STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care & Rehabilitation Center	714 Southbend Avenue Mankato, MN 56001

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and document review the facility failed to identify a change in condition, comprehensively assess weight gain, monitor, and notify the physician for 1 of 1 residents (R1). As a result R1 had a total weight gain of 37 pounds over 13 days that resulted in heart attack, respiratory failure, and death. This resulted in a past non-compliance at an Immediate Jeopardy (IJ). The Immediate Jeopardy (IJ) began on [DATE] when R1 had a 7.1 pound (lb.) weight increase that was not reported to the physician nor comprehensively assessed and monitored. The Administrator and Director of Nursing (DON) were notified of the IJ on [DATE] at 5:48 p.m. The facility had implemented immediate corrective action on [DATE] to prevent recurrence, the IJ was issued at past non-compliance (PNC). Findings include: R1's face sheet dated [DATE], identified diagnoses of mild intellectual disabilities and lack of expected normal physiological development in childhood (disorder that interferes with brain development), congestive heart failure (long term condition where the heart can't pump blood well enough to meet the body's needs) (CHF), cardiomyopathy (disease of the heart muscle that makes it difficult for the heart to pump blood to other parts of the body), long QT syndrome (heart rhythm disorder that can cause fast, chaotic heartbeats), peripheral vascular disease (causes narrowing or blocking of the blood vessels outside the heart), edema (swelling caused by too much fluid trapped in the body's tissues), atrial fibrillation (irregular and fast heartbeat), hypertension (high blood pressure), and presence of automatic cardiac defibrillator (implanted device in the chest that detects and stops irregular heartbeats). R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had no cognitive impairment. R1 had no prognosis for a life expectancy of less than 6 months, did not use oxygen and weighed 248 lbs. R1's dietary care plan dated [DATE], identified R1 had alteration in cognition related to mild intellectual disabilities, included a 2 gram no added salt diet. Education provided to R1 regarding requests for large mugs of V8 juice at meals and salty snacks that he kept in his room, and R1 was angry at education provided. R1's dietary goal was to maintain current weight +/- five pounds and obtain weight per physician orders. R1's care plan did not address cardiac concerns, edema or edema management. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's physician orders reviewed [DATE] thru [DATE] included the following orders: -[DATE], daily weights, notify physician if the weight had increased three pounds (lbs.) in one day or five lbs. in one week. - [DATE] Lasix 60 milligrams (mg) in the morning and 40 mg daily at noon. This order discontinued on [DATE]. R1's progress note dated [DATE] at 3:26 p.m., identified registered nurse (RN)-A spoke with a nurse in cardiology and informed her R1 ate salty snacks at times, the current Lasix dose was 60 mg in the a.m. and 40 mg at noon. Cardiology would check with the provider and see what can be done for testing and schedule an appointment with cardiology sooner than April. R1's cardiology communication record dated [DATE], identified R1's current dose of Lasix was 40 mg twice daily (BID) and should increase Lasix to 80 mg in the morning and 40 mg in the afternoon for three days and then resume Lasix 40 mg BID (which was inconsistent with the previous physician order and 20 mg less daily than what R1 had received since [DATE]). Update on weights requested for [DATE]. The orders also included to draw basic metabolic panel on [DATE]. A handwritten note on the bottom of this communication identified R1 was currently receiving Lasix 60 mg in a.m. and 40 mg at noon not 40 mg BID. Attempted to call cardiology five times. The handwritten note also included initials of a a nurse and was dated [DATE]. R1's record did not identify the physician order to increase the Lasix to 80 mg in the morning for three days. Review of R1's medication administration record identified R1 continued to receive Lasix 60 mg in the morning and 40 mg at noon on [DATE], [DATE], and [DATE]. R1's cardiology visit note dated [DATE], identified the facility had not received the faxed order with the updates for Lasix and basic metabolic panel (BMP) from [DATE]. A facility nurse would administer the extra dose of Lasix at noon