage Presence of tunneling or undermining Drainage Amount Drainage Color Odor - If present after cleaning Appearance of wound bed Appearance of wound edges Appearance of peri wound Pain Effectiveness of treatment. Clinical record review for ID #1 revealed the resident has [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] revealed the resident had an unstageable pressure ulcer. A care plan, dated 3/18/2020, revealed a pressure area to her coccyx with interventions to monitor nutritional status and to follow facility policies and protocols for the prevention and treatment of [REDACTED]. A review of the Wound Physician's report, dated 3/18/2020 and 3/25/2020, revealed a description of the wound under the heading of Other visible tissues stating, this wound is in an [MEDICAL CONDITION] stage and is unable to progress to a healing phase because of the presence of biofilm (overgrowth of bacteria embedded in the tissue fluid of a wound). An order was added on 3/18/2020 for Santyl (used as a chemical debridement) treatment once daily with a foam silicone border dressing and to apply skin prep daily. Review of the resident's weekly pressure injury evaluations from 3/18/2020 until 5/11/2020 revealed the following: - 3/18/2020: Stage 3 pressure ulcer (full-thickness tissue loss, subcutaneous fat may be visible) to the right coccyx; measurements of 1.0 cm (centimeter) in length x 0.6 cm in width x 0 cm in depth; the wound bed has 50% granulation tissue (pink or red tissue with a bumpy appearance), 50 % Dermis (skin), and 0% unhealthy tissue with no drainage. Under the heading current treatment it states, Santyl treatment order in place. - 3/25/2020: Stage 3 pressure ulcer to the right coccyx, now measuring 1.3 cm in length x 0.8 cm in width x 0 cm in depth with moderate serous (clear or pale-yellow fluid) exudate (accumulation of fluid); wound bed has 50% granulation tissue and 20% slough (non-viable yellow/white/ or brown tissue that impedes wound healing); wound bed has 25% unhealthy tissue; no odor. - 5/11/2020: coccyx wound is Unstageable (full thickness wound where the entire wound bed is completely obscured by slough and or eschar); wound measurements are 5 cm in length x 4 cm in width x 0.2 cm in depth. The evaluation continues to describe the wound as white to tan and dark green slightly firm slough noted to upper wound bed going to mid wound bed with areas of white slough .100 % unhealthy tissue, wound edges described as unhealthy, irregular, rolled under, red hard/indurated, macerated. The wound was documented as having 25-75% of purulent (pus production in infected tissue)-thin/thick tan to yellow drainage, and the surrounding skin was documented as red-warm-swollen-macerated/white-abraded/denuded. The evaluation further stated that the current treatment was effective and to continue current treatment, which was Santyl ointment to wound bed followed by an [MEDICATION NAME] dressing daily. - 5/19/2020: the coccyx wound is Unstageable, measuring 3 cm in length x 4 cm in width x 0.3 cm in depth, with small areas of pink tissue noted with dark red areas of tissue .75% unhealthy tissue with yellow slough to the wound bed, wound edges described as unhealthy, irregular, rolled under, red hard/indurated, macerated. The wound was documented as having < 25% of serosanguinous (yellow drainage with small amounts of blood) drainage, and the surrounding skin was documented as red-warm-swollen-macerated/white-abraded/denuded. Further documentation states the current treatment was effective and to continue current Santyl and [MEDICATION NAME] treatment. - 5/24/2020: the coccyx wound is Unstageable, measuring 3 cm in length x 2 cm in width x 0.5 cm in depth, with loose fibrous green slough noted throughout wound bed .100 % unhealthy tissue, wound edges described as unhealthy, irregular, rolled under, red hard/indurated, macerated. The wound was documented as having < 25% of serosanguinous drainage. Further documentation states to apply Santyl to the wound bed then lightly pack with gauze followed by a dry clean dressing. - 5/29/2020: the coccyx wound is Unstageable, measuring 4 cm in length x 2 cm in width x depth unknown, and the wound now has undermining (the destruction of tissue or ulceration extending under the skin edges, pressure ulcer larger at base than at skin surface) noted at 7 o'clock to 12 o'clock, measuring 0.8 