| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525373 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care and Rehab - Boscobel | 207 Parker St<br>Boscobel, WI 53805 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253<br><br>Based on interview and record review, the facility failed to ensure residents received adequate fluid and food intake to maintain acceptable parameters of hydration and nutrition for 1 of 3 Residents reviewed for nutrition (R1).<br><br>R1's fluid intake was not documented or evaluated to ensure he was meeting his required daily fluid needs. R1's care plan was not updated with individualized approaches to increase fluid intake to prevent dehydration after it was revealed on 12/27/24 that he had elevated labs indicative of reduced kidney function. R1 was hospitalized with elevated lab value, dehydration, an acute kidney injury, hypernatremia, metabolic encephalopathy, and severe sepsis. The facility did not have a systematic process in place to monitor and assess R1's daily fluid intake or needs and implement corrective actions to prevent dehydration for R1. Despite R1 being his own person, the facility did not provide education and risks versus benefits to R1 about the risk of continuing to refuse food and drink.<br><br>The facility failed to ensure residents receive adequate fluid intake to maintain acceptable parameters of hydration by its:<br><br>* Failure to consistently record and assess fluid intake data being gathered;<br><br>* Failure to accurately assess and complete assessments for signs and symptoms of dehydration (e.g., sunken eyes, cool/clammy skin, dry tongue, dark colored urine, and sticky saliva);<br><br>* Failure to develop individualized care plan approaches for encouraging fluid intake.<br><br>R1 lost 37.3 lbs. within a month following admission (almost 20% of body weight). Although the facility respected R1's right to refuse meals, the facility did not provide risks/benefits to the residents, did not immediately begin giving foods that he liked (e.g. ice cream), did not monitor the percentage of supplements consumed, and did not update R1's nutritional plan after admission. There was no assessment of why R1 refused to eat beyond, I don't like the food here.<br><br>These failures to ensure R1 maintained acceptable parameters of nutrition and hydration created a finding of Immediate Jeopardy that began on 12/26/24. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were notified of the immediate jeopardy on 1/23/24 at 12:15 PM. The Immediate jeopardy was removed on 1/24/25; however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.<br><br>(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 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Findings include<br><br>The facility's weight monitoring policy states the following:<br><br>*Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance; unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.<br><br>*The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: . developing and consistently implementing pertinent approaches . monitoring the effectiveness of interventions and revising them as necessary.<br><br>* A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status. Assessments could include the following information: a.) Height b.) Weight c.) Food and fluid intake d.) Fluid loss or retention e.) Laboratory/diagnostic evaluation<br><br>*Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible: a.) Identified causes of impaired nutritional status b.) Reflect the resident's personal goals and preferences c.) Identify resident-specific interventions d.) Time frame and parameters for monitoring e.) Updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or a new cause of nutrition-related problems are identified f.) If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate.<br><br>*Weight will be monitored at least monthly unless otherwise specified by physician orders.<br><br>* Weight analysis: the newly recorded weight should be compared to the previous recorded weight. A significant change in weight is defined as: a.) 5% change in weight in one month (30 days) b.) 7.5% change in weight in three months (90 days) c.) 10% change in weight in six months (180 days).<br><br>The facility's hydration policy states the following:<br><br>* The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health.<br><br>* The facility will utilize the systematic approach to optimize the residence hydration status: a.) Identifying and assessing each resident's hydration status and risk factors b.) Evaluating/analyzing the assessment information c.) Developing and consistently implementing pertinent approaches d.) Monitoring the effectiveness of interventions and revising them as necessary.<br><br>* Nursing staff shall assess hydration status upon admission and throughout the residence stay in accordance with assessment protocols.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | * The dietician will assess hydration as part of the comprehensive nutritional assessment within 72 hours of admission.<br><br>* The dietician shall use data gathered from the nutritional assessment to the residence fluid needs and whether intake is adequate to meet those needs. A general guideline for oral hydration of the resident is: residents body weight in kilograms x 30cc = estimated fluid needs per 24 hours.