| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **17E210** | A. BUILDING _____ B. WING _____ | **09/17/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **FRANKLIN HEALTHCARE OF PEABODY LLC** | **500 PEABODY PEABODY, KS 66866** |

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 0625<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility reported a census of 41 residents with six selected for review. The facility reported five residents transferred from the facility since June 2020, with four residents who required a Bed Hold Notice upon transfer. Based on interview and record review, the facility failed to issue a Bed Hold Notice which indicated the duration of the bed-hold for the four sampled residents (R)#1, #4, #5, and #6. Findings included: - Review of R1's Physician order [REDACTED]. Review of the Annual Minimum Data Set (MDS) dated , 02/26/20, assessed the resident with normal cognitive status, disorganized thinking, hallucinations, and delusions. The Nurses' Note, dated 08/18/20, documented the resident transferred to an acute psychiatric care facility on 08/18/20. The Bed Hold Notice upon transfer, indicated the resident signed the notice on 08/18/20. This notice lacked the specification of the duration of this bed hold. Interview, on 09/17/20 at 03:40 PM, with Administrative Staff A, confirmed the Bed Hold lacked specification of the duration of the bed hold. Further reviews of the following three residents revealed their Bed Hold letters also lacked the specific duration of the bed hold policy. Review of R6's medical record revealed a Bed Hold notice dated 08/06/20. The resident transferred to acute care on 08/06/20. This Bed Hold lacked specification of the duration of the bed hold. Review of R5's medical record revealed a Bed Hold notice, dated 09/14/20. The resident transferred to acute care on 09/14/20. This Bed Hold lacked specification of the duration of the bed hold. Review of R4's medical record, revealed Nurses' Note dated 08/29/20 which documented that staff provided a verbal a Bed Hold notice, to R4's responsible party and indicated to the responsible party that the facility would hold the bed for 21 days. A Bed Hold notice was with staff documentation that a verbal notice was given to the responsible party, with the indication that the bed would be held for 21 days. The facility awaited a signature from the responsible party. This Bed Hold document lacked specification of the duration of the bed hold. The facility policy Bed Hold Notice Upon Transfer, dated 11/17, instructed staff to provide to the resident and/or the resident representative written notice which specifies the duration of the bed hold policy. The facility failed to provide to this resident a Bed Hold notice with specification of the duration of the bed hold policy as required for these four residents. |
| F 0692<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **Provide enough food/fluids to maintain a resident's health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility reported a census of 41 residents with six residents selected for review, which included 3 residents reviewed for nutrition. Based on observation, interview and record review, the facility failed to ensure Resident (R)2 (with a weight loss of 6.53 percent (%) from 07/27/20 to 09/01/20 or 12.7 % in 48 days 07/27/20 through 09/13/20) received nutritional interventions to prevent weight loss . The facility failed to ensure the resident received timely assessments by the registered dietician. Findings included: - Review of R2's Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with modified independence with decision making. The resident had inattention constantly present. The resident was independent with ambulation, required set up assistance with eating, and had functional limitations in range of motion in the upper and lower extremities. The resident had no dental or swallowing issues. The resident was 68 inches tall and weighed 147 pounds (lbs). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 08/14/20, assessed the resident could make his needs known, but required patience and more time to verbalize what he needed. The resident was on a regular diet with cut meats and set up assistance. The resident remained in his room most of the time and would only come out for meals or walking in the hallway. The Baseline Care Plan, dated 07/27/20, instructed staff the resident was on a regular diet with bite sized foods. The resident was at risk for weight loss and instructed staff to serve an ice cream shake at 03:00 PM and 10:00 AM. The resident ate in the dining area. The facility failed to develop a comprehensive care plan as of 09/17/2020, with instructions for any special individualized dietary needs of the resident. The Dietary History and Initial Screening, form, dated 07/27/20, completed by the dietary manager assessed the resident ate 50-100% of meals and instructed staff to monitor for weight loss. The resident's preferences included Kool Aid, water, Mexican food, salads, peanut butter, and jelly. The