in addition to the extra doses on [DATE] and [DATE]. BMP would be drawn on [DATE], and weights to be sent to cardiology office for review. R1's progress note dated [DATE] at 6:34 p.m., identified cardiology called and said they had new orders for R1, and to give a Lasix 20 mg at noon (to equal 60 mg for the noon dose instead of 40 mg). R1's treatment administration record (TAR) dated [DATE], directed to contact cardiology to clarify that R1 was taking Lasix 60 mg in a.m. and 40 mg at noon and should return to that dose again after the three days of taking the 80 mg in AM. Was NOT taking 40 mg BID. This was a one-time only nursing order signed by RN-B at 4:31 p.m. on [DATE]. R1's medication administration record (MAR) identified R1 was administered Lasix 80 mg in the morning and 40 mg at noon on [DATE], [DATE], [DATE], [DATE]. R1's medication administration records for January and February identified R1 was administered Lasix 40 mg twice daily from [DATE]-[DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:45 p.m., director of nursing (DON) stated upon review of R1's Lasix orders the last time R1 had an order for Lasix 40 mg twice a day was [DATE]. DON was unsure how or why the cardiologist did not have the most recent orders for Lasix 60 mg in the morning and 40 mg at noon. DON indicated the order should have been clarified because it was the last dosing used. During a return phone interview on [DATE] at 10:34 a.m., nurse practitioner (NP)-C stated she was unaware of any phone call the facility made to cardiology regarding the Lasix order decrease from 60 mg in the a.m. and 40 mg at noon to the 40 mg twice a day. R1's weight record identified -On [DATE], R1 was 247.5 lbs. This was an increase of 0.4 lbs. in one day and 10.1 lbs. in one week. -On [DATE], R1 was 255.1 lbs. This was an increase of 7.6 lbs. in one day and 8.2 lbs. in one week. R1's progress note dated [DATE] at 5:20 p.m., identified cardiology had been called (previously) for weight increase and Lasix order was updated to help with fluid. R1's weight record identified: -On [DATE], R1 was 256.2 lbs. This was a decrease of 1.1 lbs. in one day but an increase of 9.3 lbs. in one week. -On [DATE], no weight was recorded according to physician's orders. -On [DATE], no weight was recorded according to physician's orders. -On [DATE], R1 was 267.1 lbs. This was 0 lbs. change for daily and an increase of 20 lbs. in one week R1's progress note dated [DATE] at 4:53 p.m., identified NP-A was called and updated on weights. Weights have been off lately in record. Leg edema is down today, denies shortness of breath (SOB). No other assessment of edema or full respiratory assessment (oxygen saturations, respirations, lung sounds) was compelted. During an interview on [DATE] at 1:26 p.m., RN-B stated on [DATE] she thought she had casually mentioned to NP-A, while she was on the phone with her discussing another resident, that R1 was not going to bed like he was supposed to or putting his feet up in the recliner. RN-B stated R1 carried a lot of edema in the abdomen and upper thighs, and had thought they were at baseline, but could not press on his lower extremities too much because his legs were full of ulcers but had not seen any red flags. RN-B explained when someone has uncontrolled systolic heart failure, usually they decline fast. During a phone interview on [DATE] at 11:57 a.m., NP-A stated she was on-call on [DATE] (which was a weekend day) and did not receive a call from the facility regarding R1's increased weight. NP-A reviewed her call log for the day and there was not a call from the facility on the log and did not have any notes in her records of a call regarding R1. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's weight record identified -On [DATE], R1 was 269.2 lbs. This was an increase of 2.1 lbs. in one day and 20 lbs. in one week. -On [DATE], R1 was 268.0 lbs. This was a decrease of 1.2 lbs. in one day and an increase of 20.5 lbs. in one week. R1's progress note dated [DATE] at 3:50 p.m., identified cardiology office and NP-A were notified of R1's 20. 