| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525523 | A. BUILDING _____ B. WING _____ | 06/22/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ALEXIAN VILLAGE OF MILWAUKEE | 9255 N 76TH ST MILWAUKEE, WI 53223 |

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<br><br>**Level of harm -** Immediate jeopardy<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>Based on a complaint received at the Southeastern Regional Office, interview and record review the Facility did not ensure 1 (R4) of 4 Residents a risk for dehydration was provided with sufficient fluids to maintain proper hydration and health. R4 has [DIAGNOSES REDACTED]. R4 is dependent upon staff for all his ADL's (activities of daily living) including eating. R4 has short & long term memory problems, unclear speech with English not being his primary language. Prior to visitor restriction on 3/11/20 R4's family would feed R4 his meals and provide fluids to him each day. R4 was assessed as being at risk for for dehydration on 1/16/20, 4/1/20 & 4/17/20. R4 was hospitalized from [DATE] to 3/31/20. R4 had a critical sodium level upon admission to the hospital and was diagnosed with [REDACTED]. The discharge summary documented R4 needed his intake to be closely monitored to ensure adequate fluid intake. Upon return to the facility on [DATE] the Facility did not revise R4's dehydration/fluid maintenance care plan; they continued to combine food & fluids together on their daily charting for meal consumption, which was completed for all three meals only five days in April 2020. The facility was not monitoring R4's total daily fluid intake comparing the intake to R4's assessed daily fluid needs. There is no evidence interventions of assessing for signs & symptoms of dehydration and assessing skin turgor & mucus membranes each shift were completed. On 5/2/20 R4's physician was notified of a critical sodium level of 173 (136-145). R4 was admitted to the hospital a second time for being extremely dehydrated and was administered fluids & antibiotics. R4 was readmitted back to the facility on [DATE]. Upon return to the facility on [DATE] the Facility did not revise R4's dehydration/fluid maintenance care plan; they continued to combine food & fluids together on their daily charting for meal consumption, which was not consistently completed. The facility was not monitoring R4's total daily fluid intake and comparing it with his assessed daily fluid need. There is no evidence interventions of assessing for signs & symptoms of dehydration and assessing skin turgor & mucus membranes each shift were completed. This situation resulted in a finding of immediate jeopardy which began on 3/31/2020. On 6/10/2020 at 2:35 p.m. Administrator-A and Corporate-D were informed of the immediate jeopardy and substandard quality of care. The immediate jeopardy was removed on 6/12/2020. The immediate jeopardy continues at a scope and severity level of D (potential for more than minimal harm/isolated) as the facility continues to monitor their removal plan with the results reviewed at the QAPI (Quality Assurance Performance Improvement) committee during the next 3 months. Findings include: According to Monique Ferry MD, PhD article Strategies to Ensuring Good Hydration in the Elderly Dehydration is a frequent etiology of morbidity and mortality in elderly people. It causes the hospitalization of many patients and its outcome may be fatal. Indeed, dehydration is often linked to infection, and if it is overlooked, mortality may be over 50%. Older individuals have been shown to have a higher risk of developing dehydration than younger adults. Modifications in water metabolism with aging and fluids imbalance in the frail elderly are the main factors to consider in the prevention of dehydration. Particularly, a decrease in the fat free mass, which is hydrated and contains 73% water, is observed in the elderly due to losses in muscular mass, total body water, and bone mass. Since water intake is mainly stimulated by thirst, and since the thirst sensation decreases with aging, risk factors for dehydration are those that lead to a loss of autonomy or a loss of cognitive function that limit the access of beverages. The prevention of dehydration must be multidisciplinary. Caregivers and health care professional should be constantly aware of the risk factors and signs of dehydration in elderly patients. Strategies to maintain normal hydration should comprise practical approaches to induce the elderly to drink enough. This can be accomplished by frequent encouragement to drink, by offering a wide variety of beverages, by advising to drink