<br><br>* The resident will be monitored for signs and symptoms of dehydration including, but not limited to: . confusion or change in mental status .decreased urinary output .abnormal laboratory values (elevated hemoglobin hematocrit, potassium, chloride, sodium, albumin, transferrin, blood urea nitrogen (BUN), BUN/creatinine ratio, or urine specific gravity).<br><br>* The resident will be monitored for signs and symptoms of electrolyte imbalance: .unexplained fatigue or lethargy.<br><br>* The resident will be monitored for conditions that may increase fluid needs: .new cardiac medication or diuretic.<br><br>According to Strategies for Ensuring Good Hydration in the Elderly, Dehydration is a frequent etiology of morbidity and mortality in elderly people. It causes the hospitalization of many patients, and its outcome may be fatal. Indeed, dehydration is often linked to infection, and if it is overlooked, mortality may be over 50%. Older individuals have been shown to have a higher risk of developing dehydration than younger adults. Modifications in water metabolism with aging and fluid imbalance in the frail elderly are the main factors to consider in the prevention of dehydration. Particularly, a decrease in the fat free mass, which is hydrated and contains 73% water, is observed in the elderly due to losses in muscular mass, total body water, and bone mass. Since water intake is mainly stimulated by thirst, and since the thirst sensation decreases with aging, risk factors for dehydration are those that lead to a loss of autonomy or a loss of cognitive function that limit the access to beverages. The prevention of dehydration must be multidisciplinary. Caregivers and health care professionals should be constantly aware of the risk factors and signs of dehydration in elderly patients. Strategies to maintain normal hydration should comprise practical approaches to induce the elderly to drink enough. This can be accomplished by frequent encouragement to drink, by offering a wide variety of beverages, by advising to drink often rather than large amounts, and by adaptation of the environment and medications as necessary. https://onlinelibrary.[NAME].com/doi/pdf/10.1111/j.1753-4887.2005.tb00151.x<br><br>R1 was admitted to the facility on [DATE] and had diagnoses that included hemiplegia (one-sided paralysis) and hemiparesis (one-sided muscle weakness) following cerebral infarction (stroke; brain bleed, restricted blood flow to the brain), dysphagia (difficulty swallowing) following cerebral infarction, hypertension (high pressure in the arteries), COPD (Chronic Obstructive Pulmonary Disease; progressive lung disease that makes it difficult to breathe), and type 2 diabetes (problem in way the body regulates and uses sugar as fuel). His admission Minimum Data Set (MDS), dated [DATE], includes a Brief Interview for Mental Status (BIMS) score of 14, indicating R1 was cognitively intact. R1 had a power of attorney (POA), but this had not been activated and R1 was his own decision maker during his stay at the facility.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's nutrition care plan states, Focus: nutritional status: potential for alteration in nutrition/dehydration related to stroke-left sided weakness, hypertension, anxiety, hypercholesteremia, gastroesophageal reflux disease, obesity, chronic obstructive pulmonary disease exacerbation, recently diagnosed type 2 diabetes, dysphagia manifested by altered texture diet, able to feed self .Goal: resident will consistently consume 75-100% of diet .Interventions: daily weights for 1 week, encourage fluids with and between meals, monitor resident food intake and record percentage for each meal, regular diet, minced and moist texture with ground meats, thin liquids, speech therapy as ordered, supplement per registered dietitian. All interventions on R1's care plan were put into place on 12/6/24. No further additions were made.<br><br>Of note, R1's admission orders included Spironolactone 25 mg (diuretic; a medication that increases urine production, helping the body get rid of excess fluid and salt), once daily. Additionally, R1 had orders for Metformin 500 mg once daily for type 2 diabetes and Sennosides (laxative) 8.6 mg once daily for constipation. Facility Medication Administration Record (MAR) for R1 indicates these medications were dispensed daily.<br><br>It should be noted R1's weights, in pounds (lbs.) during his stay at the facility (12/5/24 - 1/9/25) were as follows:<br><br>12/5/24 202.8<br><br>12/6/24 200.4<br><br>12/7/24 195.8<br><br>12/8/24 194.4<br><br>12/9/24 194.3<br><br>12/10/24 195<br><br>12/11/24 193.6<br><br>12/12/24 190<br><br>12/13/24 192.6<br><br>12/16/24 191.8<br><br>12/17/24 188.8<br><br>12/19/24 186.8<br><br>12/26/24 180<br><br>1/2/25 175.4<br><br>1/2/25 176<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 1/9/25 165.5<br><br>On 12/11/24 a progress notes for R1, written by RD C (Registered Dietician), states, Admission assessment . regular diet, minced and moist texture, thin consistency. Meal intakes are ~ 50% consumed. Resident reports he has had a decreased intake for a while even at home. Resident has permanent implants with no difficulties chewing or swallowing per resident report. Eats independently