STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIBERTY HEALTH & WELLNESS	2201 GLENN HENDREN DR LIBERTY, MO 64068

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** - 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 review the facility failed to maintain the nutritional needs for two of four sampled residents (Resident #1 and Resident #2). Resident #1 had a significant weight loss of 8.5% in three months and Resident #2 had significant weight loss of 13.8% in one month. The facility census was 81. Review of the facility's Nutrition, Impaired and Unplanned Weight Loss policy dated September 2017, showed: - Nursing staff would monitor and document the weight and dietary intake of residents weight in a format which permits comparisons overtime; - The staff and physician would define the individual's current nutritional status including weight, fluid intake, food intake, and pertinent laboratory values and identify individuals with anorexia, weight loss or gain, and significant risk for impaired nutrition; - The physician would consider whether any assessment including additional diagnostic testing was indicated to help clarify the severity or consequences of weight loss and or impairment of nutrition; - Staff would report to the physician any significant weight gain or loss and any abrupt or persistent change from baseline appetite or food intake; - The staff and physician would identify pertinent interventions based on identified causes and overall resident conditions, prognosis and wishes; - The physician would authorize appropriate interventions as indicated including tapering, stopping or switching medications known to be associated with undesirable anorexia or weight loss; - The staff and physician would consider existing dietary restrictions and modified consistency diets; - The physician and staff will monitor nutritional status, and individuals response to interventions and possible complications of such interventions; - The physician and staff will collaborate to address any ethical issues related to weight and nutrition (example, possibly use of artificial nutrition and hydration related to severe or prolonged impairment of nutritional status and weight loss). 1. Review of Resident # 1's care plan revised on 5/20/20, showed: - The resident had impaired visual function; - The resident had an actual risk for wound development due to a current wound; - Interventions included monitoring the resident's nutritional status and record the resident's intake; - The resident had a potential for nutritional problems related to a therapeutic diet and required foam utensils; - Interventions included providing foam utensils and monitoring and recording the resident's intake every meal. During an interview on 8/13/20, at 2:00 P.M., Registered Nurse (RN) A said the facility did not log meal intakes for residents. Review of the resident's medical records showed: - On 11/18/19, the resident weighed 219 pounds (lbs); - On 2/14/20, the resident weighed 207.6 lbs; - On 3/3/20, the resident weighed 210.6 lbs; - On 4/3/20, the resident weighed 204 lbs. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/24/20, showed: - The resident's Brief Interview for Mental Status (BIMS) score was 13 indicating the resident was cognitively intact; - The resident needed supervision, oversight, encouragement, queuing and setup help only with eating; - [DIAGNOSES REDACTED]. Review of the care plan meeting notes dated 5/26/20, showed the resident could make his/her needs known verbally to others. The resident ate a regular diet and needed assistance with meal set up. Review of the Registered Dietitian (RD) notes showed: - On 5/26/20, there were no new weights and the resident ate well. The resident received a multivitamin, Prostat (protein supplement) 30 milliliters (ml) a day and Med-Pass (nutritional shake) 60 ml two times a day; - On 6/29/20, The resident's appetite varied and the resident received multivitamins with minerals, Prostat 30 ml each day and Med-Pass 60 ml two times a day. Recommendations include current nutrition interventions. Review of the care plan dated 7/10/20, showed special instructions were added to the care plan and included the use of a mechanical lift for all transfers and a wheelchair with bilateral leg rest. The resident needed to be fed due to limited mobility and range of motion in bilateral hands and severe contractures (fixed or tightening of a muscle, ligament or tendon) due to a [DIAGNOSES REDACTED]. The last weight obtained on 4/3/20 showed the resident weighed 204 lbs. Review of the RD notes showed: - On 7/31/20, weight and wound review included July weight of 192 lbs, down eight pounds in three months, down 17 lbs in six months. The resident's weight trended down some. Treatment continued to pressure ulcer on the resident's right foot. The resident ate 50 to 100% of most meals and received multivitamins with minerals, Proheal (protein supplement) 30 ml daily and Med-Pass 60 ml two times a day. Some weight loss is beneficial due to obesity. Recommendations included Proheal two times a day and add more calories and protein due to weight loss and for wound healing; - On 8/12/20, weight review showed a significant weight loss of 8.5% in 