| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265564 | A. Building<br>B. Wing | 09/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Medicalodges Butler | 103 East Nursery<br>Butler, MO 64730 |

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| F 0923<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have enough outside ventilation via a window or mechanical ventilation, or both.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain required negative airflow in the following areas: The South Hall Soiled Utility Room, resident rooms 132, 130 and 128. This practice potentially affected at least 10 residents who resided on the [NAME] Short Hall where the South soiled utility room was located and rooms on the South Hall. The facility census was 65 residents.**Note: Air flow was tested by holding one piece of tissue paper to the ceiling vent. If the paper was drawn to the vent, then negative air flow was present; if the paper fell, then negative airflow was absent. Observations on 9/4/25 with the Maintenance Supervisor showed:-At 11:53 A.M., there was the absence of negative airflow in the South side soiled utility room. -At 1:13 P.M., there was the absence of negative airflow in resident room [ROOM NUMBER].-At 1:21 P.M., there was the absence of negative airflow in resident room [ROOM NUMBER].-At 1:27 P.M., there was the absence of negative airflow in resident room [ROOM NUMBER].During an interview on 9/4/25 at 1:49 P.M., the Maintenance Supervisor said he/she has not had a chance to check for negative airflow in all the rooms in the 3 weeks he/she has been at the facility. |

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 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>Based on observation and interview, the facility failed to maintain the attic areas over the short [NAME] Hall, and the attic area over the South Hall free from openings that could allow pests into the attic areas and failed to maintain those attic areas free from numerous animal droppings (the waste product of animals). This practice potentially affected 17 residents who resided on or used those halls. The facility census was 65 residents.1. Observation on 9/3/25 at 12:34 P.M., with the Maintenance Supervisor, showed a 15 inch (in.) long by 1 in. wide opening along the outer wall of the attic above the short [NAME] Hall along with numerous amounts of animal droppings in that attic area. Observation on 9/3/25 at 12:46 P.M., with the Maintenance Supervisor showed a 15 in. long by 3 in. wide opening on the outer wall of the attic area above the south Hall along with numerous amounts of animal droppings in that attic area.During an interview on 9/3/25 at 12:21 P.M., the Administrator said:-The attic areas were checked monthly, when the previous maintenance person was employed at the facility.-The facility had a special vacuum cleaner that was used to vacuum-clean out the animal droppings.-The droppings identified in the photograph were squirrel droppings. |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to invite two residents (Resident #7 and Resident #55) to care plan meetings out of 16 sampled residents. The facility census was 63 residents. A policy was requested from the facility for care plan meetings and was not provided.<br><br>Review of the undated Care Plan Invitation Form showed:-A place for the residents' name.-Three boxes in which one would be checked for if the person invited would be:-Attending in person.-Join in by telephone.-If neither the resident, nor family member would be in attendance.<br><br>1. Review of Resident #7's admission record showed the resident was admitted to the facility on [DATE].<br><br>Review of the resident's care plan dated 6/19/24 showed:-The resident needed partial to maximum assistance with:--For transfers.--With dressing.-Needed partial assistance with ambulation.-Was at risk for falls.--Needed assistance for:--Going to the bathroom.--Getting ready for the day.--Going to and coming from the dining room.-Being monitored for side effects of medications.<br><br>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool used by facilities for care planning), dated 7/26/25, showed:-He/She was cognitively intact.-He/She required supervision with oral care, personal care.-He/She was independent with eating.-He/She was dependent on staff for toileting.-He/She required partial to moderate assistance for bathing, dressing, putting on or taking off shoes, to lay down in bed, to go from laying down to sitting on side of the bed, going from sitting to standing, with transfers, and with ambulation.<br><br>During an interview on 09/04/2025 at 12:46 P.M., the resident said that he/she had not been invited to a care plan meeting that he/she could remember.<br><br>Requested the care plan invitations for the resident but none were provided.<br><br>During an interview on 9/5/2025 at 9:51 A.M., Social [NAME] Designee (SSD) said:-He/She met with the resident a week before the care plan meeting and family was invited to the care plan meeting, but the resident was not since the SSD and the resident had a meeting the week before. -He/She thought the meeting a week prior to get the residents' concerns was enough.