STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to clearly identify the current code status to obtain a copy of an advance directive and provide the written information regarding the rights to formulate the advance directives for three of 26 final sampled residents (Residents 24, 48, and 99) reviewed for advance directives. * The facility failed to clarify and honor Resident 99's desire not to prolong life in case of incapacity. Resident 99's advance directive showed the resident did not wish to prolong life in case of incapacity, while Resident 99's POLST showed to attempt CPR. * The facility failed to ensure the copy of Resident 48's advance directive for healthcare was obtained and maintained in the resident's medical record. * The facility failed to ensure Resident 24 was offered information on how to formulate an advanced directive. These failures had the potential to not provide care in accordance with Resident 24, 48, and 99's treatment wishes. Findings: Review of the facility's P&P titled Advance Directives dated ,d+[DATE] showed the following: - The facility will provide written information to residents and/or their representative, should they desire, on formulation of an advance directive with respect to advance directives and applicable State law; - Upon admission or as soon as practicable thereafter, the resident and/or his/ her legal representative or surrogate decision maker will be provided with information regarding preferred intensity or care and/or advance directives; - If there is an advance directive or individual healthcare instruction(s) documented by a healthcare worker, then this information shall be placed in the clinical record when provided by the resident or their representative. This document will be filed in the resident's clinical record in a place that is easily accessible in the event of an emergency. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Medical record review for Resident 99 was initiated on [DATE]. Resident 99 was readmitted to the facility on [DATE]. Review of Resident 99's H&P examination dated [DATE], showed Resident 99 had the capacity to make medical decisions. Review of Resident 99's Advance Directives dated [DATE], showed Resident 99 did not wish to prolong her life in case of incapacity. Review of Resident 99's POLST dated [DATE], showed Resident 99's code status was to attempt resuscitation/ CPR. The POLST, under Section D, was left blank and not completed to show Resident 99 had an advance directive. Review of Resident 99's Order Summary Report showed a physician's order dated [DATE], showing Resident 99 was a full code. On [DATE] at 1017 hours, an interview and concurrent medical record for Resident 99 was conducted with the SSD. The SSD verified the above findings. The SSD verified Resident 99's wish to not to prolong her life in case of incapacity per her advance directives, did not match Resident 99's POLST showing a full code status. The SSD stated the social services department and/or the nursing department had to ensure the POLST and advance directive matched. The SSD stated if the POLST and advance directive did not match, the social services department had to follow-up with the resident and/or his/ her representative, to make sure the resident's code status reflected the resident's wishes. When asked who responsible to update the resident's POLST to reflect the existence of Resident 99's advance directive, the SSD stated the social services department did not fill out nor update the POLST, and the nursing department would have to update it. 2. Medical record review for Resident 48 was initiated on [DATE]. Resident 48 was initially admitted to the facility [DATE]. Review of Resident 48's H&P examination dated [DATE], showed Resident 48 had the capacity to understand and make decision. Review of Resident 48's POLST dated [DATE], under Section D Information and Signatures, showed Resident 48 had capacity, and an advance directive was available and reviewed. However, review of Resident 48's medical record failed to show a copy of Resident 48's advance directive was obtained, or an attempt was made to obtain Resident 48's advance directive. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0923 hours, an interview and concurrent medical record review for Resident 48 was conducted with RN 2. RN 2 verified the above findings. When asked about the advance directive, RN 2 stated the admitting nurse would ask the resident or any family member or representative about advance directive upon admission, and the nurse would complete Section D on the POLST to show whether the resident had an advance directive or not. When asked about following up for a copy of the advance directive, RN 2 stated any of the nurses would usually follow-up about the advance directive on the next day after admission. RN 2 verified Resident 48's POLST showed Resident 48 had an advance directive; however a copy of Resident 48's medical record was not available in the resident's medical record. RN 2 verified there was no documentation showing the nurses had followed up for a copy of Resident 48's advance directive. On [DATE] at 0948 hours, an interview and concurrent medical record review for Resident 48 was conducted with the SSD. The SSD verified the above findings. The SSD stated the POLST and advance directive should be initiated upon admission and followed up the next day. The SSD stated the social services department followed up for the copy of the residents' advance directive. The SSD stated if a follow-up had been done, it would be documented in the baseline care plan or the progress notes. The SSD verified Resident 48's POLST showed Resident 48 had an advance directive; however a copy of Resident 48's medical record was not available in the resident's medical record. The SSD verified there was no documentation showing the social services department had followed up for a copy of Resident 48's advance directive. 50126 3. Medical record review for Resident 24 was initiated on [DATE]. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's POLST dated [DATE], showed Resident 24 had capacity to make decisions. In addition, the POLST showed Resident 24 did not have an advance directive. Review of Resident 24's H&P examination dated [DATE], showed the resident had the capacity to make decisions. On [DATE] at 1446 hours, an interview and concurrent medical record review for Resident 24 was conducted with the SSD. The SSD stated Resident 24 had a POLST dated [DATE], and the POLST did not show Resident 24 had an advanced directive. The SSD further stated the Advance Directive Acknowledgment Form was not signed indicating information about formulating an advanced directive was not given to Resident 24 or a family member. On [DATE] at 1115 hours, an interview was conducted with LVN 4. LVN 4 stated when the residents were admitted to the facility, the Social Services would meet with the resident and or family member and ask if the resident had an advanced directive or would provide information. LVN 4 verified Resident 24 did not have an advanced directive in the medical record. On [DATE] at 1145 hours, an interview was conducted with Resident 24. Resident 24 was asked if the facility staff offered information about, or assistance with formulating an advance directive. Resident 24 stated he did not receive information about, or assistance with formulating an advance directive.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview and medical record review, the facility failed to ensure the comprehensive plan of care was revised to reflect the resident's care needs for one of 26 final sampled residents (Resident 116). * The facility failed to ensure Resident 116 comprehensive care plan was revised to show the resident's current antibiotic medication and contact isolation precaution. This failure had the potential for not providing necessary care and services to meet the resident's needs. Findings: Medical record review for Resident 116 was initiated on 7/16/24. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's Order Summary Report for July 2024 showed a physician's order dated 7/14/24, to administer Levaquin (an antibiotic used to treat bacterial infections) 500 mg one tablet by mouth one time a day for UTI for seven days. Review of Resident 116's urine culture laboratory results dated [DATE], showed urine culture, >100,000 CFU/ml Proteus mirabilis (Proteus mirabilis is a common pathogen responsible for complicated UTI that sometimes causes bacteremia) ESBL. Further review of Resident 116's Order Summary showed no order for contact isolation for ESBL in urine Review of Resident 116's urine culture laboratory results dated [DATE], showed urine culture >100,000 CFU/ml Proteus mirabilis ESBL. Review of Resident 116's care plan initiated on 7/13/24, showed the resident was on antibiotic therapy (Cipro) oral tablet related to UTI. Further review of Resident 116's care plan failed to show a care plan problem for UTI was revised for the Levaquin ordered on 7/14/24, and a contact isolation initiated for the resident. On 7/16/24 at 0940 hours, during an initial tour, a contact precautions sign was observed by Resident 116's door informing everyone must clean their hands, including before entering and when leaving the room. The sign also showed the providers and staff must put on gloves before room entry and discard gloves before room exit; and put on gown before room entry and discard gown before room exit. On 7/16/24 at 0945 hours, an interview with LVN 7 was conducted. LVN 7 verified Resident 116 was on contact isolation for ESBL in urine. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	On 07/18/24 at 1411 hours, an interview and concurrent record review with LVN 7 was conducted. LVN 7 verified Resident 116 was on Levaquin for UTI. LVN 7 verified the care plan for Resident 116 was not revised to show the resident was on Levaquin instead of the Cipro antibiotic and to include the resident was placed on contact isolation. On 7/19/24 at 1520 hours, an interview with the DON was conducted. The DON was informed and acknowledged above findings.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility document review, the facility failed to provide the necessary ADL care and services for two of two residents (Residents 48 and 374) investigated for ADL care. * Resident 48 was provided with only two showers on 7/15 and 7/18/24, instead of twice a week since his admission on 7/1/24. * Resident 374 was provided with only one shower on 7/14/24, instead of twice a week since her admission on 7/6/24. These failures posed the risk of the residents not being provided with the appropriate care which could negatively impact their psychosocial well-being. Findings: 1. On 7/16/24 at 0857 hours, during the initial tour of the facility, Resident 48 was observed lying in bed. Resident 48 was observed wearing a gown, and his hair was unkempt. Resident 48 was observed not on any isolation precautions. Medical record review for Resident 48 was initiated on 7/16/24. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's H&P examination dated 7/3/24, showed Resident 48 had the capacity to understand and make decisions. Review of Resident 48's Order Summary Report showed the following physician's orders dated: - 7/2/24, to administer Amoxicillin (antibiotic medication) 500 mg one capsule by mouth two times a day for pneumonia. This order was discontinued on 7/2/24; -7/2/24, for contact isolation for Escherichia coli, Klebsiella pneumoniae, and ESBL in the sputum. This order was discontinued on 7/2/24, and the note showed, clarification of order. -7/2/24, for contact and droplet precautions related to pneumonia. This order was discontinued on 7/5/24, and the note showed, antibiotic treatment course is completed. -7/3/24, to administer Amoxicillin 500 mg by mouth two times a day for pneumonia. This order was discontinued on 7/15/24. -7/15/24, to administer Amoxicillin 500 mg by mouth two times a day for jaw necrosis (osteonecrosis of the jaw, a severe bone disease affecting the the maxilla and the mandible, which was a rare side effect of some drugs for osteoporosis and cancer). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Follow-Up Question Report (CNA documentation) showed Resident 48 received bed baths on 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/12, 7/13, and 7/14/24; and a shower on 7/15/24. On 7/18/24 at 0813 hours, an interview was conducted with Resident 48. Resident 48 was observed in bed wearing a hospital gown. When asked about showers, Resident 48 stated he was provided with only one shower last Monday (7/15/24) since his admission on 7/1/24. Resident 48 stated the staff changed his gown and bed linen, but it would be nice to get showers. On 7/18/24 at 1121 hours, an interview and medical record review for Resident 48 was conducted with the DSD. The DSD stated she worked as the IP when Resident 48 was admitted . The DSD stated Resident 48 was scheduled to have showers every Monday and Thursday each week. The DSD stated if a resident refused showers, the CNAs were supposed to report to the LVN; and the LVN would document in the progress notes. The DSD verified Resident 48 received bed baths on 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/12, 7/13, and 7/14/24; and a shower on 7/15/24. The DSD verified there was no documentation Resident 48 refused showers. The DSD stated Resident 48 was not provided showers but only bed bath because he was on contact and droplet precautions when he came. The DSD stated she had to clarify the physician's orders for the Amoxicillin medication and isolation precautions. When asked to show documentation of the follow-up calls to the physician, the DSD could not provide documentation in Resident 48 medical record. On 7/18/24 at 1402 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 48 did not refused showers, and she provided a shower to Resident 48 today. 2. On 7/16/24 at 0923, 1020, and 1146 hours, during the initial tour of the facility, the Contact and Droplet Isolation Precaution signs were observed posted by the entrance of Resident 374's room. On 7/17/24 at 0824 and 0919 hours, 7/18/24 at 0750 and 1605 hours, and 7/19/24 at 1147 hours, a Droplet Isolation Precaution sign was observed posted by the entrance of Resident 374's room. Medical record review for Resident 374 was initiated on 7/16/24. Resident 374 was admitted to the facility on [DATE]. Review of Resident 374's H&P examination dated 7/9/24, showed Resident 374 was able to make medical decisions by herself. Review of Resident 374's Order Summary Report showed the following physician's orders dated: -7/8/24, for Contact Precautions for C. auris; -7/8/24, for Enhanced Barrier Precautions related to GT; -7/8/24, for Enhanced Barrier Precautions related to wound care; and -7/17/24, For Droplet Precautions related to Acinetobacter species. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Follow-Up Question Report (CNA documentation) showed Resident 374 received bed baths on 7/6, 7/7. 7/9, 7/10, 7/11, 7/12, 7/13, 7/15, 7/16, 7/17, 7/18, and 7/19/24; and a shower on 7/14/24. The report also showed Resident 374 had refused bathing on 7/8/24. On 7/19/24 at 1119 hours, an interview and concurrent medical record review for Resident 374 was conducted with the IP. The IP stated a resident on isolation could be given showers or take showers but the resident had to wear a mask, and would have to be the last resident to use the shower room. On 7/19/24 at 1146 hours, an interview was conducted with CNA 3. When asked about providing showers to Resident 374, CNA 3 stated Resident 48 was scheduled to have showers every Monday and Thursday each week; however, they did not provide showers for the residents on droplet precautions such as Resident 374. CNA 3 stated only bed baths were provided to the residents on a droplet precautions. On 7/19/24 at 1147 hours, an interview was conducted with Resident 374. Resident 374 was observed in bed wearing a hospital gown. When asked about showers, Resident 374 stated, I would like to get a shower. I have never been given one. A shower would surely feels nice. Resident 374 stated she did not refused shower on 7/8/24, and was not given a shower on 7/14/24. On 7/19/24 at 1406 hours, an interview and concurrent medical record review for Residents 48 and 374 was conducted with the DON. The DON stated a resident on isolation could be provided with showers provided the staff and resident adhered to isolation protocols such as the resident had to wear a mask, the resident was the last one to get a shower, and the housekeeping had to clean the shower room after. The DON verified Residents 48 and 374 were not provided their scheduled showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to provide the necessary care and services to ensure one of 26 final sampled residents (Resident 48) attained and maintained his highest practicable well-being. * The facility failed to coordinate and follow up for Resident 48's needed medical appointments per the transfer orders from the acute care hospital. Resident 48's scheduled medical appointment to the infectious disease clinic was marked as completed; however, there was no documentation Resident 48 went to the infectious disease clinic. In addition, Resident 48 was supposed to be scheduled for a medical appointment with the oncology clinic, but it was discontinued, and no documentation it was scheduled nor followed up. This failure had the potential for Resident 48 to not receive appropriate medical care and treatments. Findings: Medical record review for Resident 48 was initiated on 7/16/24. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's acute care hospital record titled Skilled Nursing Transfer Orders dated 7/1/24, showed the appointments and consultations were needed with the oncologist and infectious disease physician. Review of Resident 48's H&P examination dated 7/3/24, showed Resident 48 had the capacity to understand and make decisions. Review of Resident 48's Order Summary Report showed the following physician's orders dated: -7/1/24, to schedule an appointment with the infectious disease physician. The physician's order showed the address and the phone number. This order showed it was discontinued; -7/1/24, to schedule an appointment with the oncologist. The physician's order showed the address and the phone number. This order showed it was discontinued; - 7/10/24, an appointment with the infectious disease physician on 7/16/24 at 1100 hours. The physician's order showed the address and the phone number. This order showed it was discontinued; and -7/15/24, an appointment with infectious disease physician on 7/16/24 at 1100 hours. The physician's order showed the address and phone number. This order showed it was completed. Further review of Resident 48's medical record did not show Resident 48 went to the medical appointments with the infectious disease physician nor to the oncologist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 0923 hours, an interview and concurrent medical record review for Resident 48 was conducted with RN 2. When asked about Resident 48's medical appointments, RN 2 verified there were appointments needed for Resident 48, the appointments to the infectious disease physician and oncologist per the transfer orders from the acute care hospital. RN 2 verified the appointment with the infectious disease physician showed it was completed. RN 2 also verified there was no documentation Resident 48 went to the infectious disease clinic. RN 2 verified