STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Parkwood	1001 N Grant St Lebanon, IN 46052

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48525 Based on observation, interview and record review, the facility failed to ensure staff treated residents with respect and dignity and to ensure a resident was provided clothing for 4 of 4 residents reviewed for respect and dignity. (Residents J, D, K, and C) Findings include: 1. During an interview, on 1/30/24 at 3:13 p.m., Resident J indicated a few nights ago she fell asleep in her wheelchair in her father's room next to his bed. A staff member came in the room when she was in there and rudely told her to get out. She was unsure of who the staff member was. The clinical record for Resident J was reviewed on 2/1/24 at 1:45 p.m. The diagnoses included, but were not limited to, major depressive disorder, anxiety, and other reduced mobility. During an interview, on 1/30/24 at 3:56 p.m., the Administrator indicated Resident J's father reported an incident when the staff asked Resident J to leave her father's room in a disrespectful tone. During an interview, on 2/2/24 at 11:25 a.m., Resident J's father indicated Resident J fell asleep in his room the other night and a staff member rudely told Resident J to get out and wheeled her away. He heard Resident J express frustration while being wheeled away. He was unsure of who the staff member was or what they looked like. 2. During an interview, on 1/31/24 at 10:34 a.m., Resident D indicated a staff member (CNA 5) had given him rough care including throwing him around when changing him, putting his socks on roughly, and being rude to him. The clinical record for Resident D was reviewed on 2/1/24 at 11:07 a.m. The diagnoses included, but were not limited to, reduced mobility, major depressive disorder, vascular dementia, and muscular weakness. During an interview, on 2/2/24 at 3:25 p.m., CNA 9 indicated she did know of the incident between the aide and the resident. CNA 5 no longer worked at the facility. When you provided care to the resident, you had to be gentle because he was sensitive with care. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 2/5/24 at 3:03 p.m., the Administrator and Clinical Support Nurse indicated CNA 5 no longer worked at the facility due to customer service issues. 49891 3. During an observation, on 1/30/24 at 1:19 p.m., Resident K was in bed wearing a hospital gown and no pants with stains on the front of the gown and had a noticeable mustache and long chin hair. During an observation, on 1/31/24 at 11:55 a.m., Resident K was in bed wearing a stained hospital gown, incontinence brief, no pants, or socks, and had a noticeable mustache and long chin hair. During an observation, on 2/1/24 at 11:39 a.m., Resident K was in bed in a clean hospital gown with no pants or socks. During an observation, on 2/1/24 at 1:53 p.m., Resident K was in bed in a clean hospital gown with no pants or socks. During an observation, on 2/2/24 at 11:56 a.m., Resident K was wearing a clean hospital gown with no pants or socks. The clinical record for Resident K was reviewed on 2/1/24 at 4:16 p.m. The diagnoses included, but were not limited to, catatonic disorder due to known physiological condition, paranoid personality disorder, schizophrenia, acute embolism, and thrombosis of unspecified deep veins of left lower extremity, need for assistance with personal care, and cognitive communication deficit. A resident admission belonging list, dated 12/19/23, indicated Resident K had no belongings. The electronic medical record did not include documentation of any facility requests for clothing. During an interview, on 2/5/24 at 2:53 p.m., the Administrator indicated Resident K arrived at the facility with no belongings and had no clothes. 44598 4. During an interview, on 1/30/24 at 12:56 p.m., Resident C indicated CNA 5 was very rude and provided rough peri-care. The clinical record for Resident C was reviewed on 2/2/24 at 12:18 p.m. The diagnoses included, but were not limited to, Wernicke's encephalopathy, bipolar disorder, intellectual disabilities, depressive disorder, cognitive communication deficit, borderline personality disorder, schizoaffective disorder, and anxiety disorder. In a facility reported incident, dated 1/8/24 at 8:49 a.m., Resident C indicated CNA 5 was rough with morning peri care. CNA 5 was suspended pending the investigation. On 1/16/24, the allegations were unsubstantiated. CNA 5 was returned to work. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 1/31/24 at 2:30 p.m., an anonymous resident indicated there were issues with some staff being rude and providing rough care. The resident was very uncomfortable with the second shift and did not look forward to them coming into the resident's room. The resident was not treated with dignity or respect and had rough care provided by a CNA. When the resident was incontinent with diarrhea, the CNA would ask why the resident had a bowel movement in their depends and not use the toilet. The resident indicated they had not reported these incidents to management in fear they would take it out on them. During an interview, on 2/2/24 at 4:06 p.m., the same anonymous resident indicated the rude CNA who treated the resident rough had also dropped the resident on the floor during a transfer. The CNA who provided rough care did not work again. During the resident council meeting, on 2/1/24 at 1:31 p.m., the residents indicated if /they or their families complained about their care someone would retaliate against them. During an interview, on 2/2/24 at 4:10 p.m., a second anonymous resident indicated they witnessed a CNA on second shift speaking in a rude tone and being rough while providing care to a resident. During an interview, on 2/5/24 at 3:03 p.m., the Director of Nursing (DON) indicated the incident for Resident C was investigated and there were no findings. She thought there was a cultural conflict with the CNA involved and CNA 5 was let go after the second incident was reported. A current policy, titled Resident Rights, dated as revised on 9/15/23 and received from the Administrator on 1/30/24 at 12:26 p.m., indicated .All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility. All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life .The facility will make every effort to support each resident in exercising his/her right to assure that the resident is always treated with respect, kindness, and dignity This citation relates to Complaints IN00423010, IN00425810 and IN00427356. 3.1-3(t)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36454 Based on observation, interview and record review, the facility failed to ensure a cognitively impaired and dependent resident was safe from an injury of unknown origin (Resident F), failed to ensure a resident did not have vaping materials in the room (Resident 72) and failed to prevent recurring falls for a resident who was identified as a high risk to experience falls (Resident H) for 3 of 3 residents reviewed for accidents. The deficient practice resulted in Resident F sustaining a left arm fracture. Findings include: 1. During an observation, on 2/1/24 at 12:01 p.m., Resident F was sitting up in a wheelchair in the dining room, a Hoyer pad was under the resident and there was a splint on the left upper arm. A Facility Reported Incident (FRI), dated 1/9/24, indicated a Certified Nursing Aide (CNA) had reported to the charge nurse Resident F had a bruise on the left elbow and was complaining of pain. The resident was assessed, and an order was obtained to send the resident to the emergency room (ER) for an evaluation. The resident had an injury of a left distal humerus fracture (the largest bone of the arm). The follow-up on the incident report included the resident was returned to the facility with a splint to the left arm. The follow-up incident report did not include documentation to show the facility completed an investigation of the injury or the facility had identified the root cause of the injury. The clinical record for Resident F was reviewed on 2/1/24 at 4:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, a fracture of the shaft of the humerus in the left arm, a history of falling, recurrent major depressive disorder, unsteadiness on feet, a cognitive communication deficit, restless leg syndrome, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 12/12/23, indicated the resident had a Brief Interview for Mental Status (BIMS) of 00 which indicated a severe cognitive impairment. The resident was totally dependent on staff for transfers to and from a chair to the bed, totally dependent on staff to propel in the wheelchair, totally dependent on staff to shower, totally dependent on staff to get dressed, and totally dependent on staff to eat. A care plan, dated 2/28/22 and last revised on 2/2/24, indicated the resident was at risk for falls due to decreased cognition, safety awareness, and a history of falls. The goal included the resident would be free of falls with injury. The approaches included, but were not limited to, the bed would be in the lowest position 2/2/24, the wheelchair would have anti rollbacks 7/17/23, a bolster mattress for the bed 2/17/23, to lay the resident down after lunch 2/23/23, and to encourage the resident to be up for breakfast each morning 12/7/22. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A care plan, dated 2/28/22 and last revised on 1/29/24, indicated the resident had a need for assistance with activities of daily living (ADL) including hygiene, dressing, grooming, toileting, transfers, bed mobility, eating and locomotion related to the diagnosis of dementia, muscle weakness, re-current urinary tract infections, and a history of Covid-19. The approaches included, but were not limited to, cue, set up, supervise, and assist as needed with eating, toileting and transfers. The care plan did not include the Quarterly MDS information, dated 12/12/23, of the resident being totally dependent on staff for transfers to and from a chair to the bed, to propel in the wheelchair, to shower, to get dressed, and to eat. A hospital service note, dated 1/9/24, indicated the resident presented from an extended care facility with the Emergency Medical Services (EMS) for an evaluation of a fall. The history was obtained by the EMS. The facility did not call the hospital to provide the history of the injury. The resident reportedly had a fall believed to be 2 days ago and was unwitnessed. The resident had pain in the left arm and was holding it close to the body. There was pain in the distal humerus with bruising posteriorly (behind) with the soft tissue. The resident was holding the arm flexed and pronated (turned so the palm was facing downward or inward) and unable to assess range of motion. The resident also had pain in the left wrist and tenderness in the left hip. Differential considerations were broad and included a mechanical fall, chronic gait disturbance, medication side effects, and many others. The facility was updated. The resident was discharged back to the facility, was to wear the splint, and to not remove the splint or get it wet. An x-ray report, dated 1/9/24, indicated the impression was a distal (close to the elbow) humerus (the long bone which runs from the shoulder to the elbow) fracture. During an interview, on 2/1/24 at 3:44 p.m., the Administrator indicated there was no written conclusion on the FRI. No one could explain the bruising and the injury to the resident's arm. The facility did not have cameras. The staff who worked on the dementia unit were interviewed and no staff had observed a fall for the resident. During an interview, on 2/1/24 at 3:45 p.m., the Director of Nursing (DON) indicated Resident F required the assistance of two staff for transfers and was not able to propel the wheelchair independently. There were no staff who had witnessed the resident trying to get up independently during the time frame prior to the injury. The DON had ruled out abuse as a root cause of the injury since there were no finger marks on the resident's skin or changes in the resident's psychosocial well-being. It was typical for the resident to be grumpy, a loner, holler out, not wanting to be changed and not liking to be provided with any care. The DON suspected the resident had a fall but was not able to provide sufficient documentation to corroborate the suspicion. The resident's bruising was more consistent with a fall or the resident bumping her arm and not from abuse. During an interview, on 2/2/24 at 3:50 p.m., the Clinical Support Nurse indicated abuse was ruled out because skin assessments for the resident and other residents did not show finger marks and abusers usually leave finger marks. A bruise on the resident's elbow would not be typical unless someone grabbed the resident and then there would be finger marks or something different. The Clinical Support Nurse did not have written documentation of the outcome of the FRI. 48525 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. During an observation, on 1/31/24 at 10:19 a.m., Resident 72 had two vapes (battery-powered device used to inhale an aerosol) in his room on his bed. The clinical record for Resident 72 was reviewed on 2/1/24 at 1:28 p.m. The diagnoses included, but were not limited to, cognitive communication deficit, brain injury without loss of consciousness, and attention-deficit hyperactivity disorder (ADHD). A Minimum Data Set (MDS) assessment, dated 1/12/24, indicated Resident 72 had current tobacco use. A document, titled Admission Paperwork Signature HealthCARE, dated as revised on 5/15/23 and received from the Administrator on 2/2/24 at 11:50 a.m., indicated .Certain Items Are Not Allowed in Your Room, Ever . Any type of smoking or vaping materials or items, including lighters During an interview, on 2/1/24 at 1:42 p.m., Resident 72 indicated he did use his vape in his room occasionally. He did not use cigarettes. He was not sure if he was supposed to use the vape in his room or not. During an interview, on 2/2/24 at 9:45 a.m., the Administrator indicated nobody vapes in the facility, and nobody should have a vape in their room or be using it in their room. During an interview, on 2/6/24 at 4:15 p.m., the Clinical Support Nurse indicated the resident was not smoking when he was readmitted on [DATE]. 