<br><br>During an interview on 9/5/2025 at 12:29 P.M., Certified Nursing Assistant (CNA) A said that he/she had never seen Resident #7 go to a care plan meeting but thought they occurred every three months.<br><br>During an interview on 9/5/2025 at 12:32 P.M., Registered Nurse (RN) C said he/she had not seen the resident go to the care plan meeting.<br><br>During an interview on 9/5/25 at 1:13 P.M., the Director of Nursing (DON) said:-All residents should have been invited to the care plan meeting. -The resident should have received a written invitation for the care plan meeting.-The resident should have been allowed to attend the care plan meetings so the residents would feel empowered and know the care the resident could have expected.<br><br>2. Review of Resident 55's quarterly MDS dated [DATE] showed the resident was cognitively intact.<br>(continued on next page) |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's care plan meeting form dated 3/21/25 showed the resident's family had been invited to his/her care plan meeting and not the resident.<br><br>During an interview on 9/3/25 at 9:40 A.M. the resident said:-He/She had not been getting invited to his/her care plan meetings.-He/She wanted to go to his/her care plan meetings.<br><br>During an interview on 9/4/25 at 12:19 P.M. the SSD said:-He/She had been inviting the resident's son to his/her care plan meetings.-He/She typically mailed out the care plan invitations.-The resident's son did not typically return the invitations back to him/her.-The resident was his/her own person.-The resident was able to fully participate in his/her care plan meetings.-The resident had an additional family member that lived close to the facility and would normally come to the facility and talk about the resident's care outside of a typical care plan meeting.-When asked about care plan meetings the resident's normal response was for his/her son to speak on his/her behalf.<br><br>During an interview on 9/4/25 at 12:46 P.M. the resident said:-He/She was upset that she/she was not invited to his/her care plan meetings.-He/She felt that his/her family did not come to the facility often enough to be involved in his/her care decisions.-He/She wanted to be more involved in his/her care decisions.<br><br>Review on 9/4/25 at 5:37 P.M. of the resident's electronic medical record (EMR) showed the resident's care plan meeting form had not been completed for his/her quarterly meeting in June 2025.<br><br>During an interview on 9/5/25 at 12:49 P.M. Certified Nursing Assistant (CNA) A said:-He/She was unsure if the resident was his/her own person.-All residents should be invited to their care plan meetings.-He/She thought care plan invitations needed to be written.-The resident should have been invited to his/her own care plan meeting and not just a family member.-Residents needed to be invited and involved in their care plan meetings because they were the ones getting the care that was discussed.<br><br>During an interview on 9/5/25 at 12:59 P.M. RN B said:-The resident was his/her own person.-Residents should be invited to their care plan meetings.-If a resident had a change in condition or cognition that would be the only reason why a family member would be invited and not the resident.-A resident could also give permission for the resident to have their family involved in their care plan meetings.-Residents should be involved in their care plan meetings so they could give input into the care that they receive.<br><br>During an interview on 9/5/25 at 1:11 P.M. the DON said:-The resident was his/her own person.-All residents who were cognitively able should be invited to their care plan meetings.-Care plan invitations needed to be written.-If a resident was deemed incapacitated then that would be when the family would be the ones solely invited to care plan meetings.-Residents should be invited to their care plan meetings because all residents have the right to be informed about and have say in their care. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on interview and record review, the facility failed to ensure a prompt resolution to a grievance filed by one sampled resident (Resident #55) out of 16 sampled residents. The facility census was 65 residents.Review of the facility's policy titled Grievances dated June 2019 showed:-The facility created the policy to ensure the prompt resolution of grievances.-Grievances may include those with respect to care and treatment, behavior of staff and other residents, and any other concerns a resident may have.-Residents and others could expect contact from the facility's Grievance Officer typically within seven to ten days following the voicing of a grievance.