with set up assistance required. Has been eating meals in his room. Seeing speech language pathology until 1/7 with no recent changes to diet order. Estimated needs: 1880 Kcal/day, 88 to 106 g protein/day, one mL/Kcal recommended . resident is somewhat sleepy on visit, had just had therapy period resident is tolerating current minced and moist texture at this time period he reports his appetite is down but is happy with the weight loss he has had (10 pounds since admit). This writer reviewed his weight could gradually come down another 5 to 10 lbs. and be considered appropriate for him, but not at a rapid rate. Current BMI 29.4 is normal for age with a gradual decline to 25-30 acceptable. Resident reports he does not drink milk. He was living at home alone prior and preparing food for himself. He did not drink supplements and does not wish to have them here. He was interested in a snack of ice cream. Will review the option to offer a snack at HS (hour of sleep) for resident. RD C also conducted a mini nutrition assessment on 12/11, which R1 put R1 at risk for malnutrition due to a decrease in food intake and a weight loss greater than 3 kg (6.6 lbs.) in the last 3 months.<br><br>On 12/12/24 at 2:14 PM, an electronic note was sent to R1's physician, stating Resident has lost 8 pounds since admission on 12-5-24. Stated nothing looks or sounds good. Talked over menu items and a salad that has eggs for proteins was chosen for supper. Resident thinks colder lite foods are most appealing at this time. Will notify dietary. Lungs are clear and no edema. This note was acknowledged and signed by R1's physician on 12/19/24, but no recommendations were made.<br><br>On 12/16/24, RD C noted, Resident is reviewed for monthly skin weight. Current weight 12/16 191.8 lbs. are decreased 5% since admission 2 weeks ago. It is noted resident is pleased with weight loss and did want to lose some weight. BMI is 29.2 which is the upper end of acceptable for his age. Meal intakes have been scattered, 0-100% over the past week. Will consider supplementation if resident experiences further loss (will have to be Boost Breeze/Ensure Clear as he does not drink milk). No new recommendations at this time.<br><br>On 12/18/24, it was noted that R1 was coughing up brown sputum (mucus). R1's physician was notified, and orders were placed for Azithromycin and Cefdinir for 10 days.<br><br>Additional progress notes for R1:<br><br>* 12/20/24 at 7:15 AM: Refused breakfast and lunch today stating, I don't like the food here and I can stand to lose a few pounds.<br><br>* 12/25/24 at 6:48 PM: Resident has been refusing most meals. Drinks some liquids.<br><br>* 12/26/24 at 11:11 AM: Has lost 22 pounds since admission and 6 pounds in the last week. Has refused meals. Continues to drink cola and orange juice .Resident declined for any medications or treatments. Is own person. Dietary updated.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | * 12/26/24 at 11:35 AM: It was reported that resident has had recent weight loss and refuses meals . Resident states he does not care for food, which is why he doesn't eat. Write offered to have other options provided for meal, but resident stated he will eat when he gets hungry .Resident did begin to get a little agitate when asked about all of these concerns, as well as the offer for a medication to help with appetite/mood, stating he is tired of being prodded with questions all the time and wants staff to understand he is fine and feels good .<br><br>* 12/26/24 at 1:34 PM: Spoke with RD and we are going to do a trial of Boost Breeze, and she is going to check on what is going on, RD will do further charting on this resident. He refused to talk to me about his dislikes. States he will eat when he is hungry.<br><br>R1's physician was notified on 12/26/24 of the 6 lb. loss in one week and 22 lb. loss since admission.<br><br>A document titled, Diet History/Food Preference List, dated 12/27/24 states, Resident stated I will eat when I am hungry. Stated he liked all fruits .resident to get fruit daily .refused to give me any other food choices.<br><br>An RD note, dated 12/26/24 at 1:38 PM states, Resident has continued to lose weight since admission weight of 202 lbs. Upon admit, resident stated he was happy with some weight loss. He has, however, lost weight rapidly 20 lbs. over 3 weeks. He does not drink milk and refused the milk based Ensure. He has refused any appetite stimulants and reports he eats when he is hungry and decides when to eat. The resident's rights will be honored while offering snacks. Please offer him ice cream or another option at HS as he said he likes ice cream. He also agreed to trial Boost Breeze so these will be provided to nursing to see if and when he might accept these. The dietary manager has offered to take preferences and individualized meal selections.<br><br>A physician's order was placed on 12/27/24 to offer R1 ice cream at HS. This was started on 12/28/24 and tracked on R1's Treatment Administration Record (TAR). Additionally, Boost Breeze was documented in the progress notes but not tracked to include how much or how often it was being offered. A meal ticket for R1 (no date) was provided to surveyors showing fruit daily and Boost Breeze daily for each meal. No documentation was provided showing this was being tracked, how much was being drank, or if/when it was refused.