often rather than large amounts, and by adaptation of the environment and medications as necessary. The Facility's Guidelines for Charting and Documentation policy and procedure last revised 1/2018 under General Rules for Charting and Documentation documents H. Document assessments, interventions, treatments, outcomes, etc. Under the section Nursing Summaries and/or assessments for when charting nursing summaries or making assessments, include (as they may apply) the following information: K. Nutritional Status: Document the diet, appetite, food consumption, eating habits, assistance needed and where, diet normally consumed, weight variations, hydration status, fluid intake, tolerance of tube feeding, etc. The Facility's Hydration policy last revised 1/2019 under policy statement documents It is the policy of Ascension Living that residents shall remain adequately hydrated as indicated by the absence of signs and symptoms of dehydration. Under policy interpretation and Implementation documents; A. A minimum of 480 ml's (milliliters) of fluid should be offered to each resident at meal time for a total of 1440 ml's per day from meals alone. B. Ancillary fluids should also be available at the resident's bedside. Encouragement to drink should be offered to residents upon every interaction by the nursing associate. Water pitchers should be refilled and refreshed as per the Water Pitcher policy. C. Ancillary fluids should also be available at activity functions. D. Any resident requiring modifications to liquid consistency shall have the appropriate liquids offered at meals, bedside, with medication pass, and during activities. RECORD REVIEW R4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Dehydration/Fluid Maintenance care plan dated 12/8/18 documents approaches all dated 12/8/18 of; * Assess for signs/symptoms of dehydration (dizziness/confusion/decreased urine output/poor skin turgor/fever/constipation). * Assess family's understanding of the reasons for maintaining adequate hydration and methods for reaching goal of fluid intake. * Keep fresh water, or beverage of preference, in reach based on current dietary order. * Assess client's preferred fluids and provide. * Assess color and amount of urine. * Assess skin turgor and mucus membranes for signs of dehydration every shift. * Monitor blood pressure for orthostatic changes as needed. * Monitor for active fluid loss from diarrhea, bleeding, vomiting. * Note resident is on honey thickened liquids. The CNA (Certified Nursing Assistant) care plan dated 12/8/18 documents approaches all dated 12/8/18 of; * Weigh resident weekly. * Record meal intake. * Record total shift fluid intake. * Bathing. The hydration risk evaluation dated 1/16/2020 asks: does hand dexterity limit resident's ability to grasp a cup? Yes is checked. Eating ability is checked for totally dependent. Under summary of evaluation Resident is at risk for dehydration, as evidenced by Total assist with eating/drinking is checked. The total score/value documents 11 at risk. A resident who scores 8 or higher may be at risk for dehydration. The APNP (Advanced Practice Nurse Prescriber) note dated 2/15/20 under subjective includes Per records patient/wife has been refusing weights or labs so patient's nutrition status has not been assessed. DON (Director of Nursing)-B informed Surveyor visitors were restricted to essential visits only on March 11, 2020. Surveyor reviewed the March 2020 daily charting for meal consumption report from 3/11/2020 to 3/25/2020 (prior to R4's 3/25/20 hospitalization ). Surveyor noted under guidance documents Percent consumed. Enter overall percent of total meal eaten. On 3/11/20 breakfast, lunch, and dinner documents 76-100% for each meal. On 3/12/20 thru 3/25/20 breakfast & lunch are blank for each of these days and dinner each day is documented as 76-100%. Surveyor noted the daily charting does not differentiate between food eaten and fluids consumed for R4. The nurse's note dated 3/25/20 documents Resident's BG (blood glucose) 547, BP (blood pressure) 156/65, P (pulse) 122, T (temperature) 98.2, SPO2 92%. Vitals and BG reported to Medical Director-E. NOR (new order received) to give 10 u (units) of [MEDICATION NAME] and 2.5 mg (milligram) [MEDICATION NAME].<br>POA (power of attorney)-F updated. The nurse's note dated 3/25/20 documents Resident BG 541, NP (nurse practitioner) updated. NOR to send resident to ER (emergency room ) for eval (evaluation) and treat. POA-F updated. The nurse's note |