5 lbs. weight gain in one week. A list of weights and past months Lasix orders was sent to the cardiologist office. R1's physician encounter note dated [DATE], identified NP-A had a visit for wound care. Weight is up again, with a recent 20 lb. weight gain; facility reported they had a call out to cardiology. Lower extremity edema worsening. Edema was bilateral ,d+[DATE]+ edema to the pedal (foot), bilateral 2+ edema to the ankles, bilateral ,d+[DATE]+ pretibial (front lower legs and shin) edema. No new orders were noted. R1's weight record identified on [DATE], R1 weighed 264.1 lbs. This was a decrease of 3.9 lbs. in one day and increase of 9 lbs. in one week. R1's progress note dated [DATE] at 7:03 p.m., identified the nurse manager, licensed practical nurse (LPN)-A was updated on what cardiology would like and the nurse manager would speak to the director of nursing (DON). During an interview on [DATE] at 1:26 p.m., RN-B stated she received a phone call from cardiology on [DATE] asking who was in charge that could take over managing R1's fluid management. RN-B passed the information from the phone call to licensed practical nurse (LPN)-A, who was the care manager for R1. During an interview on [DATE] at 3:54 p.m., LPN-A stated RN-B told her cardiology called and wanted to talk to the DON in regard to the primary care physician taking over management of R1's care because cardiology did not see R1 often enough to write orders and monitor the effectiveness of the Lasix. LPN-A stated she wrote the information in an email to the DON, however she was on vacation until [DATE], so the facility physician was not made aware and did not take over R1's diuretic management. According to R1's weight record on [DATE], the weight was not completed per physician order. R1's progress note dated [DATE] at 3:40 p.m., identified cardiology called and set up an appointment for R1 on [DATE] at 9:00 a.m. R1's weight record identified -On [DATE], R1 weighed 265.1 lbs. This was an increase of 1 lb. and marked as not applicable (NA) for the week. - On [DATE], R1 weighed 272.2 lbs. This was an increase of 7.1 lbs. in one day and 5.1 lbs. in one week. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE], R1 weighed 270.6 lbs. This was an increase (sic) of 1.6 lbs. in one day and 5.1 lbs. increase in one week. R1's progress note dated [DATE] at 4:46 p.m., identified as nutrition review related to weight and wounds. Current weight 271 lbs. which was an increase of 27 lbs. in 30 days. Significant weight gain of 11% in 30 days. Weight gain likely related to increased bilateral lower extremity edema. Noted from NP-A's dictation on [DATE]: R1's wounds typically heal best when his weight is around 230 lbs., and he is currently significantly higher than that. R1's progress note dated [DATE] at 11:02 p.m., identified R1 had an x-ray to verify PICC line placement. Indicated stable cardiomegaly (enlarged heart) and clear lungs. R1's weight record identified on [DATE], R1 weighed 271.5 lbs. This was an increase of 0.9 lbs. in one day and 2.5 lbs. increase in one week. R1's progress note dated [DATE] at 3:33 p.m., identified R1 had been unable to urinate since 8:00 a.m. and it appeared he had only urinated 150 cubic centimeters (cc) at that time. R1 requested to go to the emergency department. Vital signs were 97.1, 51, 18, ,d+[DATE]. R1 complained of SOB with exertion and bending over at the waist. Was unable to urinate at 2:00 p.m. Discussed with medical doctor (MD)-A and recommended straight catheterization at facility first and then determine the need for emergency department. R1 was straight catheterized with some difficulty and had 450 cc's of dark yellow/orange urine with a scant amount of blood and pain but stated no pain after removal of catheter. R1 did not want to go to the emergency department anymore. MD-A recommended to bladder scan or straight catheterize R1 every 8 hours if he does not void and to continue to monitor for retention and worsening edema. R1's late progress note dated [DATE] at 10:33 a.m. for [DATE], identified for clarification: discussed with MD-A by phone about residents' inability to urinate, feeling SOB with bending at waist and the continued dependent edema surrounding entire abdomen and upper thighs, however weight had increased by only 1 lb. in one day and increased 2.5 lbs. in 7 days. During an interview on [DATE] at 1:07 p.m., RN-A stated on [DATE], R1 looked a little pale, close to baseline. RN-A also recalled R1 seemed like he was short of breath, however, he did not report shortness of breath to her. RN-A did not complete a respiratory assessment. R1 had dependent edema around his abdomen and upper thighs which seemed to be worse 2+ around those areas. Around 2:00 p.m. R1 told RN-A he was having difficulty with urinating. RN-A called MD-A and reported the difficulty with urinating and 1.2 lbs. weight gain in one day and 2.5 lbs. for the week, however, was not sure if she had told MD-A about the increase in edema and shortness of breath. During a phone interview on [DATE] at 10:19 a.m., RN-D stated when he got to work on [DATE] RN-A had straight catheterized R1 between 3:00 and 4:00 p.m. During his shift R1 had urinated just a little bit in the urinal but did not recall the amount or how the urine appeared. R1 told him he felt better. Around 6:00 p.m., R1 had asked for his inhaler for shortness of breath. R1's abdomen was slightly distended but did not look different from his baseline. RN-D did not complete a respiratory assessment, or identify the baseline of edema. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE], RN-E stated she worked the overnight shift on [DATE]. RN-E was unaware of any issues with R1 and could not recall anything from the nurse's report that would have been concerning for R1 such as R1's recent weight gain, difficulty with urinating, and shortness of breath. If RN-E would have been aware she would have assessed respiratory, oxygen levels and edema but would not have been aware of what his baseline edema was because it was not documented. RN-E felt that if R1 had shown any signs of distress during the night, the NAs would notify her immediately. R1's weight record identified on [DATE], R1 weighed 283.2 lbs. This was identified as not applicable for both daily and week difference. R1's progress note dated [DATE], identified LPN-A informed RN-C that NP-A wanted RN-C to contact cardiology regarding R1's fluid overload. Cardiology updated at 8:45 a.m. regarding the weight gain (which had been 20 lbs. in the past 7 days and 11.7 lbs. increase since [DATE]). RN-C informed cardiology R1 had symptoms of SOB and generalized edema. Cardiology would pass the information on to the physician but stated it would be faster to get an order from NP-A to have R1 sent to the emergency department. R1's physician encounter note dated [DATE], identified the visit was for follow-up wound care. Weight had increased 11.7 lbs. since the previous day. R1 complained of increased SOB and was wearing supplemental oxygen. R1 had increased edema in abdomen and legs from thigh to toes. NP-A felt that R1 needed to be seen in the emergency department for aggressive diuresis. Also to note, cardiology had called the facility on [DATE] and had requested that R1's primary care physician take over the management of his diuretics due to them not seeing him enough and the primary care physicians more frequent visits. Physician was not contacted or aware of this request. There is also a concern that a provider was not called on [DATE] when R1's weight went from 265.1 lbs. to 272.2 lbs. Exam of pulmonary R1 at baseline had no respiratory distress and normal respiratory rhythm and effort. Currently on supplemental oxygen 6 liters per minute and was at 99%. When oxygen was decreased to 1 LPM, R1 began to have respiratory distress. Abdomen was distended due to fluid retention and was hard to the touch. Peripheral edema present, edema into bilateral thighs 3+, edema in abdomen. Bilateral 3+ edema to pedal, bilateral 2+ edema to the ankles, bilateral , d+[DATE]+ pretibial. Review of R1's record between [DATE] through [DATE], identified R1 had gained 35.7 lbs. in 20 days. Although cardiology had been notified on [DATE], [DATE], [DATE], and [DATE], there was no indication the physician order was followed to notify the physician when R1's weight had increased by three lbs. in one day or five lbs. in one week. Further not evident the facility reconciled and/or clarified the Lasix order given by cardiology on [DATE], that directed to give R1 20 mg less a day even though R1 continued to gain weight. Further there was no indication of ongoing assessments and monitoring of edema and respiratory status were completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's hospital discharge summary dated [DATE], identified on [DATE], R1 presented to the emergency department for weight gain and concern for heart failure exacerbation. While enroute from facility with ambulance R1 was talking without complaint and suddenly complained of dyspnea (difficulty breathing) and became unresponsive. Upon arrival to the emergency department, R1 was unresponsive, found to be in pulseless electrical activity (PEA) arrest, required intubation (tube inserted into trachea to assist with breathing), received one heart shock with achievement of return of spontaneous circulation (ROSC). R1 was transferred to a higher level of care for further management. On [DATE], R1 was extubated (tube removed that assisted with