STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185334	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAVER DAM NURSING & REHAB CENTER, INC	**1595 S US HIGHWAY 231 BEAVER DAM, KY 42320**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, hospital record review, and facility policy review, it was determined the facility failed to revise the comprehensive care plans for two (2) of three (3) sampled residents (Resident #1 and Resident #2). The facility identified Resident #1 and Resident #2 had significant weight loss; however, the facility failed to revise the resident's care plans to include goal and specific interventions to address the residents' identified weight loss. The findings include: Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological, and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The Interdisciplinary Team (IDT) must review and update the care plan when there has been a significant change in the resident's condition and when the resident has been readmitted to the facility from a hospital stay. Record review revealed the facility admitted Resident #1, on 08/06/16, with [DIAGNOSES REDACTED]. Further review revealed the resident was hospitalized from [DATE] through 04/18/2020. Review of Resident #1's Significant Change Minimum Data Set (MDS) assessment, dated 04/26/2020, revealed the resident had been identified as having significant weight loss and he/she was not on a physician prescribed weight-loss regimen. Review of Resident #1's Comprehensive Care Plan for Nutritional Problem, History of Obesity related to Spinal Cord Injury/[MEDICAL CONDITION]; recent decreased intakes and significant weight loss, not dated, revealed a goal for the resident to maintain adequate nutrition status as evidenced by maintaining weight within gain/loss of five (5) pounds of 223 pounds. Further review of the care plan revealed interventions to monitor/record/report to Medical Doctor (MD) s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, and significant weight loss of three (3) pounds in one (1) week, greater than five percent (5%) in one (1) month, greater than seven.five percent (7.5%) in three (3) months, or greater than ten (10) percent in six (6) months. Review of Resident's #1's Weight Record revealed the resident was weighed 223 pounds on 03/19/2020, and hospital records revealed a weight of 164.1 pounds on 04/18/2020 (after dieuresed: hospitalized [DATE]-04/18/2020); and the facility Weight Record revealed the resident weighed 162.2 pounds on 05/11/2020. However, further review of the Care Plan for Nutritional Problem revealed there were no revisions to the care plan goal to address the resident's weight loss and new weight of 162.1 pounds and not specific interventions to address the resident's identified weight loss. 2. Record review revealed the facility readmitted Resident #2 from the hospital, on 04/24/2020, with [DIAGNOSES REDACTED]. Further review revealed the resident was hospitalized from [DATE] through 04/24/2020. Review of Significant Change (MDS) assessment, dated 05/01/2020, revealed the resident was not identified as having weight loss in the last month and was not on a physician prescribed weight-loss regimen. Review of Resident #2's Comprehensive Care Plan for Nutritional Problem, Obesity as Evidenced by Basic Metabolic Index (BMI) of 36.9, not dated, revealed goal to maintain adequate nutritional status, target date 07/14/2020. Further review of the care plan revealed interventions to provide and serve diet as ordered, monitor intake and record every meal, provide and serve supplements as ordered, and weigh per MD (medical doctor) orders prn (as needed). Review of Resident #2's Weight Record revealed the resident weighed 248.4 pounds on 03/30/2020 and 213.8 pounds on 05/15/2020. The facility identified a significant weight loss of 13.9 percent; however, further review of the Care Plan for Nutritional problems revealed there was no specific interventions to address the resident's identified weight loss. Interview with the Registered Dietician, on 05/27/202 at 4:07 PM, revealed recommendations and care interventions should be reflected on resident's care plan. Interview with the Director of Nursing (DON), on 06/03/2020 at 1:59 PM, revealed staff is expected to review and revise care plans which is ongoing to reflect changes residents' condition.
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 interview, record review, hospital record review, and facility policy review, it was determined the facility failed to ensure two (2) of three (3) sampled resident's weights were obtained on readmission (Resident #1 and #2). The facility failed to obtain Resident #1's and #2's weight on readmission from the hospital; per facility policy. The residents were admitted to the COVID Unit and there was no scale located on the unit to obtain weights. Resident #1 was readmitted on [DATE] and his/her weight was not obtained until 05/11/2020. Resident #2 was readmitted on [DATE], and his/her weight was not obtained until 05/15/2020 at which time he/she was identified to have a 13.9 percent weight loss. The findings include: Review of the facility's policy titled, Weight Assessment and Intervention, dated September 2008, revealed the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff will strive to measure resident weights on admission and weekly for 2 weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 1. Record review revealed the facility admitted Resident #1, on 08/06/16, with [DIAGNOSES REDACTED]. Review of Resident #1's Significant Change Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6) which indicated the resident was not interviewable. Further review of the MDS, Section K-Swallowing/Nutritional Status, K0300, did not indicate the resident had been identified as having weight loss and he/she was not on a physician prescribed weight-loss regimen. Review of Resident #1's Comprehensive Care Plan for Nutritional Problem History of Obesity related to Spinal Cord Injury/[MEDICAL CONDITION]; recent decreased intakes and significant weight loss, not dated, revealed a goal for the resident to maintain adequate nutrition status as evidenced by maintaining weight within gain/loss of five (5) pounds of two-hundred twenty three (223)pounds, no signs/symptoms (s/sx) of dehydration, target date 08/21/2020. Further review of the care plan revealed interventions to monitor/record/report to Medical Doctor (MD) s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, and significant weight loss of three (3) pounds in one (1) week, greater than five percent (5%) in one (1) month, greater than seven.five percent (7.5%) in three (3) months, or greater than ten (10) percent in six (6) months. Review of Resident #1's Weight Record revealed the resident weighed 223 pounds at the facility on 03/19/2020 and review of hospital records revealed the resident was hospitalized for [REDACTED]. The resident was readmitted back to the facility on [DATE]; however, there was no documented evidence on the weight record that Resident #1's weight was obtained on readmission and/or a monthly weight was obtained. Further review of the Weight Record revealed the resident's weight was not obtained by the facility until 05/11/2020 (52 days after last weight) and the resident weighed 162.2 pounds. The facility called the Registered Dietician(RD) and she recommended Med Pass 2.0 (to equal 540 calories and 22 grams of protein a day). Interview with the RD, on 05/27/2020 at 4:07 PM, revealed the resident was transferred to the hospital where the resident remained until 04/18/2020. The RD stated during that time the resident was dieuresed with an significant amount of fluid removed. RD #1 revealed Resident #1 was

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.

