IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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October 21, 2015

Joseph Rudd, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

FILE COPY

Provider #: 135079

Dear Mr. Rudd:

On **October 1, 2015**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **September 23, 2015**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0325 -- S/S: G -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable
F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 3, 2015.**
The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.

- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the Bureau of Facility Standards' letter of , following the survey of **July 17, 2015**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **January 17, 2016**, if substantial compliance is not achieved by that time. The findings of non-compliance on **October 1, 2015**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On September 4, 2015, CMS notified the facility of the intent to impose the following remedies:

- A 'per instance' civil money penalty of **$1,700.00 per instance for the instance on July 17, 2015 described at deficiency F0325 (S/S: G)**

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **November 3, 2015**. If your request for informal dispute resolution is received after **November 3, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135079	A. BUILDING _____ B. WING _____	R-C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following deficiencies were cited during the onsite follow-up federal recertification and complaint survey conducted at the facility from September 29 to October 1, 2015. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Kendra Deines, RN, BSN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed TAR = Treatment Administration Record SBAR = Subject, Background, Assessment, Recommendation	{F 000}	*"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."*	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	RECEIVED NOV 12 2015 FACILITY STANDARDS F 314 **Identified Residents** Resident #34 had head to toe skin assessment and new Braden score completed by licensed nurse on or before 10/9/15 to identify any new risk factors and that no further	

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

TJB Cdd | Administrator | 11/11/15

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.

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F 314	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure 1 of 8 residents (Resident #34) did not develop pressure sores while in the facility when *the resident's skin breakdown care plan was not updated to reflect current interventions; *interventions to prevent further pressure sores and help current sores heal were not implemented as ordered; *the resident's input on preferences, needs, goals, and alternative interventions were not provided with resident refusals; *the resident's body alignment in the wheelchair was not addressed; and, *the wheelchair cushion positioning was not assessed proper placement was not ensured. The failure resulted in harm when the resident developed an unstagable pressure sore and a suspected deep tissue injury. Resident #34 was admitted to the facility 9/26/2011 with multiple diagnoses including mild intellectual disabilities and osteoarthritis in the legs, B-complex deficiencies, and breast cancer. The resident's 6/30/15 quarterly MDS documented the resident as cognitively intact, had no resistance to care, was at risk for developing pressure sores, had pressure reducing devices to her chair and bed, and was on a turning/repositioning program. The resident's care plan, initiated 10/10/14, documented the resident was at risk for skin breakdown due to the resident's preference to sleep in her recliner and wheelchair. Interventions for skin breakdown, all created on 10/10/14,	F 314	breakdown was identified. Care plan was updated by interdisciplinary team on or before 10/12/15. Center LSW met with resident on 10/1/15 regarding self-care and risks associated with. Resident continues to choose to direct her care. Resident's wheel chair cushion and positioning was assessed by licensed nurse on or before 10/12/15. No new issues were noted at time of assessment. **Potential Residents** A head to toe skin assessment was completed for other residents residing in the center by members of the nurse management team on or before 10/12/15 to assess need for potential follow-up for those with self-directed goals, cushion assessments, and body alignment review for any new pressure ulcers identified. No follow up needed due to no other residents were identified with pressure ulcers. Residents residing in the center with pressure sores were assessed by skin integrity coordinator on or before 10/9/15 to validate timely recognition of changes in the	

