

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/09/2024
NAME OF PROVIDER OR SUPPLIER  Legacy Nursing and Rehabilitation of Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE  1907 Chinaberry Street Franklin, LA 70538	
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)		
<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46361</p> <p>Based on interviews and record reviews, the facility failed to ensure nursing staff communicated a significant change in condition to the resident's physician and responsible party in a timely manner for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) residents reviewed for notification of change.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 07/12/2024 at 6:08 p.m. for Resident #1, when Resident #1 was unable to adequately eat or drink and Resident #1's physician and responsible party were not notified. This deficient practice continued on 07/13/2024 when Resident #1 was unable to adequately eat or drink and Resident #1's responsible party was not notified. On 07/14/2024, Resident #1 was observed to be lethargic with what was described as involuntary jerky movements and was sent to the emergency room for treatment. Resident #1 was hospitalized in critical condition and diagnosed with severe dehydration, severe hyponatremia [Sodium (Na) 168], moderate acute renal failure [Blood Urea Nitrogen (BUN) 104 and Creatinine 3.2], and metabolic encephalopathy.</p> <p>S1Administrator was notified of the Immediate Jeopardy on 08/08/2024 at 3:10 p.m.</p> <p>The Immediate Jeopardy was removed on 08/09/2024 at 3:04 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal prior to the survey exit.</p> <p>This deficient practice had the likelihood to cause more than minimum harm to any of the residents residing in the facility who could have a significant change in condition.</p> <p>Findings:</p> <p>Review of the facility's undated Change in Condition Policy and Procedure revealed, in part, the purpose of the policy was to ensure that people involved in the resident's care were made aware of any changes to the resident. Further review revealed the staff were to ensure the people involved in the resident's care, including the physician, responsible family members or legal representatives, were made aware of any changes to the resident.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 195388
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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #1's Minimum Data Set with an Assessment Reference Date of 07/05/2024 revealed, in part, Resident #1 was admitted to the facility on [DATE]; and had a diagnosis of Alzheimer's Disease, malnutrition, and muscle wasting and atrophy to the right arm. Further review revealed Resident #1 was rarely or never understood and dependent on staff for eating.</p> <p>Review of Resident #1's Weight Note dated 04/10/2024 revealed, in part, Resident #1 had a weight loss of 10.7% over 3 months. Further review revealed the Registered Dietitian recommended Twocal (nutritional supplement) 2 ounces twice a day for 60 days.</p> <p>Review of Resident #1's record revealed, in part, no documented evidence and the facility did not present any documented evidence Resident #1's physician was notified of the Registered Dietitian's recommendation on 04/14/2024 for Twocal 2 ounces twice daily for 60 days.</p> <p>In an interview on 08/07/2024 at 2:00 p.m., S4Quality Improvement (QI) Nurse confirmed she did not notify Resident #1's physician of the above mentioned recommendation and should have.</p> <p>Review of Resident #1's Nurse's Note dated 07/12/2024 revealed, in part, Resident #1 had possible dental issues and would not chew his food for lunch and dinner.</p> <p>In an interview on 08/07/2024 at 3:55 p.m., S5LPN indicated she was responsible for Resident #1 on the day shift on 07/12/2024. S5LPN indicated the nursing staff had difficulty getting Resident #1 to eat lunch and dinner. S5LPN indicated Resident #1 was nonverbal and unable to communicate his wants and needs to staff. S5LPN indicated she did not feel it was necessary to notify Resident #1's physician or responsible party that he had not eaten well on 07/12/2024.</p> <p>Review of Resident #1's Nurse's Note dated 07/13/2024 revealed, in part, Resident #1 was found holding food in his mouth and the food and fluids dripped out of the sides of his mouth. Further review revealed no documented evidence and the facility did not present any documented evidence Resident #1's responsible party was notified of Resident #1's decline in oral intake.</p> <p>In an interview on 08/07/2024 at 12:49 p.m., S8LPN indicated on the morning of 07/13/2024 she received report from S9LPN who indicated Resident #1 had not been eating well. S8LPN confirmed on 07/13/2024 Resident #1 continued with poor oral intake and was letting food and fluids drip out of the sides his mouth. S8LPN indicated she could not recall notifying Resident #1's responsible party of his change in condition.</p> <p>Review of Resident #1's Nurse's Note dated 07/14/2024 revealed, in part, Resident #1 was found lethargic with involuntary jerking movements. Resident #1's physician was notified and he was sent to the hospital for evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Resident #1's hospital records dated 07/14/2024 through 07/21/2024 revealed, in part, Resident #1 was treated for severe dehydration, hypernatremia, moderate acute renal failure, and metabolic encephalopathy. Further review revealed Resident #1 had laboratory testing completed on 07/14/2024 which indicated Resident #1's sodium level (used to monitor conditions that affect fluid and electrolyte balance) was 168 mEq (normal range 136 - 145 milliequivalents), blood urea nitrogen (BUN) [a test used to determine kidney function] level of 104 mg/dL (normal range 7 - 18 milligrams per deciliter), and Creatinine 3.2 mg/dL (normal 0.7 - 1.3 milligrams per deciliter). Further review revealed Resident #1's weight was 144.6 pounds, which was a difference of 41 pounds compared to Resident #1's last documented weight by the facility on 07/02/2024.</p> <p>In an interview on 08/06/2024 at 4:41 p.m., Resident #1's daughter/responsible party indicated she had not been notified by the facility of Resident #1's decline in oral intake on 07/12/2024 or 07/13/2024. Resident #1's daughter/responsible party indicated had she been made aware on 07/12/2024 and 07/13/2024 she would have gone to the facility to check on her father and she could have ensured that his needs were addressed.</p> <p>In an interview on 08/08/2024 at 2:03 p.m., Resident #1's physician indicated he had not been notified by the facility on 07/12/2024 of Resident #1's decline in oral intake.</p> <p>In an interview on 08/08/2024 at 4:39 p.m., S3Prior Director of Nursing (DON) indicated Resident #1 had a very good appetite and required double portions due to a history of taking food from other people's plates. S3Prior DON indicated if Resident #1 was not able or willing to eat this would be a significant change Resident #1 and the nursing staff should have immediately notified the physician and the responsible party.</p> <p>In an interview on 08/09/2024 at 12:19 p.m., S2DON confirmed the nursing staff did not notify Resident #1's physician and responsible party timely on 07/12/2024 and/or 07/13/2024 of Resident #1's decline in oral intake and confirmed this resulted in an immediate jeopardy situation.</p> <p>In an interview on 08/09/2024 at 12:19 p.m., S1Administrator confirmed the nursing staff did not notify Resident #1's physician and responsible party timely on 07/12/2024 and/or 7/13/2024 of Resident #1's decline in oral intake and confirmed this resulted in an immediate jeopardy situation.</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46361</p> <p>Based on interviews and record reviews, the facility failed to maintain acceptable parameters of nutritional status/electrolyte balance for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) reviewed for nutritional status as evidence by:</p> <ol style="list-style-type: none"> <li>1. Failing to ensure staff followed-up on and/or implemented a dietitian's recommendation (Resident #1); and,</li> <li>2. Failing to ensure staff assisted a resident with maintaining their food and/or fluid intake to suit their dietary needs (Resident #1).</li> </ol> <p>This deficient practice resulted in an Immediate Jeopardy situation on 07/12/2024 at 6:08 p.m. for Resident #1 when Resident #1 was unable to adequately eat or drink and no adjustments were made to suit Resident #1's dietary needs. On 07/14/2024 Resident #1 was observed to be lethargic with involuntary jerky movements and was sent to the emergency room for treatment. Resident #1 was hospitalized in critical condition and diagnosed with severe dehydration, severe hypernatremia [Sodium (Na) 168], moderate acute renal failure [Blood Urea Nitrogen (BUN) 104 and Creatinine 3.2], and metabolic encephalopathy. Resident #1 was noted to have a 41.4 pound weight loss from 07/02/2024, which was the last documented weight in the facility, compared to the weight collected in the emergency roaignom on [DATE].</p> <p>S1Administrator was notified of the Immediate Jeopardy on 08/08/2024 at 3:10 p.m.</p> <p>The Immediate Jeopardy was removed on 08/09/2024 at 3:04 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal prior to the survey exit.</p> <p>This deficient practice had the likelihood to cause more than minimum harm to any of the residents residing in the facility who can have unintended weight loss or poor food and/or fluid intake.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled, Weight Evaluation Policy and Procedure revealed, in part, the Director of Nursing (DON)/designee would review the resident's weights weekly, monthly, and as needed. Further review revealed residents who have had a 5% loss in less than 31 days, 7.5% weight loss in less than 91 days, and/or 10% loss in less than 181 days would be weighed weekly for 4 weeks until stable, unless prescribed by the physician. Further review revealed DON/designee will address weight loss with recommendations in residents chart.</p> <p>Review of Resident #1's Minimum Data Set with an Assessment Reference Date of 07/05/2024 revealed, in part, Resident #1 was admitted to the facility on [DATE]; and had a diagnosis of Alzheimer's Disease, Type 2 Diabetes, malnutrition, and muscle wasting and atrophy to the right upper arm. Further review revealed Resident #1 was rarely or never understood and dependent on staff for eating.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #1's Physician Orders dated July 2024 revealed, in part, Resident #1 had an order for a regular diet with double portions for all meals with a start date of 01/25/2024.</p> <p>Review of Resident #1's Care Plan revealed, in part, Resident #1 required staff assistance with feeding related to dementia.</p> <p>Review of Resident #1's Weights and Vitals Summary from 01/16/2024 through 07/02/2024 revealed, in part, Resident #1 had the following weights:</p> <p>On 01/16/2024 196.0 pounds;</p> <p>On 04/09/2024 175.0 pounds; and,</p> <p>On 07/02/2024 186.0 pounds.</p> <p>Further review revealed no documented evidence and the facility did not present any documented evidence of any weights being obtained on Resident #1 after 07/02/2024.</p> <p>Review of the facility's Weights and Vitals Exceptions documentation for Resident #1 for the time period of 01/01/2024 through 08/01/2024 revealed, in part, on 04/09/2024 Resident #1 had a 10.7% weight loss (comparison weight 01/16/2024).</p> <p>Review of Resident #1's Weight Note dated 04/10/2024 revealed, in part, Resident #1 had a weight loss of 10.7% over 3 months. Further review revealed the Registered Dietitian recommended Twocal (nutritional supplement) 2 ounces twice a day for 60 days.</p> <p>Review of Resident #1's record revealed, in part, no documented evidence and the facility did not present any documented evidence Resident #1's physician was notified of the Registered Dietitian's recommendation for Twocal 2 ounces twice daily for 60 days.</p> <p>In an interview on 08/07/2024 at 2:00 p.m., S4Quality Improvement (QI) Nurse indicated she was responsible for notifying the physician of any significant weight changes and recommendations made by the Registered Dietitian. S4QI Nurse further indicated she was not aware of the Registered Dietitian's recommendation for Resident #1 to receive Twocal 2 ounces twice daily for 60 days by staff. S4QI Nurse confirmed she did not notify Resident #1's physician of the above mentioned recommendation and should have.</p> <p>Review of Resident #1's Activities of Daily Living (ADL) documentation for eating for July 2024 revealed, in part, on 07/12/2024 Resident #1 was dependent on staff for assistance with all meals and fluid intake. Further review revealed staff documented at 8:00 a.m. Resident #1 ate 76%-100% of his meal, at 12:00 p.m. Resident #1 ate 51%-75% of his meal, and at 5:00 p.m. Resident ate 0-25% of his meal. Further review revealed on 07/13/2024 staff documented at 8:00 a.m. Resident #1 ate 26 %- 50% of his meal, at 12:00 p.m. Resident #1 ate 0-25% of his meal, and at 5:00 p.m. Resident #1 refused his meal.</p> <p>Review of Resident #1's Nurse's Note dated 07/12/2024 revealed, in part, Resident #1 would not chew his food for lunch and dinner.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 08/07/2024 at 3:55 p.m., S5LPN indicated she was responsible for Resident #1 on the day shift on 07/12/2024. S5LPN indicated the nursing staff had difficulty getting Resident #1 to eat lunch and dinner. S5LPN indicated Resident #1 was nonverbal and unable to communicate his wants and needs to staff. S5LPN indicated she did not feel it was necessary to notify Resident #1's physician or responsible party that he had not eaten well on 07/12/2024.</p> <p>Review of Resident #1's Nurse's Note dated 07/13/2024 revealed, in part, Resident #1 was found holding food in his mouth and the food and fluids dripped out of the sides of his mouth.</p> <p>Review of Resident #1's nurse note dated 07/14/2024 revealed, in part, Resident #1 was found lethargic with involuntary jerking movements.</p> <p>Review of Resident #1's hospital records dated 07/14/2024 through 07/21/2024 revealed, in part, Resident #1 was treated for severe dehydration, hypernatremia, moderate acute renal failure, and metabolic encephalopathy. Further review revealed Resident #1 had laboratory testing completed on 07/14/2024 which indicated Resident #1's sodium level (used to monitor conditions that affects fluid and electrolyte balance) was 168 mEq (normal range 136 - 145 milliequivalents), BUN (a test used to determine kidney function) level of 104 mg/dL (normal range 7 - 18 milligrams per deciliter), and Creatinine 3.2 mg/dL (normal range 0.7 - 1.3). Further review revealed Resident #1's weight was 144.6 pounds.</p> <p>In an interview on 08/08/2024 at 2:03 p.m., Resident #1's physician confirmed he was not notified of the Registered Dietitians 04/14/2024 recommendation of Twocal 2 ounces twice daily for 60 days. Resident #1's physician further indicated Resident #1 was severely dehydrated when he was hospitalized on [DATE]. Resident #1's physician further indicated Resident #1's level of dehydration was so severe Resident #1 had to have very poor oral intake for a minimum of a week, and the level of Resident #1's dehydration did not happen in 3 days.</p> <p>In an interview on 08/08/2024 at 4:39 p.m., S3Prior Director of Nursing (DON) indicated Resident #1 had a very good appetite and required double portions due to a history of taking food from other people's plates. S3Prior DON indicated if Resident #1 became unable or unwilling to eat, then this would have been a significant change for him, and the nursing staff should have immediately notified the physician.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46361</p> <p>Based on observations, interviews, and record review, the facility failed to ensure medications were stored in a secure manner for 1 (Nursing Station x) of 2 (Nursing Station x and Nursing Station y) nursing stations observed.</p> <p>Findings:</p> <p>Review of the facility's undated Medication Storage policy and procedure revealed, in part, the purpose of the policy was to ensure medications were stored safely, securely, and properly. Further review revealed medications are stored in a medication cart or other designated area and only those lawfully authorized to administer medications were allowed access to medications.</p> <p>Observation on 08/05/2024 at 2:05 p.m. of Nursing Station x revealed a medication card and a medication bottle left unattended by staff on the counter. Further observation revealed both medications were for Resident #3 and filled by the pharmacy on 08/05/2024. Observation of the medication card revealed 15 Ropinrole (a medication used to treat restless leg syndrome) 0.5 milligram (mg) tablets were on the card. Observation of the medication bottle revealed 240 milliliters (ml) of Guaifenesin (a liquid used to treat cough and chest congestion) 100mg/5ml liquid was observed in the medication bottle.</p> <p>In an interview on 08/05/2024 at 3:00 p.m., S6Minimum Data Set Nurse indicated she reviewed the camera footage of Nursing Station x and observed S7Licensed Practical Nurse (LPN) place Resident #3's above mentioned medications on the counter at Nursing Station x and then left the above medications unattended, and should not have.</p> <p>In an interview on 08/06/2024 at 10:50 a.m., S7LPN indicated she received the above mentioned medications for Resident #3 from the pharmacy and placed them on the counter at Nursing Station x. S7LPN further indicated the nurse responsible for the medications was not available so she placed the above mentioned medications on the counter at Nursing Station x under the supervision of a certified nursing assistant (CNA). S7LPN stated she should have secured Resident #3's above mentioned medications inside the locked medication room instead of leaving them with an unauthorized CNA.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46361</p> <p>Based on interviews and record reviews the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently by failing to implement a system to provide quality care to meet the needs of each resident by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure staff communicated a resident's change in condition in a timely manner to the physician and responsible party for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) residents reviewed for notification of change;</li> <li>2. Ensure staff followed-up on and/or implemented a dietician's recommendation for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) residents reviewed for nutritional status; and,</li> <li>3. Ensure staff assisted a resident with maintaining their food and/or fluid intake to suit their dietary needs for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) residents reviewed for nutritional status.