STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure/ Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1/4 300.610a) 300.686b)4) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications b) A resident shall not be given unnecessary medications. An unnecessary medication is any drug used: 4) Without adequate indications for its use; Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure the administration of injectable anti-psychotic medications are used to treat medical symptoms and not for the convenience of the staff and failed to attempt less restrictive alternative treatments prior to administering and injectable anti-psychotic medication for 1 of 6 residents (R32) reviewed for psychotropic medications in a sample of 28. This failure resulted in R32 receiving an injectable anti-psychotic medication which R32 resisted without an adequate indication for use which would cause a reasonable person emotional and psychological distress. Findings include: According to R32's Physician Order sheet dated 7/1/2022 through 7/31/2022 R32 was admitted to this facility on 5/20/2022 with diagnosis of Cerebral Infarction, Dysphasia, dysarthria, Hypertension, Atrial Fibrillation, Gastro Esophagitis with bleeding, Benign Prostate Hyperplasia with lower urinary tract symptoms, Obstructive and Reflux Uropathy, Moderate Protein Malaise Malnutrition, Depressive Episode, Restless Leg Syndrome, Chronic Kidney Disease, Anemia, Generalized Muscle Weakness, Change in Bowel Habit, Vitamin Deficiency and Dementia. R32 ' s MDS (Minimum Data Set) dated 5/30/2022 documented R32 with a BIMS (Brief	S9999		

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S9999	Continued From page 2 Interview for Mental Status) score of 03 on a scale up to 15 indicating R32 has severe cognitive impairment. It also documented R32 uses a walker and needs extensive assistance of 1 person for ambulation, dressing and most personal hygiene tasks. A Social Service Noted dated 5/20/2022 documents R32 cannot read or write, likes working on items like watches, radios, and broken things. R32 likes the outdoors and mostly likes to stay in his room to watch TV, listen to music or just relax. A Physician's order was noted in R32's medical record, dated 6/4/2022 and showed R32 was ordered an injection of a Psychotropic drug to be given for aggressive behaviors. The order documented as follows "6/4/2022 Give Haldol 5 mg (Milligrams) injection for aggressive behaviors. " R32 ' s nurse ' s noted for the date of 6/4/2022 are written as follows and are listed without omissions: Nurse's notes dated 6/4/2022 at 4:15am documented "Res (resident) resting in bed quietly with eyes closed. 0 (zero) s/s (signs/symptoms) of distress noted at this time. Will continue to monitor. (the signature of this note is illegible). Nurse's note dated 6/4/2022 at 08:40am and entered R32's medical record by V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) dated 6/4/2022 documented "Haldol 5mg (Milligrams) injection given in R (right) glute (buttocks). 3 CNAs (Certified Nursing Assistants) assisted with injection. Resident Currently aggravated. Yelling at staff at nurse's	S9999		

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S9999	Continued From page 3	S9999		

desk. Wants his money and wants to go home. R32's physician (V21/Medical Doctor) gave order via phone to (V7/Licensed Practical Nurse) POA (Power of Attorney) notified. Will continue to monitor. "

Nurse's note dated 6/4/2022 at 1330 (1:30pm) and entered into R32's medical record by V3, documented "0 (zero) behaviors noted at this time. Resident resting in bed. will continue to monitor."

R32 ' s nurse ' s notes for the date of 6/5/2022 are written as follows and are listed without omissions:

Nurse's note dated 6/5/2022 at 1845 (6:45pm) and entered into R32's medical record by (signature illegible) documented "Resident came to NS (Nurse ' s Station) requesting to go home. Was able to redirect resident and resident went back to room to watch tv."

Nurse ' s noted dated 6/5/2022 at 1900 (7:00pm) documented "Resident was yelling " Help " this nurse went to res (resident) room and noted resident lying on his bed he stated he wanted to go to the hospital and to go home. "

On 7/20/2022 at 9:00am, V3 said she was the nurse who cared for R32 on the date of 6/4/2022 and she was the nurse who administered R32 the injectable anti-psychotic medications at 8:40am. V3 said R32 was confused and up at the nurse ' s station requesting his money and to go home. V3 said she tried to talk to R32, but he would not listen and wanted to remain at the nurse ' s station and yell, but she had work to complete. V3 said while she was talking to R32, she felt R32 was becoming more agitated and would become

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S9999	Continued From page 4 aggressive, so the staff called R32 ' s physician and requested the injectable anti-psychotic medication to calm R32 down. V3 said other than trying to talk with R32, she had not attempted any non-pharmacological interventions prior to giving R32 the injection. V3 said she did not know she was supposed to attempt non-pharma logical interventions and document their outcomes prior to giving R32 the injectable anti-psychotic medication. V3 denied R32 attempting to hurt her, himself, or other residents. V3 denied R32 attempting to destroy property or throw items. V3 denied R32 trying to exit the facility on 6/4/2022 or at any point since his admission to this facility. V3 said it took herself and three CNAs to give R32 the injection. V3 said R32 did not agree with the injection and fought the staff during administration. V3 said the medication did calm R32 and he rested in his room the rest of that day. V3 reviewed R32 ' s care plan and said she could not find any plan of care for behaviors or the use of psychotropic medications. On 7/18/2022 at 2:30pm, V5 (Social Service Director) was asked about what types of behaviors they were monitoring for R32. V5 replied the staff were not doing any specific behavior monitoring because they did not know they were supposed to be doing any. V5 said she thought behavior monitoring meant keeping track of resident-to-resident altercations and said she has not really been trained at her job, V5 said she did not know psychotropic medications need to be prescribed to treat a specific medical symptom/illness and those symptoms/medications needed to be tracked. V5 presented two facility documents titled Behavior Tracking for (R32). Both documents have R32 ' s name written on the top with one form having June 2022 written on it and the other with July	S9999		