cm. The wound bed has 100 % unhealthy tissue with dark green fibrous loose slough, wound edges described as unhealthy, irregular, rolled under, red hard/indurated, macerated. The wound was documented as having 25-75% of purulent thin/thick tan to yellow drainage, and the surrounding skin was documented as red-warm-swollen-macerated/white-abraded/denuded. Documentation further states to start Silver Alginate followed by a dry clean dressing twice daily. - 6/04/2020: the coccyx wound is Unstageable, measuring 3.1 cm in length x 4.0 cm in width, the wound now has undermining from 11-1 o'clock measuring 3.1 cm, 4-5 o'clock, measuring 4.0 cm and 7-8 o'clock, measuring 3.1 cm. The wound now has presence of tunneling (a passageway of tissue destruction under the skin level under the wound) at the center of the wound measuring 3.1 cm. Further description of the wound states in part, 100 % Eschar (dead tissue either hard or soft in texture; usually black, brown, or tan in color) to the wound bed and draining 75% of purulent-thin/thick tan to yellow drainage, wound edges described as unhealthy, irregular, rolled under, red hard/indurated, macerated, and the surrounding skin was documented as red-warm-swollen-macerated/white-abraded/denuded. Documentation further states that the current treatment is effective, although [MEDICATION NAME] (antibiotic to treat an overgrowth of bacteria) was added to the treatment. Instructions were to crush [MEDICATION NAME] and put in wound bed with Santyl ointment daily. Record review revealed no evidence of a weekly pressure ulcer assessment, including location, measurement in centimeters (length, width and depth), stage, presence of tunneling or undermining, drainage amount, drainage color, odor (if present), appearance of wound bed, wound edges, and peri wound, pain, and effectiveness of treatment from 3/25/2020 to 5/11/2020 (6 weeks). During this time the resident's wound progressed from a Stage 3 with 25% unhealthy tissue, moderate drainage, and no odor to an unstageable wound with 100% unhealthy tissue, purulent drainage, and an unhealthy odor. Additionally, weekly wound rounds by the Wound Team Physician and Nurse were not conducted from 4/1/2020 until 6/4/2020. During a surveyor interview on 6/22/2020 at 11:05 AM with nurse, Staff A, who is filling in for the Wound Nurse, revealed that the last time the Wound Physician came to the facility for wound rounds was on 3/25/2020. The last time wound rounds was conducted by the Wound Team was 3/25/2020. Additionally, she stated that she began conducting weekly wound rounds without the Wound Physician starting on 5/11/2020 and the physician returned on 6/4/2020. Further record review revealed that the resident lost 9.4 pounds or 6.7 % of body weight (classified as severe weight loss) from 4/7/2020 to 5/5/2020. During this time, the facility failed to obtain three weekly weights in a row. Additionally, during this time the resident's HiCal (high calorie oral supplement) (60 ml by mouth three times a day) and Liquacel (supplement given for extra protein) (30 ml by mouth once daily) were held from 4/12/2020 to 4/26/2020 due to a recommendation by pharmacy to discontinue supplements as clinically appropriate (as part of the Covid-19 Action Plan). This weight loss occurred during the time frame in which pressure ulcer assessments were not completed weekly. Refer to F692. Review of the nursing progress note, dated 5/28/2020 at 1:16 PM, revealed the MD was notified of the resident's temperature of 99 and worsening wound, which was described as copious (abundant) amounts of purulent drainage noted to dressing and foul odor/warmth/redness to area. A new stat order was given to give [MEDICATION NAME] (antibiotic used to treat bacterial infections) 1 gram x 1 intramuscular (IM), obtain a wound culture, lab work and to [MEDICATION NAME](antibiotic used to treat bacterial infections) 500 mg BID (twice daily) x 7 days. Review of the lab work results, dated 5/28/2020, revealed an elevated white blood cell count (WBC - cells of the immune system involved in protecting the body against infectious disease) of 20.0 (normal range 4-10), and an elevated [DIAGNOSES REDACTED] (type of WBC involved in body's immune response) count of 86.8 (normal range 40-70). A nurse's note on 5/29/2020 at 12:03 PM revealed the resident was noted to have a decrease in intake and a decrease