46961 3. During an interview, on 1/30/24 at 10:36 a.m., Resident H indicated she had fallen many times and was afraid of falling out of the bed again. The clinical record for Resident H was reviewed on 1/31/24 at 4:47 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following a CVA (cerebrovascular accident or stroke) affecting the left non-dominant side, contracture of the left hand, altered mental status, TIA (transient ischemic attack is a brief stroke like attack), abnormal posture, repeated falls, muscle spasms, sciatica, peripheral vascular disease (narrowed blood vessels in the limbs), and a history of falling. An annual Minimum Data Set (MDS) assessment, dated 6/16/23, indicated the resident was totally dependent with transfers requiring two persons to assist. A. An interdisciplinary team fall review progress note, dated 7/24/23 at 3:20 p.m., indicated a fall occurred on 7/22/23. The resident was found on the floor next to the bed. The resident stated she slid off the bed. The new intervention was to evaluate a low air loss mattress with bolsters. A fall event report, dated 7/31/23 at 11:59 a.m., indicated the resident had a fall on 7/22/23 with no injuries. The resident slid off the low air loss mattress. She was in her room and fell from the left side of the bed. The fall was unwitnessed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	B. A fall event report, dated 11/28/23 at 9:50 a.m., indicated the resident fell from the shower bed in the shower room. She sustained a skin tear on her head and right elbow. The resident complained of pain in the right elbow and had a headache. A progress note, dated 11/28/23 at 10:00 p.m., indicated at approximately 9:15 a.m., the nurse was called to the shower room by the QMA (Qualified Medication Aide) due to the resident having a fall. The resident was laying on the floor on her right hip with her right leg extended and bilateral arms supporting her head. Bleeding was noted to the right elbow. The resident complained of neck, head, right shoulder, and right arm pain. Bruising, swelling, and lacerations were noted to the right eye with minimal bleeding. A skin tear to the right elbow was noted with a moderate amount of bleeding. emergency room discharge instructions, dated 11/29/23 at 7:18 a.m., indicated the diagnosis for the emergency room visit was a ground-level fall, contusions with multiple sites, and a skin tear to right elbow without complications. A progress note, dated 11/29/23 at 11:00 a.m., indicated the resident returned from the hospital. The resident was seen due to a fall with contusions and a skin tear to the right elbow. An interdisciplinary fall review progress note, dated 11/29/23 at 1:10 p.m., indicated the resident had a fall on 11/28/23. The resident rolled off the shower bed onto the floor. A skin tear was noted on the right elbow. The resident was sent to the emergency room . The new interventions were to have showers in the shower chair or a bed bath. A root cause analysis, dated 11/29/23, indicated an event was to be investigated and to gather preliminary information for a fall from the shower bed for Resident H. Resident H was lying on the shower bed, the Certified Nursing Assistant (CNA) 12 walked away from the resident to get supplies and the resident rolled off the shower bed. The identified contributing factors was the resident was too large for the shower bed and CNA 12 did not have supplies ready before the shower. The root causes identified were CNA 12 walked away from the resident without engaging the side rails, did not lock the wheel on the shower bed, should have used a shower chair due to the resident being too large for the shower bed, and did not have supplies ready prior to starting the shower. The changes to be implemented were staff to offer a shower in the shower chair or a bed bath only and staff education. An investigation statement, not dated and timed at 9:15 p.m., indicated RN 7 was called to the shower room related to the fall. The shower bed was unlocked, and the bilateral sides were down. The bed was dry and there was no water involved. An investigation note, not timed or dated, indicated the DON (Director of Nursing) had spoken with the resident regarding the events with the fall. The resident indicated CNA 12 took her to the shower room in her wheelchair and transferred her without any assistance. The resident had a bowel movement, CNA 12 rolled her onto her side towards the wall to clean her up, and the resident noted the side rail was down. CNA 12 diverted her attention away from her to get towels and wash cloths as she felt the bed slide away from the wall and she went rolling to the ground. A termination notice, dated 12/6/23, indicated CNA 12 was terminated, on 12/6/23, due to conduct and behavior. CNA 12 failed to follow policy and procedure related to the care plan. The termination notice was completed via telephone, on 12/6/23. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 2/05/24 at 11:49 a.m., the DON indicated CNA 12 was bathing the resident on the shower bed, turned away from the resident to get linens, and the resident fell off the bed. She now receives a bed bath due to the resident being afraid of falling in the shower. C. A progress note, dated 12/15/23 at 9:15 p.m., indicated the resident arrived at 8:35 p.m. today on a stretcher by ambulance. The resident transfers with 2 assists with a mechanical lift. The resident's bed mobility was extensive assist of one. An emergency department note, dated 1/30/24, indicated the resident arrived via ambulance for evaluation after a mechanical fall. The resident indicated she slipped getting out of bed this morning. She was found by the staff immediately. Steri-strips had been placed on her upper extremities. The resident stated she thought she hit her head. She complained of pain to the entire left side. The exam indicated the head had scuffs and abrasions without lacerations to the head. The extremities had lacerations and steri-strips which had been applied to the bilateral forearms. A fall event report, dated 1/31/24 at 9:59 a.m., indicated the resident had a fall off the left side of her bed in her room. The injury was located on her head. The intervention put into place was mats to both sides of the bed and the bed should be placed in the low position. A wound management detail report, dated 1/31/24 at 10:05 p.m., indicated the resident had a skin tear on the left elbow, identified on 1/30/24 at 8:50 a.m., which measured 3 centimeters (cm) by 4 cm. A wound management detail report, dated 1/31/24 at 10:06 p.m., indicated the resident had a skin tear on the right ring finger, identified on 1/30/24 at 8:50 a.m., which measured 0.3 cm by 1 cm. A wound management detail report, dated 1/31/24 at 10:07 p.m., indicated the resident had a skin tear on the right wrist, identified on 1/30/24 at 8:50 a.m., which measured 1 cm by 1 cm. A wound management detail report, dated 1/31/24 at 10:08 p.m., indicated the resident had a skin tear on her right hand, identified on 1/30/24 at 8:50 a.m., which measured 1 cm by 0.5 cm. A wound management detail report, dated 1/31/24 at 10:09 p.m., indicated the resident had a skin tear on her right hand, identified on 1/30/24 at 8:50 a.m., which measured 1.2 cm by 1 cm. A wound management detail report, dated 1/31/24 at 10:10 p.m., indicated the resident had a skin tear to the right hand measuring 1.3 cm by 1 cm. During an observation, on 2/02/24 at 3:20 p.m., the resident was laying in the bed with the head of the bed elevated and her eyes closed. The resident had a low air loss mattress with bolsters and the bed was in a low position with mats on both sides. The bolsters on the bed were snuggly against the resident's arms without room to roll in the bed. During an interview, on 2/05/24 at 11:54 a.m., the Administrator indicated the resident had requested a regular mattress and not an air mattress due to the air mattress scaring her. She did not feel safe. They had not assessed her for a bariatric bed. (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 0689 Level of Harm - Actual harm Residents Affected - Few	This citation relates to Complaints IN00423010, IN00425810 and IN00427356. 3.1-45(a)(1) 3.1-45(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	Provide enough food/fluids to maintain a resident's health. 36454 Based on record review and interview, the facility failed to recognize significant weight changes, complete re-weights, implement timely interventions, and to make notifications to the physician and resident representative for 3 of 5 residents reviewed for nutrition. (Resident F, L and J) Findings include: 1. The clinical record for Resident F was reviewed on 2/1/24 at 4:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, unspecified protein-calorie malnutrition, dysphagia (difficulty swallowing), type 2 diabetes mellitus, and recurrent major depressive disorder. The resident had the following weights: a. On 12/8/23, the weight was 140.1 pounds. b. On 1/3/24, the weight was 112.2 pounds which was a 19.91% significant weight loss in 26 days. c. On 1/16/24, the weight was 129.5 pounds which was a 15.42% significant weight gain in 13 days. d. On 1/25/24, the weight was 132.5 pounds which was still a 5.42% significant weight loss from the weight on 12/8/23 of 140.1 pounds. The resident did not have a re-weight documented in the clinical record after the significant weight changes on 1/3/24, 1/16/24 and 1/25/24. A facility event, dated 1/4/24, indicated the Registered Dietitian (RD) recommended a supplement of med pass 30 ml two times daily and to weigh weekly. The physician and the family were notified. A physician's order, dated 1/10/24, indicated to offer 30 milliliters (ml) of med pass supplement twice daily. A physician order, dated 1/10/24, indicated to weigh the resident weekly. The resident did not have a weight documented for the week of 1/10/24. The order for the weekly weights was not implemented until 12 days after the RD made the recommendation. A RD note, dated 1/25/24 at 10:20 a.m., indicated the resident was nutritionally at risk. The weight was up three pounds in 9 days and down one pound in 181 days. The resident received adequate nutrition. The RD note did not include the significant weight changes from 1/3/24 to 1/16/24 with the significant weight gain. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician and the family representative were not notified of the significant weight change on 1/16/23. During an interview, on 2/2/24 at 4:02 p.m., the Director of Nursing (DON) indicated the weekly weights did not get entered until 1/10/24 so a weight was not done until 1/16/24. The Registered Dietician had recommended weekly weights on 1/4/24 and the facility waited until the physician gave the order for the weekly weights until they were completed. The nutrition at risk (NAR) would only be added for 30, 60 and 90 days. If the significant weight change occurred earlier than 30 days, then the resident would not be added to the NAR. 2. The clinical record for Resident L was reviewed on 2/1/24 at 10:11 a.m. The diagnoses included, but were not limited to, dementia with agitation, anxiety disorder, severe protein-calorie malnutrition, dysphagia (difficulty swallowing), and generalized anxiety disorder. A care plan, dated 2/2/21, indicated the resident had a potential for nutritional risk related to the diagnoses of dementia, dysphagia, and the use of a mechanically altered diet. The approaches included, but were not limited to, the RD to assess the resident's nutrition status and make appropriate recommendations as needed. The resident had the following weights: a. On 11/2/23, the weight was 94.1 pounds. b. On 11/7/23, the weight was 101.3 pounds which was a 7.65% significant weight gain of 7.2 pounds in 5 days. c. On 11/28/23, the weight was 100.7 pounds. d. On 12/8/23, the weight was 95.1 pounds which was a 5.56% significant weight loss from 11/28/23. There was no re-weight after the significant weight gain on 11/7/23 documented in the clinical record. A RD progress note, dated 11/28/23, indicated the residents most recent weight was up 5 pounds in 28 days which was a gain of 5.7%. The resident continued weekly weights and current nutrition interventions. The RD progress note was 21 days after the significant weight gain on 11/7/23. A facility event, dated 12/28/23, indicated the resident had a weight loss. Labs and a speech therapy referral were ordered. The event was entered 20 days after the significant weight loss on 12/8/23. 3. The clinical record for Resident J was reviewed on 2/1/24 at 12:16 p.m. The diagnoses included, but were not limited to, unspecified dementia with other behavioral disturbance, dysphagia, unspecified protein-calorie malnutrition, and a psychotic disorder with delusions due to a known physiological condition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident had the following weights: a. On 12/8/23, the weight was 158.3 pounds. b. On 1/3/24, the weight was 138.8 pounds which was a significant 12.32% weight loss in 25 days. c. On 1/16/24, the weight was 147.3 pounds which was a 6.12% significant weight gain in 13 days. The re-weight for the significant weight loss was not completed after 1/3/24 until 13 days later, on 1/16/24. A nutrition progress note, dated 1/16/24 at 1:37 p.m., indicated the resident's January weight indicated a weight loss in 28 days. The RD recommended the resident was re-weighed as a nursing measure and to increase the 2 Cal supplement from 60 ml twice daily to 120 ml twice daily. The RD nutrition note, and recommendations occurred 13 days after the significant weight loss and then did not acknowledge the significant weight gain from 1/3/24 to 1/16/24. During an interview, on 2/2/24 at 4:11 p.m., the DON indicated the resident was not seen by NAR since the computer did not pick up the resident's significant weight changes. There were no re-weights documented in the electronic record. A current policy, titled Weighing and Measuring Height, dated 3/22/22 and received from the DON on 2/1/24, indicated .Resident's weight will be obtained and documented int the EMR [electronic medical record] upon . Admission and weekly x 2 .Re-admission .Monthly .Physician order .As needed .Notify the Charge Nurse, Physician, Registered Dietician, responsible party/resident of any significant weight loss or gain .Significant weight changes are considered significant changes in condition and require facility staff assessment/intervention .1 month .5% .Greater than 5% .3 months .7.5% .Greater than 7.5% .6 months . 10% .Greater than 10% .In order to accommodate timely notification of changes, a schedule for weighing residents will be established and followed .Facility staff will notify the Charge Nurse and Registered Dietician of 5% gain or loss .The Charge Nurse will .Recheck weight .notify physician of weight change .Evaluate cause of change .Outline plan for at least weekly weight, if indicated .Notify physician of significant changes as noted .Notify resident or family of significant changes as noted 3.1-46(a)(1)