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S9999	Continued From page 5 2022 written on it. Both documents are completely blank and do not have any behaviors noted on them. On 7/20/2022 at 9:30am, V1 (Administrator/Registered Nurse) said after R32 was given the injectable anti-psychotic medication, they did not have an ID (Interdisciplinary) team meeting to discuss R32 ' s situation and to update and revise R32 ' s care plan. V1 said they did not do this because they did not know it was supposed to be done. V1 said she has only worked at this facility for a few months and was still learning her job duties. During the survey R32 ' s care plan was reviewed. R32 ' s care plan did not include a plan for behavior monitoring or personalized interventions to attempt if R32 develops agitation. On 07/25/22 at 1:00 PM, V20 (Nurse Practitioner) said she has had a few conversations with the nursing staff at this facility cautioning them about using injectable anti-psychotic medications for immediate behavior control. V20 said for some reason a chemical restraint seems to be their first go to option. V20 said she discussed the need for non-pharmacological interventions to be attempted first. V20 said she also emphasized that just because a resident becomes upset, and yells does not constitute the use of an injectable anti-psychotic medication. V21 (Medical Doctor) could not be reached during this survey therefore V21 ' s Nurse Practitioner (V20) was obtained. A facility policy titled Psychotropic Medication Policy with revision date of 11/28/2018 states "Definition of Chemical Restraint: Any medication that is administered with the intent of altering consciousness responsiveness, or to modify	S9999		

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S9999	Continued From page 6 behavior, convenience, punishment or discipline. Under the heading labeled Procedure under #2 it states "Psychotropic medications shall not be prescribed prior to the attempted non-pharma logical interventions to decrease behavior. "Under #7 it states: " Any resident receiving such medications shall have a psychiatric diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others, destructive to property, or if emotional problems exist which cause the resident frightful distress. "Under #19 it states: " Any resident receiving any psychotropic medications will have certain aspects of their use and potential side effects addressed in the resident care plan at least quarterly. The care plan will identify target behaviors causing the use of psychotropic medications. The care plan will address the problem, approaches and goals to address these behaviors." (B) 2/4 300.1210b) 300.1210d)2)5) 300.3210t) Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for	S9999		

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S9999	Continued From page 7 Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5)A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidenced by: Based on interview and record review the facility failed to provide care and treatment in accordance with professional standards of practice for a resident with wounds as ordered for 1 of 6 residents R8 reviewed for skin conditions in a sample of 28. The failure resulted in 2 hospitalizations of R8 for cellulitis of the bilateral lower extremities. Findings include: 1.) The "Admission Information Sheet" in R8's	S9999		

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S9999	Continued From page 8 medical record documents that R8 was admitted to the facility on 7/23/19. The "Cumulative Diagnosis Log" (undated) in R8's medical record documents that R8 has diagnoses including Alzheimer's with behavioral disturbance, anxiety, and bilateral lower extremity (BLE) edema. On 7/19/22 at 12:15 PM, V7 (Licensed Practical Nurse) said that R8 has swelling and weeping of the bilateral lower extremities and gets a daily dressing change. V7 said that R8 used to see a wound care specialist for her legs and has been hospitalized in the past for cellulitis. V7 said the wounds were healed at one point but continue to weep form the edema and they have resumed R8's previous treatment orders. V7 said that a lot of times R8 won't let them do her dressing changes. R8's wound consultation note by V24 (Advanced Practice Nurse-Wound Clinic) dated 3/10/22 documents under "Wound Status" that R8 has left leg cellulitis with a documented "date acquired" of 12/26/21. Left leg wound measurements documented are length-20 centimeters (cm), width- 22 cm. A wound consultation on the same date also documents under "Wound Status" that R8 has right leg cellulitis with a documented "date acquired" of 2/15/22. "Assessment Notes" document that the right leg is healed. "Physician's Order Details" document treatment orders for the wound of the left leg of "Apply (silver antimicrobial dressing) to left leg open weeping wounds cover with 4 x4 and abdominal (ABD) pads and wrap with cotton gauze wrap. Change dressing daily" and "Single layer (elasticized tubular bandage) in the morning upon arising and may remove at night." R8's wound consultation note by V24 dated	S9999		

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S9999	Continued From page 9 3/17/22 documents the left leg wound measurements are length-31 cm, width- 36 cm. The right leg wound measurements documented are length- 4 cm, width- 3 cm. "Physician's Order Details" document "Infectious Disease Consult: bilateral leg cellulitis-tomorrow at 9 AM." R8's Nurse's Note dated 3/18/22 at 0845 (8:45 AM), documents that R8 left the facility to go to an infectious disease appointment. At 1015 (10:15 AM) the same date the Nurse's Note documents that R8 was admitted to the hospital with a diagnosis of cellulitis. A Nurse's Note dated 3/22/22 at 11:35 AM documents that a report from the hospital nurse was received and R8 has an admission diagnosis of BLE cellulitis, has been receiving intravenous antibiotics, and has 2 open ulcers on BLE and R8 will be returning by ambulance. On 7/26/22 at 9:00 AM, V1 (Administrator/ Registered Nurse) said that they do not have any consultation notes from the appointment with the infectious disease specialist and subsequent hospital admission. V1 said R8 was directly admitted to the hospital for cellulitis from the appointment with the infectious disease specialist. R8's wound consultation note by V24 dated 3/24/22 documents left leg wound measurements are length-23 centimeters (cm), width- 18 cm. A wound consultation on the same date also documents under "Wound Status" that R8 has right leg cellulitis with a documented "date acquired" of 2/15/22. "Assessment Notes" document that R8 has no open areas to the right leg. "Physician's Order Details" document treatment orders for the wound of the left leg of "Apply (silver antimicrobial dressing) to left leg	S9999		