<br><br>It should be noted the facility tracks food and fluid intake in percentages from 0, 1-25, 26-50, 51-75, and 76-100.<br><br>According to this documentation, R1 refused breakfast lunch and dinner from December 21-29.<br><br>Additional meal refusals:<br><br>Breakfast: December 17, 20, 30, 31 and January (2025) 1, 2, 3, 4, 6 and 9<br><br>Lunch: December 17, 18, 19 and January 1, 2, 4, 6, 7, 8<br><br>Supper: December 12, 13, 17, 19, 20, 30 and January 1, 3, 4, 7, 8<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1 also refused or drank 0% of fluids for breakfast lunch and supper from December 22-31 and January 3-8, with additional refusals or 0% intake as noted:<br><br>Breakfast: December 19, 21 and January 2<br><br>Lunch: December 12-15, 17-21 and January 1<br><br>Supper: December 10, 11, 13, 16, 17, 20 and January 1<br><br>Routine labs were conducted for R1 on 12/27/24 showing R1's BUN (blood urea nitrogen- waste product created when your liver breaks down protein) was 43 mg/dl (Normal range is between 8-23 for adults 60 and over in age). R1's creatinine (a level test that measures the amount of creatinine in your blood or urine. Creatinine is a waste product created when your muscles break down. It determines how well your kidneys are functioning) was 1.57 mg/dl (Normal creatinine level for men is between 0.7 and 1.3). On the labs, PA F (Physician's Assistant) wrote (and dated 12/30/24), Decrease in kidney function, was recently on 2 antibiotics. Any edema or change in fluid status? A 12/30/24 (11:37 PM) progress note replies to this, stating, .Resident already being monitored for edema.<br><br>Additional progress notes for R1:<br><br>*12/27/24 at 5:23 AM: resident agitated this AM due to running out of Pepsi. Explained to resident we carry cola and Shasta. Resident said he doesn't like either of those. Gave resident vanilla ice cream and Boost Breeze. Resident consumed alternative snacks until Pepsi can be purchased.<br><br>*12/27/24 at 10:22PM: resident was offered an ice cream cup with HS meds. Resident agreed and said he liked vanilla ice cream. Resident was given a vanilla ice cream cup and ate the whole thing.<br><br>*12/28/24 at 10:12 AM: refuses all meals. Will only drink liquids. Boost Breeze given and has only taken sips thus far after being prompted.<br><br>*12/28/24 at 4:37 PM: resident drank 1 carton of Boost Breeze. Sipped on it until gone.<br><br>*12/29/24 at 10:11 AM: continues to refuse meals. Has snacks in room and does not eat. Is sipping on boost breeze with much encouragement. Drinks regular Pepsi and juice.<br><br>*12/31/24 at 5:46 PM: Has been requesting and receiving pineapple for snack.<br><br>*1/1/25 at 4:14 AM: resident is reviewed for weight changes in December. Weight on 12/26 180 lbs. is documented as a significant loss from admission. Interventions include offering the resident various snacks especially at HS, offering Boost Breeze as resident allows. He has been accepting both of these. Resident's family expresses resident may take extra fruit sent on tray.<br><br>1/1/25 at 10:15 AM: Refuses meals. Drinks liquids.<br><br>1/1/25 at 1:26 PM: Refused meals. Accepted liquids to sip on during day.<br><br>1/2/25 at 10:15 AM: Resident had 4 LB weight loss in one week. Dietary notified. Physician notified. Resident often refuses meals.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 1/2/25 at 3:53 PM: Poor appetite/likes fruit<br><br>On 1/2/25 at 10:50 PM, a progress notes for R1 states, Resident started on Levaquin 500 mg four times a day times 10 days for coughing up phlegm. Tolerated antibiotic without ill effect. Chest X-ray to be done tomorrow.<br><br>Additional progress notes for R1:<br><br>*1/3/25 at 2:07 PM: Poor appetite. Eating fruit.<br><br>*1/3/25 at 6:21 PM: Does accept fruit dishes. Drank 1 Boost Breeze with encouragement.<br><br>*1/4/25 at 4:55 AM: .Has 8 three fruit cups .<br><br>*1/4/25 at 10:02 PM: Refused supper but did eat some fruit cups.<br><br>*1/5/25 at 3:46 PM: Poor appetite, likes fruit<br><br>*1/5/25 at 10:11 PM: Resident refused supper tray, but writer did get him a bowl of cut up pineapple around 8 PM.<br><br>A progress notes for R1, dated 1/9/25 at 8:36 AM states, Resident is very weak this morning. Three staff for a transfer. Skin color pale. No complaints of pain. No shortness of breath. Resident has refused most meals and will only eat a bite or two of fruit or ice cream. Weight down 10.5 lbs. in one week. Continues on antibiotic for excess phlegm. Call place to clinic to update and will wait on a call back. R1 was sent to the ED (emergency department) at approximately 9:00 AM.<br><br>R1's ED Notes, dated 1/9/25, states, in part: .<br><br>Date of Service: 1/9/25 .<br><br>Assessment & ED/UC Department Course:<br><br>. Leukocytosis (a high level of white blood cells in the blood) .<br><br>. Acute renal failure (a condition in which the kidneys suddenly can't filter waste from the blood) .<br><br>. Hypernatremia (condition that occurs when the level of sodium in the blood is too low) .<br><br>. Lactic acidosis (a condition that occurs when lactate builds up in the blood and lowers the body's pH balance) .<br><br>. Altered mental status .<br><br>. Weight loss<br><br>(continued on next page) |