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 -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>dated 3/26/20 documents Writer spoke with Hospital-G from SMO (Saint Mary's Ozaukee) speech therapy. Diet clarification given. Hospital-G stated resident is admitted with [MEDICAL CONDITION], dehydration, and [MEDICAL CONDITION]. During review of R4's March 2020 nurse's notes, Surveyor was unable to locate any assessments relating to the monitoring of signs/symptoms of dehydration and assessing skin turgor and mucus membranes for signs of dehydration every shift as directed in R4's dehydration/fluid maintenance care plan. R4 was hosptalized on [DATE] and returned on 3/31/20. The hospital history and physical dated 3/26/2020 under history of present illness documents The patient was brought into the emergency room for increasing shortness of breath. Reportedly, paramedics were called for [MEDICAL CONDITION]. Upon arrival they found him to be hypoxic on room air in the 70s and they put him on 100% nonrebreather, given nebulizer treatment en route. The patient unable to provide any history, family was not present at that time and I interviewed him in the emergency room . They have not seen him for the last 10 days or more due to nursing home status and the fact that they were not allowed due to this [MEDICAL CONDITION] illness and they do not know if the patient has been eating or drinking. They do not know if the patient has had diarrhea and they do not have much information otherwise and they have been very frustrated about this current issues. The patient has not had any recent travel or known sick contacts. Seen and evaluated in the emergency room . Labs were ordered with elevated WBC (white blood count) of 17.2. Elevated sodium as of 163 and creatinine at 1.95, which is not too far from his baseline. Glucose elevated to 690 and concern for dehydration, given IV (intravenous) in the emergency room and also with elevated glucose and anion gap that given [MEDICAL CONDITION]. A chest x-ray was ordered with no acute abnormality. Concern for COVID infection, the patient was put in isolation. Upon discussion with the family, the family does not want any aggressive measures for him including [MEDICAL CONDITION] intubation, central line placement. They are more interested in IV hydration, antibiotics if necessary and transition to palliative care hospice if not improving. The patient is, therefore, admitted to medical floor. The patient is nonverbal. Under current medical issues documents [MEDICAL CONDITION] secondary to dehydration. The patient likely has not been eating and drinking well, wife has been feeding him regularly, but not so in the last two weeks. We will continue with IV hydration and monitor sodium level closely to avoid overcorrection. The patient unfortunately having hard time with blood draw and may need PICC line in the morning if the family is interested. The hospital discharge summary for admission date of [DATE] & discharged date of 3/31/2020 documents under discharge information for [DIAGNOSES REDACTED]. Under hospital course documents Resident's name (R4) is a 74 yo (year old) with advanced dementia, from Alexian Village, who was found to be hypoxic when evaluated by paramedics. They were called because his blood sugar was over 600. He was found to be saturating in the 70's and was brought in. He is essentially nonverbal due to his dementia. His family, prior to the lockdown for COVID, was very involved in ensuring that he was getting adequate intake. He was found to also have a sodium of 163 while his glucose was 609. His creatinine was 1.95. He was admitted with a presumed aspiration pneumonia with infection. He was treated with [MEDICATION NAME] with vanco, no on oral [MEDICATION NAME] for two more days. This will be a total of 7 days of antibiotic coverage. He should have a speech therapy evaluation. He was extremely dehydrated on presentation. Nephrology was consulted. He was treated with a [MEDICATION NAME] drip with normalization of his sodium and creatinine. His intake will need to be closely monitored to ensure adequate fluid intake. (Emphasis added.) The facility's admission observation/evaluation dated 3/31/20 under the oral/nutrition section under nutrition is checked for difficulty swallowing and dysphagia. The nurse's note dated 3/31/20 documents Resident returned back to the facility via ambulance, resident is alert to self, bowel sounds present in all the four quadrant, skin warm/pink, no s/s (signs/symptoms) of pain/discomfort, no SOB (shortness of breath) noted and staff will continue to monitor. The Dehydration/Fluid Maintenance care plan dated 3/31/2020 is the same as the care plan dated 12/8/2018. Surveyor noted although the hospital discharge summary dated 