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F 314	Continued From page 2 included: -encourage repositioning in wheelchair-recliner every 2 hours and prn; -evaluate for any localized skin problems; -evaluate skin risk factors per protocol; -if resident chooses not to use cushion in recliner place blanket under her while in recliner as she will allow; -monitor skin for signs/symptoms of skin breakdown; -observe skin condition with ADL care daily and report abnormalities; -pressure redistribution surfaces to recliner as resident will allow; -pressure redistribution surfaces to wheelchair as per protocol; -provide patient and/or healthcare decision maker education regarding risk factors and interventions; and -weekly skin assessment by license nurse. No revisions were made to the skin breakdown care plan after 10/10/14. The care plan did not reflect efforts seeking alternatives to address the resident's risk of skin breakdown when she refused. The care plan was not revised to modify prevention strategies. A 7/28/15 nursing note documented the resident had a new skin concern on her buttocks, and the resident was encouraged to turn, but the resident continued to sit in the wheelchair, reluctant to move. The documented intervention was to encourage the resident to turn. There was no documentation as to why the resident stated she was reluctant or what the facility did to address the identified barriers. Documentation of similar reluctance from the resident, and encouragement from the facility, was noted on 8/1, 8/5, and 8/8,	F 314	wound. Notifications, orders, and care plan updates were completed as indicated at time of review. Residents residing in the center, or their representatives as indicated, with history of refusing current care plan interventions were interviewed by center LSW on or before 10/12/15 for choice, preferences, and solutions. Care plans were updated at time of interview as indicated with alternative approaches and interventions. Residents residing in the center had wheel chair cushions reviewed on or before 10/12/14 by members of the nurse management team to assess for positioning placement and verify cushion was pressure relieving. Corrections made as indicated at time of review. **System Changes** Regional manager of clinical operations completed skin integrity clinical process monitor on or before 10/9/15 to ensure skin integrity system was followed. Process monitor includes but is not limited to staff awareness of interventions that prevent pressure ulcers, quality	

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F 314	Continued From page 3 without identification of reasons for the resident's reluctance, or how the faciity attempted to address those barriers. Aside from those three instances, no further encouragement from the facility was documented during the month of August 2015. No care plan revisions were noted. On 8/17/15 a communication form to the physician documented the reddened area on the coccyx was becoming more red. No further assessments or interventions were documented at that time. A PT (physical therapist) note on 9/16/15 documented when the resident stood up from her chair, a soiled pad was observed by the therapist with what appeared to be drainage on the pad. It documented the drainage was reported to the Rehab Manager, who investigated the situation with the nurse manager. In addition, PT notes on 9/15/15 and 9/17/15 documented the resident slumped to the left in her wheelchair. Follow up on the resident's alignment and positioning in the wheelchair was not documented, and investigation of where the drainage came from was not documented. On 9/19/15 the resident's previously noted area to the coccyx was tender. The resident was provided education, with no identification of the root cause of resident refusals or attempt to address her objections. No new interventions were implemented. A physician order written on 9/21/15 documented the resident sat in either the wheelchair or recliner at all times. It documented the resident refused to offload properly and sleep in her bed, in addition to a preference to sleep in her	F 314	improvement committee reviews skin integrity process, nursing assessment identifies skin integrity, completion of Braden scores, skin integrity reports are initiated as indicated and bed/chair surfaces heel lift devices and repositioning are employed. No breaks in the system were identified during review. Center nurse management team was educated by regional manager of clinical operations on or before 10/9/15 regarding policies and procedures for pressure ulcer prevention including the identification/anticipation of skin integrity issues with a patients declining condition. Center IDT, including social services, will review residents with changes in pressure ulcers, self-direction of care, wheelchair positioning needs and changes of condition during morning clinical meeting as well as weekly customer at risk meeting. New admission records will be reviewed during morning clinical meeting and weekly CAR meeting to identify skin integrity risk factors by	

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F 314	Continued From page 4 wheelchair and sometimes the recliner. An SBAR communication form dated 9/22/15 documented the resident had an unstageable pressure ulcer on the left ischial tuberocity and lower superior area of the posterior thigh measuring 8cmx3cmx<0.1cm, with 95% slough and 5% eschar tissue. Treatment orders were obtained, along with an order for an air mattress, and an order for the resident to lie down in bed when in her room every 2 hours. This form documented the problem may be due to resident's end stage cancer, refusals of getting out of the wheelchair, and sleeping in the recliner. A change of condition note dated 9/22/15 documented the resident was educated regarding lying in bed to offload. The September 2015 MAR documented the resident lay down in bed every 2 hours a total of 30 of 158 opportunities, was in the wheelchair 41 of 158 opportunities, refused 15 of 158 opportunities, sat in the recliner 5 of 158 opportunities, and 4 of 158 were blank. On 9/29/15, the MAR documented the resident had not lay in her bed since 6:00 a.m. on 9/26/15 (approximately 104 hours or 3 days). The MAR did not document interventions which had been attempted when the resident refused to lay in the bed. On 9/28/15 the resident's nutritional assessment documented the resident was not meeting calculated nutritional needs and lost 15.9% of her weight in 60 days. There is a potential the weight loss relates to the development of pressure sores. Refer to F-325 for more details. On 9/30/15 at 11:15 a.m., the resident's wound	F 314	the interdisciplinary team and needed social services follow up related to self-directing care. **Monitoring** Beginning the week of 11/02/15, members of the IDT Management will conduct audits of 5 current patients with pressure ulcers and/or palliative goals to identify skin integrity changes and/or non-compliance with preventive measures or treatments including pressure relieving wheelchair cushions in accordance with formulary of approved pressure relieving devices. Beginning the week of 11/2/15, members of the nurse management team will conduct a review of 5 current for wheelchair positioning each week for 4 weeks then 5 residents monthly for 2 months. The Director of Nursing or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or	