-There was not specific time frame in the policy related to the timing of the resolution of the grievance.1.Review of Resident #55's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/6/25 showed the resident was cognitively intact.Review of the resident's grievance dated 7/14/25 showed:-The incident date was unknown.-The resident's sons stated that the resident was missing two gowns, two dusters, and an undergarment.-The resident identified one aqua gown, one seafoam gown, one dark aqua duster, one white background with flowers duster, and an undergarment that were missing.-An inventory of the resident's closet was completed, and the resident had seven gowns and three dusters in his/her closet and multiple undergarments in his/her drawers.-The resident had stated that at that time there were three gowns and three dusters that had been soiled and were sent down to laundry over the past two days.-The Social Services Designee (SSD) had followed up with laundry who communicated that they were already aware of the missing items, and they could not be found.-The SSD emailed the current inventory of the resident's closet to the sons.-The sons were also notified on 7/28/25 that the facility would continue to look for the missing items and that if they could not be found, then the SSD would assist the resident in picking out new items.Review of an email correspondence dated 7/28/25 between the SSD and the family showed:-If the facility was still unable to locate the missing items in the next couple of weeks, then he/she would get the Administrator involved.-The facility would replace the missing items.During an interview on 9/3/25 at 9:41 A.M. the resident said:-A few months ago, he/she had lost some gowns and dusters.-He/She was upset because the grievance had never been resolved.-He/She was unsure if the resolution to the grievance was replacing the items.During an interview on 9/4/25 at 12:27 P.M. the SSD said:-The resident's grievance had not been resolved.-The facility was still waiting for laundry to cycle through to see if the missing items could be found.-He/She had completed an inventory of the resident's closet, and the resident had plenty of gowns, dusters, and undergarments.-He/She had emailed the resident's family about the grievance on 7/28/25 to communicate that they facility was waiting for the laundry to cycle through and that they would replace the missing items if they could not be found.-The missing items were still on his/her radar.During an interview on 9/5/25 at 12:51 P.M. Certified Nursing Assistant (CNA) A said:-He/She was unsure if the resident had any missing clothes.-The resident had not reported to him/her anything about missing clothes.-If a resident had reported missing clothes to him/her then he/she would do the following:--He/She would have gone down to the laundry to see if he/she could find the missing items.--He/She would also look in other resident's closets to see if the missing items had been given to the wrong resident.--If the missing clothes were still unable to be found he/she would help the resident make a grievance.-The SSD was responsible for reviewing and resolving grievances.-Grievances should be resolved between two weeks to a month.-The resident's missing items should have been replaced by that point in time.During an interview on 9/5/25 at 1:02 P.M. Registered Nurse (RN) C said:-He/She was unsure if the resident was missing clothes.-The resident had not reported to him/her anything about missing clothes.-If a resident had reported missing clothes to him/her then he/she would go check the laundry and tell nurse management and the SSD.-He/She was unsure of the facility's grievance protocol.-He/She thought that the SSD and the Administrator<br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | worked on grievances.-The resident's missing items should have been replaced by that point in time.During an interview on 9/5/25 at 1:11 P.M. the Director of Nursing (DON) said:-He/She thought the resident was missing two gowns.-If a resident reported missing clothes to a staff person, then he/she should expect staff to make an attempt to find the missing clothes.-If staff could not find the missing clothes, then he/she would expect staff to report the issues to the SSD.-He/She was unsure if there was a specific time frame related to grievance response time.-He/She thought that grievances should be resolved within a month.-The SSD and the Administrator were responsible for reviewing and resolving grievances.-A resolution to the resident's missing clothes should have been found by that point in time. -He/She was unsure why a resolution to the resident's missing clothes had not been found promptly. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Ombudsman of a planned discharge for one resident (Resident #77) out of 16 sampled residents and three closed records. The facility census was 63 residents.A policy was requested from the facility for Ombudsman notification and was not provided. 1. Review of Resident #77's admission record showed the resident was admitted to the facility on [DATE]. Review of the resident's care plan dated 7/12/25 showed:-The resident was admitted for skilled nursing services for a fall with a fractured hip.