3 months and 12.4% in 6 months. The resident seemed to eat around 50 to 75% of meals . The resident continued to receive a wound treatment to the resident's right foot wound. Prostat recently increased to 30 ml two times a day and received Med-Pass 60 ml two times a day and multivitamin with minerals. Recommendations included increasing Med-Pass to 120 ml two times a day due to significant weight loss and monitor weights weekly. Make sure staff offers snacks in the afternoon and at bedtime. During interview and record review on 8/12/20 of the resident's progress notes showed: - On 8/12/20, the surveyor requested a weight for the resident and there was a weight change noted. The interdisciplinary team asked the RD to review and make recommendations; - On 8/12/20, the resident weighed 182.6 lbs with the last weight on 7/29/20, when the resident weighed 191.7 lbs. (a 9.1 lb weight loss in two weeks); - On 8/13/20, The resident's physician was notified of the resident's significant weight loss and RD recommendations. The resident was his/her own person, however the resident's family was notified of a condition update as a courtesy. During an interview on 8/11/20, at 12:20 P.M., Facility Staff (FS) said the residents were not being assisted with eating and there were several residents who lost a lot of weight. The RD had not been to the facility in months and the facility did not have a Dietary Manager (DM). Management was aware of the issue and nothing was being done. During an interview on 8/17/20, at 2:35 P.M., Family Member (FM) A said about two weeks ago the resident told him/her staff would not feed the resident and the resident was hungry. He/she talked to the Director of Nursing (DON) who told him/her the resident was unable to move his/her hands to reach his/her mouth and the resident lost weight. He/she told the DON he/she did not want the resident to be hungry and the DON told him/her facility staff were feeding the resident and that she would make sure all of the staff were aware of the resident's needs. The resident was on the heavy side and could lose some weight but he/she did not want the resident to be hungry. He/she recently visited the resident through the window and the resident appeared thinner. During an interview on 8/17/20, at 1:50 P.M., the facility RD said initially when the resident lost some weight, she was not overly concerned due to the resident being overweight but as the resident continued to lose weight she implemented more aggressive interventions including supplements. During an interview on 8/12/20 at 11:30 A.M., Hospitality Staff (HS) A said the resident could not feed him/herself for at least a few weeks. Staff left the resident's tray in the resident's room and the resident could not eat the food. He/she was not trained to feed residents but he/she felt sorry for the resident because he/she knew the resident was hungry and he/she would go in and help the resident eat when he/she could. The resident would say he/she was hungry and nobody would help him/her eat. During an interview and observation on 8/12/20, at 12:40 P.M., the resident said Nobody feeds me. They tell me I can do it by myself. My roommate feeds me or I won't eat a lot of the time. Observation showed the resident's right hand was visibly swollen and the resident's left hand appeared contracted and closed. When the surveyor asked the resident to lift up his/her hands after several seconds the resident was only able to lift his/her bilateral hands less than a half an inch. During an interview on 8/12/20, at 12:50 P.M., the Director of Nursing (DON) said staff fed the resident and the resident could feed

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

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) him/herself at times. The resident recently had a physical decline. During an interview on 8/12/20, at 12:55 P.M., the resident's roommate said he/she fed the resident three times in the previous week. Staff told the resident he/she could do it him/herself but the resident could not. The resident recently went downhill and could not feed him/herself so he/she assisted the resident. Observation and interview showed the resident was alert and oriented to person, place, time and current events during the interview. During an interview on 8/13/20, at 2:01 P.M., the DON said the resident had good and bad days. She did not know how long the resident was not able to feed him/herself. There were times the resident could not feed him/herself at all. During an interview on 8/12/20, at 3:35 P.M., Certified Nurse Aide (CNA) A said the CNA's do not have care plans to follow when they provide care. The CNA's do walking rounds and tell each other what the residents' needs are at shift change. The resident could feed him/herself at times and at other times the resident needed assistance. 