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F 314	Continued From page 5 was observed. There was an approximately 9 inch purple colored round area on the resident buttocks, which did not blanch. The area started in the middle of the resident's bottom and ended just after the gluteal fold on the back of the thigh. On the left leg at the gluteal fold, a 7cmx3cmx<0.1cm wound was observed with another wound inside this area. The outer wound area was yellow with less than 0.1cm depth. The inner wound was approximately 2.5cmx2.5cm (this inner wound was not measured by the wound nurse separately from the wound area surrounding it) with 90% slough, 5% granulation, and 5% necrotic tissue. The wound had a strong odor. Another wound, identified by the wound nurse as "new," was lateral and superior to the aforementioned wound. The wound was 0.5cmx1.2cm, did not blanch, and was black in color. The wheelchair cushion at this time was observed to be an inch short of the edge of the wheelchair seat. When the resident stood there was a visible crease across the skin on both legs where the edge of the wheelchair cushion had been. On 9/30/15 at 12:15 p.m., The resident reported she awakened in her wheelchair at 2:00 a.m. and had to request assistance to bed. She stated she slept in her bed when she was at home and that her "bottom" felt better when she laid down. On 10/1/15 at 1:35 p.m., the occupational therapist (OT) stated the resident's routine was to stay in her wheelchair or recliner. When asked about the wheelchair cushion and if it should line up with the edge of the wheelchair or be about an inch short of the edge, to where it was putting a crease in the resident's skin, she stated it had to be turned 90 degrees from its current position to	F 314	the need for process changes as required.. Any findings will be corrected with re-education and performance improvement plans as indicated. Beginning in November 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated. **Date of Compliance** **11/02/2015**	

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F 314	Continued From page 6 fit in the wheelchair properly. She stated wheelchair cushions would be assessed with a change in condition, or when the cover was cleaned to see if there were any tears. There was no documentation of staff education regarding the positioning of the wheelchair cushion in the seat or re-assessment of the efficacy of the current cushion. When asked about the resident's tendency to lean left, she stated she was unaware of the leaning and did not assess this. The facility failed to recognize or address the resident's body alignment in the wheelchair as a risk factor, and was not addressed. In addition, the facility did not recognize the possibility of the resident's wheelchair cushion being improperly placed as a risk factor and this was not addressed. There was no assessment or education to ensure proper placement by staff. The manufacturer's specifications for the wheelchair cushion in use for the resident documented the resident was on an EquaGel General Cushion. The specifications did not document the cushion had pressure-relieving qualities, corrected lateral lean, or was appropriate to be used for pressure ulcer prevention or healing. On 10/1/15 at 3:00 p.m., UM #1 and the wound nurse (WN) were interviewed regarding the resident's pressure sores. The WN stated the resident primarily needed to be offloaded, and if the resident refused the bed to offload then the resident would offload by transferring from the wheelchair to recliner. She stated the head of the recliner needed to be less than 30 degrees for optimal offloading. The WN stated the resident's use of the recliner wasn't routinely documented,	F 314		