-The plan was to discharge home.Review of the resident's Progress notes dated 7/18/25 showed:-The resident was discharged home.-The resident was alert and oriented and able to make decisions. -The resident was safe to discharge home. Review of the resident's Discharge Minimum Data Set (MDS - a federally mandated assessment tool used by facilities for care planning), dated 8/2/25, showed:-Short term memory was ok.-Was independent in making decision regarding daily life. -There was no evidence of an acute change in mental status from the resident's baseline.-The resident did not have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?-The resident's thinking was not disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).Requested copy of Ombudsman notification from the facility on 9/4/25 and was not provided. During an interview on 9/5/25 at 9:48 A.M., the Administrator said:-The resident was a planned discharge, and he/she did not think that the Ombudsman needed to be notified.-He/She did not notify the Ombudsman of the discharge. -The State Operations Manual (SOM) he/she used did not say that the Ombudsman had to be notified. -The SOM he/she used was dated 8/4/2024.-He/She did not know the current SOM was dated 7/23/25.During an interview on 9/5/25 at 1:13 P.M., the Director of Nursing (DON) said:-He/She did not do the notifications to the Ombudsman.-He/She would have expected that all the Ombudsman would have been notified since that was the regulation. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to identify and direct the care of one sampled resident's (Resident #38) cardiac pacemaker (a small battery-operated device surgically implanted in the body to deliver electrical pulses to help the heartbeat at a normal rate and rhythm), and failed to develop a policy to direct staff responsibilities involved in the care of residents with pacemakers and/or implanted medical devices out of 16 sampled residents. The facility census was 65 residents. A pacemaker policy was requested and not received. 1. Record review of Resident #38's hospital referral information, page nine of six, dated 6/10/25 showed a past surgical history of pacemaker implantation. Review of the resident's electronic medical record (EMR) showed:-He/She was admitted to the facility on [DATE].-He/She had a diagnosis of presence of cardiac pacemaker, dated 6/12/2025. Review of the resident's licensed nurse's admission assessment dated [DATE] showed he/she had a cardiac pacemaker. Review of the resident's care plan dated 7/12/25 showed no mention of or interventions for his/her cardiac pacemaker. During an interview on 9/5/25 at 12:40 P.M. the Care Plan Coordinator said:-He/She reviewed admission paperwork for all resident admissions.-Normally that was how he/she would become aware that a resident had a pacemaker.-He/She had reviewed the resident's admission paperwork but had missed seeing that the resident had a pacemaker.-He/She did not know of the resident's pacemaker until the evening of 9/4/25 when he/she was made aware.-Upon becoming aware of the request for the pacemaker policy, he/she ran a report that identified the resident had a pacemaker.-He/She then added to his/her activities of daily living (ADLs - daily self-care activities) care plan that he/she had a pacemaker and a pacemaker monitoring device in his/her room, had a remoter pacemaker check on July 17, 2025.-The facility addressed pacemakers only on care plans and not on physician's orders. Review of the resident's EMR care plan with the Care Plan Coordinator on 9/5/25 at 12: 48 P.M. showed:-His/Her ADL care plan interventions now showed that he/she had a I have a biventricular pacemaker and have a continuous monitoring device in his/her room.-His/Her remote pacemaker check was July 17, 2025.-The name and contact information for his/her cardiologist (a physician who specializes in the care of the heart and blood vessels).Observation in the resident's room with the Care Plan Coordinator on 9/5/25 at 12:50 A.M. showed a continuous monitoring device plugged into an electrical outlet. During an interview on 9/5/2025 the Director on Nursing (DON) said:-The facility did not have a policy that addressed pacemakers or any other implanted medical device (IMDs - electronic or mechanical devices that are surgically inserted into the body to monitor, treat, or replace bodily functions). -The facility did not obtain and include physician's orders directing care for residents' pacemakers.-The facility process regarding pacemakers or any other IMD was that the interdisciplinary team (IDT - professionals from various disciplines who work in collaboration to address resident care needs) reviewed resident referral information prior to and at the time of resident admission and then pacemakers or other IMD were addressed on individual care plans but were not addressed in physicians' orders.