in activity. The physician was made aware and new orders were given for STAT labs, a STAT x-ray of the sacrum, coccyx and chest, a STAT U/A C&S (urinalysis with culture and sensitivities), and an order was given to place a Foley catheter (helps to drain urine). A Foley catheter was placed, x-rays were completed, and urine was obtained for testing. The physician was called to report results and was unable to be reached so a message was left. A nursing progress note, dated 6/1/2020 at 3:23 PM, revealed the physician was made aware of the wound culture results, UA C&S results, and chest x-ray results. A new order was given to start [MEDICATION NAME] (initiated 6/2 in the morning) (antibiotic used to treat bacterial infections) 500 mg twice daily x 7 days, [MEDICATION NAME](initiated 5/29) for elevated WBC's as previously ordered. A review of the 6/1/2020 lab results revealed a low [MEDICATION NAME] (a protein made in the liver; the lab tests the amount of [MEDICATION NAME] in the blood) of 2.5 (normal range 3.5-5.2), a low [MEDICATION NAME] (a protein made in the liver; the lab tests the amount of [MEDICATION NAME] in the blood) of 6.6 (normal range 20-40), and an elevated white blood cell count of 21.9. Further clinical review of the sacral/coccyx x-ray report, dated 5/29/2020, revealed soft tissue ulceration posterior/inferior to the coccyx. A follow up bone scan or MRI was recommended. The UA C&S report, dated 6/1/2020, revealed positive results for Ecoli (bacteria) and confirmatory test for Extended Spectrum Bata Lactamase (ESBL) (bacteria) in the urine. The wound culture results on 5/29/2020 revealed gram-negative bacteria. Review of a nursing progress note, dated 6/3/2020 at 9:54 AM, revealed the physician was made aware of the sacral/coccyx x-ray results with no new orders ([MEDICATION NAME] in place). Review of a nursing progress note, dated 6/4/2020 at 11:07 AM, revealed the physician was made aware of purulent exudate with odor and tunneling in the wound. A new order was given to crush and add [MEDICATION NAME] to the wound bed with the Santyl treatment. A subsequent nursing progress note, for that same day at 12:05 PM, revealed that the resident's son was updated on the resident's status, wound progression, intake, code status, and possible Hospice Consult. Further noting resident's son agreed to sending resident out to (hospital) for second opinion on wound to coccyx. POA (Power of Attorney) is not ready to change code status or ready for a Hospice Consult. A subsequent nursing progress note dated 6/4/2020 at 1:20 PM revealed the resident's physician was contacted about resident's condition and son requesting a second opinion for the resident's wound. An order was given to send the resident to the hospital. Review of the hospital documentation, dated 6/4/2020, revealed that the resident had an elevated White Blood Count of 24.8 and that a CT scan showed a large sacral decubitus ulcer with changes involving the coccyx, concerning for osteo[DIAGNOSES REDACTED] (bone infection). While in the Emergency Department, the resident had a surgical consult, an incision and drainage were performed, and a wound culture was obtained. After the surgical consult, there was concern that the sacral ulcer was a stage 4 and would require a bone biopsy. Additionally, neurosurgical was consulted due to CT findings of possible involvement of spinal canal at distal sacrum. Intravenous fluids were initiated for hydration. Broad spectrum Intravenous [MEDICATION NAME] (an antibiotic used to treat infections) and [MEDICATION NAME] (antibiotic used to treat infections caused by bacteria) were initially started due to the stage 4 sacral ulcer and osteo[DIAGNOSES REDACTED] of the sacrum. The physicians report states in part, recent COVID +, PNA (pneumonia) and ESBL infection .(the resident) presented from SNF (skilled nursing facility) with an infected stage 4 sacral decubitus ulcer found to have osteo[DIAGNOSES REDACTED] of sacrum .her sacral decubitus likely took significant time to form, as it tracks and probes to bone, not just the past week (per SNF documents) .consult with plastic surgery for [REDACTED]. Patient started on Intravenous Ertapenem (antibiotic used to treat bacterial infections) every day for 6 weeks. Palliative Hospice was consulted. During a surveyor interview on 6/22/2020 at 12:05 PM, with the Director of Clinical Operations, she revealed that beginning on 4/11/2020 to the end of April or beginning of May evaluations had stopped due to the pandemic, including weekly pressure evaluations, as the facility had many cases of Covid-19. She further stated that they were focused on keeping patients safe and sustaining life. During a

