STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. Building B. Wing	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	512 49th Avenue North Minneapolis, MN 55430

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure an extended period of repeated refusals of insulin and medication were reported and addressed with the medical provider and responsible party to reduce the risk of complication or adverse event for 1 of 3 residents (R1) reviewed for notification of change. Findings include: R1's significant change Minimum Data Set (MDS), dated [DATE], identified R1 had severe cognitive impairment, required extensive assistance with most of her activities of daily living (ADLs), and had diabetes mellitus. R1's care plan, closed 12/20/21, identified R1 had behaviors which included yelling, hitting, biting staff, and refusing cares. Further, the care plan outlined R1 had diabetes mellitus and listed a goal which read, The resident will have no complications related to diabetes . There was a single intervention listed to help R1 meet this goal which read, Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. R1's nursing home History and Physical note, dated 11/9/21 (the day following R1's admission), identified R1 was being seen to establish care and listed R1 as admitting from the acute hospital for syncope and seizure secondary to a history of alcohol dependence. R1 was recorded as receiving glipizide, metformin, and insulin to help treat her diabetes, along with having Wernicke's encephalopathy [a disorder that primarily affects the memory system in the brain] with dictation reading, +behaviors, verbal yelling and refusing cares. The report listed an, Assessment and Plan, which reviewed R1's diabetes and directed, . Patient has documented noncompliance with meds and cares so unclear if no BG [blood glucose] checks cause she is refusing??? Too little info to continue scheduled short acting insulin at this time. R1's most recent Evaluation and Management note, dated 12/10/21, identified R1 was seen by a physician's assistant (PA) and recorded, BG range: 128-182 over past 2 wks [weeks] (not being recorded daily). R1 continued on glipizide, metformin, and insulin. However, after R1's NP visit on 12/10/21, R1's Medication Administration Record (MAR), dated 12/2021, identified several medications were refused and/or not provided for various reasons including: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Insulin Glargine (a long-acting insulin) with directions to administer 20 units subcutaneously every morning. This was recorded as being refused and/or not provided on 12/10/21, 12/11/21, 12/12/21, 12/13/21, 12/14/21, 12/15/21, 12/16/21, and 12/17/21; next being given on 12/18/21 with a recorded blood sugar of 143 mg/dl (a normal blood sugar reading is less than 140 mg/dl). 2) Omeprazole (used to treat heartburn or stomach ulcers) with directions to administer 20 milligrams (mg) once a day. This was recorded as being refused and/or not provided on 12/10/21, 12/11/21, 12/13/21, 12/14/21, 12/15/21, 12/16/21, and 12/17/21; next being given on 12/18/21. 3) Albuterol Sulfate HFA Inhaler with directions to administer 1 puff two times day. This was recorded as being refused and/or not provided on 12/10/21 (AM), 12/11/21 (AM), 12/12/21 (AM and PM), 12/13/21 (AM), 12/14/21 (AM), 12/15/21 (AM), 12/16/21 (AM), 12/17/21 (AM); next being given on 12/18/21. 4) Insulin Aspart (a short-acting insulin) with directions to administer 4 units subcutaneously three times a day. This was recorded as being refused and/or not provided on 12/10/21 (two of three doses), 12/11/21 (two of three doses), 12/12/21 (all three doses), 12/13/21, (two of three doses), 12/14/21 (two of three doses), 12/15/21 (all three doses), 12/16/21 (two of three doses), and 12/17/21 (two of three doses). On 5/2/22 at 8:09 a.m. R1's family member (FM)-B was interviewed. FM-B explained R1 admitted to the nursing home in November 2021, and she was R1's responsible party and helped R1 make decisions about her care due to her cognition. R1 was focused more on palliative (non-curative) care when she admitted , however, was not considered to be terminal or at the end of her life. FM-B expressed she visited R1 at the nursing home on 12/19/21, and found R1 appearing severely dehydrated and malnourished so R1 was subsequently transferred to the hospital where she passed away. FM-B expressed frustration with the lack of notification of R1's condition and stated she was never contacted or told by the nursing home R1 had declined or had been refusing medications for several days prior to her death at the hospital. R1's medical record was reviewed and lacked evidence R1's medical provider (i.e., medical doctor and/or nurse practitioner) or their responsible party was updated with the repeated refusals of medications from 12/10/21 to 12/17/21, despite R1 having diabetes mellitus and severe cognitive impairment. There was no evidence the nursing home had contacted the medical provider or R1's responsible party with these refusals to help ensure a plan was developed to facilitate any potential increased monitoring as a result of the refusals or improve adherence to the medication regimen to reduce the risk of disease complication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 5/2/22, at 2:15 p.m., registered nurse (RN)-B recalled R1 and had worked with her once in awhile. RN-B described R1 as feisty and would reject cares most of the time when offered to her. RN-B explained if a resident refuses medications, then the medical provider should be updated and the notification should be documented in the medical record. RN-B reviewed R1's medical record and acknowledged there