3/31/20 documented R4 was extremely dehydrated and his intake will need to be closely monitored to ensure adequate fluid intake, R4's dehydration/fluid maintenance care plan was not revised and had the same approaches which were dated 12/8/18. The CNA care plan dated 3/31/2020 documents approaches all dated 3/31/2020 of * Weigh resident weekly. * Record meal intake. * Record total shift fluid intake. * Bathing. The resident care guide with a start date of 3/31/20 under the diet section documents Diet/Special Instructions: Mechanical Soft honey thick liquid see NURSE for detail instruction. I need 1:1 total assistance with eating. I have dysphagia and need to sit up 30 minutes after meals. I need to be fed 1 tsp (teaspoon) bites and sips. NOT TO BE LEFT ALONE FOR MEALS. Wife provides all feeding support she will ask for help as needed. Res wife and POA (power of attorney) refusing to have weights taken. Requests res. to be comfortable and getting res. up to be weighed causes to much stress on res per POA. Lower HOB (head of bed) to 45 degrees 1/2 hour after meals to prevent sliding down, causing pressure at feet at foot board. [MEDICATION NAME] powder supplement provided to wife who maintains supply in resident room. Offer me a clothing protector for meals. The hydration risk evaluation dated 4/1/2020 has a total score/value of 14 at risk. A resident who scores 8 or higher may be at risk for dehydration. The nutrition risk assessment dated [DATE] for feeding ability is checked for total dependence. For average meal intakes is checked for 26-50%. Under swallowing disorder, difficulty swallowing is checked. Under comments documents Res (resident) readmitted to facility after hospitalization for aspiration pneumonia, dehydration, acute [MEDICAL CONDITION] and respiratory distress. Res diet downgraded in hospital to puree with honey thick liquids. Res had been on a Mechanical Soft diet with honey thick liquids prior to hospitalization . ST saw res. in hospital and downgraded diet to puree ad (and) continue with honey thick liquids. Appetite is fair. Res needs total assistance with eating. Res weight is down 6.6% in one month d/t (due to) decreased appetite and dehydration. Res UBW (usual body weight) is 160s. Current weight is 154.2 lbs (pounds) Ht (height): 66 in (inches) BMI (body mass index): 24.8 indicating weight is WNL's (within normal limit). Does does receive a magic cup BID (twice daily) for additional nutritional support. Res noted on admission with a blister to right foot (see skin assessment) Wound nurse to follow. Will f/u (follow up) with any further concerns. Res also receives a daily MVI (multivitamin) with mineral and Vit (vitamin) C to help promote skin integrity. Res is on ABT (antibiotic) for pneumonia. Res is not on a [MEDICATION NAME] and could benefit one for GI (gastrointestinal) health. Res continues to receive insulin as ordered. Res MNA (mini nutritional assessment) score is 4 indicating res. is malnourished. Staff to encourage honey thick fluids and po (by mouth) intake and assist with all meals. Refer to RD (registered dietitian) for further interventions. Will proceed with nutritional plan of care. For Registered Dietician review under estimated nutritional needs for fluid documents 2100 for 30 ml/kg (milliliter per kilogram). Under potential at risk factors yes is checked for at risk for dehydration due to inadequate fluid intake. Under interventions magic cup and weekly weights are checked. Under comments/recommendations documents Agree with nutritional assessment above. Hx (history) reduced intake dehydration, 6.6% weight loss in last month. Has [MEDICATION NAME] 3 times/day, magic cups BID. Total dependence. Needs assistance wth (with) feeding. Plan for [MEDICATION NAME] if MD (medical doctor) feels appropriate. The correction/addendum nurse's note dated 4/1/20 documents Res. (resident) tolerated all due medications via crushed with applesauce. PO antibiotics [MEDICATION NAME], without adverse effects noted. Head of bed elevated for feedings by caregiver. 