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F 0692

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Patient presenting from nursing due to concerns about weakness, altered mental status, not eating, 40-pound (lb.) weight loss in 1 month. Per the report patient went to rehab after a stroke. He has not been wanting to eat . Patient appears very dry. Initial blood pressure in the 70s systolic. Given 2 liters intravenous (IV) fluids. Patient noted to but in acute renal failure with creatinine 4.76 this is increased from baseline of 1. 57. Patient with sodium of 150. Patient with white count of 22.73 (normal range between 4,500 - 11,000) with leukocytosis. Patient started on empiric antibiotics ceftriaxone and vancomycin. Foley catheter placed no urine output initially, bladder scanned and nothing in the bladder .Most concerning of all is lactic acid (a chemical produced by the body when it breaks down carbohydrates for energy) of 7.3 repeat of 5.3 (normal range between 0.5 and 2.2 millimoles per liter (mmol/L). Creatinine Phosphokinase (CPK) (enzyme that helps your muscles produce energy, can help diagnose and monitor muscle, heart, or brain injuries and diseases) is 297. (normal range is between 10 and 120 micrograms per liter (mcg/L)). Family informed of plan to transfer and that this is a serious condition .

Labs Reviewed:

Glucose- 133 (average range between 70 and 100mg) .

BUN 127 .

Sodium 150 (average range between 135 and 145) .

Lactate Sepsis with 4-hour reflex (refers to a medical situation where a patient with sepsis (a severe systemic infection) has significantly elevated lactate level in the blood) 7.4 (normal level below 2 mmol/L) . Lactate (chemical produced by the body when cells break down food for energy) 5.3 (normal level is less than 2 mmol/L) .9:18AM- Arrived . 1:49PM discharged .

R1 was transferred to another hospital.

R1's Discharge Summary, dated 1/16/25, states, in part: .

Date of Admission: 1/9/25. Date of Discharge: 1/16/25 .

Principal Diagnosis: Acute metabolic encephalopathy (a brain condition that occurs when there's a lack of oxygen, glucose, or vitamins in the body) .