breathing) and was using 3 liters of oxygen via nasal cannula. On [DATE], R1 developed acute hypoxic (not enough oxygen or too much carbon dioxide in the body) and hypercapnic (too much carbon dioxide in the blood) respiratory failure. On [DATE], R1's urine output dropped and concerns for renal (kidney) failure began. R1 passed away at 6:45 p.m. During an interview on [DATE] at 8:57 a.m., nursing assistant (NA)-B stated R1 had been an assist of two people with a walker for transfers, but the staff had started using a mechanical standing lift for the last while (NA-B could not recall dates) because he required more assistance. NA-B did not recall R1 ever using his oxygen that was kept in the room. NA-B did not think R1 had ever been short of breath when she would care for him. R1 was a daily weight, and the nurses kept mentioning how his weight was going up. NA-B was unaware if weights increased or decreased and would just give the nurse a handwritten list of the weights requested each day. It was the nurses who would identify differences in the weights. During an interview on [DATE] at 9:04 a.m., NA-C did not recall R1 ever using his oxygen and could not recall him being SOB. During an interview on [DATE] at 9:12 a.m., RN-A stated at the beginning of January R1 weighed around 237 lbs. and then by [DATE] had a major weight gain he was 264 lbs. RN-A recalled R1 getting additional Lasix doses but could not remember what days that occurred. Cardiology was notified about R1 on either [DATE] or [DATE] about his 20 lb. weight gain. RN-A thought she notified cardiology on [DATE] but knew she had told NP-A in-person while she was at facility. R1 always said he was not short of breath however, he seemed to be moving slower, his respirations would be between ,d+[DATE] when RN-A would check it. His vital signs were fine every time they were checked. R1 did have oxygen in his room but his saturations were always ,d+[DATE]% (within normal limits) on room air. The oxygen was as needed mostly at night if he was laying down, which he seldom did. RN-A did not endorse assessing lungs and edema as part of her assessment. During an interview on [DATE] at 3:54 p.m., LPN-A stated on [DATE], she was in R1's room with NP-A completing wound rounds on R1. LPN-A did not notice R1's shirt being tight on him. The edema was up to his thighs. NP-A told LPN-A that R1 should be sent to the emergency department. LPN-A stated floor nurses monitored lung sounds episodically. Towards the end they should have been monitoring R1 more closely. The nurses should monitor lung sounds, difficulty breathing because the lungs could fill with fluid, blood pressure, vital signs in general should be done, monitored for edema full body such as face, hands, and abdomen and report to the physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:05 p.m., NP-A was not aware that cardiology requested the primary care provider take over management of R1's diuretics until after R1 was sent to the hospital when she read the progress note from [DATE]. NP-A stated R1's legs and abdomen on [DATE] were huge. R1 could not fit his shirt over his abdomen. R1 had his oxygen on at 6 liters per minute and told NP-A he put the oxygen on himself and turned the oxygen liters up until he could feel the air. R1 had been on daily weights Notification was to be made to cardiology if the weight had increased three pounds in one day or five pounds in one week. Cardiology had overseen the adjustment of diuretics and facility was encouraged to notify cardiology, not R1's primary care physicians regarding the weights. The whole point of the facility calling to notify of weight increases was so intervention could happen to prevent hospitalization . The facility failed to notify us not once, but twice with two significant weight jumps. NP-A felt that if they had been notified, they could have prevented hospitalization , given R1 more time, if they would have known sooner, and he may not have died . NP-A felt this weight increase led to R1's exacerbation of heart failure, pulmonary edema, and ultimately, for him it led to his cardiac arrest and death. During an interview on [DATE] at 11:59 a.m., medical doctor (MD)-A stated she was unaware cardiology wanted to have them take over R1's heart failure and medication adjustments. MD-A stated RN-A called her on [DATE] and told her R1's abdomen had been a little firm from the bladder but could not recall an update about a significant weight increase. R1 wanted to go to the emergency department to get