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S9999	Continued From page 10 open weeping wounds cover with 4 x4 and abdominal (ABD) pads and wrap with kerlix (cotton gauze wrap). Change dressing daily" and "Single layer (elasticized tubular bandage) in the morning upon arising and may remove at night." A return appointment in week is ordered. R8's "Nursing Home Progress Note" dated 3/28/22 by V20 (Nurse Practitioner) documents that R8 has an encounter diagnosis of "non-pressure chronic ulcer of other part of left lower leg with unspecified severity" and "edema of the left lower leg". The note documents that R8 was "hospitalized 3/18/22- 3/22/22 with cellulitis the BLE." R8's wound consultation note by V24 dated 3/31/22 documents the left leg wound measurements of length- 18 cm and width- 24.5 cm. "Physician Order Details" document the continuation of the previous visits orders. R8's Physician's Order Sheet (POS) for March 2022 documents a treatment order dated 3/10/22 of "Apply (silver antimicrobial dressing) to left leg open weeping wounds cover with 4 x4 and abdominal (ABD) pads and wrap with kerlix (cotton gauze wrap). Change dressing daily" and "Single layer (elasticized tubular bandage) in the morning upon arising and may remove at night." R8's March 2022 Treatment Administration Record (TAR) documents the orders for treatment of the left leg as documented on the March POS and the wound consultation notes. There are no initials indicating that the treatment of the silver antimicrobial dressing was completed for R8's left leg for 16 days in March. The order for the elasticized tubular bandage application was not initialed as being completed for 15 days	S9999		

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S9999	Continued From page 11 in March and the remaining days contained the circled initials of the nurse indicating that the treatment was refused by R8. R8's Nurse's Notes documented that R8 refused the dressing changes on 3/8/22 and 3/10/22. R8's Nurse's Notes on 3/23/22 and 3/30/22 document the dressing was completed, and old dressing removed was saturated with drainage. R8's wound consultation note by V24 dated 4/7/22 documents the left leg wound measurements of length- 19.5 cm and width- 15.5 cm. "Physician Order Details" document the continuation of the previous visits orders. A new wound with a "date acquired" documented of 4/5/22 to the left medial leg. The wound type documented is "cellulitis" with measurements of length- 2 cm, width-2.3 cm, and depth of 0.1 cm. A new wound with a "date acquired" documented of 4/6/22 to the right leg. The wound type documented is "cellulitis" with measurements of length- 0.7 cm, width- 0.7 cm. The Physician's Order Detail" documents an order to both left and right leg wounds of "Apply (silver antimicrobial dressing) to open weeping wounds cover with 4 x4 and abdominal (ABD) pads and wrap with kerlix (cotton gauze wrap) Change dressing daily" and "Single layer (elasticized tubular bandage) in the morning upon arising and may remove at night." A 2 week return appointment is ordered. R8's wound consultation note by V24 dated 4/21/22 documents the left leg wound measurements are now documented as: length- 29.5 cm, width- 22.5 cm. The wound measurements of the left medial leg are now documented as: length 4 cm, width- 4.5 cm, and depth- 0.1 cm. The right leg wound measurements are now documented as: length	S9999		

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S9999	Continued From page 12 15.5 cm, width- 11 cm. Dressings orders are the same as documented at the consultation on 4/7/22. A return appointment is ordered for 2 weeks. R8's April 2022 POS does not document the order for the treatment of the left leg as ordered per V24 on the 4/7/22 wound consultation note. There is no documentation of the order for dressing change on the POS for the right leg as ordered by V24 as documented on the 4/7/22 wound consultation note. R8's April 2022 TAR documents the order for the treatment of the left leg with silver antimicrobial dressing as written per wound consultation notes and POS. The treatment is initialed as being completed 4 times in the month of April. There are no initials indicating the treatment was completed for 26 days in April. There is no new order documented on the April TAR for the treatment of the right leg as ordered on 4/7/22 per V24 as documented on the wound consultation notes from 4/7/22. The order for the elasticized tubular bandage is initialed as being completed one day (4/2/22), initialed and circled as being refused by the resident for 4 days, and the 25 remaining days are left blank. There is no documentation in the Nurse's Notes of R8 refusing the treatments ordered to the BLE in April. On 7/20/22 at 11:30 AM, V3 (Minimum Data Set/ Care Plan Coordinator/ Infection Preventionist/ Licensed Practical Nurse) said that R8 said they do R8's dressing changes depending on what kind of mood R8 is in. V3 said that R8 sometimes doesn't want to get her dressing changes done. A Physician's Telephone Order Sheet dated	S9999		

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5/1/22 documents an order to send R8 to the emergency room (ER) for evaluation and treatment (Tx). There were no Nurse's Notes provided from the facility containing documentation of the rationale for the order to send R8 to the ER.

A "Transfer Orders for Receiving Facility" form from the hospital documents that R8 was admitted to the hospital on 5/1/22 and discharged on 5/5/22. The discharge diagnosis documents "Cellulitis of both lower extremities."

R8's wound consultation note dated 5/18/22 documents under "Physician's Order Details" a treatment order of "apply a single layer (elasticized tubular bandage) to both kegs- apply in the AM and remove at bedtime" and an order to "Discharge from Outpatient Services."

R8's May 2022 POS documents an order to discontinue (d/c) BLE dressing changes. Apply (elasticized tubular bandage) to BLE in the AM and remove at bedtime. BLE cellulitis healed per wound clinic. Discharged from wound clinic." On 7/20/22 the May 2022 TAR was requested for review. On 7/21/22 at 10:30 AM, V1 said that they were unable to locate R8's May TAR.

On 7/21/22 at 1:30 PM, V20 (Nurse Practitioner) said that if the staff would have been doing R8's dressing changes like they were ordered from the wound clinic, it would have prevented R8's hospitalizations for cellulitis. V20 said any time a dirty dressing is left in place the risk for infection is increased.

On 7/28/22 at 9:00 AM, V24 (Nurse Practitioner-Wound Clinic) said that if you have a dressing that is left in place for a prolonged period, or do

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S9999	Continued From page 14 not have a dressing in place to cover a wound, it will increase the introduction of bacteria in the wound subsequently causing an infection. V24 said that R8's dressing changes not being completed as ordered contributed to R8's hospitalization of cellulitis to the bilateral lower extremities. (B) 3/4 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 15 Section 300.1210 General Requirements for Nursing and Personal Care d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on interview, observation and record review the facility failed to initiate fall risk and elopement assessments, and failed to implement and develop progressive and effective interventions for residents with multiple falls for 4 of 7 residents (R20, R7, R16, R290) reviewed for accidents in the sample of 28. This failure resulted in R20 going to the emergency room and receiving 4 staples to a head laceration. Findings include: 1. According to R20 ' s Physician Order Sheet dated 7/1/2022 through 7/31/2022, R20 was admitted to this facility on 8/23/2020 and has the following diagnosis: Dementia, Encephalopathy, Seizures, Diabetes Mellitus type 2, History of falls, Depression, Anxiety, Anemia, Constipation, Gastro Esophageal Reflux Disease, Glaucoma, BPSD (Behavioral and Psychological Symptoms of Dementia), Vitamin D Deficiency, and Shingles Left Eye.	S9999		

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S9999	Continued From page 16 R20 ' s most recent MDS (Minimum Data Set) assessment dated 5/13/2022 and completed by V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) documents R20 has a BIMS (Brief Interview for Mental Status) score of 03 on a scale up to 15 indicating R20 has severe cognitive impairment. This assessment shows R20 needs limited assistance of 1 staff for bed mobility, transferring, walking, dressing, toileting, all personal hygiene tasks and uses a walker to walk. R20's medical record contained a facility document titled Fall Risk Assessment with room for documenting 4 different assessments. This form has the first assessment section completed with the date listed as 3/10/2022. R20's fall risk score totaled 17 in which a score above 10 is high risk. On 7/20/2022 at 12:30pm, V1 (Administrator/Registered Nurse) presented a list of falls that had occurred at the facility from February 2022 through July 10, 2022. R20 was listed as having falls on these dates: 3/12/22, 3/14/22, 4/9/22, 4/30/22, 5/17/22, 5/31/22, 6/1/22, 6/5/22, 6/7/22, 6/13/22 x2 and 6/16/22. A review of R20 ' s care plan for falls lists R20 as having the targeted problem of " Resident does not understand mobility limits due to cognition limitations. Risk factors include: Cog (Cognitive) Impairment, use of walker and poor safety awareness. " The targeted goal for R20 ' s fall prevention plan is " Number of falls per month will be reduced by next review. " Interventions to reduce R20 ' s future falls are listed as follows by start date of implementation. Starting	S9999		

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S9999	Continued From page 17 8/18/2021:1. Fall risk assessment quarterly and as needed with change in condition or fall status, 2. review quarterly and a needed during daily care, 3. IDT (Interdisciplinary Team) review and referral to PT (Physical Therapy) and, 4. IDT to review and refer to OT (Occupational Therapy) as needed, 5. Observe for unsteady/unsafe transferring or ambulation and provide assistance, 6. Remind of safety precautions and limitations, 7. IDT review of ADL (Activities of daily living) status and fall potential and report significant findings to the doctor, 8. Assess cognitive deficits and accommodate forgetfulness, 9. Inform doctor of any falls, 10. Encourage resident to use call light and ask for help (8/18/21). Starting 4/18/2022: 11. Encourage resident to sit when signs of fatigue are noted, 12. Monitor for unsteady gait. Starting 5/16/2022: 13. Wear non-slip foot wear, 14. Encourage resident to rest in between wandering behaviors when fatigued. Starting 5/31/2022: 15. Remind to use walker. Starting 6/1/2022: 16. Monitor for fatigue. Starting 6/5/2022: 17. Reduce noise level. Starting 6/7/2022: 18. Obtain basket for walker for items. Starting 6/13/2022: 19. 1:1 when ambulating during moments of fatigue. Starting 6/16/2022: 20. Offer snacks and soda. On 7/20/2022 at 2:30pm, V3 (MDSC-Minimum Data Set Coordinator/CPC-Care Plan Coordinator/ LPN-Licensed Practical Nurse/ IP-Infection Preventionist) was asked what interventions were being implemented to prevent R20 from having future falls. V3 said the staff remind her to use her call light and to use her walker. V3 was asked if any other interventions were in place and V3 said not really, we just have to keep reminding R20. V3 said R20 has seizures and so it is assumed that R20 is having seizure activity and that is causing her falls. V3 said she	S9999		

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doesn't consider falls caused by seizure activity as actual fall and R20 has the behavior of putting herself in the floor for attention. V3 said she did not know why falls occurring before 4/18/2022 did not have interventions because she was not appointed to this position until March 2022 and could not speak for the previous care plan coordinator, who no longer worked at the facility.

On 7/18/2022 at 9:45am, R20 was observed leaving her bedroom without assistance and entering the restroom down the hall. No staff were observed on R20 ' s hallway or at the nearest nurses station approximately 30 feet away from R20 ' s room.