</li> </ol> <p>This deficient practice resulted in an Immediate Jeopardy situation on 07/12/2024 at 6:08 p.m. for Resident #1, when Resident #1 was unable to adequately eat and/or drink. Resident #1's physician and responsible party were not notified of Resident #1's decline in oral intake in a timely manner as required, a dietitian's recommendation, and/or assisted Resident #1 with his food and/or fluid intake to suit their dietary needs. On 07/14/2024, Resident #1 was observed to be lethargic with involuntary jerky movements and was sent to the emergency room for treatment. Resident #1 was hospitalized in critical condition and diagnosed with severe dehydration, severe hypernatremia [Sodium (Na) 168 moderate acute renal failure [Blood Urea Nitrogen (BUN) 104 and Creatinine 3.2], and metabolic encephalopathy. Resident #1 was noted to have a 41.4 pound weight loss from 07/02/2024, which was the last documented weight in the facility, compared to the weight collected in the emergency roaignom on [DATE].</p> <p>S1Administrator was notified of the Immediate Jeopardy on 08/08/2024 at 3:10 p.m.</p> <p>The Immediate Jeopardy was removed on 08/09/2024 at 3:04 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal prior to the survey exit.</p> <p>This deficient practice had the likelihood to cause more than minimum harm to any of the residents residing in the facility who could have unintended weight loss, poor food/fluid intake, required dietician recommendations, and/or a significant change in condition.</p> <p>Findings:</p> <p>Cross Reference F580 and F692.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 08/07/2024 at 3:55 p.m., S5LPN indicated she was responsible for Resident #1 on the day shift on 07/12/2024. S5LPN indicated the nursing staff had difficulty getting Resident #1 to eat lunch and dinner. S5LPN indicated Resident #1 was nonverbal and unable to communicate his wants and needs to staff. S5LPN indicated she did not feel it was necessary to notify Resident #1's physician or responsible party that he had not eaten well on 07/12/2024.</p> <p>In an interview on 08/06/2024 at 4:41 p.m., Resident #1's daughter/responsible party indicated she had not been notified by the facility of Resident #1's decline in oral intake on 07/12/2024 or 07/13/2024. Resident #1's daughter/responsible party indicated had she been made aware on 07/12/2024 and 07/13/2024 she would have gone to the facility to check on her father and she could have ensured that his needs were addressed.</p> <p>In an interview on 08/07/2024 at 2:00 p.m., S4Quality Improvement (QI) Nurse indicated she was responsible for notifying the physician of any significant weight changes and recommendations made by the Registered Dietitian. S4QI Nurse further indicated she was not aware of the Registered Dietitian's recommendation for Resident #1 to receive Twocal 2 ounces twice daily for 60 days by staff. S4QI Nurse confirmed she did not notify Resident #1's physician of the above mentioned recommendation and should have.</p> <p>In an interview on 08/08/2024 at 2:03 p.m., Resident #1's physician confirmed he was not notified of the Registered Dietitian's recommendation on 04/14/2024 of Twocal 2 ounces twice daily for 60 days. Resident #1's physician further indicated Resident #1 was severely dehydrated when he was hospitalized on [DATE]. Resident #1's physician further indicated Resident #1's level of dehydration was so severe Resident #1 had to have very poor oral intake for a minimum of a week, and the level of Resident #1's dehydration did not happen in 3 days.</p> <p>In an interview on 08/08/2024 at 4:39 p.m., S3Prior Director of Nursing (DON) stated Resident #1 had a very good appetite and required double portions due to a history of taking food from other peoples plates. S3Prior DON indicated if Resident #1 became unable or unwilling to eat, then this would have been a significant change for him, and the nursing staff should have immediately notified the physician.</p> <p>In an interview on 08/09/2024 at 12:19 p.m., S2DON confirmed the nursing staff did not notify Resident #1's physician and responsible party timely on 07/12/2024 and/or 07/13/2024 of Resident #1's decline in oral intake, and confirmed this resulted in an immediate jeopardy situation.</p> <p>In an interview on 08/09/2024 at 12:19 p.m., S1Administrator confirmed the nursing staff did not notify #1's physician and responsible party timely on 07/12/2024 and/or 7/13/2024 of Resident #1's decline in oral intake and confirmed this resulted in an immediate jeopardy situation.</p>		