STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255219	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Walk Healthcare Center	570 North Solomon Street Greenville, MS 38703

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47158 Based on staff interview, record review and facility policy review, the facility failed to notify the Nurse Practitioner (NP) of Registered Dietitian (RD) recommendations for a resident with significant weight loss (Resident #1) and a change in condition (Resident #2) for two (2) of six (6) residents reviewed for physician notification. Findings include: Record review of the facility policy titled, Change in a Resident's Condition or Status revealed, Policy Statement, Our facility shall promptly notify the resident, his or her Attending Physician .of changes in the resident's medical/mental condition and/or status . Resident #1 A record review of Registered Dietitian Assessment Summary for Resident #1, dated 10/16/2023, indicated that Resident #1's weight was 160 pounds (lbs.) with a weight change of 6.98 percent (%) since admission, which indicated a significant weight loss. A record review of weights documented for Resident #1 revealed: 9/29/23 weight 172 lbs (pounds)., 10/2/23 weight 160 lbs., 10/18/23 weight 151.2 lbs. and 11/3/23 weight 127.4 lbs. Record review of a Subjective, Objective, Assessment, Plan (SOAP) note dated 10/17/23, signed by the Nurse Practitioner (NP) revealed no documentation that she was aware of Resident #1's weight changes. Record review of a SOAP note dated 10/18/23, signed by the Physician revealed no documentation that he was aware of Resident #1's weight changes. Telephone interview with the Registered Dietitian (RD) on 7/9/24 at 12:05 PM, she stated the Director of Nursing (DON) was responsible for notifying the practitioner of weight loss and obtaining orders for recommendations that she gave. (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 0580 Level of Harm - Actual harm Residents Affected - Few	An interview with the Dietary Manager (DM) and record review of the Resident #1's summary of weights on 7/9/24 at 2:44 PM, revealed the resident's weight on 10/2/23 was 160 pounds. The DM stated that she notified the DON of the resident's weight change from 172 lbs. on 9/29/23 to 160 lbs. on 10/2/23 but did not document the notification. She stated that the DON is responsible for notifying the physician or nurse practitioner of weight changes. A telephone interview on 7/10/24 at 11:21 AM, with the NP verified that she was not notified of Resident #1's weight loss. An interview with the DON on 7/10/24 at 12:00 PM, confirmed that no documentation could be located that the NP was notified of the residents weight loss. An interview with the Administrator on 7/10/24 at 12:15 PM, revealed it was his expectation that the DON would have notified the NP of the resident's weight loss. A record review of Resident #1's Face Sheet revealed that the facility admitted him on 9/29/2023 with diagnoses that included Encounter for attention to gastrostomy and Gastroparesis. Resident #2 Record review of Departmental Notes for Resident #2, dated 6/20/24 and 6/24/24, revealed that the nurse held the 4:00 PM dose of Ativan because the resident was lethargic. There was no documentation that the NP was notified of the resident being lethargic on 6/20/24 or 6/24/24. Record review of July 2024 Physician Orders revealed that Resident #2 had an order for Ativan 0.5 mg (milligram) give one tablet by mouth twice a day with an order date of 6/6/24. During a telephone interview on 7/10/24 at 11:26 AM, the NP stated that she was not notified of Resident #2 being lethargic on 6/20/24 or 6/24/24 and would have expected the staff to notify her. In an interview with the DON on 7/10/24 at 12:05 PM verified that no documentation could be found that the NP was notified of Resident #2 being lethargic on 6/20/24 or 6/24/24. During an interview with the Administrator on 7/10/24 at 12:20 PM, he agreed that it was his expectation that the staff would have notified the NP of Resident #2's change in status. Record review of the Face Sheet for Resident #2 revealed that the facility admitted him on 12/13/23 with diagnoses of Cerebral Infarction and Other seizures.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47158 Based on record review, staff interview and facility policy review the facility failed to implement care plan interventions to prevent significant weight loss for one (1) of seven (7) care plans reviewed. Resident #1. Findings include: Record review of the facility policy titled, Care Plans-Comprehensive revised September 2010, revealed, Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet resident's medical, nursing, mental and psychological needs is developed for each resident .5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. Record review of Resident #1's summary of weights revealed: 9/29/23 weight 172 lbs, 10/2/23 weight 160 lbs, 10/18/23 weight 151.2 lbs and 11/3/23 weight 127.4 lbs. A record review of Registered Dietitian Assessment Summary for Resident #1, dated 10/16/2023, indicated that Resident #1's weight was 160 pounds (lbs) with a weight change of 6.98 percent (%) since admission, which indicated a significant weight loss. The Registered Dietitian (RD) recommended to change tube feeding to fissure 1.5 at mealtimes if resident consumes 75% or less of meals and one (1) can of isosource 1. 