STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555702	A. BUILDING _____ B. WING _____	**09/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE ORCHARDS POST-ACUTE	**730 34 STREET BAKERSFIELD, CA 93301**

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 observation, interview, and record review, the facility failed to accurately and consistently record food and fluid intake for one of three sampled residents (Resident 1). This failure had the potential to result in unintentional weight loss for Resident 1. Findings: During a review of the clinical record for Resident 1, the Admission Record indicated Resident 1 was admitted on [DATE], with a [DIAGNOSES REDACTED]. The Monthly Weight Report indicated on 2/20 Resident 1's weight was 126.4 pounds (lbs. - unit of measure) and on 6/20, Resident 1's weight was 113.8 lbs. (12.6 lbs. wt. loss in 4 months). The Quarterly Dietary Evaluation, dated 4/13/20, indicated Resident 1 required assistance during feedings. The care plan (CP) with the focus on unintentional weight loss, initiated 4/14/20, included the following interventions: offer between meal snacks and bedtime snacks, monitor the acceptance of prescribed diet and encourage Resident 1 to drink fluids and to eat at each meal. The Interdisciplinary Team (IDT) Care Conference, dated 7/9/20, indicated Resident 1 had a significant wt loss. During a concurrent interview and record review, on 8/27/20, at 3:56 PM, with Staff Developer (SD), SD reviewed Resident 1's clinical record. SD stated the facility identified a significant weight loss for Resident 1. SD reviewed the activities of daily living (ADL) report dated 7/20, and verified the following: Amount of Meals Eaten: 7/16/20 no documentation of the amount of the dinner meal eaten. 7/24/20 no documentation of the amount of the dinner meal eaten. 7/27/20 no documentation of of the amount of the breakfast, lunch or dinner meal eaten. 7/28/20 no documentation of the amount of the lunch meal eaten. Snacks: 7/6/20 - no documentation of a bedtime snack. 7/10/20 - 97 (means not applicable) was documented for a bedtime snack. 7/13/20 - 97 was documented for bedtime snack. 7/14/20 - 97 was documented for bedtime snack. 7/16/20 - no documentation of a bedtime snack. 7/20/20 - 97 was documented for between meal snack. 7/26/20 - 97 was documented for between meal snack. 7/27/20 - no documentation for between meal snack or a bedtime snack. 7/28/20 - no documentation for between meal snack. 7/29/20 - 97 was documented for between meal snack. Fluid Intake: 7/6/20 - no fluid intake documented from 10:30 PM to 7 AM (8.5 hours). 7/16/20 - no fluid intake documented from 2:30 PM to 11 PM (8.5 hours). 7/24/20 - no fluid intake documented from 2:30 PM to 11 PM (8.5 hours). 7/26/20 - 97 (not applicable) was documented from 10:30 PM to 7 AM (8.5 hours). 7/27/20 - no fluid intake documented for 24 hours. 7/28/20 - no fluid intake documented from 6:30 AM to 3 PM (8.5 hours). During a continued interview on 8/27/20, at 3:56 PM, with SD, SD stated for a resident experiencing weight loss, it is very important for the dietitian to have a complete and accurate record of a resident's intake. SD stated the expectation is for certified nursing assistants (CNA) to accurately chart all ADL's by the end of their shift. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation revised 7/17, the P&P indicated, All services provided to the resident, progress toward the care plan goals . shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . 3. Documentation in the medical record will be objective . complete, and accurate. During a review of the facility's P&P titled Weight Assessment and Intervention revised 9/08, the P&P indicated, The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents.

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