STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065195	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN JUAN LIVING CENTER	1043 RIDGE ST MONTROSE, CO 81401

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 observations, record review and interviews, the facility failed to ensure nutritional parameters were maintained for one (#5) of 12 sample residents. Specifically, the facility: -Failed to complete an accurate nutritional assessment upon admission; -Failed to acquire weekly weights for the newly admitted resident; -Failed to follow registered dietitian recommendations regarding nutritional supplements between meals; -Failed to assess, communicate and consistently provide resident preferences and pureed food consistency. Findings include: I. Facility policy and procedure The Weight Management policy, revised July 2017, provided by the director of nursing (DON) on the afternoon of 6/9/2020, included the following: -Residents' nutritional status will be monitored on a regular basis to aid in the maintenance of acceptable parameters such as body weight and protein levels. -Weigh all residents upon admission and readmission; weigh weekly for an additional three weeks, then monthly or as indicated by physician orders and/or the medical status of the resident. -As residents are weighed, staff can compare current weight to previous weight. Residents with weight variance are re-weighed within 48 hours. Weight variances include: . weight change of 3 lbs if weight less than 100 lbs. -Meal intake records, supplement-nourishment/snack/fortified-food list with intake information, and diet order list will be made available by the food service manager and/or registered dietitian during the (nutritional at risk) meeting. -The assigned IDT member will discuss recommended interventions related to weight status with the resident and/or the resident's representative. -The director of nursing or designee will notify the attending physician of significant weight changes and document . The attending physician will be notified of recommendations of the IDT and orders obtained if indicated. -The IDT will update the care plan and communicate interventions to the staff as indicated. II. Resident status Resident #5, age 79, was admitted on [DATE]. According to the June 2020 computerized physician orders, [DIAGNOSES REDACTED]. According to the 3/30/2020 minimum data set assessment, the resident had severe cognitive impairment with a brief interview for mental status score of seven out of 15. Mood symptoms included being tired with little energy and poor appetite. No behavioral symptoms were documented. The resident needed extensive two-plus person assistance with bed mobility and extensive physical assistance with all activities of daily living including eating. The resident was 64 inches tall and weighed 68 pounds. Weight loss status was no or unknown. The resident's edentulous status was not documented in the MDS. III. Resident observation and interview Observation of the lunch meal revealed the resident was served mechanical soft meatballs instead of the ordered pureed texture (see dietary manager and RD interviews below). The resident was observed on 6/8/2020 at 12:11 p.m. being assisted with her meal by CNA #7. The CNA helped her sit up in bed and offered her a bite but the resident said she wasn't hungry. The CNA asked her to try a taste and gave her a sip of cranberry juice and a bite of food, talking to her as she coaxed her to eat. The resident indicated she didn't like her second bite of food and said she couldn't chew her bite of meatball which looked like a regular meatball but was actually mechanical-soft texture (not pureed). The CNA asked her if she wanted another bite of mashed potatoes and the resident said she didn't know what she wanted. The CNA held up a cup of pudding and asked the resident if she would like some and the resident shook her head no. At 12:16 p.m. the resident said she didn't want any more. Observation of the lunch meal revealed the resident was served mechanical soft meatballs instead of the ordered pureed texture (see dietary manager and RD interviews below). CNA #7 was interviewed at approximately 12:20 p.m. and said the resident usually took only five bites of food at her meals and didn't like her fortified pudding. She didn't know if the resident received any other nutritional supplements. She said the resident didn't like pureed foods or fortified foods or pudding because the fortified pudding contained peanut butter which the resident didn't like. She said it was a struggle to assist all the residents who needed to be fed or needed assistance, as there were about eight to 10 residents who required some type of meal assistance. The resident was interviewed on 6/9/2020 at 8:30 a.m. and asked if she had eaten breakfast. She replied that she wasn't hungry and wanted to go back to sleep. CNA #1, who had fed the resident breakfast, was interviewed on 6/9/2020 at 9:45 a.m. She said the resident ate 10 bites of scrambled eggs and gravy and had one and a half cups of cranberry juice. She always drinks very well. She said there were eight residents who needed assistance with meals and there were only four of us to assist. She said food was sometimes cold by the time residents received assistance with eating. She said the resident received fortified pudding but they were going to try it with just chocolate because the resident did