5 at bedtime. A record review of Resident #1's care plan revealed, Care Plan Description, Potential for Altered Nutrition related to therapeutic diet, start date of 9/23/24. Care Plan Goal, Resident will accept adequate food intake as evidenced by (AEB) no significant weight loss through the next review period. Interventions: Serve a renal diet as ordered per Medical Doctor (MD), Obtain weight per facility protocol, Determine/Monitor for likes and dislikes, RD consult as appropriate, Monitor and record meal intakes daily, Allow ample time to finish meals. There were no interventions implemented after Resident #1's significant weight loss identified by the RD on 10/16/24. An interview with the Director of Nursing (DON) on 7/10/24 at 12:02 PM, she verified that the facility failed to implement care plan interventions to prevent Resident # 1 from having a significant weight loss. A record review of Resident #1's Face Sheet revealed that the facility admitted him on 9/29/2023 with diagnoses that include Encounter for attention to gastrostomy and Gastroparesis.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47158 Based on record review, staff interview and facility policy review the facility failed to put interventions in place for a resident identified as having had significant weight loss for one (1) of four (4) residents reviewed for weight loss. Resident #1. Findings include: Review of the facility policy, titled Weight Assessment and Interventions, revised September 2008, revealed Policy Statement: The multidisciplinary team will strive to prevent, monitor and intervene for undesirable weight loss for our residents. Policy Interpretation and Implementation, Weight Assessment .5. Any Registered Dietitian Recommendations will be forwarded to the resident's Physician for action as indicated. Subsequent Physician orders will be provided to the facility within 72 hours. A record review of Registered Dietitian Assessment Summary for Resident #1, dated 10/16/2023, indicated that the resident received a Renal Diet and Isosource 1.5, three (3) times a day by percutaneous endoscopic gastrostomy tube (PEG). Resident #1's weight was 160 pounds (lbs.) with a weight change of 6.98 percent (%) since admission, which indicated a significant weight loss. The resident had inadequate oral intake related to decreased appetite as evidenced by 38% intake by mouth recently and required enteral nutrition. The Registered Dietitian (RD) recommended to change tube feeding to Isosource 1.5 at mealtimes if resident consumes 75% or less of meals and one (1) can of Isosource 1.5 at bedtime. Goals included that intake meet estimated needs, tolerate tube feeding and by mouth diet, weight stability/gain to ideal body weight is desired. A record review of Resident #1's October 2023 Physician's Orders revealed an order for Isosource 1.5 three times a day, with a start date of 9/30/24, with no changes indicating that the RD recommendations were followed. A record review of the weight summary documented for Resident #1 revealed: 9/29/23 weight 172 lbs., 10/2/23 weight 160 lbs., 10/18/23 weight 151.2 lbs. and 11/3/23 weight 127.4 lbs. Record review of a Subjective, Objective, Assessment, Plan (SOAP) note dated 10/17/23, signed by the Nurse Practitioner (NP) revealed no documentation that she was aware of the RD recommendation the facility received for Resident #1. Record review of a SOAP note dated 10/18/23, signed by the Physician revealed no documentation that he was aware of the RD recommendations the facility received for Resident #1. A record review of Registered Dietitian Assessment Summary for Resident #1, dated 11/8/23, indicated that the resident's weight was 127.4 pounds (lbs.), which is a 20.38 % loss, indicating a significant weight loss in 30 days. Resident received Isosource 1.5 three (3) times a day by PEG tube. The resident had oral intake of 43% by mouth. The RD continued to recommend to change tube feeding to Isosource 1.5 at mealtimes if resident consumes 75% or less of meals and 1 can of Isosource 1.5 at bedtime. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 7/9/24 at 11:00 AM, revealed that the DON is responsible for notifying the physician of the RD evaluation and obtaining orders for the RD recommendations. She stated that she was not the DON on 10/16/23. Interview with the Minimum Data Set (MDS) Nurse on 7/9/24 at 11:52 AM, revealed she was the Assistant Director of Nursing until sometime in October/November 2023. She stated that at that time the DON was responsible for follow up on RD recommendations. She was not aware of the 10/16/23 recommendations not being followed up on. Telephone interview with the RD on 7/9/24 at 12:05 PM, revealed she assessed the resident on 10/16/23 and gave recommendations for his weight loss. She stated that once she sees the residents she emails a copy of her evaluation and recommendations to the DON, Dietary Manager (DM) and Administrator and then meets with the DON to discuss concerns and interventions. She stated the DON was responsible for notifying the practitioner of weight loss and obtaining orders for recommendations that she gave. She stated that on her visit on 11/8/23 she noted that the DON had not followed up on the recommendations that she had left in October. The RD stated that during that time period she was having trouble getting the DON to follow-up on recommendations. An interview with DM on 7/9/24 at 2:44 PM, revealed she was aware that the DON did not follow up on the 10/16/23 RD evaluation and recommendations. She stated that she did not notify anyone that the DON had not done it. A telephone interview on 7/10/24 at 11:21 AM, with Nurse Practitioner (NP) revealed, usually the DON sends her the RD recommendations and she reviews them and sends them back. She verified that she was not notified of the 10/16/23 RD notifications at the time the facility received them. During an interview with the DON on 7/10/24 at 12:00 PM, revealed no documentation could be found that Resident #1's providers were notified of the dietary recommendations received from the RD on 10/16/23. In an interview with the Administrator on 7/10/24 at 12:15 PM, revealed it was his expectation that the DON would have followed up and obtained orders for the RD recommendations on Resident #1. A record review of Resident #1's Face Sheet revealed that the facility admitted him on 9/29/2023 with diagnoses that include Encounter for attention to gastrostomy and Gastroparesis.