STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106049	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of New Port Richey	7400 Trouble Creek Road New Port Richey, FL 34653

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility failed to complete a significant change assessment within 14 days of determining a weight loss for one (#162) of four residents reviewed for nutrition. Findings included: Review of a facility document titled Nutrition At Risk dated 2/27/25, showed Resident #162 had the following weights recorded: -On 2/18/25 the resident weighed 114.6 lbs. (pounds). -On 2/25/25 the resident weighed 108.6 lbs. -On 2/26/25 the resident weighed 102.8 lbs. The review showed a 10.53% weight loss. Review of the Minimum Data Assessments (MDS) section showed there were no documented assessments relate to a change in status for Resident #162. On 03/02/25 at 10:38 a.m., Resident#162 was observed in the dayroom visiting with family members. The family members stated the resident had lost a lot of weight and did not eat very much anymore. Review of the admission record for Resident #162 revealed the resident was admitted to the facility on [DATE] with diagnoses to include dysphagia, oropharyngeal phase and unspecified protein - calorie malnutrition and unspecified dementia. Review of an order summary report dated 3/5/25, showed active orders for Resident #162 included a regular diet - mechanically altered texture, thin consistency, 2 cal. (calorie) Med Pass supplement two times a day, 120 ml (milliliters), and nutrition consult. (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nutritional progress note for Resident #162 dated 2/27/25 revealed CBW (current body weight) 102.8 lb reflects -10.6% wt. (weight) loss x 1 week which is significant however reflects residents previous weight range of 97.0-111.0 in 2022. BMI 20.1 WNL. Staff to encourage PO fluids per orders. Potential for weight loss/decreased appetite r/t (related to) ABT (activity based) therapy. Variable PO (by mouth) meal intake noted along with refusal of meals per % PO intake documentation. Resident at risk for weight loss/nutritional decline r/t advanced age and disease process of Dementia. Recommend 2.0 Medpass 120 cc BID (twice daily) between meals. Will monitor weekly weight and f/u (follow up) prn (as needed). This review did not show a change in condition was submitted or the physician was notified of the significant weight loss. On 03/03/25 at 1:10 p.m., Resident #162 was observed in bed with her eyes closed. The resident did not respond to an interview. An immediate interview was conducted with Staff Q, Certified Nursing Assistant (CNA). She stated OT (Occupational Therapy) had assisted the resident with her meal earlier. She stated the resident had had an early tray for OT observation. She said, this resident does not eat much. We set up her tray. She stated Resident #162 was not assisted with her meal. Staff Q stated the resident ate less than 25% of her meal almost all the time. Review of a care plan last updated on 2/24/25, showed resident #162 - has nutritional problem related to Advanced age, Right Femur fracture with hemi-arthroplasty, Weakness, Dysphagia on altered diet consistency, Chronic Constipation, Dementia, and variable intake with refusals at times. The goal section showed - The resident will maintain adequate nutritional status as evidenced by maintaining weight at 115# with no significant change through the review date. Interventions included: RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). Administer medications as ordered. Lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. Invite the resident to activities that promote additional intake. Observe and report PRN (as needed) any signs/symptoms of dysphagia: Pocketing, Choking, Coughing. On 03/04/25 at 3:15 p.m., an interview was conducted with the facility's Diet Technician, (DT). The DT stated when a resident was admitted she did the initial nutritional and intake assessments. She stated she set up meal preferences. She stated the dietician monitored weight loss and initiated the triggers. She stated she did not know this resident had a significant weight loss. She stated if she did, it would be documented in an assessment or the plan of care. On 03/05/25 at 11:20 a.m., an interview was conducted with the facility's Registered Dietician, RD. The RD stated she saw residents once a month. She stated for Resident #162, she documented on her weight loss last week. She said the resident was on antibiotic therapy and staff should be encouraging her to eat her meals. She stated they should be documenting if she refused. She confirmed she had reviewed the resident's weight record and identified a significant weight loss. She stated she had recommended her for supplements. She stated she had not seen the resident in person. She stated if the resident was losing a lot of weight, there should be a follow -up. She stated the majority of times the IDT (interdisciplinary team) would meet to discuss a plan for the change, and it would be documented. She stated they would discuss if the resident needed 1:1 assistance. The RD stated the resident only required tray set up. She stated if her intake had changed, the CNA should let the nurse know and possibly obtain another weight. She stated as the RD, she would see them weekly and obtain weekly weights for monitoring. The RD confirmed the resident's assessment had not been updated. She confirmed the care plan should have been updated with new interventions. She confirmed the team had not met to address this resident's significant weight loss. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/25 at 11:51 a.m., an interview was conducted with Resident #162's Occupational Therapist (OT). She stated they had been working on strengthening, standing, dressing and toileting. She stated related to the resident's meal intake, she was able to independently scoop the meal and drink from the cup. She stated she had not assessed the resident for meal consumption. She said, intake was not the focus, but the ability to eat independently. She stated usually the dietician would come and speak with the DOR if there were weight loss concerns. She stated it should be documented in the notes and assessments. The OT stated the Director of Rehab (DOR) had been notified of the weight loss to see if there was any trouble with feeding. On 03/05/25 at 12:11 p.m., an interview was conducted with the Director of Nursing (DON). She stated the RD had identified weight loss, initiated med pass 120 cc twice daily, and initiated the NAR (nutrition at risk) assessment with recommendations for med pass on 2/27/25. She stated they had requested labs on 2/19/25 with concerns related to low Hemoglobin, low creatinine and elevated BUN (Blood Urea Nitrogen). The DON said, We should have contacted the physician, done a change in condition, updated care plan. Review of a facility policy titled, Changes in Resident's Condition or Status., dated 9/5/24 showed - This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status. Notification of Changes: (I) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is - (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications).