Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Healthcare	620 Laurel Street Lee, MA 01238

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42690 Based on interview and record review, the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNC - - notice issued to a resident who is receiving benefits under Medicare Part A when all covered services end) and a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN - notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) were issued for one Resident (#36) out of a total applicable sample of three residents. Specifically, the facility failed to issue advance NOMNC and SNF ABN notice to Resident #36's Guardian (a court appointed person who makes important personal and healthcare decisions for an adult who lacks sufficient capacity to make their own decisions) so the Resident/ Guardian could decide if they wish to continue receiving skilled services that may not be paid for by Medicare, and were aware of the financial responsibility they may have to assume. Findings include: Resident #36 was admitted to the facility in August 2023. Review of the NOMNC form indicated the following boxes were checked and filled in: -Unable to contact responsible person (name and phone number were blank) on 6/11/24 for 3 attempts (time) 10:15 A.M., 11:50 A.M. and 1:30 P.M.[sic] -Notice sent via certified mail, return receipt requested, to address on record, on 6/11/24, and signed by the Minimum Data Set (MDS) Nurse. Review of the SNF Beneficiary Protection Notification Review indicated the following: -Last covered day of Medicare Part A Service - 6/13/24 -The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. -Facility attempted to obtain the Guardian's signature, no response. (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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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 7/24/24 at 1:33 P.M., the Administrator said that the MDS Nurse was not available (for the duration of the survey) but could speak on the concern. He said that the process in this case should have been for the facility staff to send out a certified letter to the Guardian and maintain the return receipt for the facilities records. The administrator said that he could not find the certified mail receipt or any other evidence that the letter had been mailed to the Guardian as required (or as indicated by the MDS Nurse on the NOMNC Form dated 6/11/24).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, interview and policy review, the facility failed to maintain a clean and homelike environment on one (Unit One) out of two Units observed. Specifically, the facility staff failed to clean a resident's room with visible marking/drippings on the wall. Findings include: Review of the Complete Room Cleaning list, located on the cleaning closet door, undated, indicated the following: -Wipe walls as needed. -Windows and window sill [sic] Review of the Daily Patient Room Cleaning, revised on 9/5/2017, indicated the following: 3) Spot clean. With a cloth and disinfectant spot clean all vertical surfaces. On 7/23/24 at 8:50 A.M., the surveyor observed the following on Unit One, in room [ROOM NUMBER]: -The windowsill and wall, directly under the window/windowsill, located directly to the right of the Resident's bed to have multiple brown, dried drip marks down the wall. -During the observation the Resident was lying in his/her bed and facing the wall with the visible marks. On 7/24/24 at 2:42 P.M., the surveyor observed the following in room [ROOM NUMBER] on Unit One: -The windowsill and wall, directly under the window/windowsill, located directly to the right of the Resident's bed remained with multiple brown, dried drip marks down the wall. -During the observation the Resident was lying in the bed and facing the wall with the visible marks. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 9:18 A.M., the surveyor and the Director of Housekeeping observed multiple brown, dried drip marks on the windowsill and the wall under the window/windowsill and directly to the right of the Resident's bed in room [ROOM NUMBER]. The surveyor observed the Resident lying in the bed and facing the wall with the marks. During an interview at the time, the Director of Housekeeping said that the Resident rooms are cleaned daily and deep cleaned monthly. The surveyor and the Director of Housekeeping reviewed the cleaning schedule and she said that room [ROOM NUMBER] was scheduled to be deep cleaned on the 7/22/24. The Director of Housekeeping said that the wall should not have drippings like that and something like that would be expected to be cleaned during daily cleaning and during the deep clean.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42741 Based on record review and interview, the facility failed to provide a written Notice of Transfer and Discharge to the Resident and Resident's Representative at the time of discharge for one Resident (#40) out of a total sample of 14 residents. Specifically, the facility staff failed to provide Resident #40/ Resident Representative a written Notice of Intent to Transfer and Discharge when the Resident was transferred from the facility to the hospital. Findings include: Resident #40 was admitted to the facility in July 2023. Review of the Discharge Transfer Evaluation, effective date 5/12/24, indicated Resident #40 was transferred from the facility to the hospital on 5/12/24. Further review of the Resident's medical record indicated no documentation that a written Notice of Intent to Transfer and Discharge was provided to the Resident and Resident Representative at the time of discharge or shortly thereafter. During an interview on 7/24/24 at 10:09 A.M., the Social Worker (SW) said she does not provide the Resident or Resident Representative with a Notice of Intent to Transfer and Discharge when a resident is transferred to the hospital and that nursing was the one to provide the notice. During an interview on 7/24/24 at 1:56 P.M., the Infection Preventionist (IP-who also assisted as the Unit Manager (UM) #1 for the facility) said neither Resident #40 nor his/her Resident Representative received a Notice of Intent to Transfer and Discharge when Resident #40 was transferred to the hospital on 5/12/24. The IP/UM #1 said no education had been provided to nursing staff that this notice was required as part of a hospital transfer for a resident.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 42741 Based on interview and record the facility failed to ensure that a Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings) Level I Screening (A preliminary screening of all nursing facility applicants, conducted prior to their admission to a nursing facility that identifies whether an applicant for admission to a nursing facility has, or may have, Intellectual Disabilities [ID], Developmental Disabilities [DD], and/or Serious Mental Illness [SMI]) was completed prior to one Resident's (#35) admission to the facility out of a total sample of 14 residents. Specifically, for Resident #35 the facility failed to ensure that a Preadmission Level I Screening was completed prior to the Resident's admission to the facility when the Resident was diagnosed with SMI, and a Post Admission Level I Screening and Resident Review (a screening completed after a Resident is admitted to the facility and has a new SMI diagnosis or significant change in status related to SMI) was completed when the Resident was newly diagnosed with Borderline Personality Disorder (a SMI characterized by unstable moods, behaviors, and relationships), resulting in delayed evaluation and determination of appropriate care and services. Findings include: Resident #35 was admitted to the facility in May 2024, with diagnoses of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops from having experienced a traumatic event, causing flashbacks, nightmares and severe anxiety), Major Depressive Disorder, and Anxiety Disorder. Review of Resident #35's Level I Preadmission Screening indicated the Preadmission Level I Screening was completed 5/22/24, nine days after Resident #35 had been admitted to the facility. Further review of the Level I Preadmission Screening did not indicate the Resident had a diagnosis of Borderline Personality Disorder. Review of the Physician's visit note, dated 5/15/24, indicated Resident #35 had a diagnosis of PTSD with an onset of 1/24/23. Review of the Physician's visit note, dated 5/25/24, indicated Resident #35 had a new diagnosis of Borderline Personality Disorder with an onset of 5/25/24. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/24 at 10:09 A.M., the Social Worker (SW) said Preadmission Level I Screenings should be completed prior to a Resident being admitted to the facility. The SW further said she was away when the Resident was admitted to the facility, she is the only staff member in the facility who is trained to complete Preadmission Screenings and Resident #35's Preadmission Level I Screening was not completed prior to the Resident's admission to the facility as required. The SW said she was unaware of Resident #35's PTSD diagnosis until after she had completed the initial Preadmission Level I Screening and at the time she became aware of the PTSD diagnosis she did not complete a Post Admission Level I Screening or request a Resident Review. The SW further said she was not aware that the Physician had diagnosed Resident #35 with Borderline Personality Disorder. The SW said no other staff members had made her aware of this new diagnosis which would have also required her to complete a Post Admission Level I Screening and request a Resident Review but this was not done.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45435 Based on observation, interview, record and policy review, the facility failed to provide care in accordance with professional standards of practice relative to the application and monitoring of a wound dressing for one Resident (#201) out of a total sample of 14 residents. Specifically, the facility staff failed to: -accurately assess Resident's #201 skin. -obtain a Physician's order for a dressing that was applied to the Resident's left elbow. -provide on-going assessment of the left elbow area resulting in the applied dressing not being changed timely and putting the Resident at risk for worsening wound status and infection. Findings include: Review of the facility policy titled, Medication and Treatment Orders, dated 4/2018, indicated the following: -Orders for medications and treatments will be consistent with regulatory standards. Review of the Lippincott Nursing Procedures Manual - 9th edition (2023) indicated the following: -Comprehensive skin assessment shouldn't be a one-time event limited to admission. Repeat it regularly to determine any changes in skin condition. -If the patient has fragile skin, use dressings and tape specially formulated for fragile skin to prevent skin stripping and tearing during removal. -Document the date, time, and type of wound management procedure . Resident #201 was admitted to the facility in July 2024, with the diagnosis of displaced intertrochanteric fracture of the right femur (right hip fracture). Review of Resident #201's Care Plan, dated 7/10/24, indicated the following: -Complete Skin Condition check weekly. -House barrier cream (used to protect the skin from skin irritation and breakdown) to heels, hips, elbows and coccyx (tail bone) every shift and as needed. Review of the Physician's orders dated July 2024, showed no evidence of an order for the placement of a dressing to the Resident's left elbow. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing progress notes, dated 7/10/24 through 7/24/24, showed no documentation of a change in the skin condition of the Resident's left elbow or the placement of a dressing on the Resident's left elbow. Review of the Non-Pressure Ulcer Evaluation (weekly skin observation), dated 7/18/24, showed no documentation of a change in the Resident's left elbow skin condition or the presence of a dressing on the Resident's left elbow. Review of the Treatment Administration Record (TAR), dated July 2024, showed no evidence of a dressing on the Resident's left elbow. On 7/23/24 at 10:12 A.M., the surveyor observed a four-inch by four-inch (4x4) foam dressing on the Resident's left elbow. The surveyor observed that the dressing was intact and was labeled with the date 7/14 (ten days prior). On 7/25/24 at 7:47 A.M., the surveyor observed the same 4x4 foam dressing dated 7/14 (12 days prior) on the Resident's left elbow and the dressing was lifted at the edges. On 7/25/24 at 1:33 P.M., the surveyor observed Nurse #2 remove the dressing on the Resident' left elbow. The surveyor further observed the following: -a moderate amount of dry tan drainage on the dressing that was removed from the Resident's elbow. -a pink/red area approximately 1.5 centimeter in length (cm) by 1 cm in width (1.5 cm x 1 cm), without depth that appeared to be covered with epithelial tissue (tissue formed in the final stages of healing made up of sheets of cells that cover body surfaces and appears pink or pearly white). -the surrounding skin was intact with no signs of infection. During an interview on 7/25/24 at 1:40 P.M., Nurse #2 said that she had put the dressing on the Resident on 7/14/24 and at that time the Resident's skin was intact but fragile. Nurse #2 said that she had put the dressing on for protection. Nurse #2 said that she never expected the dressing to stay on so long and that she had not worked with this Resident for a while. Nurse #2 said that she should have obtained a Physician's order for the dressing so that it would be checked and changed by other Nurses, and that she should have documented her assessment of the elbow and application of the dressing in the Nurses Notes. Nurse #2 said that she did not know why there was drainage on the old dressing because when she put the dressing on the Resident, his/her skin was intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24 at 1:44 P.M, the Infection Preventionist (IP-who also assisted as the Unit Manager [UM] #1 for the facility) said she had not been aware that the Resident had a dressing on his/her elbow. The IP/UM #1 observed the soiled dressing and said that she was not sure why there was drainage on the dressing because the Resident's elbow was now intact. The IP/UM #1 said that the drainage on the old dressing could have been from the Resident rubbing his/her elbow against the dressing or from scratching him/herself. UM #1 said that Nurse #2 should have obtained a Physician's order for the dressing so that other Nurses would know to check the skin and change the dressing. The IP/UM #1 further said that the facility protocol is for all residents to have a weekly full body skin observation performed and documented on the Non-Pressure Ulcer Evaluation. The IP/UM #1 said the Non-Pressure Ulcer Evaluation dated 7/18/24, should have identified the dressing on the Resident's elbow since the dressing was dated 7/14, but that it had been missed.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interview and record review, the facility failed to ensure that a discharge summary was completed for one Resident (#35) out of a total sample of 14 residents. Specifically, for Resident #35, the facility failed to ensure that: -a post discharge plan of care was developed with the participation of the Resident. -a discharge summary was completed at the time of discharge that included any arrangements that had been made for the Resident's follow-up care. -communication was provided to continuing care providers. Findings include: Resident #35 was admitted to the facility in May 2024, with diagnoses of Parkinson's Disease (a chronic degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination) and status post fall with a right femur (thigh bone) fracture. Review of the most recent comprehensive Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #35 scored 11 out of 15 on the Brief Interview of Mental Status (BIMS) Assessment indicating that the Resident was moderately cognitively impaired, usually was understood, and usually understands. During an interview on 7/23/24 at 10:52 A.M., Resident #35 said he/she had ended therapy on 7/22/24, but was unsure what the plan was for discharge. Resident #35 said he/she wanted a certain Visiting Nurse Agency (VNA-community agency that would provide in-home nursing care and therapy services) but no one had discussed discharge planning with him/her and he/she was unsure when they would be discharging him/her. Review of the Social Services Evaluation, effective date 5/15/24, indicated the following: -Discharge to Assisted Living Facility (ALF) or other Group Setting. Review of the baseline Discharge Planning Care Plan within the Social Services Evaluation, effective date 5/15/24, indicated the following: -The Resident's goal was to return to ALF. -Establish a pre-discharge plan with the resident/family/caregivers and evaluate progress and revise plan as needed. -Make arrangements with required community resources to support independence post-discharge (specify: home care, Physical Therapy (PT), Occupational Therapy (OT), Medical Doctor, Wound Nurse) (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan titled Discharge Planning, initiated 6/3/24 indicated the following: -Identify and discuss care goal and education needed to prepare for level of discharge desired -Identify need for community resources -Interdisciplinary team and resident discuss plan Review of the Care Plan Meeting note dated 7/9/24, indicated that Resident #35 was scheduled to end therapy on 7/18/24, and return to his/her ALF apartment on 7/19/24. Further review of the Care Plan Meeting note indicated no documentation as to what services were discussed for the Resident for when he/she was discharged back to his/her ALF. Further review of the Resident's medical record indicated no documentation as to why the Resident did not discharge 7/19/24, or any ongoing documentation for a new discharge date or what VNA services would be in place for the Resident at the time of discharge. During an interview on 7/24/24 at 9:53 A.M., the surveyor went to conduct a follow-up interview with Resident #35 but Nurse #1 said that Resident #35 was discharged back to his/her ALF on 7/23/24. Nurse #1 said the discharge was a planned discharge for the Resident and nursing had completed their portion of the Discharge/Transfer Evaluation and provided it to the Resident at the time of his/her discharge on 7/23/24. Review of the Discharge/Transfer Evaluation, effective date 7/23/24, indicated nursing had completed their discharge summary of the Resident stay but no discharge summary was completed by the Therapy Department or by the Social Work Department, including information about ongoing community services that would be available to the Resident once back at home, such as VNA services. During an interview on 7/24/24 at 1:35 P.M., the Social Worker (SW) said last week it was determined the Resident could discharge back to his/her ALF on 7/23/24. The SW said Visiting Nurse Services including Physical Therapy (PT) and Occupational Therapy (OT) were put into place through a local VNA that the Resident requested but the SW was unaware of who at the facility had made the referral to the VNA as she was not in the facility when the decision was made for the Resident to discharge on 7/23/24. The SW further said the Discharge/Transfer Evaluation should have been completed prior to the Resident discharging back to his/her ALF so he/she had post discharge information available to him/her when he/she was home, and this was not done. During an interview on 7/25/24 at 8:51 A.M., the Director of Rehabilitation (DOR) said Therapy should have completed their portion of the Discharge/Transfer Evaluation, but this was not done prior to the Resident discharging. The DOR further said she thought VNA services were put into place but she was unaware of who made the referral to the VNA and if the VNA had received any information about the Resident's status regarding his/her therapy needs once he/she was home. During a phone interview on 7/25/24 at 9:24 A.M., the surveyor spoke with the VNA contact person who said no referral had been made to the VNA until approximately five minutes before the surveyor called and that the VNA had received no information about Resident #35's discharge. The VNA contact person further said because the referral was just made it would take the VNA about week before they would be able to provide services. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 42741 Based on interview and record review the facility failed to develop a comprehensive Trauma Informed Care Plan for one Resident (#35)out of a total sample of 14 residents. Specifically, for Resident #35, the facility failed to complete an assessment and ensure that a comprehensive Trauma Informed Care Plan was developed relative to the Resident's history of PTSD (Post -Traumatic Stress Disorder- a mental and behavioral disorder that develops from having experienced a traumatic event, causing flashbacks, nightmares and severe anxiety). Findings include: Resident #35 was admitted to the facility in May 2024, with a diagnosis of PTSD. Review of the Social Services Evaluation, dated 5/15/24, indicated the following: -The Resident had past experiences that were so upsetting they changed him/her emotionally, spiritually, physically, or behaviorally. Further review of the Social Services Evaluation indicated a Care Plan should be created related to Trauma Informed Care. Review of the