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) readmitted to the COVID (quarantine) Unit at the facility on 04/18/2020 and a readmission weight was not obtained. Interview with Licensed Practical Nurse (LPN) #1, on 06/02/2020 at 2:39 PM, revealed she was the nurse assigned when Resident #1 was readmitted to the facility on [DATE]. LPN #1 stated the resident had lost a significant amount of weight; however, a readmission weight was not obtained due to the quarantine (COVID) unit not having access to a scale. LPN #1 revealed there was a scale in the facility; however, it was a wheelchair scale and the resident needed a bed scale. Further interview revealed it was facility policy to obtain weights on all residents on admission, readmission, monthly, and/or as ordered by the physician. Interview with the Director of Nursing (DON), on 05/27/2020 at 12:52 PM, revealed Resident #1 weight at the facility on 03/19/2020 was 223.6 pounds. The DON stated the resident was not weighed in the facility again until 05/11/2020 because the resident was readmitted from the hospital to the COVID Unit and there was no weight scale for a wheelchair. Interview with the Administrator and DON, on 06/03/2020 at 1:59 PM, revealed Resident #1 was hospitalized [DATE] through 04/18/2020 and was dieuresed while hospitalized which attributed to a significant weight loss. The Administrator and DON stated it was identified the resident had a significant weight loss, but he/she was not weighed on readmission to assess weight. They further revealed there was not a scale on the COVID Unit to minimize possible exposure to COVID-19 although, no positive residents were identified in the facility. 2. Record review revealed the facility readmitted Resident #2 from the hospital, on 04/24/2020, with [DIAGNOSES REDACTED]. Review of Significant Change (MDS), dated [DATE], revealed the facility assessed Resident #2's cognition as severely impaired with a BIMS score of zero (0), which indicated the resident was rarely/never understood. Further review of the MDS, Section K-Swallowing / Nutritional Status, K0300, did not indicate the resident had been identified as having weight loss in the last month and was not on a physician prescribed weight-loss regimen. Review of Resident #2's Comprehensive Care Plan for Nutritional Problem Obesity as Evidenced by Basic Metabolic Index (BMI) of 36.9, not dated, revealed goal to maintain adequate nutritional status, target date 07/14/2020, with interventions to provide and serve diet as ordered, monitor intake and record every meal, provide and serve supplements as ordered, weigh per MD (medical doctor) orders prn (as needed). Review of Resident #2's Weight Record revealed the resident weighed 248.4 pounds on 03/30/2020. Further review of the Weight Record revealed resident weight was not obtained again until 05/15/2020 (forty-six {46} days later) at which time the resident weighed 213.8 pounds, which the facility identified as a significant weight loss of 13.9 percent. Further review of the record revealed the Physician and/or Registered Dietician was not notified of the significant weight loss until 05/28/2020 (thirteen {13} days later). Review of the Registered Dietician's (RD) Notes dated 05/28/2020, revealed a significant change in Resident #1's nutritional status with weight fluctuating; weighed 213.8 pounds on 05/15/2020, with eleven (11) percent significant weight loss in three (3) months; eighteen (18) percent in six (6) months. Resident #2 was previously on self planned weight loss program, and is currently receiving pureed diet with honey-thickened liquids. Further review of the note, revealed she recommended fortified foods with meals and magic cup supplement once a day for weight maintenance. Interview with Registered Nurse (RN) #2, on 06/04/2020 at 8:36 AM, revealed Resident #2 was hospitalized [DATE] through 04/24/2020. RN #2 stated the resident returned to the facility on [DATE]; however, a readmission weight was not obtained because he/she was readmitted to the COVID (quarantine) Unit and a scale was not available to obtain weight. RN #2 further revealed the facility had scales however, weights were not being obtained for residents quarantined. She stated the facility's policy was to obtain weights on all residents on admission, readmission, and monthly unless otherwise indicated. Interview with the Administrator and DON, on 06/03/2020 at 1:59 PM, revealed weight scale was not used on the COVID (quarantine) Unit to minimize possible exposure to COVID-19 although, no positive residents were identified in the facility. The stated no weights were obtained for residents while in quarantine until a weight device was obtained for the quarantine unit.