On 7/18/2022 at 1:00pm, R20 again was observed leaving her bedroom without assistance and entering the restroom down the hall. V3 was at the nurse ' s station approximately 30 feet away from R20 during this observation. V3 made no attempt to assist R20 or call for assistance for R20. When R20 finished in the bathroom R20 was observed walking back to her room without staff assistance.

On 7/18/2022 at 2:30pm during an interview with V5 (Social Service Director) at the nurse ' s station, R20 was observed ambulating in the hallway by her room with her walker and without staff assistance. No other staff were observed in the hallway, nor at the nurse ' s station. V5 was asked if R20 was supposed to be up walking with her walker by herself in which V5 said, " I think it's alright, I know she is supposed to be using her walker."

On 7/18/2022 at 3:15pm, R20 was observed with blood in her hair and V3 putting pressure on R20 ' s head. V3 said R20 had fallen and was going to

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S9999	Continued From page 19 the hospital to be checked out. R20's Nurses Notes dated 7/18/22 at 15:05 (3:05PM), "Was called into another res room notes res lying on R20 (right) side in doorway. Assessment completed. Laceration noted to R side of head in hair-line. 3 cm (centimeters) long. Area cleaned.. No other injury noted.." at 15:10 (3:15PM), "called (V21, informed of laceration. Red (received) order to send to ER eval & tx (treatment)." At 18:00 (6:00PM), "Res returned to facilities via wheel chair. Resident escorted to own room. Res has 4 staples in place to laceration. No drng (dressing) noted." A hospital emergency room report dated 7/18/2022 at 16:00 (4:00pm) documented R20 was seen at the local emergency room for complaints of fall injury. On the same evening, this report documented at 17:46 (5:46pm) R20 had "wound repair of 2.5 cm (Centimeters) full thickness laceration to right temporal area and linear shaped. Anesthesia: Wound infiltrated with 5 mL (milliliters) of Lidocaine, Wound Prep: simple cleaning with betadine. Skin closed with 4 large staples using staple gun." Final Report sent to the Department dated 7/25/22 regarding R20's fall documents in part, "On 7/18/22 at approximately 3:05PM R20 was notes on the floor in the doorway of her bedroom. Subsequently sent to the emergency room for evaluation. Resident's family and MD (Medical Doctor) were notified. An investigation was started per facility protocol. Investigation revealed R20 is impulsive and has impaired cognitive status/poor safety awareness coupled with unsteady gait which lead to her fall. In conclusion, the facility was able to substantiate the alleged fall with injury and determined that R20 lost her	S9999		

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S9999	Continued From page 20 balance and fell resulting in the laceration to right forehead.." On 7/19/2022 at 3:00pm during an interview with V22 (Therapy Director), R20 was again observed ambulating in the hallway in front of her room with her walker and without staff. V22 was asked if R20 was supposed to be walking without assistance and V22 said no R22 is supposed to have someone walking with her. V22 said therapy staff had noticed R20 having several falls over the past few months. V22 said R20's room is a few doors away and across the hall from the therapy room and they notice her frequently walking without staff. V22 said R20 received physical and occupational therapy services for few weeks in June 2022. V22 said R20 did very well and seemed to enjoy working with the therapy staff. V22 said R20 still comes to the therapy room to sit and visit with the staff. On 7/20/2022 at 9:30am, V1 (Administrator/Registered Nurse) said the facility has not been having IDT meeting to discuss falls and develop new fall prevention interventions because until last week she did not know they were supposed to be doing that.V1 said she did not realize R20 ' s care plan had the same intervention implemented several times over and over again and agreed the interventions had not been very effective at reducing R20 ' s falls. V1 said she could see how most of the interventions were not reasonable due to R20 ' s severely impaired cognitive functioning. When asked to review documentation concerning how falls were investigated, root cause analysis determined and new fall interventions were developed, V1 said the facility has not been investigating falls and completing a root cause analysis of the falls because she did not know they were supposed to	S9999		

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S9999	Continued From page 21 do that. V1 said all fall investigation paperwork was considered a matter of QA (Quality Assurance) and those documents could not be released or copied. V1 allowed the QA fall paperwork to be reviewed but not copied. None of the documents contained a fall root cause analysis and the section under QA review were blank. A facility policy titled Fall Prevention was presented by V1 (Administrator). Under the section labeled Procedure #1 " Conduct fall assessments on the day of admission, quarterly and with a change in condition. #2 All staff must observed residents for safety. If residents with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident. #4 Final risk category will be determined by the IDT (Interdisciplinary Team) at their conferences based on: fall score, history of falls, medical conditions which directly impacts equilibrium and/or ambulation and discussion of individual circumstances. #5 Immediately after an resident fall the unit nurse provide care for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. #7 During morning Quality Assurance meetings Monday through Friday, all falls will be discussed and any new interventions will be written on the care plan. 2. The "New Admission Information" sheet in R7's medical record documents an admission date of 1/25/17. The "Cumulative Diagnosis Log" (undated) in R7's medical record document R7's diagnoses include Alzheimer's Dementia, seizures, hypertension (HTN), depression, constipation, vitamin D deficiency, dementia with behavioral disturbance, and anxiety.	S9999		