there was no documentation of the appointment to the oncologist was scheduled. RN 2 also verified the physician's order for a visit with the oncologist showed it was discontinued. On 7/18/24 at 0948 hours, an interview and concurrent medical record review for Resident 48 was conducted with the SSD. The SSD stated when the nurses carried out the physician's orders for appointment, the social services department scheduled the medical appointments and transportation. The SSD stated the nurses would then carry out the physician's order for the scheduled medical transportation with the date, time, and location. The SSD verified Resident 48 had a medical appointment with the infectious disease physician. The SSD stated Resident 48 was not able to go to his medical appointment with the infectious disease physician due to transportation issues. The SSD also verified there was a physician's order to schedule a medical appointment to the oncologist. The SSD stated she was not able to schedule a medical appointment to the oncologist. When asked for documentation about Resident 48, the SSD verified there was no documentation showing why Resident 48 was not able to go to his scheduled appointment to the infectious disease physician, and why Resident 48 was not scheduled for his oncologist appointment. On 7/18/24 at 1055 hours, an interview and concurrent medical record review for Resident 48 was conducted with the DON. The DON stated there should be a documentation in the resident's progress notes regarding his medical appointment, or if it needed to be followed-up or rescheduled. The DON verified Resident 48's appointment to the infectious disease clinic was marked as completed, but there was no documentation showing it was done. The DON showed Resident 48's physician's order to schedule an oncology appointment was discontinued on 7/10/24, and the notes showed, cannot schedule while at SNF due to billing. The DON could not find any documentation regarding following up with the oncology clinic nor to Resident 48's physician.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to ensure two of five residents (Residents 48 and 120) reviewed for nutrition and hydration status maintained their acceptable nutritional and hydration status. * The facility failed to follow the RD's recommendations to provide two Boost VHC (a very high calorie complete nutritional drink which provides 530 calories per eight fluid ounce serving, with 22 grams of protein and 26 vitamins and minerals) every meals and to discontinue health shakes. In addition, the facility to clarify the physician's order whether to provide Boost VHC TID (three times a day) or with meals. * The facility failed to monitor Resident 120's fluid intake while on fluid restriction to assess and maintain proper hydration. These failures had the potential to compromise Resident 48's nutritional status, and Resident 120's hydration status and posed the risk for negative health outcomes. Findings: 1. On 7/16/24 at 0857 hours, during the initial tour of the facility, Resident 48 was observed in bed. Two bags containing cartons of regular Boost were observed at bedside. When asked about his meals, Resident 48 stated he was on a full liquid diet, and the facility usually gave him one carton of Boost each meal. On 7/16/24 at 1213 hours, during the initial dining observation, Resident 48 was observed in bed. A lunch tray containing one carton of Boost VHC, one carton of health shake, one carton of milk, a cup of apple juice, and a cup of water. Review of Resident 48's meal ticket showed Resident 48 was on a full liquid diet. Resident 48 stated he was on a full liquid diet because of his difficulty with swallowing. Resident 48 stated he felt tired and did not have the energy. Resident 48 felt that he was losing weight and stated he may not be able to do his rehabilitation treatments. Medical record review for Resident 48 was initiated on 7/16/24. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's H&P examination dated 7/3/24, showed Resident 48 had the capacity to understand and make decisions. Review of Resident 48's Order Summary Report showed the following physician's orders dated: -7/11/24, to provide health shake with meals. This order was discontinued on 7/17/24; -7/11/24, to provide Boost VHC with meals. This order was discontinued on 7/17/24; and -7/17/24, to provide Boost VHC after meals. Vanilla flavor if/ when available. Provide two Boost VHC with meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 48's plan of care showed a care plan problem to address Resident 48's risk for weight loss, nutrition, hydration, and skin integrity complication related to altered diet. Review of Resident 48's Nutritional Assessment - V5 dated 7/2/24, showed Resident 48's estimated nutritional needs were 1480 to 1775 kcal calories, and 60 to 70 grams of protein. On 7/17/24 at 1230 hours, Resident 48 was