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| | surveyor interview with the resident's Physician (also the Medical Director) on 6/24/2020 at 9:49 AM, he revealed that he was unaware that evaluations were stopped, including weekly pressure evaluations. Additionally, he stated he would have expected weekly assessments, measurements, and description of the wound to be done by nursing in absence of the Wound Physician and Wound Nurse. The physician also added that with the Wound Nurse and Wound Physician being out, he would have hoped that wounds would have been checked remotely by the Wound Team. When asked if he was aware of the resident's status of his/her wound prior to leaving the facility, he revealed he was unaware of the specific description or stage of the wound. During a subsequent surveyor interview with the resident's physician at this time, he was asked about the Covid-19 Action Plan, recommended by pharmacy, that was put into place regarding supplements being held. The MD could not recall the recommendations made from pharmacy relative to supplements being held during the COVID outbreak at the facility. He further stated that he would not have held Resident ID #1's nutritional supplements with his/her ongoing weight loss and active wound. While reviewing the resident's overall weight loss since January, and further weight loss during the month of April/May, with the MD, he revealed he was not aware of the amount of weight loss the resident had and could not recall if the nursing staff called him specifically about his/her weight loss. |
| F 0692<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Some | **Provide enough food/fluids to maintain a resident's health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>Based on surveyor record review and staff interview, it has been determined that the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight, for 4 of 4 residents reviewed for nutrition (ID #'s 1, 3, 5, 6) and offer sufficient fluid intake to maintain proper hydration for 1 of 1 residents reviewed for hydration (ID #3).<br>Findings are as follows: Review of the facility's policy titled, Weights, states in part: If a significant weight loss/gain is identified (> 5% in 30 days or > 10% in 6 months), the IDT (Interdisciplinary Team), Dietitian, Physician and Family are notified. All residents with a significant weight loss are reviewed by the Interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly. Review of the facility's document titled, COVID-19 ACTION PLAN, recommended by a consultant pharmacy company, states in part . 2. D/C (discontinue) SUPPLEMENTS: Wherever possible and appropriate, D/C vitamins and supplements (Multivitamins, Vitamins B, C, D, and E, Calcium, Folate, and other OTC supplements) unless part of COVID-19 regimen a. Consider a 14 day (or longer) hold order if permanent D/C is not appropriate. b. Work with dietician to assess and eliminate Ensure and other supplements given as part of the med pass whenever possible and clinically appropriate . 1. Resident ID #1 was admitted to the facility in January 2015 and has [DIAGNOSES REDACTED]. Review of the resident's advanced directives, signed and dated by the resident's physician on 8/30/2019, indicates that the resident wishes to be a Full Code with indication for artificial nutrition and hydration, if required. Review of the resident's Minimum Data Set (MDS), dated [DATE], indicates that the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months, while not on physician-prescribed weight-loss regimen. Review of the resident's nutrition care plan reveals an intervention, initiated 3/22/2018, to Monitor/evaluate energy intake and/or food/beverage intake via meal intake records and observation. An additional intervention, revised on 7/1/2019, states, Obtain weights q (every) week as per physician order [REDACTED]. Review of the physician's orders [REDACTED].: Liquacel (supplement given for extra protein), give 30 ml by mouth (mix w/ 30-90 ml of beverage), every day at bedtime Further review of the