2. Review of Resident #2's progress notes dated 4/22/20, showed the RD noted the resident was on a regular diet and was able to make his/her needs known. The resident fed him/herself and did not like cereal or bread. The resident's intake was 50 to 75% of each meal but fluctuated. The resident refused to be weighed at times and the resident's last weight was 198.6 lbs on 1/13/20. Review of the resident's medical record showed: - On 5/5/20, the resident weighed 166.2 lbs; - On 5/6/20, the resident weighed 160.6 lbs; - On 5/8/20, the resident weighed 157.4 lbs; - On 5/21/20, the resident weighed 154.6 lbs; - On 6/19/20, the resident weighed 143.2 lbs; - There were no additional weights obtained until 8/12/20 Review of the RD notes dated 6/29/20, the resident's June weight was 143 lbs, down 23 lbs in one month, down 57 lbs in six months with a significant weight loss of 13.8% in one month and 28.5% in six months. The resident was started on 2 cal (protein supplement) three times a day and weekly weights. Weekly weights were not noted in the resident's medical record and a weight was not obtained until 8/12/20. Review of the resident's progress notes dated 7/23/20, showed facility staff had a care plan meeting and the resident's family member could not attend. The resident was alert and oriented only to self and could verbalize his/her wants and needs to others. The resident was on a no added salt diet with thin liquids. The resident was at risk for falls, pain and pressure ulcers. The resident had a Durable Power of Attorney (DPOA) that was invoked and on file. The note did not indicate the resident's DPOA was notified of the care plan meeting. Review of Resident #2's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/24/20, showed: - [DIAGNOSES REDACTED]. was 143 lbs. Review of the resident's care plan updated on 7/27/20, showed the resident was at risk for weight fluctuation. Interventions included staff should monitor and report signs and symptoms of malnutrition with a significant weight loss of three lbs in one week, 5% in one month, 7.5% in three months or 10% in six months. Staff should provide and serve the resident's diet as ordered and monitor the resident's intake and record every meal. During an interview on 8/13/20, at 2:00 P.M., Registered Nurse RN A said the facility did not log meal intakes for residents. Observation on 8/12/20, at 1:00 P.M., showed the resident ate cheese puffs and dry Fruit Loops for lunch. During an interview on 8/12/20, at 1:00 P.M., Certified Medication Technician (CMT) said the resident eats the same thing every meal. The resident feeds him/herself and dry Fruit Loops and cheese puffs were the only thing the resident ate. During an observation and interview on 8/12/20, at 3:30 P.M., the resident sat in the hall with a bowl of dry Fruit Loops and cheese puffs. Nurse Aide (NA) A said this was the only thing he/she has ever seen the resident eat. He/she had never seen the resident have a regular tray for meals. Review of the resident's medical records showed on 8/12/20, the resident weighed 136 lbs. Indicating the resident lost 30.2 lbs and 18.2% weight loss since 5/5/20. During an interview on 8/17/20, at 4:40 P.M., FM B, with an invoked DPOA, said he/she visited the resident several times a week until COVID-19 precautionary measures were implemented. The facility called him/her yesterday to let him/her know the resident lost 18 lbs. This was the first time he/she was notified the resident had weight issues and he/she called additional FM to make sure the facility had not notified any of them and they all said they did not receive any updates from the facility related to weight loss. The resident was a picky eater prior to the precautionary measures being put in place but the resident did not have an issue with weight loss. He/she went to the facility three to four times a week and assisted the resident at mealtime but he/she had not been in the facility since February. During an interview on 8/17/20, at 1:50 P.M., the RD said she had not been onsite for several months due to COVID-19 precautions and was able to access the residents records through the electronic medical record. Staff should always offer a regular tray and if the resident declines the tray, the resident should be offered food as desired. During an interview on 8/12/20, at 12:00 P. M., the Administrator said the previous Dietary Manager (DM) was off work for eight weeks due to having COVID-19. The dietary manager returned to work about two weeks ago and suddenly quit. The facility has a new DM hired and they are just waiting on the new employees COVID-19 test to come back negative prior to starting work. During an interview on 8/13/20, at 3:00 P.M., Dietary Staff (DS) A said nursing staff always ordered Fruit Loops and cheese puffs for the resident's meals. DS have to fill the order as requested by nursing. He/she tried to send an extra tray back with regular foods sometimes. The staff have only ordered Fruit Loops and cheese puffs every meal for the resident for at least a month. During an interview on 8/13/20, at 2:26 P.M., the Administrator said he was not aware the resident ate Fruit Loops and cheese puffs for meals until the previous day. He fed the resident spaghetti the previous night and the resident ate the entire serving. During an interview on 8/13/20, at 2:01 P.M., the DON said the resident refused meals at times. She expected staff to offer a regular tray and if the resident refused the regular tray the resident could have alternative foods as desired. The DM updates the care plan including the residents preferences. MO 3