100 percent consumed for breakfast. Adequate fluids pushed throughout shift, pureed diet with honey thick fluids. Vitals obtained 98.6 90 20 124/88 96%. Plan of care to continue. The next nurse's note that documents fluids is dated 4/4/20 and notes, Res is alert and responsive. Adequate fluid intake & appetite this shift. Lungs clear upon auscultation. No s/s respiratory distress. No A/R (adverse reaction) R/T (related to) meds (medication)/tx (treatment). The next nurse's note that documents fluids is dated 4/7/20: Resident alert to verbal and tactile stimuli. New orders for [MEDICATION NAME] decreased and fiber tab discontinued. No adverse effects to change in medication orders. Res is a one; one feeder. Good appetite noted for breakfast and lunch this shift. Head of bed elevated for feedings via pureed diet. Fluids pushed throughout shift via honey thickened liquids. No noted pain or facial grimacing. Vitals 97.5 92 18 130/84 97%. Plan of care to continue. Call light in reach. The resident at risk dated 4/7/20 under the nutrition/eating section documents height 66, current weight 157 & date of weight 4/3/20 Diet Puree with honey thick liquids. Is checked for history of weight loss, cognitive deficit & poor intake. Under Interventions/recommendations is checked for dietary consult & Supplements ADL (activities daily living)/physical. Under comments documents Res triggered for nutrition risk d/t (due to) weight loss and decreased po (by mouth) intake. Res is tolerating puree diet with honey thick liquids. Res is fed by staff or all meals. Honey thick fluids are encouraged throughout day. Res is eating and drinking 100% of meals/fluids with staff assistance. Does receive a magic cup BID for additional nutrition support. Will dc (discontinue) from at risk and monitor for any further changes. The nurse's note dated 4/8/20 documents, Sleeping comfortably easily awakened with verbal stimuli. Assisted at mealtime. No adverse reaction noted to med changes VS (vital signs) WNL (within normal limits) stable. The dietary note dated 4/8/20 documents, New recommendations from ST (speech therapy) to upgrade diet to Mechanical Soft with honey thick liquid and continue with 1:1 feedings by staff. Diet card and plan of care updated with diet change. The next nurse's note that documents fluids is dated 4/13/20 and reads: F/U (follow up) [MEDICATION NAME] BP 138/81 no adverse reactions noted ate and drank fluids well . |

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| F 0692<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 2)<br>The next nurse's note addressing fluids is dated 4/13/20 and states, Ate 100% of meal and drank 100% of fluids. The hydration risk evaluation dated 4/17/2020 has a total score/value of 11 at risk. A resident who scores 8 or higher may be at risk for dehydration. The care conference note dated 4/17/20 includes documentation of Family Member-H stated staff need to make sure they are pushing fluids with res, nurse manager aware, Family Member-H requested res bed not be lowered for at least 30 minutes after res eats, nurse manager aware. The next nurse's note addressing fluids is dated 4/18/20: Resident alert and oriented. bed rest maintained. Honey thickened fluids about 16 oz (ounces) offered. Head of bed elevated for 30 mins (minutes) after feeding. The nurse's note dated 4/24/20 documents Writer spoke with POA (Power of Attorney) this date and shared that writer went to see R4 and he ate all of his food and magic cup this date for lunch. POA was greatful (sic) for the phone call, and told writer to be safe and have a good weekend. There is no documentation regarding R4's fluid consumption. The nurse's note dated 4/29/20 documents, Writer called POA this date for an update. Shared writer spoke with today's CNA and shared he had a good breakfast and ate 75%. POA thanks writer for the call. There is no documentation regarding R4's fluid consumption. During review of R4's April 2020 nurse's notes, Surveyor was unable to locate any assessments relating to signs/symptoms of dehydration and assessing skin turgor and mucus membranes for signs of dehydration every shift as directed in R4's dehydration/fluid maintenance care plan. Documentation of R4's food/fluid intake was completed for all three meals on only five days in April (4/4, 4/25, 4/28, 4/29, and 4/30/20) and ranged from less than 25% to 76-100%. The SBAR (situation, background, assessment or appearance, request) dated 5/1/20 under the request section for nurse's notes documents Resident with intermittent cough, heart (heart) rte (rate) was 103, refused dinner, took few fluid, with history of aspiration pneumonia. The nurse's note dated 5/1/20 documents F/U (follow up) Resident is monitored for intermittent cough, writer updated Physician-I, got a new order for chest X ray AP lateral 2 view, CBC, CMP, writer updated DON (Director of Nursing)/resident's spouse. Upon assessment thre (the) following vital sign was obtained, BP 118/66, Temp 97.9, P 103, SPO2 90%, refuse dinner, current BS (blood sugar) 188 and chest auscultation diminished at base. Surveyor noted the CNA documentation for meal consumption on this day was 76-100% for dinner. The laboratory report for collection date of 