observed in bed. A lunch tray containing one carton of Boost VHC, one carton of health shake, one carton of milk, a cup of apple juice, and a cup of water. On 7/18/24 at 0800 hours, an interview for Resident 48 was conducted with CNA 4. When asked about Resident 48's meals, CNA 4 stated Resident 48 was on a liquid diet, and he drank most of it. CNA 4 stated Resident 48 usually would have one carton of Boost VHC, one carton of health shake, one carton of milk, a cup of apple juice and a cup of water. On 7/18/24 at 0806 hours, CNA 4 was observed delivering Resident 48's breakfast tray. The breakfast tray was observed containing one carton of Boost VHC, one carton of health shake, one carton of milk, a cup of apple juice and a cup of water. On 7/18/24 at 1257 hours, an interview and concurrent medical record review was conducted with the RD. The RD stated she recommended two Boost VHC per meals which should be able to meet Resident 48's recommended caloric and protein intake. The RD stated she sent her recommendations in a word document via email to the Administrator, DON, and licensed nurses. Review of the RD recommendations dated 7/15/24, showed the following: - Change Boost VHC to Boost VHC TID (three times a day), vanilla flavor if/when available; - Provide two Boost VHC with meals per the resident request; and - Discontinue house shakes. On 7/18/24 at 1258 hours, Resident 48 was observed in bed. A lunch tray containing a carton of Boost VHC, a carton of vanilla health shake, a cup of water, and a cup of cranberry juice was observed at bedside. On 7/18/24 at 1402 hours, CNA 4 verified Resident 48 was served with a carton of Boost VHC, a carton of vanilla health shake, a cup of water, and a cup of cranberry juice. On 7/19/24 at 0811 hours, Resident 48 was observed in bed. A breakfast tray containing a carton of Boost VHC, two cartons of vanilla health shake, a cup of water, and one cup of cranberry juice was observed at bedside. A carton of a regular Boost was observed on the tray. Resident 48 stated he wanted two cartons of Boost VHC but was only served one, so Resident 48 drank a carton of regular Boost to add to the Boost VHC given by the facility. On 7/19/24 at 0812 hours, an observation for Resident 48 and concurrent interview was conducted with Dietary Aide 2. Dietary Aide 2 stated he was the team lead when the RD and DSS were not available. Dietary Aide 2 verified Resident 48 was served with a carton of Boost VHC, two cartons of vanilla health shake, a cup of water, and one cup of cranberry juice. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 1353 hours, an interview and concurrent medical record review for Resident 48 was conducted with the DON. The DON verified the RD recommended to change Boost VHC to Boost VHC TID, vanilla flavor if/when available, to provide two Boost VHC with meals per the resident request; and to discontinue house shakes. The DON stated the licensed nurses had to carry out the orders and follow the RD recommendations, and then the DSS should verify the orders were followed by the dietary staff as well. When asked if the RD recommendations to change Boost VHC to Boost VHC TID and to provide two Boost VHC with meals were clarified to show Boost VHC was provided three times a day (0900, 1300, and 1700 meals) and/or with meals (breakfast, lunch, or dinner), the DON did not find documentation to show the RD recommendations were clarified. 48853 2. Medical record review for Resident 120 was initiated on 7/16/24. Resident 120 was admitted to the facility on [DATE]. Review of Resident 120's Order Summary Report for July 2024 showed a physician's order dated 7/4/24, for fluid restriction 1,500 ml per day: Dietary 720 ml (breakfast 240 ml, lunch 240 ml, and dinner 240 ml) and Nursing 780 ml (7 AM-7 PM shift for 400 ml and 7 PM-7 AM shift for 380 ml). Review of Resident 120's plan of care failed to show a care plan problem addressing the resident's fluid restriction. Review of the laboratory report for Resident 120 dated 7/15/24, showed the blood urea nitrogen (BUN) was 20 mg/dl (normal range: 7-17 mg/dl). Review of the Task Monitor Fluid Intake Follow Up Question Report for 7/1/24 to 7/19/24, showed the following: - 7/18/24 at 1356 hours, fluid intake was 720 ml; and - 7/18/24 at 1911 hours, fluid intake was 253 ml. On 7/18/24 at 1100 hours, an interview with CNA 13 was conducted. CNA 13 stated she was not sure if Resident 120 was on fluid restriction and if fluid intake was being monitored and need to be documented. On 7/19/24 at 1027 hours, an interview and concurrent record review was conducted with RN 2. RN 2 verified no monitoring of Resident 120's intake was done until 7/18/24 at 1356 hours. On 7/19/24 at 1530 hours, an interview with the DON was conducted. The DON verified the findings and stated the intake and output for Resident 120 were not monitored. Cross reference to F656, example #2.