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F 314	Continued From page 7 and placing the recliner at less than 30 degrees for offloading was not documented in the care plan. UM #1 and the WN were unsure of social work involvement regarding the resident's refusals to offload out of the wheelchair. The WN stated the resident did not use her bed, because it was uncomfortable to lay flat. The WN stated the new lateral area found on 10/1/15 was a suspected deep tissue injury. UM #1 was unsure of the results of the investigation of drainage found by PT on 9/16/15. On 10/1/15 the resident record documented the first social services consult related to the resident's refusals. The resident developed an unstageable pressure ulcer and suspected deep tissue injury when the facility failed to recognize and assess factors that placed the resident at risk for developing pressure ulcers, implement interventions for pressure ulcers in accordance with the residents preferences, and revise the resident's skin breakdown care plan. The facility identified the resident had risk of skin breakdown due to refusals to lay down or get out of her wheelchair; it could not be determined why the resident refused to offload out of the wheelchair, or if encouragement on offloading was an effective intervention to prevent pressure sores. Social work involvement was not documented regarding refusal. Discussion with the resident regarding her condition, options for preventing and treating pressure sores with alternatives to refused interventions, or the resident's concerns regarding pressure sores including her preferences, needs, and goals, were not documented. The facility documented the resident had a history and preference of not	F 314		

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F 314	Continued From page 8 utilizing her bed; the resident reported she awakened in her wheelchair at 2:00 a.m. on 9/30/15 and had to request assistance to bed. In addition, the resident had skin breakdown without re-assessment of risk factors or interventions that addressed possible root causes of the skin breakdown before 9/22/15. The facility identified the resident's tendency to lean left and no interventions addressed this; assessment and education on positioning of the cushion in the wheelchair was not documented. The skin breakdown care plan was not updated after 10/10/14. Interventions to offload the resident out of the wheelchair were not implemented as ordered; the resident did not exit the wheelchair from 9/26/15 to 9/29/15.	F 314		
{F 325} SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review it was determined the facility failed to ensure interventions were consistently implemented, reviewed, and revised	{F 325}	**F 325** **Identified Resident** was assessed for current weight loss on 9/28/15 by center registered dietician and supplements increased from twice per day to three times per day. Anticipated weight loss order was received from physician extender on 9/28/15 related to resident # 34s clinical conditions. Weights were discontinued per physician order on 9/30/15 and nutritional supplements intakes were added to the MAR. Orders received on 9/30/15 for sores in her mouth by licensed nurse. Orders were processed and implemented. Center dietary services manager met with resident on 9/30/15 and obtained an updated food preference list. Center	

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APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

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{F 325}	Continued From page 9 for a resident identified with severe nutritional risks and significant weight loss. This was true for 1 of 3 (#34) residents sampled for weight loss. This failed practice resulted in harm when Resident #34 experienced a severe weight loss of 8.5% in 18 days. Resident #34 was admitted with multiple diagnoses including B-Complex deficiencies, mild intellectual disabilities, headaches, chewing difficulties, and breast cancer. The 9/30/15 Significant Change MDS assessment coded the resident: * Cognitively intact; * Required set-up help only for meals; * Had protein/calorie malnutrition; * Experienced unplanned significant weight loss of 5% or more in the last month or loss of 10% or more in the last six months; * Provided a mechanically altered diet; and * Difficulty with chewing. The Current Care plan documented the resident ate meals in her room per her preference with assistance to set-up her meal. If she slept through a meal she should be offered an alternative meal. Monitor weight as ordered; Honor food preferences within meal plan; Weigh monthly; Monitor for changes in nutritional status; Provide diet as ordered, dysphagia advanced per resident request; Offer alternate food choices if less than 50% consumed at mealtime; Offer snack when rises if refuses/misses breakfast; and encourage the resident to come to the dining room for meals... The September 2015 Physician Orders documented:	{F 325}	LSW met with resident on 10/1/15 to address dentures and risks associated with her self-directed care. Resident once again declined dental treatment at time of interview on 10/1/15 as well as stating she has the right to refuse treatments and medications and will continue to do so. Family care conference was held on 10/5/15 to discuss resident's self-determination of care and dentures and educated on recent weight loss. Once again, resident declined dental treatment and changes to dietary preferences and textures. Family verbalized support of resident's wishes discussed in care conference on 10/5/15. Resident's primary physician and oncologist provided input related to weight loss on 10/2/15 stating it is a result of her cancer progression. Care plan was updated by members of the interdisciplinary team on or before 10/9/15. Resident #34 was reviewed in Clinical at Risk meeting by the Interdisciplinary Team including the Social Worker on or before 10/8/15 related to self-direction of care,	