Resolved Hospital Problems- Diagnosis

- Acute metabolic encephalopathy

-Hypovolemic shock (form of shock caused by severe dehydration or blood loss)

-UTI (urinary tract infection)

-Acute kidney injury

-Severe sepsis (life-threatening condition that occurs when the body's immune response to an infection damage organs) due to staph epidermidis UTI .

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525373 | A. Building<br>B. Wing | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care and Rehab - Boscobel | 207 Parker St<br>Boscobel, WI 53805 |

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 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Summary of Admission .<br><br>Patient presented to an outside ED from [Boscobel] skilled nursing facility for worsening weakness and altered mental status. Reportedly he had not been eating or ranking for past 3 weeks. He was initially admitted [DATE] to the nursing home and weight 202-pound, patient today weighs 165.5 pounds .<br><br>Hospital Course: Patient was admitted for management of UTI, AKI, and metabolic encephalopathy. Patient was also hypernatremia (a high concentration of sodium in the blood) at presentation. AKI thought to be due to prerenal which improved slowly with antibiotics and fluids. Hyponatremia was managed with 100 mL/h D5W (dextrose 5% in water that treats dehydration, low blood sugar, and insulin shock). UTI was managed with ceftriaxone . ciprofloxacin total 7-day course . Acute metabolic encephalopathy improved, though his dementia is advanced .<br><br>R1's hospital notes, encounter date 1/9/25, states, in part: .<br><br>BUN 1/9/25 - 127 mg/dl (12/27/24 - 43 mg/dl)<br><br>Creatinine 1/9/25 - 4.76 mg/dl (12/27/24 - 1.57 mg/dl)<br><br>WBC 1/9/25 - 22.73 (11/11/24 - 11.11)<br><br>Magnesium 1/9/25 - 3.7 (2/1/24 - 2.2)<br><br>HS-cTnT, Baseline (a measurement of the amount of troponin T in the blood, a level of above 14 indicates a likelihood of heart damage) 1/9/25- 48 11/11/24 - 13 .<br><br>R1's family submitted a grievance to the facility regarding weight loss to which NHA A (Nursing Home Administrator) responded, documenting: Concern about resident's weight loss since admission. RD progress notes 12/16, 12/26, and 1/1/25. MD updated on weight loss 12/19 and 1/8/25. This writer discussed weight loss and resident's refusal to eat, take in fluids and supplements given. Fruit offered .Resident is own decision maker .Refusals of cares monitored on the TAR began 12/31/24. Dietician reviews and resident had desire to lose weight. Resident was provided supplements. Resident stated he desires fresh fruit.<br><br>On 1/22/25 at 9:00 AM, Surveyor interviewed RN D (Registered Nurse) who stated that a significant weight loss would be 3 pounds in a day or 5 pounds in 1 week, 10% in 30 days. RN D stated that if such a weight loss would occur, he would notify POA, physician.<br><br>On 1/22/25 at 9:26 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) stated that if there were weight loss she would update the MD the day it is found, send a slip to dietary- it has lung sounds, edema, medications. LPN E stated that she would notify physician of 3 lb. or greater in 1 week, 5% in 1 month, 10% in 6 months.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525373 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Care and Rehab - Boscobel | | STREET ADDRESS, CITY, STATE, ZIP CODE: 207 Parker St Boscobel, WI 53805 | |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Additionally, LPN E stated that R1 did feed himself but refused to eat. They tried all different foods. LPN E stated they offered to assist him with eating-he refused all. R1 would say I will eat when I am hungry. LPN E recalled R1 stating, Nothing looked good. LPN E stated R1 would eat fruit and ice cream at first but then stopped. Facility tried Boost and Breeze supplements. It would take a very long time to get him to drink a breeze. We would have to keep coming back throughout day to get him to drink whole breeze. LPN E stated R1 struggled with eating ever since he came to the facility. LPN E also stated R1 would say I will eat when I am ready and that he would eat pineapple and ice cream but that wasn't enough; he would not allow staff to assist him. LPN E stated that when R1 would not eat, alternatives were offered but specific items were not charted, only alternatives refused. LPN E stated the facility tried the Breeze for a while and offered ice cream at night but stated the ice cream did not get documented; nursing would not put stuff on the MAR until something was found that he liked or they would be constantly charting refusals. LPN E stated fluid amounts did not get documented, just percentages. When asked for a resident with that amount of weight loss in such a short period of time if she would expect to see specific amounts of fluid and food intakes to be charted, LPN E stated, He was his own person, but she would update MD on the weight loss.