straight catheterized but they could do that at the facility and MD-A told RN-A to straight catheterize R1. RN-A called back and reported R1 was straight catheterized and the amount she was able to get out. At that point, R1 did not want to go to the hospital. MD-A was not aware that R1 had felt short of breath (SOB) with bending, had dependent edema around abdomen and upper thighs, but was aware of the 1.2 lbs. weight gain in one day. During an interview on [DATE] at 11:50 a.m., MD-A stated that daily weights were ordered to monitor weight gain in heart failure patients so they can avoid heart failure exacerbations because by the time the patient shows symptoms of SOB or edema it might be too far gone, and they would have to go to the hospital. That is why they have it in the orders to notify of a weight increase of two lbs in one day or five lbs in one week, to catch the more gradual increase and get an overall assessment from the facility. Each patient is different, and some patients change quickly and some change gradually over time and we want to monitor both. First line the facility should notify us of a patient with increased weight. Residents with a weight increase that have CHF could go into heart failure and require hospitalization and it could lead to death. During an interview on [DATE] at 12:46 p.m., DON stated she would expect the nurses to call the physician to update for weight increases. The nurses should look at the whole picture and not just what the weight gain was within the week because it could be up one-to-two lbs here and there not requiring an intervention and then boom, at the end of the month the resident is up 12 lbs and in CHF overload. At 4:17 p.m., DON stated if she saw a weight gain, she would want edema, oxygen levels, and lung sounds checked. They should be charted in a progress note and in the TAR. During a return phone interview on [DATE] at 10:34 a.m., NP-C stated cardiology was getting inconsistent weights from the facility. R1 was the type of person that did not complain and would be up 20 lbs. in weight and would say he was fine. That is why it would have been better for someone to see him in-house that could look at R1 and see how he was doing. Cardiology requested MD-A take over the day-to-day care of R1's diuretic management. NP-C would expect the facility to monitor edema that would include where it was and how much he had. (continued on next page)

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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility weight policy dated [DATE], identified at the discretion of the interdisciplinary team and/or physician, residents at high risk may be continued on more frequent weight monitoring. The registered dietician shall review residents who trigger for significant weight gain or loss. Significant is defined as a person with 5% weight change over 30 days, 7.5% weight change over 90 days, or 10% weight change over 180 days. The interdisciplinary team shall review weights for significant weight changes and will be discussed to determine individualized care plan interventions and documented in the electronic medical record. The facility notification of changes policy dated ,d+[DATE], identified changed in a residents condition or treatment be shared with the resident and/or resident representative, and reported to the attending physician or delegate. Nurses and other care staff are educated to identify changes in a residents status and define changes that require notification of the resident and/or their representative, and the residents physician, to ensure best outcomes of care for the resident. The past non-compliance IJ that began on [DATE], was removed on [DATE] when it was verified the facility implemented the following: 1) New process for daily weights which included updating all daily weight orders to include what the daily weight was, the difference between that weight and the prior days weight, what the seven day look back period was. 2) Reviewed all the residents with daily weight orders on [DATE]. 3) Added another level to the morning meeting and review weights from the previous day on [DATE]. 4) Education to NA's that weights are collected prior to breakfast on [DATE]. 5) Educated nurses on daily weight process, documentation, reporting changes on [DATE]. 6) Educated leadership team on the whole process on [DATE]. 7) Education that anytime a change of condition is identified the physician is notified on [DATE]. 8) Updated care plans to reflect edema monitoring on [DATE].