-Information regarding how and when to complete pacemaker checks (periodic or continuous monitoring of pacemaker functioning) were addressed only on individual care plans and were not included in individual resident physicians' orders.-Residents admission records only included the primary care physician and did not include cardiologists or other physician specialists relevant to residents' care.-The Care Plan Coordinator was responsible to ensure that pacemakers were addressed on resident care plans.-He/She was ultimately responsible for ensuring each resident's care plan addressed all aspects of their care, including for pacemakers or any other IMD.-He/She had not been aware that the resident had a pacemaker that was not included in his/her care plan until the Care Plan Coordinator notified him/her that interventions were added to the resident's care plan on 9/4/25.-The resident's comprehensive care plan should have clearly identified the presence of the resident's pacemaker with a stand-alone care plan statement, I have a<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | pacemaker and should have included the name and medical group group/hospital affiliation of the resident's cardiologist and the specific method and frequency for monitoring the resident's pacemaker, rather than adding interventions to the resident's ADL care plan. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on observations, interviews, and record review, the facility failed to follow a Registered Dietician (RD) supplement recommendation for one sampled resident (Resident #65) out of 16 sampled residents. The facility census was 65 residents.Review of the facility's policy titled Fortified Foods (items prepared in house that provide additional calories and/or protein and are not required to be ordered by the physician), Two Calorie Med Pass (commercially prepared product designed to provide two calories per one milliliter (ml) and be distributed with the medication pass ordered by the physician), Other Supplements and Snacks dated May 2019 showed:-Residents who were at risk or with poor nutritional intake, declining intake, weight loss, and/or pressure ulcers would be referred to the RD.-The RD would determine if a resident required nutritional intervention or increased oral intake and select appropriate types on interventions.-The RD would document the need for interventions and initiate orders for any that required physician's approval before usage and update the care plan as needed or provide information to the dietary manager so the care plan could be updated.-All two calorie med pass products would be given between meals and would be documented on the electronic medication administration record (EMAR).-The two-calorie med pass would be distributed by nursing staff with intake percentage recorded.1.Review of Resident #65's admission record showed he/she admitted to the facility with the following diagnoses:-Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses), Unspecified Severity, With Other Behavioral Disturbance.-Diabetes Mellitus (DMII- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).-Hypertensive Heart (heart damage from long-term high blood pressure) and Chronic Kidney Disease (CKD- long-standing kidney damage and can no longer filter waste appropriately) Without Heart Failure, With Stage One through Stage Four Chronic Kidney Disease.Review of the resident's significant change Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 5/28/25 showed:-The resident had severely impaired cognition.-The resident received a therapeutic diet.-The resident's base weight in the last 30 days was 208 pounds (lbs.).-The resident did not have any weight loss or gain of five percent or more in the last 30 days.-The resident did not have any weight loss or gain of 10 percent or more in the last six months.Review of the resident's Order Summary Report dated August 2025 showed:-The resident's diet was a regular diet with pureed texture, thin consistency, diabetic and sodium precautions.-Staff were to weigh the resident daily and to notify the resident's nephrologist (kidney doctor) if the resident had weight gain greater than two lbs. in 24 hours or five lbs. in one week.-It did not show an order for any type of wight loss supplement.Review of an RD Note dated 8/15/25 showed:-The resident showed a five percent weight loss in one month and an eight percent weight loss in three months which was a significant weight loss for that time frame.-The resident's diet changed to a pureed texture about a month prior which could have contributed to the weight loss.-The resident received a diuretic (helps the body get rid of extra fluid) and could cause some weight fluctuations.-The resident consumed 50-100 percent of his/her meals.-The resident's main goal was to maintain his/her current weight.-He/She recommended a sugar free house supplement two times a day to aid in weight maintenance.Review of a weight progress note dated 8/15/25 completed by the Director of Nursing (DON) showed:-The resident's current weight 189 lbs.-The current weight interventions section was blank.-The current commercial supplement section was blank.-The resident consumed 75-100 percent of his/her meals.-Snacks were offered to the resident three times a day.-The resident took diuretics and diabetes medications that could affect his/her weight.-The resident had edema (excess fluid that accumulates in the body's tissues, causing swelling) to his/her bilateral (involving both sides) lower extremities.-The new weight intervention that was in place was to monitor the resident's weight and (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265564 | A. Building<br>B. Wing | 09/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Medicalodges Butler | 103 East Nursery<br>Butler, MO 64730 |