physician's orders [REDACTED]. Review of the resident's intake documentation from 4/12/2020 to 4/26/2020 revealed 29 out of 45 opportunities where the resident's meal intake was not documented. Review of the resident's weights from 1/7/2020 (169.6# (pounds)) to 4/7/2020 (149#) reveals that the resident lost 20.6# or 12% of body weight (classified as severe weight loss) in 3 months. Review of the resident's weekly weights from 4/7/2020 until 6/5/2020 revealed the following: - 4/7/2020: 149# - 4/14/2020: no weight obtained - 4/21/2020: documented unable to obtain - 4/28/2020: documented will obtain next shift - 5/5/2020: 139.6# - 5/12/2020: no weight obtained - 5/19/2020: documented unable to obtain - 5/26/2020: 138# - 6/2/2020: documented unable to obtain The resident lost 9.4 pounds or 6.7 % of body weight (classified as severe weight loss) from 4/7/2020 to 5/5/2020. During this time, the facility failed to obtain three weekly weights in a row. Additionally, during this time the resident's above supplements were held from 4/12/2020 to 4/26/2020. The facility continued to fail to obtain weekly weights on 5/12/2020, 5/19/2020, and 6/2/2020. Further record review revealed that the resident had a Stage 3 pressure ulcer to the coccyx on 3/25/2020. As of |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| | **415059** | A. BUILDING _____ B. WING _____ | **06/22/2020** |

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| F 0692<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>5/11/2020, the resident's pressure ulcer was documented as an unstageable pressure ulcer with 100% unhealthy tissue. Refer to F686. Review of the Registered Dietitian's (RD) progress note, dated 5/15/2020, states the following: Risk note - wt (weight) on 5-5-20 .139.6# more recent wgt (weight) n/a (not available) Wt shows 9.4# loss x past month due to poor intakes. Wt loss may also be attributed to increased kcal (calorie) needs for wound healing .Intakes appear to have declined, consumes <50% meals per flow sheet documentation. Rec'ng (receiving) supplements 6x qd (daily) - res (resident) usually consumes . The RD recommended to continue current interventions. No additional recommendations were noted. Review of the resident's labs, dated 6/1/2020, reveals the following: - [MEDICATION NAME] (a protein made in the liver; the lab tests the amount of [MEDICATION NAME] in the blood) = 2.5 gm/dl (grams/deciliter) (normal range = 3.5-5.2 gm/dl) - [MEDICATION NAME] (a protein made in the liver; the lab tests the amount of [MEDICATION NAME] in the blood) = 6.6 mg/dl (milligrams/deciliter) (normal range = 20.0-40.0 mg/dl) Resident ID #1 was admitted to the hospital in June 2020. Review of the hospital documentation from 6/4/2020 indicates that s/he meets criteria for severe protein calorie malnutrition. During a surveyor interview with the RD on 6/17/2020 at 11:40 AM and 6/25/2020 at 3 PM and 4:40 PM, she revealed that she was unaware that the resident's supplements were held from 4/12/2020 to 4/26/2020. Additionally, she indicated that she was out of work from 4/2/2020 to 5/1/2020 and that there was no other RD covering for her. The RD acknowledged that the resident was a Full Code, with indications for artificial nutrition, if necessary. The RD revealed that she did not discuss pursuing the use of artificial nutrition with the doctor or family after the resident experienced severe weight loss in May 2020. During a surveyor interview with the Medical Director (resident's primary physician) on 6/24/2020 at 9:49 AM and 6/25/2020 at 2:15 PM, he indicated that he would not have agreed to discontinuing the resident's HiCal and Liquacel supplements given her history of weight loss and present pressure ulcer. While reviewing the resident's overall weight loss since January, and further weight loss during the month of April/May, with the MD, he revealed he was not aware of the amount of weight loss the resident had and could not recall if the nursing staff called him specifically about his/her weight loss. He was unaware that the resident's weekly weights were not being obtained and intake was not being documented. Additionally, he could not recall if a discussion was held regarding artificial nutrition for this resident. During a surveyor interview with the Director of Nursing Services (DNS) on 6/26/2020 at 9:12 AM, he could not provide evidence that a