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S9999	Continued From page 22 R7's most recent MDS assessment dated 4/21/22 documents in section G- Functional Status that R7 requires limited assistance with a one person physical assist with bed mobility, transfers, walking in room and corridor, and locomotion on and off the unit. Section J- Health Conditions is marked "No" to the question "Has the resident had any falls since admission or the prior assessment, whichever is more recent?" On 7/20/22 at 11:30 AM, R7 was observed walking in the hallway without assistance. The list of falls that had occurred at the facility from February 2022 through July 10, 2022 provided by V1 documents that R7 had falls on 4/3/22, 4/16/22, and 5/19/22. On 7/20/22 at 3:30 PM, R7's most recent care plan and fall risk assessments were requested for review. The Care Plan (undated) provided for review did not identify R7's risk for falls or any interventions implemented to prevent falls. There was no Fall Risk Assessment provided by the facility for review. The "Investigation Report for Falls/ Quality Care Reporting Form" for the falls occurring on 4/3/22, 4/16/22, and 5/19/22 were reviewed. The sections documenting the investigation completion date, date of Quality Assurance (QA) review date, summary of events and actions taken, Medical Director signature, Administrator signature, and Director of Nursing signature were all left blank for all 3 falls. The sections documenting "Areas of concern identified for further analysis" and "what new interventions were implemented to prevent further falls?" on the Investigation Report form the fall occurring on	S9999		

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S9999	Continued From page 23 4/3/22 and 4/16/22 were left blank. The Investigation Report for the fall on 5/19/22, the question "What fall prevention techniques were in use prior to the fall?" has a documented response of "all requirements of care." The response to the question "were the fall prevention techniques in place?" was left blank. On 7/20/22 at 2:45 PM, V10 (Licensed Practical Nurse/ Alzheimer's Unit Coordinator) said that the fall investigation reports are completed by the nurse on duty at the time of the fall. V10 said the nurses assess the resident and the physician and family are notified. V10 said that they have kind of gotten away from the Interdisciplinary Team (IDT) meetings but V10 and V3 (MDS/ Care Plan Coordinator) usually get together and implement a new intervention to add to the care plan. 3. The "New Admission Information" sheet in R16's medical record documents an admission date of 1/20/22. The "Cumulative Diagnosis Log" (undated) in R16's medical record document R16's diagnoses include dementia, Urinary Tract Infection (UTI), falls, diabetes mellitus (DM) type 2, dizziness, cardiomyopathy, hearing loss, hypertension (HTN), hypokalemia, hyponatremia, osteoporosis, atrial fibrillation (A-Fib), history of subdural hematoma, insomnia, and violent outbursts. R16's most recent MDS assessment dated 4/30/22 documents in section G- Functional Status that R16 requires extensive assistance with a 2 person physical assist with transfers, walking in the room and corridor, and locomotion on and off the unit. Section J-Medical Conditions is marked "yes" to the question "Has the resident had any falls since admission or the prior assessment, whichever is more recent?" and	S9999		

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S9999	Continued From page 24 documents R16 has had 2 or more falls with no injuries. A Fall Risk Assessment dated 3/14/22 documents a score of 14. The assessment documents that a score of 10 or more equal a high risk for falls. The list of falls that had occurred at the facility from February 2022 through July 10, 2022 provided by V1 documents that R16 had falls on 2/2/22, 2/3/22, 2/4/22, 2/22/22, 3/16/22, 3/19/22, 5/2/22, 5/11/22, 5/23/22, 5/29/22, and 6/21/22. R16's care plan documents a goal under the section "Falls" of "number of falls per month will be reduced by next review" with a goal start date of 2/4/22. Interventions documented on the care plan with a start date of 2/4/22 include: fall risk assessment quarterly and as needed with change in condition of fall status, review quarterly and as needed (PRN) resident's Activities of Daily Living (ADL), mobility, cognitive, behavior and overall medical status, IDT review of changes and needs with resident and/ or responsible party during care plan, discuss fall related information to review and revise plan as needed, IDT review of function and referral to Physical Therapy (PT) and Occupational Therapy (OT) as needed, remind resident to lock wheel chair brakes & assist to keep locked and ready for transfer as needed, and attempt to anticipate needs-toileting, hydration, hunger and provide care before resident attempts to fulfill on own. There are no new interventions added to the car plan for falls occurring on 2/22/22, 3/16/22, 3/19/22, and 5/2/22. An intervention added to the care plan dated 5/29/22 documents anticipate toileting needs. The intervention of anticipating toileting needs was already listed as an intervention with a start date of 2/4/22.	S9999		

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S9999	Continued From page 25 The "Investigation Report for Falls/ Quality Care Reporting Form" for R16's falls occurring on 2/2/22, 2/3/22, 2/4/22, 2/22/22, 3/16/22, 3/19/22, 5/2/22, 5/11/22, 5/23/22, 5/29/22, and 6/21/22 were reviewed. The sections documenting the investigation completion date, date of Quality Assurance (QA) review date, summary of events and actions taken, Medical Director signature, Administrator signature, and Director of Nursing signature were all left blank for all falls. The Fall Investigation Report section documenting "what intervention was implemented to prevent any further falls?" was left blank. The report for the fall occurring on 2/4/22 in the section "were fall prevention techniques in place?" the response is documented as "no Certified Nurse's Aide (CAN) available for COVID hall." On the reports for falls occurring on 3/17/22 and 3/19/22 in the section documenting "area of concern identified for further analysis" and "What new intervention was implemented?" were left blank. The reports for falls on 5/2/22 and 5/11/22 in the section documenting "What new intervention was implemented?" was left blank. There was no "Quality of Care Reporting Form" available for the fall occurring on 5/29/22. The report for the fall occurring on 6/21/22 in the sections documenting "what fall prevention techniques were in use prior to fall" and "were the fall prevention techniques in place?" the responses are both documented as "n/a". The section documenting the "Area of concern identified for further analysis" and "what new intervention was implemented?" were left blank. 4. A document titled "New Admission Information" in R290's medical record documents an admission date of 7/5/22. A document titled "Cumulative Diagnosis Log" (undated) documents	S9999		