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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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | notify the nephrologist of weight gain per orders.Review of the resident's care plan dated 8/19/25 showed:-The resident was at risk for altered nutrition with a goal that the resident would have adequate nutrition and maintain his/her weight within five percent during the next review period with the following interventions:--The resident was able to feed himself/herself with set-up assistance and supervision, at times he/she may need partial assistance.--Staff were to monitor the resident for any changes to his/her intake, or any difficulties with chewing or swallowing.--Staff were to weigh the resident physician orders.--Staff were to refer the resident to the facility's RD as needed.Review of a weight progress note dated 8/20/25 completed by the DON showed:-The resident's current weight was 187.2 lbs.-The current weight interventions section was blank.-The current commercial supplement section was blank.-The resident consumed 75-100 percent of his/her meals.-Snacks were offered to the resident three times a day.-The resident took diuretics and diabetes medications that could affect his/her weight.-The resident had edema to his/her bilateral lower extremities.-The resident had been seen by the RD and the DON copied and pasted the RD note into the progress note.-There was no mention of a discussion related to the RD's recommendation.Review of a nurse note dated 8/21/25 completed by Nurse Practitioner (NP) A showed:-The resident was seen for a regular follow-up for his/her CKD and DM II.-The resident's kidney function was impaired but stable.-There were no changes in the resident's plan of care.-There was no mention of the RD's recommendation.Review of a weight progress note dated 8/26/25 completed by the DON showed:-The resident weighed 187.6 lbs.-The current weight interventions section was blank.-The current commercial supplement section was blank.-The resident consumed 75-100 percent of his/her meals.-Snacks were offered to the resident three times a day.-The resident took diuretics and diabetes medications that could affect his/her weight.-The resident had edema to his/her bilateral lower extremities.-The new weight intervention that was in place was to monitor the resident's weight and notify the nephrologist of weight gain per orders.-There was no mention of a discussion related to the RD's recommendation.Review of a Dietary Progress Note dated 8/26/25 at 10:18 A.M. completed by the Dietary Manager showed:-The resident received a pureed diet with diabetic/sodium precautions.-The resident was able to feed himself/herself with some assistance from staff.-He normally consumed 76-100 percent of his/her meals.-The Dietary Manager would continue to monitor and refer any new changes to the RD for further review.Review of the resident's Order Summary Report dated September 2025 showed the resident did not have any supplements ordered.Review of a weight progress note dated 9/2/25 completed by the DON showed:-The resident weighed 182.4 lbs.-The current weight interventions section was blank.-The current commercial supplement section was blank.-The resident consumed 75-100 percent of his/her meals.-Snacks were offered to the resident three times a day.-The resident took diuretics and diabetes medications that could affect his/her weight.-The resident had edema to his/her bilateral lower extremities.-The new weight intervention included: --Facility was to monitor the resident's weight and amount consumed.--Notify nephrologist of weight gain.-There was no mention of a discussion related to the RD's recommendation.Review of the resident's weights on 9/2/25 showed the resident weighed 209 lbs. on 6/4/25 and on 9/1/25 the resident weighed 182.4 lbs. which was a 12.73 percent loss in weight in three months.During an interview on 9/4/25 at 4:43 P.M. Family Member A said:-The facility had not informed him/her of the RD's recommendation of adding a dietary supplement to help the resident maintain his/her weight.-He/She had a meeting with the facility the previous week and the resident's weight was not discussed.