resident required bite size pieces of food and was hit and miss on meals related to his anxious behavior, being up and down, and constantly moving. Review of the Resident Care Flow Record for August and September 2020, lacked indication of snack consumption for 23 days and revealed one day of consuming all three snacks in 45 days. Review of the meal percentages from August and September 2020, revealed the resident ate variable intakes of 50-100%. No laboratory data was available for review. Facility staff faxed a note to the physician, dated 09/13/20, which documented the resident's weight at the beginning of the month was 137.4 pounds and currently was 128.2 pounds. The resident constantly walked and could not sit still even when eating. Staff requested a high protein shake three times a day. The physician returned the fax with an order for [REDACTED]. On 08/03/20, he weighed 145 pounds. On 09/01/20, he weighed 137.4 pounds, with a 6.53 % weight loss (9.6 pounds) in 35 days (07/27/20 through 09/01/20) or 5.2% (7.6 pounds) in 29 days (08/3/20 to 09/01/20). On 09/13/20, he weighed 128.2 pounds, which indicated a 12.7 % (18.8 pounds) weight loss in 47 days (07/27/20 through 09/13/20), or 6.69% (9.2 pounds) in 12 days (09/01/20 to 09/13/20). From admission 07/27/20 as of 09/17/20, the medical record lacked a registered dietician assessment of the resident's nutritional needs. Observation, on 09/16/20 at 05:57 PM, revealed the resident left his room and began walking to the dining room with a shuffling gait, but returned to his room after a few steps. The resident did not engage with staff or other residents. Observation, on 09/16/20 at 06:04 PM, revealed Certified Nurse Aide (CNA) M escorted the resident to the dining room. The resident ate bite sized pieces of sweet and sour chicken, rice, apple sauce, and a glass of milk. The staff failed to provide the resident with the physician ordered protein supplement. The resident stood at the table intermittently and moved his arms about, sat back down, took a few bites and stood again. CNA M sat across from the resident at the table and provided cueing to eat. CNA M stated dietary staff gave the resident the protein supplements at snack times. Interview, on 09/16/20 at 06:30 PM, with Licensed Nurse (LN) G, revealed the resident received a nutritional supplement at bedtime from the refrigerator in the nurses' station. LN G stated the resident usually drank the supplement. Interview, on 09/17/20 at 07:30 AM, with Certified Medication Aide (CMA) R, revealed she did not pass out Ensure (supplemental drink)/or health shakes, and verified the shakes were not recorded on the resident's medication administration record. Observation, on 09/17/20 at 10:00 AM, revealed the resident seated in the dining room, with a glass of juice and a cut up banana. The resident did not have a house shake to drink. Interview, on 09/17/20 at 11:20 AM with dietary staff BB, confirmed the resident lost weight, and staff attributed it to his constant motion. Dietary staff BB stated dietary staff provided the resident with nutritional supplements at snack time, at 10:00 AM and 03:00 PM. Nursing staff should provide the bedtime supplement. Dietary staff BB stated staff should document the supplement in the Resident Care Flowsheet under the snack category, by shift. Staff do not record the amount of supplement consumed. Dietary staff BB stated there was an Electronic glitch, and the registered dietician did not assess the resident's nutritional needs until |

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<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>09/17/20. Dietary staff BB stated LN H reported to the physician the resident's weight loss on 09/13/20 and implemented high protein shakes on 09/13/20. Interview, on 09/17/20 at 12:30 PM, with Administrative Nurse D, revealed staff should document the amount of supplement taken to monitor the effectiveness of the intervention to prevent further weight loss. Administrative Nurse D stated the system needed an update to include this option and currently implementing an electronic medical record monitoring system. Interview, on 09/21/20 at 11:00 AM, with consulting staff GG, revealed she assessed the resident on 09/17/20 after dietary staff BB realized the lack of registered dietician assessment of this resident on 09/17/20. Consulting staff GG stated she would expect staff to monitor the resident's intake of the nutritional supplement to determine effectiveness of the intervention to prevent further weight loss. The Weight Monitoring policy, dated 05/2017, instructed staff to ensure all residents maintain acceptable parameters of nutritional status. Staff were instructed to weigh newly admitted residents weekly for four weeks. The facility failed to assess this resident at risk for weight loss with the registered dietician in a timely manner, and failed to assess and implement consistent interventions and assess the effectiveness of the interventions to maintain this resident's weight resulting in a significant weight loss. |