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S9999	Continued From page 26 that R290 has a diagnosis of unspecified dementia without behavioral disturbance, insomnia, and anxiety. A Social Service Progress Note dated 7/6/22 documents that R290 is "an elopement risk" and "did try to elope on (R290's) first night here". A Nurse's Note dated 7/17/22 documents that R290 has been yelling over and over "I've got to go home" A Nurse's Note dated 7/18/22 documents that R290 was "exit seeking." On 07/18/22 at 9:30 AM, R290 was observed wandering the halls and in and out of other resident's rooms and yelling "where are you Billy?" and "I have got to get out of here." On 7/18/22 at 2:15 PM, R290 was observed attempting to exit the door of the dementia unit and yelling "I've got to go home." R290 was stopped by the staff and did not exit the unit. On 7/20/22 at 12:45 PM, R290 was observed wandering down the hall and into resident's rooms and yelling out "where are you?" R290's Baseline Care Plan dated 7/6/22 documents under "Identified Safety Risks" to conduct a high risk elopement assessment and initiate behavior monitoring. On 07/20/22 at 11:45 AM, V3 (Care Plan/ MDS Coordinator/ Infection Preventionist/ Licensed Practical Nurse) said that R290's care plan and comprehensive assessment have not been completed yet. V3 said that the care plan and comprehensive assessment are past due and were due on the July 17th. V3 said that she does not remember doing an elopement or fall risk assessment on R290.	S9999		

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S9999	Continued From page 27 The Behavior Tracking Record for R290 dated July 2022 documents a targeted behavior of "elopement risk". The Behavior Tracking Record is left blank for first and third shifts for July 2022. Second shift documents behaviors on 7/21/22 with a frequency of 4 times. There is no documentation in the Nurse's Notes on 7/21/22 to provide further detail of R290's behaviors. The facility policy titled "Elopement/Missing Resident Policy and Procedure" (revision date 10/2006) documents "It is the policy of (facility) that reasonable precautions are taken to prevent Resident elopement. Reasonable precautions include, but are not limited to: door alarms, wrist alarms and staff intervention." (B) 4/4 300.610a) 300.1010h) 300.1210b)4) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999		

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S9999	Continued From page 28 Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. These regulations were not met as evidenced by:	S9999		

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S9999	Continued From page 29 Based on interview, observation and record review the facility failed to identify severe weight loss of a resident, failed to provide needed interventions to prevent further weight loss, and failed to notify the physician of the severe weight loss for 1 of 6 residents (R6) reviewed for nutrition in the sample of 28. The failure resulted in R6 experiencing a 15.36% (severe) weight loss within 2 months. Findings included: R6's New Admission Information Sheet documents an Admission Date of 08/23/21. This sheet documents R6 is a 83 year old female with diagnosis including: Alzheimer's Disease, Hypertension, Diverticulitis, Dementia and Hypothyroidism. R6's Minimum Data Set dated 04/14/22 documents in section C (Cognitive Pattern) that R6's Brief Interview of Mental Status score as 02, indicating a severely impaired cognition level. Section G (Functional Status) titled "Eating" documents that R6 requires supervision/ oversight with encouragement and cueing with set up help only. Section K (Swallowing/ Nutritional Status) documents R6's height as 67 inches and weight as 140 pounds. R6's Physician Order Sheet dated 07/01/22 documents a typed order of: Supplement Orders as House Supplement 60cc two times daily for weight loss dated 08/23/21. The Physician Order Sheet dated 07/01/22 also documents an undated handwritten order of: House Supplement 240 cc four times a day. R6's Physician Order Sheet dated from 07/01/22 to 07/31/22 documents: Dietary order as Regular Diet with a Hydration program of 240 cc extra fluids at	S9999		

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S9999	Continued From page 30 meals. R6's Admission Assessment, dated, 08/24/2021, by V16 (Registered Dietician) documents: weight of 134.2 pounds is below an acceptable Body Mass Index range (21.08) - underweight for age. Resident receives a Regular Diet with 240 cc House Supplement four times a day and feeds self. R6's Intake is reported as approximately 75-100% of meals since admission. Diagnosis of Dementia/Alzheimer's/Depression may alter intakes and weights. V16 (Registered Dietician) to follow up as needed. R6's care plan documents: Resident is in need of additional nutrition with a start date of 09/03/21, Resident will consume diet including extra nutrients thru next 90 days with a goal date of 12/02/21, Serve current diet per order - see POS (Physician Order Sheet) with a start date of 09/03/2021, Provide ample time to eat. Encourage resident to eat 75-100% of meals. Record meal intake. Note and report changes in resident usual patterns with a start date of 09/03/2021, Follow recommendations of RD (Registered Dietician)/LDN (Licensed Dietary Nutritionist) of discrepancy of recommendation with resident's preferences of care goals with a start date of 09/03/2021, and offer house supplement per recommendation - see POS for amount and frequency, Observe acceptance and report consistent refusals. R6's most current Dietary Quarterly Assessment is dated 01/30/22 documenting: height 67 inches, current weight 139.3, Average Meal Intake (%) 50-100 % most meals, Feeding Ability/Adaptive Equipment as feeds self with set up. R6's Report of Monthly Weight and Vitals,	S9999		