Resident's Comprehensive Care Plan indicated no documentation that a Trauma Informed Care Plan had been developed for Resident #35. During an interview on 7/24/24 at 10:17 A.M., the Social Worker (SW) said any resident who had a history of trauma should have had a Comprehensive Trauma Informed Care Plan developed. The SW further said a Trauma Informed Care Plan should have been developed for Resident #35 and was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225749	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Lee Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Laurel Street Lee, MA 01238	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42690 Based on observation and interview, the facility failed to maintain sanitary and safe conditions for two unit kitchenettes (Unit One and Unit Two) out of two unit kitchenettes. Specifically, the facility failed to maintain clean and sanitary conditions for the toasters in both Unit One and Unit Two kitchenettes that presented a fire risk. Findings include: On 7/24/24 at 2:38 P.M., the survey observed the following on the Unit Two Kitchenette: -A crumb laden toaster. On 7/24/24 at 3:00 P.M., the surveyor observed the following in the Unit One kitchenette: -Crumbs lining the top of each toaster slot. -Larger crumbs inside of the toaster slot. During an observation and interview on 7/25/24 at 9:18 A.M., the surveyor and the Director of Housekeeping observed both kitchenettes on Unit One and Unit Two. The Director of Housekeeping said that the housekeeping staff are responsible to clean the floors, walls, counters, and microwave. The Director of Housekeeping said she was unsure who was responsible for the toasters, she thought maybe the kitchen staff were to ensure they were cleaned but was not sure. The Director of Housekeeping said when the toasters are not cleaned it can be a bacteria concern and that it could be a potential for a fire concern. The Director of Housekeeping further said that the toasters should not have that much buildup of crumbs in them and should be cleaned. During an interview on 7/25/24 at 9:22 A.M., the Food Service Director said that she was unsure which department is responsible for cleaning the toasters. During an interview on 7/25/24 at 11:26 A.M., the Regional Nurse said that the kitchenettes are completely cleaned twice monthly and then as needed. The Regional Nurse said that the Kitchen staff should maintain the toaster when they restock or check fridge temperatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225749	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42741 Based on interview and record review, the facility failed to ensure that a Certified Nurses Aide (CNA) documentation was complete and accurate for one Resident (#1) out of a total sample of 14 residents. Specifically, for Resident #1, the facility failed to ensure CNA documentation related to meal intake was documented every shift for the Resident who had a history of significant weight loss and was at increased risk for nutritional decline. Findings include: Resident #1 was admitted to the facility in May 2022, and had a diagnosis of muscle wasting and atrophy (the loss of muscle tissue or muscle mass that cause muscles to weaken, shrink or shorten and can lead to a decrease in strength and mobility) and chronic pain. Review of the Dietician's Progress Note dated 6/4/24, indicated that Resident #1 had been identified as having a weight loss. Review of the Weights and Vitals Summary indicated: -3/5/24: Resident #1 weighed 135.2 pounds (lbs.) -6/4/24: Resident #1 weighed 124.6 lbs. (indicating a significant weight loss of 7.8% in three months). Review of Care Plan titled Increased Risk for Nutritional Decline .initiated 5/13/22, indicated the following intervention: -Monitor intake and record every meal, last revised on 5/14/24. During an interview on 7/25/24 at 8:41 A.M., CNA #1 said meal intake documentation is recorded each shift for all residents in the facility and that the CNA's record the percentage of each meal the residents eat. Review of Resident #1's June 2024 CNA meal intake documentation indicated that 58 of 90 meals had the meal intake percentage recorded for the month of June. Review of Resident #1's July 2024 CNA meal intake documentation indicated 36 of 73 meals had the meal intake percentage recorded for the month of July. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225749	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24 at 9:37 A.M., the Dietician said Resident #1 had a recent significant weight loss. The Dietician said when she completed her nutrition assessments, she utilized meal intake percentages to help her with making adjustments to the Resident's dietary needs. The Dietician further said CNA documentation of meal intakes are not always completed and she often has to get additional information on meal intake for residents by going directly to staff members and asking them verbally. The Dietician said meal intakes should be documented every shift, so the information is readily available when she needs it. During an interview on 7/25/24 at 9:55 A.M., the Regional Nurse said the CNA's should be documenting meal intakes every shift. The surveyor and the Regional Nurse reviewed Resident #1's June 2024 and July 2024 CNA meal intake documentation and the Regional Nurse said the CNA's were not documenting meal intakes every shift and they should be.