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{F 325}	Continued From page 10 * Regular/liberalized diet, dysphagia advanced texture; * House Supplement two times a day with lunch and dinner was provided until 9/27/15. On 9/28/15, the supplement was changed to three times a day, per the resident's request, which the facility offered with lunch, dinner, and bedtime; and * Chart amount of meals taken, if 50% of meal not consumed offer substitution. Meal Intakes reviewed from 9/23/15 to 9/29/15 for breakfast, lunch, and dinner documented: * 9/23/15: Breakfast and lunch - 25%, * 9/24/15: Breakfast - refused, * 9/26/15: Breakfast - 25%, * 9/27/15: Breakfast - refused, * 9/29/15: Breakfast - refused and lunch - 25%. The meal intake record did not document the resident was offered a substitution for the meals when less than 50% was consumed. The Medication Administration Record (MAR) documented house supplement three times a day with breakfast, lunch, and at bedtime. The LN initialed the MAR to document the supplement had been given to the resident. The MAR did not include how much of supplement was provided, nor how much was consumed. On 9/28/15, the 5:00 PM and 8:00 PM supplements were not initialed and on 9/29/15 the noon the supplement was not initialed. On 9/29/15, Unit Manger (UM) #1 stated the house supplement was 120 mls (milliliters). The UM stated the LNs initials indicated the entire supplement had been provided and consumed. When asked by looking at the MAR how would someone know how much of the supplement was	{F 325}	weight change, and denture preference. Resident #34 was offered a dental examination by a Mobile Dental Company by social services on 10/9/15. Resident #34 was educated on dental health and proper dental hygiene at the time of offering dental services and verbalized understanding. Resident #34 continued to decline dental treatment. Resident #34 will continue to be re-approached regarding her dental needs quarterly or as resident expresses concern. **Potential Residents** Other residents residing in the center were reviewed by members of the nurse management team to validate that no unidentified significant weight changes have occurred and identified root cause to include ill-fitting dentures, need for changes in diet, care plan updates, and physician input. Reweights and notifications were completed at the time of review as indicated. Any new orders were implemented and care plans were updated as indicated.	

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{F 325}	Continued From page 11 provided and consumed, the UM stated, "A person would not know that unless [he/she] was familiar with the facility's practices." She stated it was a standard of practice for the facility. The Nutritional Assessment, dated 9/28/15, documented: * The resident had significant/severe weight loss; * There were no educational needs identified for the resident; * The resident's intakes were not meeting her calculated needs due to, "Inadequate intakes r/t [related to] terminal disease and lack of appetite." * Nutritional interventions included to continue the plan of care, honor food preferences, offer snacks and beverages, and increase supplement to three times a day per resident request. * The resident's "most recent weight" documented weight of 130 pounds was taken on 9/12/15, sixteen days prior to the assessment. On 9/28/15, the RD calculated a 8.1% weight loss based on weights from 8/2/15, 9/2/15, and 9/12/15. The assessment did not include a current weight for 9/28/15. The resident was not re-weighed until 9/30/15, at the request of the surveyors, and weighed 119 pounds. From 9/12/15 to 9/30/15 the resident had a calculated weight loss of 8.5% in 18 days. * The RD documented the resident was not on the Dysphagia diet related to swallowing concerns, but related to obvious chewing issues and the poor condition of her teeth. Additionally, the RD documented the resident "requested" to remain on the Dysphagia advanced diet without raw fruits, vegetables, or salads. On 9/29/15 the following observations were made and interviews conducted: * 1:25 PM, the resident was observed in her room	{F 325}	Residents receiving nutritional supplements were reviewed for recording of intakes on the MAR by the Regional Manager of Clinical Operations on or before 10/10/15. Corrections were made as indicated. **System Change** Regional Manager of Clinical Operations re-educated center nurse management team and dietician on monitoring physician ordered supplement intake on or before 10/9/15. The intake percentages of nutritional supplements will also be added to the Medication Administration Record (MAR). Regional manager of clinical operations completed weight management clinical process monitor on or before 10/9/15 to ensure weight management policy was followed. Process monitor includes but is not limited to residents are weighed at time of admission and per MD orders ongoing, dietitian notified of weight changes, nutritional assessments are completed, care plan is updated to reflect new goals and approaches.	