-He/She was unaware that the resident's weight had fluctuated so much in the last three months.During an interview on 9/4/25 5:05 P.M. Registered Nurse (RN) A said:-He/She had already given the resident's in the memory care unit their dietary supplements.-The nurse on the unit was responsible for giving the dietary supplements to the residents.-He/She was unsure of all of the resident's who had already received a supplement.-If a dietary supplement was ordered two times a day it was usually given at breakfast and at dinner.During an interview on 9/4/25 at 5:12 P.M. RN A said that the resident had not received a dietary supplement before dinner.During an interview on<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 9/4/25 at 5:25 P.M. the Administrator said he/she was unaware of the RD's recommendation for the resident to be put on a dietary supplement.Observation on 9/5/25 at 8:38 A.M. showed:-The resident had received his/her breakfast tray.-He/She needed cueing and then maximum assistance in eating his/her breakfast.-There was no supplement on the tray. Observation on 9/5/25 at 9:08 A.M. showed:-The resident ate 100 percent of his/her breakfast.-The resident requested a second portion of breakfast.-The resident did not receive a dietary supplement.During an interview on 9/5/25 at 9:21 A.M. the Administrator and Assistant Director of Nursing (ADON) said:-The resident was switched to a pureed diet on 7/16/25 because he/she had been pocketing his/her food.-The RD was supposed to follow the facility's weight loss flow sheet for appropriate weight loss recommendations.-The RD had not followed the facility's weight loss flow sheet when recommending a sugar free dietary supplement for the resident.-The facility would have preferred that the RD recommend larger portions or add more protein as weight loss interventions.-The RD had not been in the building since he/she had recommended the supplement.-The resident's normal weight was around 190 lbs.-In June the resident had his/her diuretic dosage changed due to the increase in fluid accumulation.-The documentation of the weight notes could be more consistent and reflect the resident's current status.-The RD's recommendation had been discussed at a weekly risk meeting, but the meeting had not been documented by the DON.During an interview on 9/5/25 at 9:36 A.M. the DON said:-He/She was the person who reviewed the RD's notes and sent the recommendations to the doctor.-The documentation in his/her weight notes were not accurate.-The facility had a meeting with NP A and the rest of interdisciplinary team and had discussed the RD's recommendation for the resident.-The meeting occurred during the week of 8/21/25.-He/She should have documented that the RD's recommendation was reviewed and that NP A disagreed with the recommendation.During an interview on 9/5/25 at 9:47 A.M. NP A said:-The DON usually gave him/her resident weights and he/she would review them on-site.-He/She liked to look at yearly weight trends instead of monthly weight trends.-He/She had looked at the resident's weights when he/she saw the resident on 8/21/25.-If a person were to look at the resident's three-month weight trend, then it would appear that the resident lost weight.-He/She expected the resident's weight to be maintained between 188 to 192 lbs.-The weight on 6/1/25 was grossly high for the resident.-The facility had to back down on the diuretic usage due to the resident's lab values.-He/She did not like the use of health shakes/supplements as the first step of weight loss prevention.-The resident's weight tended to fluctuate between 185 and 195 lbs.-When the resident has an increase in weight it was usually fluid related.-He/She did not think that the RD had looked at the resident's whole picture when making his/her recommendation on 8/15/25.-A note should have been documented related to the discussion of the RD's recommendation by the DON.-He/She felt like the facility was doing everything that he/she expected related to the resident's weight management.During an interview on 9/5/25 at 12:20 P.M. the RD said:-He/She thought that the resident had not been eating very well when he/she reviewed the resident.-His/Her recommendation would still be for the resident to be given a sugar free house supplement two times a day.-The usage of a house supplement was usually the quickest way to fix weight loss.-He/She was unaware that the supplement had not been ordered.-The facility had not communicated with him/her that they disagreed with the recommendation.-He/She had not been back to the facility since making his/her recommendation. During an interview on 9/5/25 at 12:41 P.M. RN B said:-The resident had lost weight.-The resident was weighed daily.-Sometimes the facility had issues with getting the resident to the scale first thing in the morning.-The resident did not have any dietary supplements ordered.-The facility should follow RD recommendations.-If the facility did not want to follow the recommendations then a note should be placed by nursing management in the resident's chart with the reason(s) why they were not following the recommendations. |