not like peanut butter. IV. Record review A. Failure to acquire weekly weights The resident's weight record documented weekly weights were not done starting at admission. Only three weights had been documented during the resident's stay, showing she was underweight and had lost three pounds since admission: 3/24/2020 - 68 pounds 5/5/2020 - 65.8 pounds 6/4/2020 - 65.5 pounds B. Failure to develop a comprehensive resident-centered care plan There was no specific nutrition/hydration care plan with resident preferences and assistance needs. The care plan, initiated 3/28/2020 and revised 5/20/2020, identified hospice care with failure to thrive, history of ulcerative [MEDICAL CONDITION] with [MEDICAL CONDITION], history of pressure ulcers, [MEDICAL CONDITION]; Severely underweight. On pureed diet textures d/t (due to) edentulous (without teeth). Comfort measures in place. The goal was to remain comfortable with end of life care. Interventions, all dated 3/28/20 and not revised, were: -Provide and serve supplements as ordered. -Provide and serve diet as ordered. Observe intake and record every meal. -RD to evaluate and make diet change recommendations as needed. The care plan, initiated 3/25/2020 and not revised, identified an activity of daily living (ADL) self-care performance deficit related to activity intolerance. Interventions included: I require extensive assist for my personal hygiene and eating. C. Failure to thoroughly and accurately assess nutritional status and needs The resident's 3/28/2020 Nutrition Data Collection (nutritional assessment) by the registered dietitian (RD) documented the resident's height was unknown and her weight was 68 pounds as of 3/24/2020. Her usual body weight and body mass index (BMI) were unknown. The resident had a current stage 2 pressure ulcer, had her own teeth, and was independent with eating. She was on a regular diet and ate an average of 67% of her meals. There were no laboratory test results. The summary plan/progress note included the resident needed assistance with ADLs, was on hospice, was underweight, intake was adequate, no height was available - nursing was notified. Recommend house supplement TID (three times daily) between meals due to underweight status, failure to thrive and increased protein needs related to wound healing. On hospice and comfort measures in place. Provide well liked foods and beverages. The resident's 4/23/2020 Nutrition RD Assessment documented her calorie needs were approximately 1200-1500 kcal/day; protein needs were approximately 45-60 g/day and fluid needs were approximately 1500 mls/day. The nutrition [DIAGNOSES REDACTED]. For nutrition interventions and goals, see care plan was documented. The resident's edentulous status and extensive eating assistance needs were not accurately documented. The resident's usual body weight, weight history, BMI, and food preferences were not documented. The care plan referred to in the RD assessment was also incomplete and not personalized to the resident's needs. D. Failure to implement RD recommendations Review of interdisciplinary team (IDT) progress notes revealed no mention of nutritional supplements TID as recommended by the RD. On 3/24/2020 at 9:47 p.m., the nurse documented in pertinent part, Resident has a very good appetite and enjoys the Mighty Shakes (nutritional supplements) as long as either strawberry or chocolate but does not want plain ones. Hospice is to come in for consult tomorrow. There were no further IDT notes regarding nutritional supplements between

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 -** Few	(continued... from page 1) meals. Current June 2020 physician orders did not include nutritional supplements TID between meals. On 4/6/2020, a registered nurse (RN) documented a physician order was received for a mechanical soft diet, and the medical record and kitchen were updated. On 4/17/2020 a care conference note documented the resident's daughter, social services director and assistant director of nursing (ADON) were present. However, no dietary staff or certified nurse aides (CNAs) were documented in attendance. The resident's wounds had healed and the resident was eating and drinking well. Staff sits with her during meals for prompting. On 5/20/2020 the RD documented in a nutrition note, Resident severely underweight per BMI of 10.9. On pureed textures d/t edentulous. Meal intakes inadequate at <50% 2/3 meals. Failure to thrive, on hospice with comfort measures in place. Unstageable pressure ulcer to rt (right) ear - improved per last skin assessment. Recommend adding house supplement for additional fluid, calories and protein. Will continue to follow in weekly at risk meeting. (This was the RD's second recommendation to add nutritional supplements.) On 5/22/2020 per nursing notes the IDT met to review the plan of care due to low BMI, the resident continued to be severely underweight, had good intake and took snacks at bedside frequently. The RD recommended adding fortified pudding to meals TID, order in place, continue to encourage intake, IDT recommends to continue to follow weekly. Social services, the ADON, RD and DON were present. On 5/28/2020 the IDT risk meeting notes revealed the resident's weight was unstable and RD would like to have another weight to establish a baseline for next week's review. On 5/29/2020 an RN documented protein powder with meals for weight loss and fortified pudding. On 6/2/2020 