<br><br>Surveyors conducted additional interviews with CNAs (Certified Nursing Assistant) interviews on 1/22/25:<br><br>*At 9:52 AM, CNA G stated R1 refused meals often and would keep fruit off his tray and not eat it. CNA G stated R1 was able to feed himself and was on a regular diet, not mechanically altered. CNA G stated she would document refusals for meals and fluids or document percentages. Additionally, CNA G stated that when R1 refused she and the other CNAs would let the nurse know and offer alternatives. CNA G stated she was not sure if R1 received a supplement but if a resident received a supplement, CNAs could chart the resident was given the supplement, but not the amount taken or consumed and if a supplement was given during medication pass, CNAs check yes or no if they drank it- but no specific amount. CNA G stated snacks do not get documented, but they report to the nurse that they were offered.<br><br>*At 10:00 AM, CNA H stated R1 fed himself but refused a lot of meals and this would be documented and reported to the nurse. CNA H stated R1 refused a lot. CNA H stated when a resident is weighed, if there is a 5 lbs. or more weight loss, CNAs are to tell the nurse and reweigh. CNA H stated R1 lost a lot of weight and was a daily weight.<br><br>On 1/22/25 at 2:49 PM, Surveyor interviewed RD C who stated that she sends her recaps about residents to facility administration and indicated she had sent her admission assessment of R1 to the DON (Director of Nursing). When asked why R1's interest in ice cream on 12/11/24 was not put into practice until the 12/28/24 or why it had not been used more given R1's weight loss, RD C stated, It's only 150 calories. RD C stated the initial weight loss could have been fluid loss after coming from the hospital. RD C stated that tracking fluid amounts for R1 would not have mattered as it only would have confirmed what they already knew that he was refusing. Additionally, RD C stated that when tracking fluids the way the facility currently does it with entering percentages, Percentage of what? indicating that unless there was a defined or documented amount of fluids given, percentages do not detail how much fluid is taken in.<br><br>On 1/23/25 at 10:25 AM, Surveyor interviewed PA F (Physician's Assistant) who stated that she never did get a reply when she asked about the fluid status of R1 on 12/30/24 and was not sure if that had been relayed to R1's physician as he (R1's physician) is currently on medical leave.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 1/22/25 at 3:10 PM, Surveyor interviewed DON B (Director of Nursing), along with NHA A (Nursing Home Administrator.) DON B stated that normally the physician will recommend additional daily weights, but the RD could also do that. DON B stated that there was no discussion of continuing daily weights after the initial admission orders and the facility had not talked about documenting intakes and output amounts of fluids for R1, even after his reduced kidney function was known on 12/27/24. When asked if R1 had been given a clear risks vs benefits describing the extreme risks of continuing to refuse snacks, meals and fluids, DON B indicated that had not been done. DON B stated that snacks were not tracked as to how much they are given or how much was consumed and, additionally, the Boost Breeze that was given with meals was not documented or observed for success or failure. DON B stated that they will be tracking snacks and supplements better moving forward. DON B stated the facility had not considered any sort of IV (Intravenous Fluids) or advanced hydration for R1 NHA A stated that R1 was his own person and allowed to refuse.<br><br>R1 was admitted to the facility and immediately began losing weight. R1's admission nutrition assessment was not completed until 12/11/24 at which time he had lost 9.2 pounds. At this time, R1 indicated would enjoy ice cream, but this was not put into orders until 12/27/24 after R1 had lost an additional 13.6 lbs. Daily weights were discontinued on 12/13/24. R1's physician was notified on 12/26/24 regarding a 22-lb weight loss since admission and 6 lbs. in the previous week. Ice cream was added to R1's orders in addition to a trial of Boost Breeze and added fruit at each meal. These items were not tracked as to how much was consumed. The ice cream was noted as being given staring on 12/28, but not how much was consumed or if it was consumed. R1 was taking a diuretic and there is no documentation of a discussion with the physician regarding the continued use of the diuretic in light of the resident's decreased food and fluid intake. When labs came back [TRUNCATED] |