5/1/2020 includes Sodium 173 Cef with reference range of 136-145. The laboratory report indicates the critical value was verbally reported to facility staff on 5/2/20 at 2:05 a.m. The nurse's note dated 5/2/20 documents Called in critical labs to Physician-I on call for Physician-J. Order received to send to ER for eval and treatment. Resident alert and oriented, appeared more confused. No noted resp (respiratory) distress/labored breathing. Mild congestion and intermittent unproductive cough noted VS T98.6 R30-35, Hr 116 Bp 148/70 pox 92% RA (room air). The nurse's note dated 5/2/20 documents Writer spoke with Hospital staff-K at SMO. Pt (patient) admitted with Aspiration PNA (pneumonia), acute kidney injury and [MEDICAL CONDITION]. The hospital history and physical dated 5/2/2020 under history of present illness documents Resident's name (R4) is a 74 y/o male with a hx (history) of advanced dementia, DM II, recently admitted with [MEDICAL CONDITION], aspiration pneumonia, discharged to Alexian, who represents with altered mental status . Per notes, the patient was not heating (eating) and not as alert as normal. At Alexian he was tested for COVID but tested negative reportedly. The patient had labs drawn at Alexian and was hypernatremic, thus sent to the ED (emergency department) for evaluation. On arrival to the ED, BP (blood pressure) is stable. HR (heart rate) is elevated to 120. Tachypneic sodium markedly elevated to 174, cl (chloride) 136, BUN (blood urea nitrogen) 72/ Cr (creatinine) 1.77, BNP (protein levels made by heart & blood vessels) 1142. Given 250 NS (normal saline), CXR (chest x-ray) obtained, concerning for infiltrate. Started on [MEDICATION NAME]. CT (computed tomography) head obtained with no acute findings. admitted for further cares. Under impression and plan documents Resident's name (R4) is a 74 y/o male with a hx of advanced dementia, DM II, recently admitted with [MEDICAL CONDITION], acute kidney injury and aspiration pneumonia. admitted to AAU for further cares. Severe [MEDICAL CONDITION]ly from poor free water intake given hx of prior admission also goal to lower slowly over the course of several days s/p (status [REDACTED]. Acute kidney injury likely secondary to poor PO intake fluids as above, repeat bmp. The discharge summary dated 5/26/2020 under discharge [DIAGNOSES REDACTED]. The nurse's note dated 5/26/20 documents Resident readmitted back to facility at 2:45pm from SMO via EMS (emergency medical services). Alert and awake with a discharge [DIAGNOSES REDACTED]. Resident lung sound is clear bilaterally per auscultation. Bowel sound active x (times) 4 with no tenderness. Res is on a puree diet and honey thickened liquid. Res was fed and ate 75% of his meal and drank 120 mls of fluid. No pain or grimacing noted. Res wife sent some lotions to be used on him. Res. tolerated meds with no concerns at this time. VSS (vital signs stable). The hydration risk evaluation dated 5/26/2020 Documents a total score/value of 20 at risk. A resident who scores 8 or higher may be at risk for dehydration. There were no changes on the Dehydration/Fluid Maintenance care plan dated 5/26/2020. Surveyor noted the approaches for the dehydration/fluid maintenance care plan dated 5/26/20 are the same approaches as the previous care plan dated 3/31/20. There are no revisions in the care plan following R4's second hospitalization for dehydration. The CNA care plan dated 5/26/2020 documents approaches all dated 5/26/2020 of * Weigh resident weekly. * Record meal intake. * Record total shift fluid intake. * Bathing. The resident care guide with a start date of 5/26/20 under the diet section documents Diet/Special Instructions: Puree with honey thick liquid see NURSE for detail instruction. I need 1:1 total assistance with eating. I have dysphagia and need to sit up 30 minutes after meals. I need to be fed 1 tsp (teaspoon) bites and sips. NOT TO BE LEFT ALONE FOR MEALS. Wife provides all feeding support she will ask for help as needed. Res wife and POA (power of attorney) refusing to have weights taken. Requests res. to be comfortable and getting res. up to be weighed causes to much stress on res per POA. Lower HOB (head of bed) to 45 degrees 1/2 hour after meals to prevent sliding down, causing pressure at feet at foot board. Staff to assist res with all meals during wife's absence. Encourage honey thick fluids throughout day. Offer me a clothing protector for meals. CARE PLAN: I need 1:1 total assist with feeding puree solids and honey thick fluids. No straws. Alternate solids/liquids as needed. Provide tactile cues of spoon to lips if patient does not open oral cavity