a care conference note documented in part the resident was doing well, only concern is low BMI. Staff is assisting at meal times and offering snacks between meals. Fortified pudding for increased caloric intake. No dietary staff, RD or CNAs were in attendance. On 6/4/2020 an IDT note documented the resident was stable, continued to be underweight, did not like fortified pudding due to she doesn't like sweet foods, only chocolate at bedside, will change to fortified meals to increase calories and protein with all foods offered to resident. Recommend continue weekly weights at this time. On 6/5/2020 a nutrition note by the RD read in part: Weight remains stable although severely underweight. On pureed textures due to edentulous. Meal intakes inadequate at <50% 2/3 meals . Dislikes sweets/fortified pudding - changed to fortified meals (added protein and fat to meals). Enjoys cream of wheat at breakfast. Will continue to follow weekly d/t underweight status. Current physician orders included pureed diet (start date 6/4/2020), protein powder with meals and fortified pudding (start date 5/22/2020). No between-meal nutritional supplements were included in the current physician orders or medication/treatment administration records. E. Failure to monitor meal intake The resident's Meal Consumption records, reviewed from 5/8/2020 through 6/8/2020, revealed 15 meals were void of documentation. Meal intakes were otherwise documented as zero (28 times), 25-50% (18 times), 51-75% (25 times) and rarely documented at 76-100% (five times). Two meals were documented as refused. Snacks were inconsistently documented and the type of snack and amounts were not documented. V. Staff interviews The dietary manager was interviewed on 6/8/2020 at approximately 3:35 p.m. He said he had no weight records to provide, and that nobody had told him the resident didn't like the fortified pudding. Regarding the observation of the resident's lunch with regular meatballs, he expressed surprise and he said she was on a pureed diet. He provided a tray card that documented regular, puree, fortified meals, and fortified pudding. CNA #7 approached and said the resident's meatballs were mechanical soft. The dietary manager said he did use a scoop to enhance the appearance of mechanical soft meatballs but he wasn't aware the resident had received mechanical soft meatballs and was unable to chew them. The CNA said she had talked with the nurse and they were going to try chocolate shakes since the resident liked chocolate, and the nurse was following up on orders accordingly. The RD was interviewed by phone on 6/9/2020 at 9:00 a.m. She said there were delays in properly assessing the resident because they didn't have weekly weights and it took a while to get her actual height, which was 65 inches. Even so, 68 pounds was underweight, and she had never seen a BMI that low. She said the DON had developed a process improvement plan (PIP) last week to ensure newly admitted residents had three admission weights so they had a baseline to go by. The RD said they had been able to maintain the resident's admit weight, had tried fortified pudding with meals, and she had recommended spreading out mealtimes and providing smaller meals. They had been following her in weekly at-risk meetings. She needs to have more frequent weights, weekly ideally, so we can see if the interventions are working. She said the resident was on a pureed diet, not mechanical soft. She said they should develop a PIP to verify the diet matched the point of service and when they assisted the resident to eat, to ensure the resident received the texture they needed. The RD said she wasn't sure what happened with the recommendation to add supplements TID between meals, for example if she refused once and they just stopped. She said the protein powder used to supplement meals was flavorless but it could change the texture of some foods, but could work well with cereals and soups. She said she would recommend encouraging fluids because she is so low weight. I think everybody needs that. Weekly weights would be nice. Maintaining is a good goal and providing enough fluids, providing a little more as she tolerates it and finding out what is she wanting and not wanting. The DON was interviewed on 6/9/2020 at 11:35 a.m. She said, The system for weights in the building is an issue. She said she had talked with the RD about the fortified foods and the fact that the resident didn't like the fortified pudding, so they were going to try some other things. She acknowledged the care plan wasn't showing her preferences so she added some things to the care plan. She said she didn't know if the resident's initial weight of 68 pounds was correct or not, and they should be validating weights before entering them. She said, Staff do have time to feed her, to sit and assist her. She said the resident was admitted with a low weight and with a hospice referral. She said the resident was not dehydrated, drank very well and particularly liked cranberry juice. She asks for sips every time we're in there. She said the resident had received adequate nutrition to heal the pressure injuries she was admitted with. The DON said the PIP was developed on 6/3/2020 for nutrition, hydration and weight management. She said they had trained the IDT and management on the PIP, but still needed to inservice the staff. She was asked for a copy of the PIP but did not provide it.