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{F 325}	Continued From page 12 watching the television. * 1:30 PM the resident's lunch tray was delivered to her room, without the ordered supplement, and left on the counter top by the sink. When asked if she was aware the lunch tray had been delivered, she stated she did not know because the CNAs did not always tell her. She expressed concerns related to weight loss and stated she had lost "a lot" of weight and she knew this because she had asked the CNAs on 9/28/15 and 9/29/15 to weigh her and she weighed 118 lbs. She identified her appetite has been poor for several years because nothing sounded good and she thought her taste buds were dead. When asked if she liked the texture of her food she stated it was, "okay," but she did not have a choice due to difficulty chewing without her dentures and the poor condition of her remaining teeth. When asked what happened to her dentures, she stated when she started losing weight the dentures became loose and no longer fit which caused sores in her mouth, she stopped wearing them, and now has no idea where they were. She stated she would like to have her dentures fixed so she could eat, "Fried chicken, corn on the cob, fried potatoes," and she would "love" to eat an orange. She stated she has had some sores in her mouth for awhile which have made it difficult for her to eat acidic foods. She stated she had told the Licensed Nurse about it but does not remember what the nurse said. When asked if she had a choice of what she wanted to eat, she stated the CNAs give her a paper "menu" and she picks what she wants to eat and if she did like what was on the menu she just didn't pick anything. She stated if she didn't mark anything they did not bring her anything unless she asked. * 3:00 PM, the resident's meal intake for lunch was reviewed and documented the resident ate	{F 325}	No breaks in the system were identified during review. In accordance with the Weight Management Clinical Process Physician orders will continue to be reviewed during morning clinical meeting by members of the IDT including but not limited to physician ordered supplements. Supplements will be reviewed to ensure that intake is included on the administration record. Center IDT, including social services, will review residents with changes in weights, self-direction of care, and changes of condition during morning clinical meeting as well as weekly customer at risk meeting. Center IDT will review residents with changes of condition including but not limited to significant weight changes during morning clinical meeting as well as weekly customer at risk meeting. New admission records will be reviewed during morning clinical meeting and weekly CAR meeting to	

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{F 325}	Continued From page 13 25% of her meal. There was nothing documented to indicate the resident had been offered a substitution. * 3:05 PM, when asked if she had received a supplement with her lunch, the resident stated she had not. She stated they just brought her a chocolate supplement, but she could not drink it because it was frozen solid. The resident was observed to pick up the supplement carton, pound it on the top of her dresser with an audible thunk, and stated, "See, it's frozen, can't drink it." On 9/30/15, the following observations were made and interviews conducted: * 12:00 PM, during an interview with the resident, she stated she had not been asked what her food preferences were. She stated she disliked beef, the facility's potatoes, hashbrowns, and french fries because they were never completely cooked and always cold; and the green beans and carrots because they were too hard to chew. She stated she liked onions, but could not eat them because they were too difficult for her to chew. She stated she likes chocolate ice cream and the chocolate supplements. She said the staff used to bring her the supplements three times a day with her meals, but they stopped and now she has to ask for them. 12:15 PM, the resident's lunch tray was delivered to her room and included 2 glasses of fruit punch and two 4 x 4 slices of pizza with thick crust, ground beef and cheese. The pizza was not cut up for the resident and the lunch tray did not include a house supplement. It was unclear why the resident was served pizza crust which was inconsistent with the Dysphagia advanced diet and hamburger pizza when she had identified she "disliked" hamburger on her meal ticket. The facility's Dysphagia advanced diet documented,	{F 325}	identify potential weight change risk factors by the interdisciplinary team. **MONITORS** Beginning the week of 11/02/15, members of the nurse management team will complete weekly audits related to weight changes to assure re-weights occur following the identification of the weight change, timely notification of weight change, involvement of residents' support system and physician and root cause/etiology is identified for 1 month then monthly for 2 months. The Director of Nursing or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated. Beginning in November 2015, the compiled results will be presented by the Director of Nursing during the	