as needed. Sit up in broda chair for meals only as tolerated. Remain upright for 30 minutes after meals. The nutrition note dated 5/27/20 documents Readmit Nutrition Note-Res readmitted to facility after hospitalization for AKI (acute kidney injury), aspiration pneumonia, dehydration, [MEDICAL CONDITION] and pneumonia. Res is on a Pureed diet with honey thick liquids. Res needs to be fed for all meals. Appetite has much improved during hospitalization however res. has lost 9.6 lbs (-10.7%) in the past 3 months. Res does well with magic cups and generally eats 100% when assisted. Will add magic cup TID (three times day) for additional nutrition support. Provides 290 calories, 9g/pro (grams/protein) per cup. Res BMI is 23.7 indicating weight remains w/in (within) IBW (ideal body weight). Res UBW (usual body weight) is ~160-165 lbs. Res has a hydration score of 20 indicating res. is at high risk for dehydration d/t recent hospitalization ,[DATE] (secondary to) dehydration, dependent on staff for eating/drinking and is on honey thick liquids Staff to encourage honey thick fluids with meals and throughout day. The nutritional risk assessment dated [DATE] under estimated nutritional needs for fluid documents 2010-2345 for 30-35 ml/kg. Under potential at risk factors yes is checked for at risk for dehydration due to inadequate fluid intake. On 6/4/20 Surveyor reviewed daily intake meal consumption from date of admission 5/26/20 to 6/3/20 and noted the following: 5/26 refused dinner. 5/27 breakfast & lunch 51-75%, dinner 26-50%. 5/28 breakfast 51-75%, lunch 76-100%, and dinner is blank. 5/30 breakfast & lunch are blank and dinner is 51-75%. 5/31 There is no documentation for breakfast, lunch, & dinner. 6/1 breakfast & dinner 51-75% and lunch 76-100%. 6/2 breakfast 25-50%, lunch & dinner 76-100%. 6/3 breakfast & lunch 76-100% and dinner 51-75%. The nurse's note dated 6/8/20 documents Writer saw resident and offered swallows of honey thickened fluids that resident took well. Skin turgor is good; no signs of any hydration issues. Resident awake and looking around when writer attempted to greet him. Appears in no distress. Surveyor noted this is the first nurse's note that assesses skin turgor and hydration issues. INTERVIEWS On 6/2/20 at 3:14 p.m. Surveyor asked DON (Director of Nursing)-B via telephone if the care plan indicates to monitor intake is the intake for food or fluid. DON-B informed Surveyor it is all together. Surveyor asked if a resident is at risk for dehydration where would the fluids consumed be documented in the medical record. DON-B informed Surveyor they do not record cc (cubic centimeter) of fluid intake. DON-B explained if a resident didn't drink anything then that would be in a nurse's note. On 6/3/20 at 3:16 p.m. Surveyor asked DON-B via telephone if a care plan says to monitor for signs and symptoms of dehydration where would Surveyor locate this in a Resident's medical record. DON-B informed Surveyor it's just something they monitor and doesn't have an answer off the top of her head. On 6/4/20 at 9:29 a.m. Surveyor spoke with RN (Registered Nurse)-L regarding R4. Surveyor asked RN-L how they are monitoring for signs and symptoms of dehydration for R4. RN-L informed Surveyor the nurses working with R4 would know and labs have been done on him. RN-L informed Surveyor she is still in training and started working at the Facility on 3/5/20. RN-L informed Surveyor when R4 came back from the hospital he was admitted on a puree diet with honey thick liquids. RN-L informed Surveyor she didn't see any labs scanned for R4. Surveyor asked where monitoring for signs and symptoms of dehydration would be found. RN-L informed Surveyor the CNA's would let the nurse know if R4 is not eating or drinking. Surveyor asked where food and fluids would be documented. RN-L informed Surveyor they are documented together and |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **525523** | A. BUILDING _____ B. WING _____ | **06/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **ALEXIAN VILLAGE OF MILWAUKEE** | **9255 N 76TH ST MILWAUKEE, WI 53223** |

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<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 3)<br>480 ml of fluids is offered at each meal. Surveyor asked RN-L how she would know what R4 is actually drinking not what is offered. RN-L informed Surveyor this is the way the Matrix system is set up which they don't have any control over.<br>Surveyor asked RN-L where the assessment for skin turgor and mucus membranes every shift would be located. RN-L replied that's a great question and informed Surveyor she will l |