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S9999	Continued From page 31 documents R6's weights as: April 140.1 pounds, May 141.3 pounds, June 122.6 pounds, and July as 119.6 pounds for 2022. R6's paper Chart contained the facility document titled, "Dietary Notes" which only contained R6's name, no dietary notes are documented. R6's July 2022 Medication Administration Record (MAR) documents, "MedPass 240 cc QID (4 times daily)." For the month of July a time of 1900 (7:00PM) was listed and only the first and second of the month is marked. For the 1st of the month a percentage is marked but is not legible. There were no other times or dates marked for the rest of July on R6's MAR that MedPass was given to R6. R6's July 2022 MAR does not include and order for MedPass 60cc twice daily. On 07/19/22 at 12:05 PM during lunch, R6 was observed in the dining room with her food tray containing the regular diet, she was seated at the table with the residents receiving eating assistance, she appeared thin and stared more at her food then eating any. No observation of encouragement or cueing was observed by staff. R6's total intake was less than 25%. On 07/20/22 at 12:10 PM during lunch, R6 was observed in the dining room with her food tray containing the regular diet, she was seated at the table with the residents receiving eating assistance, she appeared thin and stared more at her food then eating any. No observation of encouragement or cueing was observed by staff. R6's total intake was less than 25%. On 07/21/22 at 10:15 AM, V16 (Registered Dietician) stated, she would have to consult the	S9999		

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S9999	Continued From page 32 notes because she does not remember R6 specifically, however, "Everything I charted should be in the file on the "Dietary Notes", when V16 was asked about the Dietary Notes being blank, she stated, "I can look to see if I have anything else." Throughout the rest of the survey V16 was unable to produce any additional information regarding R6. On 07/21/22 at 1:20 PM, V16 (Registered Dietician) stated, she believes R6's weight for June was documented incorrectly, that is not the weight she has in the AOD program. She believes June's weight is 138 pounds and July's weight is still 119.6. She still currently has approximately a 20 pound weight loss in about 30 days, but it would be in July not June. She has talked today (07/21/22) to V4 (Dietary Manager) about the situation and they will implement interventions, she typically comes at the end of the month and will monitor R6 then. On 07/21/22 at 2:00 PM, V6 (Certified Nurse Aide Scheduler) stated, to weigh the residents they take the resident to the scale, weigh them, write the weight down on a piece of paper and give the piece of paper to the nurse on duty. The nurse then writes the weight in the resident's chart. On 07/21/22 at 2:23 PM, V10 (Licensed Practical Nurse/ Alzheimer's Coordinator) stated, the CNA's will weigh the residents at the beginning of the month and write it down on a piece of paper, they bring that piece of paper to the nurse on duty and the nurse will write the weight in the resident's chart. If a re-weight would have been done, it would be documented by the original weight. V10 stated she does not see where she was ever on weekly weights. V10 stated a copy of the weight will then be given to dietary. V10	S9999		

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S9999	Continued From page 33 stated, she only heard about the AOD program the other day. V10 stated she heard the weights are suppose to be done through the program, but she is not for sure about that, it is new. V10 stated, R6 has lost about 20 pounds between May and June according to her Report of Monthly Weight and Vitals document in her chart, about 13%, that would be considered significant, especially for 30 days. R6 should have had a Dietary Quarterly Assessment done around May since her last one was 01/30/22, R6 has clearly lost weight by looking at her. On 07/21/22 at 2:55 PM, V4 (Dietary Manager) stated, she has different weight than what is documented in the chart. She usually gets the weights together before V16 (Registered Dietician) comes. She usually comes towards the end of the month. She has not completed a Dietary Assessment for R6 yet, she was going to do one after talking to V16 (Registered Dietician) today. According to both sets of weights that she has for R6, R6 has lost approximately 20 pounds in 30 days, that would be considered significant. She does not know why the June weight of 138 pounds is not documented anywhere in R6's chart as opposed to the 122.6 pounds however, the July weight of 119.6 pounds is correct. V4 (Dietary Manager) stated, she did not complete the "MD (Medical Doctor) notification of weight change form" or contact the physician by the 10th of the month as per the facility policy, her weight had not been discussed with V1 (Administrator) in lack of a Director of Nursing, R6 has not been discussed in a weekly Weight Committee Meeting, and she had not discussed R6 with V16 (Registered Dietician) prior to today when V16 called, but they have an intervention incorporated now.	S9999		

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S9999	Continued From page 34 The facility policy titled, "Resident Weight Monitoring" dated 03/19 documents: 2. Monthly weights are obtained by CNAs or designated staff by the 5th of the month. 3. Monthly weights are entered in the computer in batch by the Dietary Manager, Care Plan Coordinator or designee. 4. The monthly weight report is printed and reviewed by the Dietary Manager and DON by the 8th of the month. 5. If the monthly weight shows a significant change in 30 days (i.e. 5% +/-) the resident will be re-weighed. Re-weights are done by CNA or designated staff. Re-weights are again reviewed, and entered in the computer by the Dietary Manager, Care Plan Coordinator of designee. The monthly weight report is finalized and printed by the 10th of the month. 6. Monthly weights are recorded by designated staff on the Report of Monthly Weight and Vitals form in the Progress Note section of the medical record. 7. If there is an actual significant weight change (i.e. +/- 5% 1 month, +/- 7.5% x 3 months, +/- 10% x 6 months), the resident, POAHC (Power of Attorney Health Care)//family/guardian, physician and dietitian are notified. The physician shall by notified using the MD notification of weight change form. 8. The Food Service Manager and interdisciplinary team review the resident's weights and nutritional status and make recommendations for intervention. 11. Significant weight changes are reviewed in the weekly Weight Committee Meeting. The Weight Committee will also identify any trends of gradual weight loss or gain. Significant changes in weights are documented in the care plan with goals and approaches/interventions listed. 12. Residents who have been determined by the Weight Committee to be at increased risk for weight loss will be put on weekly weights for at least 4 weeks. After four weeks, if weight has stabilized monthly weights will be re-established.	S9999		

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S9999	Continued From page 35 13. All new admissions and re-admissions will be weighed weekly for at least 4 weeks. If weight is stable, weight will be monitored monthly. (B)	S9999		