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{F 325}	Continued From page 14 "Traditional pizza crust and any dry, tough or crusty bread or rolls should be avoided." The Food Preference Questionnaire, dated 9/30/15, completed by the Senior Service Director of Dining Services (SSDDS) documented, the resident did not want french toast, cole slaw, raw vegetables, and/or raw fruits. The Questionnaire documented the resident stated she could not chew green beans, carrots, or potatoes because they were too hard. The form documented the resident would be "okay" with puree veggies and described them. The form documented the resident agreed to puteed vegetables in light of her chewing deficit. The SSDS documented dietary services would send mashed potatoes to replace diced and baked potatoes. The previous documented Food Preference Questionnaire was completed in May 2015. Progress Notes were reviewed and documented the following: * 9/30/15, the wound nurse documented, "Resident stated that things (food items) don't sound good to her. Resident offered scheduled health shake. Resident seen by NP [Nurse Practitioner] r/t [related to] new onset of canker sore in her mouth. NP discontinued monthly weights r/t anticipated weight loss and terminal cancer DX [Diagnosis]." * 9/30/15, the DNS documented, "Notified oncology of...weight loss. Currently her cancer is stable but due to stage IV (four) [cancer] resident is expected to decline. Oncologist to review case regarding weight loss...and determine a course of action." * 10/1/15, the Registered Dietician documented, "Pt [Patient] with 8.4% weight loss this month r/t end stage cancer with disease progression, from	{F 325}	QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated. **Date of Compliance** 11/02/15	

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{F 325}	Continued From page 15 (9/12) 130 lbs to (9/30) 119 lbs...Dietary Manager met with resident yesterday and made additional changes to her diet for chewing difficulties that resident requested and agreed to. Pt is receiving house supplements tid and she usually drinks those. She is additionally offered snacks tid-prn and offered substitutes with refused or low intakes at meals." On 10/1/15, The RD was asked how she determined the addition of a third supplement was an appropriate intervention for the resident's continued weight loss. She stated the third supplement was added, "per the resident's request." When asked the RD and UM #1 were unable to identify what the rationale for the chosen interventions were; how staff evaluated the effectiveness of the current interventions; and how the IDT team decided to maintain or change the current interventions. When asked if the resident's Oncologist had been involved in evaluating and addressing potential underlying causes for weight loss, poor appetite, decreased intake, and decreased taste sensation related to the resident's cancer, the RD and UM #1 stated the facility had not contacted the Oncologist prior to 9/30/15. When asked why the resident's dentures had not been fixed, the RD stated the resident was afraid to go to the "dentist." When asked what had been done to determine the root cause of the resident's fear, if the physician had been notified, and/or the resident had been re-approached, the RD stated, "I see what you are saying, I get it." UM #1 stated the resident would not wear her dentures because they did not fit well and did not know what had been done, but would look into it. When asked why the 9/12/15 weight was used for the Nutrition Assessment on 9/28/15, the RD stated, "She [the resident]	{F 325}		

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{F 325}	Continued From page 16 weighs when she wants to weigh and she did not want to be weighed that day." The RD was informed the resident had verbalized to the surveyors she had been weighed, per her request, on 9/28/15 and 9/29/15. The RD stated the resident is weighed once a month. When asked if once a month weights were frequent enough for this resident related to her weight loss, the RD stated it was not. Resident #34 was harmed when the facility failed to monitor and modify interventions consistent with the resident's assessed needs, choices, and goals, to maintain acceptable parameters of nutritional status; failed to obtain direction and input from the resident's physicians as appropriate in evaluating and managing causes of the resident's nutritional status; failed to modify the resident's care plan related to the changing needs and goals of the resident; failed to offer alternatives or other interventions to include calorie-dense meals/snacks and/or more frequent meals; failed to offer substitutions or choices at meal times as appropriate and in accordance with her preferences; failed to discuss risks associated with refusal of needed therapeutic approaches and treatment options; and failed to address the resident's poor fitting dentures and subsequent concern when she developed a sore or sores in her mouth.	{F 325}		