discussion related to artificial nutrition was had with the resident's physician or resident's representative after the resident had severe weight loss in May 2020. During a surveyor interview with the Director of Clinical Services on 6/18/2020 at 2:35 PM, she revealed that only life-sustaining medications were given while the facility was in crisis due to Covid-19. Furthermore, she indicated that there was not enough time to evaluate on an individual basis which residents' supplements were clinically appropriate to be put on hold when initiating the Covid-19 Action Plan. 2. Resident ID #3 was admitted to the facility in November of 2017 with [DIAGNOSES REDACTED]. Review of the resident's Minimum Data Set (MDS), dated [DATE], indicates that the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months, while not on physician-prescribed weight-loss regimen. Review of the nutrition care plan, initiated 5/26/2020, indicates Staff will monitor (resident's) food and beverage intake using observations and meal intake record. Review of the resident's intake documentation from 4/10/2020 to 4/26/2020 revealed no record of intake for breakfast or lunch, and for dinner there were 17 opportunities to document intake, 5 opportunities no intake was documented, there were 8 opportunities where it was documented that the resident refused, and the remaining 5 opportunities intake varied for dinner from 0-75%. Review of the physician's orders [REDACTED].# - 4/15/2020: weight not documented - 4/21/2020: documented resident refusal - 4/29/2020: resident at the hospital - 5/06/2020: resident at the hospital - 5/13/2020: readmission weight not obtained - 5/19/2020: 214.2# - 5/27/2020: documented resident refusal - 6/02/2020: 213.2# - 6/09/2020: weight not documented - 6/17/2020: weight not documented - 6/23/2020: 217.2# The resident lost 13.6 pounds or 5.97 % of body weight from 4/8/2020 to 5/19/2020. During this time, the facility failed to obtain 2 weekly weights in April. In addition, upon readmission from the hospital on [DATE], the resident's readmission weight was not obtained until 5/19/2020. Weekly weights were missed on 6/09/2020 and 6/17/2020. Review of the dietitian's note on 5/15/2020, states in part, Supplements: will add 60 cc Hical bid due to decreased intakes .readmission Wt. not obtained, continue weekly wgt a/o (as ordered) last available wgt 4-8-20 .227.8# Hosp wgt 220# .supplements to be initiated .continue to monitor intakes, weights and labs prn (as needed). Review of the dietitian's note on 5/26/2020, states in part, Risk note - wt on 5-19-20 .214.2# Wt shows significant loss of 13.6# x past 6 weeks. Wt loss due to recent hospital stay and poor intakes. Continue Cont. weekly wgt a/o (as ordered) . Further review of the nursing progress notes from 4/12/2020- 4/28/2020 revealed the resident had experienced intermittent low-grade temperatures, with periods of lethargy, and requiring oxygen use. Of note, resident was positive for COVID as of 4/18/2020. Further review of the nursing note dated 4/28/2020 reveals the resident was lethargic; the physician was made aware and new orders for a chest x-ray and labs were obtained. Lab results revealed an elevated BUN (a test to see how well your kidneys are working) of 166, a critically elevated creatinine (a test to see how well your kidneys are working) of 8.06, and a critically elevated Sodium (an electrolyte) level of 161, all results suggest dehydration. Lab results were reported to the physician and the resident was sent out to the hospital for an evaluation. Review of a nursing progress note dated 5/12/2020 revealed the resident was readmitted from the hospital with [DIAGNOSES REDACTED]. Review of the resident's Advanced Directive, dated 3/07/2018, revealed a code status of DNR/DNI (do not resuscitate/do not intubate). In addition, the advanced directive revealed s/he would want Intravenous Hydration. Record review revealed at no time in the month of April was Intravenous Hydration administered. 