STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195553	A. BUILDING _____ B. WING _____	**09/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EASTRIDGE NURSING CENTER	**2305 RICHARD ST. ABBEVILLE, LA 70510**

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 -** Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain acceptable nutritional status and usual body weight by failing to provide a nutritional supplement as recommended by the Registered Dietician for 1 (#3) of 6 sampled residents who were identified with weight loss. Findings: Resident #3 was admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of the 5/27/2020 Weight Change Comparison log and the High Risk Meeting, Weight Review section revealed that Resident #3 was identified to have had an 8.89% (16 pounds) weight loss in less than 90 days and an intervention was recommended to add 4 ounces of house supplement daily. Review of the 6/4/2020 High Risk Meeting, Weight Review section revealed that Resident #3's was identified to have lost an additional two pounds in one week, resulting in a 10% (18 pounds) weight loss. Under the Supplement section, a house supplement of 4 ounces daily was recommended. A review of the dietary progress note dated 6/4/2020 revealed that the dietician discussed providing Resident #3 with 4 ounces of house supplement daily, peanut butter sandwiches and mighty shakes with the dietary manager. A review of the Resident #3's plan of care revealed that an intervention for a house supplement was not implemented until 7/8/2020. Further review revealed no plan for peanut butter sandwiches or mighty shakes as recommended by the Registered Dietician. A review of the Medication Administration Record [REDACTED]. A review of the registered dietician note dated 7/3/2020 revealed that Resident #3 had a 8% weight loss in one month, 13% weight loss in three month and a 13% weight loss in 6 months. Further review revealed a recommendation for 4 ounces of high calorie (house) supplement daily related to weight loss. A review of the physician orders [REDACTED]. On 9/10/2020 at 1:30PM, Resident #3 was observed lying in bed on her right side in a fetal position with oxygen infusing at 2 liters via nasal cannula. She mumbled and nodded when asked how she was feeling. She was observed complaining to the staff in the room to turn off the light because it was bothering her. On 9/14/2020 at 2:15PM, Resident #3 was observed lying in bed on her left side with oxygen infusing at 2 liters via nasal cannula. Resident #3 was arousable but unable to stay awake. An opened ice cream cup was noted on the bedside table with only a few spoonful missing. Resident #3 appeared to very sleepy. Resident #3s roommate stated that Resident #3 slept all the time. On 9/10/2020 at 4PM, an interview was conducted with S1DON. S1DON stated that she took over as interim DON in mid-June. She stated at that time she conducted weight comparisons on all resident in the facility in order to capture any weight loss in the facility. She stated that the computer should automatically flag the weight there is a significant weight loss. After review of the Weight Change Comparison conducted on 5/27/2020 by the previous DON, she confirmed that computer had identified that Resident #3 had a significant weight loss of 8.89%. She also confirmed that the weight loss should have been addressed during that time. On 9/14/2020 at 11:00AM, S1DON confirmed that Resident #3 had a significant weight loss and should have been receiving 4 ounces of house supplement daily since 5/27/2020. She also confirmed that there was no documented evidence to show that Resident #3 had been receiving the house supplement until an order was written by the physician on 7/8/2020. On 9/14/2020 at 12:00PM, an interview was conducted with S4CNA. S4CNA stated that when Resident #3 was on the other hall she was able to do for herself, including feeding herself. She stated that now Resident #3 required total assistance with all ADLS (Activities of Daily Living) and staff had to feed her. S4CNA stated that Resident #3 lately only took 1 or 2 bites of her food and very little of the supplement she got on her meal trays. She stated that Resident #3 required lots of encouragement from staff to eat. She also stated that Resident #3 no longer got out of bed. On 9/14/2020 at 1PM, an interview was conducted with S2DM. S2DM stated that she is required to attend the monthly High Risk Meeting and that residents with weight concerns are discussed in the meeting. She stated that she didn't remember attending the meeting in May because during that time she was having a shortage in the dietary department and she had had to fill in for the loss of staff. S2DM stated that the RD will give her a list of recommendations for those residents with weight concerns. During the interview, the registered dietician recommendations for June 2020 was reviewed with S2DM and revealed that the dietician had made a recommendation that Resident #3 receive 4 ounces of a high calorie supplement daily related to weight loss. S2DM stated that usually the high calorie supplements are kept on the nurses' cart and given to the residents by the nursing staff. On 9/14/2020 at 2PM, an interview was conducted with S3LPN. S3LPN stated that Resident #3 was moved another hall. She stated that she provided care for the resident while she was on other hall. S3LPN stated that Resident #3 stopped eating after visitations ceased due to COVID-19. She stated that also after visitations stopped Resident #3 seemed to become depressed because her daughter was not visiting as much as before. She stated that the resident would tell the staff that she was fine and just not hungry. S3LPN stated that she was not aware of Resident #3's weight loss because the Restorative CNAs took the weights and turn them in to the DON. She stated that if there is a problem with a resident's weight, the DON will inform the staff of what interventions are to be implemented. She stated that she was made aware of the resident's weight loss by the current DON but wasn't sure when the DON had informed her. S3LPN confirmed that there was no previous order for a high calorie supplement and that Resident #3 was started on 4 ounces of a high calorie supplement daily not until 7/8/2020.

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.