3. Resident ID #5 was admitted to the facility in March of 2016 with [DIAGNOSES REDACTED]. Review of the resident's Minimum Data Set (MDS), dated [DATE], indicates that the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months, while not on physician-prescribed weight-loss regimen. Review of the nutrition care plan, initiated 3/20/2019, indicates Staff will monitor (resident's) food and beverage intake using observations and meal intake record. Review of the resident's intake documentation from 4/12/2020 to 4/26/2020 revealed 33 out of 45 opportunities where the resident's meal intake was not documented. Review of the physician's orders [REDACTED]. from 3/4/2020 to 5/26/2020 revealed the following: - 3/4/2020: 92.2# - 4/4/2020: documented as see nurses notes, no reasoning documented in notes - 5/7/2020: 82.6# - 5/12/2020: progress note indicating resident refused to get out of bed - 5/19/2020: progress note indicating resident refused to get out of bed - 5/26/2020: 76.0# The resident lost 9.6 pounds or 10.4 % of body weight (classified as severe weight loss) from 3/4/2020 to 5/7/2020. During this time, the facility failed to obtain a monthly weight in April. Record review revealed that the resident was put on weekly weights starting on 5/12/2020; however, the resident refused to be weighed on 5/12/2020 and 5/19/2020. There is no evidence that the facility re-attempted to get a weight at a different time/date. The resident lost another 6.6# or 7.9% of body weight in less than 1 month, for a total weight loss of 16.2# or 17.6 % weight loss (classified as severe weight loss) in less than 3 months. Review of the dietitian's note on 5/12/2020, states in part, Risk note - wt on 5-7-20 .82.6# Wt shows 9.6# loss x past 2 months due to poor intakes .Intakes vary - consumes 0-75% meals per flow sheet documentation . The RD recommended to continue current interventions. No additional food interventions were put into place at this time. Review of the dietitian's note on 5/28/2020, states in part, Risk note - wt on 5-26-20 .76.0# wt shows 6.6# loss x past 3 weeks. Res continues with decreased intakes - consumes 25-75% meals per flow sheet documentation with most meals <50% eaten .Granddtr called this writer - Granddtr also updated re: above. Res usually drinks health shakes and currently rec'ng 120cc 5x qd (daily). Will increase to 240cc with meals and continue 120cc bid (twice daily) with med pass. Cont to follow on risk for wgt. During a surveyor interview with the RD on 6/25/2020 at 3 PM, she revealed that she did not increase the resident's supplement on 5/12/2020 after the initial 9.6-pound weight loss as the resident was already getting supplements 5 times a day. The RD further indicated that she increased the resident's supplement on 5/28/2020, after speaking with the resident's family. 4. Resident ID #6 was admitted to the facility in November of 2018 with [DIAGNOSES REDACTED]. Review of the resident's Minimum Data Set (MDS), dated [DATE], indicates that the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months, while not on physician-prescribed weight-loss regimen. Review of the nutrition care plan revealed a goal, revised on 12/4/2019, to consume greater than 75% of nutrition supplements through next review. Review of the physician's orders [REDACTED]. Review of the April administration record revealed that this supplement was held from 4/12/2020 to 4/26/2020. Review of the resident's intake documentation from 4/12/2020 to 4/26/2020 revealed 27 out of 45 opportunities where the resident's meal intake was not documented. Review of the resident's weights from 4/2/2020 to 5/5/2020 revealed the following: - 4/2/2020: 127.4# - 5/5/2020: 119.8# The resident lost 7.6 pounds or 5.9 % of body weight from 4/2/2020 to 5/5/2020. Additionally, during this time the resident's above supplements were held from 4/12/2020 to 4/26/2020. Record review revealed that the resident was not seen by the RD until 5/19/2020. During a surveyor interview with the RD on 6/25/2020 at 3 PM, she revealed that she typically sees a resident 1-2 days after s/he experiences significant weight loss; however, she was playing catch up from being out from 4/2/2020 until 5/1/2020 and was unable to see the resident until that time. During a surveyor interview with the DNS on 6/26/2020 at 9:12 AM, he acknowledged that they did not have a dietitian covering from 4/2/2020 until 5/1/2020 while the RD was on leave. Furthermore, he indicated that he would expect nursing to monitor intake and notify the physician if there was a change in weight. During a surveyor interview with the Director of Clinical Services on 6/28/2020, she indicated that the facility was in crisis due to Covid-19 during the time of the above resident's weight loss. |