was no evidence the provider or family had been updated with R1's extended period of medication refusal (from 12/10/21 to 12/17/21) and explained the medical providers were onsite frequently and staff seem to have a rapport with them and could possibly have just updated them verbally as staff normally don't document every single communication or discussion they have with the medical providers. RN-B stated the lack of documentation demonstrating R1's medical provider(s) were updated with the refusals was an example of the poor orientation process the nursing home had and added, [It] falls back to what the expectations are. RN-B elaborated and explained several nurses likely would not even know to contact the provider with medication refusals, as demonstrated with R1, and added all refusals should be communicated to the medical provider as refusals, including extended periods of refusals, which could lead to negative outcomes. RN-B added, It's really important, and the provider should be updated as soon as possible. On 5/2/22 at 4:37 p.m., nurse practitioner (NP)-B stated she recalled R1 but expressed she hardly knew her as only recalled seeing her one time during her admission to the nursing home. NP-B reviewed their electronic record system and voiced there was no dictation or evidence they had been updated with R1's repeated refusals and subsequent lack of insulin or medication administration on and after 12/10/21 adding, We weren't made aware. NP-B stated the medical provider group should have been updated and explained, had they been notified, they would have likely involved family and discussed the refusals with R1 to potentially help better medication administration. When interviewed on 5/3/22 at 10:26 a.m., the acting director of nursing (DON) stated he had reviewed R1's medical record and was unable to locate any evidence R1's physician team or the responsible party had been notified of the repeated medication refusals, including the refused insulin dosing from 12/10/21 to 12/17/21. The DON expressed staff should have immediately contacted the physician team and responsible party to help determine if new interventions were needed or warranted (i.e., increased monitoring), and to ensure the risk of not taking the medications was explained and communicated to the resident and responsible party. On 5/3/22 at 1:45 p.m., the chief executive officer (CEO) and administrator were interviewed. The CEO expressed the admission history and physical note completed for R1 on 11/9/21 (the day after she admitted), served as notification to the medical providers with regards to her refusal of medications. The CEO added, They were aware. When discussing the lack of evidence supporting R1's responsible party had been notified of the multiple refused doses of medication, neither the CEO or administrator commented about it. A facility' policy on notification of change and/or medication refusals was requested and not provided.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44657 Based on interview and document review, the facility failed to ensure 1 of 3 residents (R2) reviewed for diabetic management were provided adequate care in accordance with current standards of practice and facility standing orders. This practice included lack of monitoring of low diabetic blood glucose (sugar) readings and interventions. This resulted in actual harm for R2 when he was found unresponsive due to low blood glucose and required emergency medical care at the hospital. Additionally, based on observation, interview and document review, the facility failed to implement interventions including completion of dressing changes as ordered with the administration order of Eucerin cream for 1 of 3 residents (R5) with non-pressure related wounds Findings include: R2's facility Admission Record, dated 10/14/21, indicated R2's diagnoses included insulin dependent diabetes mellitus (IDDM) (an autoimmune disorder in which the body destroys the cells that produce insulin) with foot ulcer, pancreatitis (inflammation of the pancreas), and osteomyelitis (inflammation of bone caused by infection). R2's quarterly Minimum Data Set (MDS), dated [DATE], identified R2 had intact cognition, exhibited no behaviors or rejection of care, and received insulin injections. R2's MDS further indicated R2 required supervision for eating and drinking during meals. R2's care plan revised 5/2/22, indicated R2 had IDDM and directed staff to monitor and document side effects and effectiveness of medications. Additionally, R2's care plan lacked interventions to reduce the risk for hypoglycemic (low blood sugar related) events, monitor for signs and symptoms hypoglycemia (low blood sugar) which included slurred speech, loss of consciousness, confusion, increased lethargy, sweating, increased thirst and urination after R2 was sent to the emergency department on 3/3/22 following an episode of blood sugars becoming dagerously low. During interview on 5/4/22, at 12:06 p.m. R2 stated the staff at the facility had a difficult time managing his blood sugars from going to low and giving insulin as ordered. R2 further stated he recently required emergency medical services for the provision of emergency hypoglycemia care, was subsequently sent to the emergency room and received emergency treatment several times since admission to the facility for low blood glucose and going into a diabetic coma. He further stated his meals vary when they are delivered to the room anywhere from 7:30 a.m. to 8:30 a.m. R2 stated no staff had followed up with him on his episodes of hypoglycemia or developed a plan to help monitor for low blood sugars. R2 further stated he was aware when his blood sugars were low and attempted to notify the staff, but staff would take too long to respond. R2 stated he was tired of going to the hospital for his low blood sugars and it could be avoided if staff would monitor or provide better diabetes management. R2's physician progress note (PN) dated 3/7/22, indicated R2 was first hospitalized for hypoglycemia from 1/1/22 to 1/6/22, while at the facility . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R2's medication order dated 3/1/22, directed staff to give Novolog (insulin) 100 unit/milliliter (ml) pen, inject 10 units subcutaneously (injection given under the skin) three times a day before meals. R2's Order Summary, dated 5/3/22, indicated R2 was ordered: - on 10/18/21, consistent carbohydrate (mild diabetic) diet. - on 4/26/22, check blood sugar before meals. - on 3/8/22, Basglar KwikPen (diabetes management medication) 100 unit/ml inject 48 units subcutaneously at bedtime. R2's Medication Administration Record (MAR), dated March 2022, indicated R2 received: - Insulin Glargine (long acting insulin) 48 units subcutaneously at bedtime for diabetes and was given on 3/1/22, 3/2/22, and 3/3/22 at bedtime. - Boost Glucose Control twice a day was to start on 3/26/22. R2's MAR lacked indication any Boost was given from 3/26/22 to 4/10/22. - Administer insulin with meals and indicated, if you do not see the meal do not administer the insulin for risk for hypoglycemia. - Check blood glucose three times a day, only check prior to meals, and as needed if R2 became symptomatic. - Continue correction scale of 1:50 greater than 150 (one unit per 50 for a blood sugar of 150) every shift for diabetes. - Novolog Solution, (Insulin Aspart) inject 10 unit subcutaneously three times a day for diabetes. Give base dose 10 units if pre-meal blood sugar is greater than 70. - Novolog Solution injection at sliding scale subcutaneously (injection under the skin) before meals for DM and continue correction scale of 1:50 greater than 150 started on 3/3/22. - 70-150 give 10 units - 151-200 give 11 units - 201-250 give 12 units - 251-300 give 13 units - 301-350 give 14 units - 351-999 give 15 units (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- 351 and over give 13 units Review of R2's MAR administration times indicated on 3/3/22, R2 received scheduled Novolog 10 units given at 6:58 a.m. and sliding scale insulin 14 units given at 7:03 a.m. for a blood sugar of 344. R2's nurse PN dated 3/3/22, at 12:12 p.m. indicated R2 was sent to hospital after being unresponsive. R2's nurse PN dated 3/3/22, at 1:22 p.m. indicated R2 was found around 10:45 a.m. unresponsive with a blood sugar of 45 and R2's nurse gave glucagon injection and called 911. R2's nurse PN, dated 3/3/22, at 5:14 p.m. indicated Resident BG check before breakfast was 344 around 8 am. As per orders this resident was given 14 units. Resident was given breakfast (scrambled eggs,oatmeal, milk and one piece of toast). Writer returned to check on the resident at 1045 AM and found him not responding. Resident was checked 45 minutes later BS was 45. Immediately help was requested, another nurse who gave Glucagon injection immediately. Writer noticed that the resident didn't eat any food item on his tray. After about 15 minutes the BG level was 103. Paramedics arrived checked his BP 156/105, P99 and he was taken for evaluation. Hospital called that he will be back today. Progress note did not include interventions or assessments were done between insulin administration and R2's unresponsiveness episode at 10:45 a.m. and the blood sugar check 45 minutes later. R2's hospital Discharge Summary (DS), dated 3/3/22, indicated on emergency medical services arrival (EMS) to the facility R2's blood sugar was 62 and EMS administered D10 (dextrose - emergency low blood surgar medication) 10 grams and R2 became more responsive enroute to the emergency department (ED). R2's DS indicated he was brought to the ED by EMS related to being hypoglycemic after administration of insulin. R2's DS further indicated R2 had a history of type one diabetes, chronic pancreatitis, and diabetic ketoacidosis (a serious complication of diabetes that can be life-threatening). Following hospitalization the following new sliding scale insulin orders were started: - Novolog Solution (Insulin Aspart) Inject as per sliding scale subcutaneously (injection under the skin) before meals for DM start date 3/8/22 indicated, if 151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units If greater than 400 units, give 10 units and call TCP (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R2's MAR dated April 2022, indicated on 4/1/22, at 7:34 a.m. R2 received 10 units scheduled and 11 units per sliding scale for a blood sugar before breakfast of 182. R2's blood sugar reading at 11:00 a.m. indicated his blood sugar was 37. R2's nurse PN dated 4/1/22, at 11:59 a.m. indicated Residents BS at 11 am is 37 mg/dl. Pt appears unresponsive, diaphoresis noticed and skin is clammy to touch. Nurse administered glucogon and alerted paramedics at 11:15 a.m. of Pt's current state. Resident's BS level at 11:15 a.m. is 49 mg/dl. Paramedics arrived at facility at 11:25 a.m. and attempted resuscitating resident via the use of IV glucagon. Resdient [sic] became responsive and was transported to the hospital via paramedics. Nursing alerted NP about patient's status. Will continue to monitor. R2's nurse PN dated 4/1/22, at 12:31 p.m. indicated R2 was returned to the facility without hospital admission on 4/1/22, after paramedics resuscitated R2 using glucogon. R2's provider PN dated 4/1/22, indicated R2 was unconscious on 4/1/22 due to a low blood sugar of 37 from not eating enough for breakfast after insulin was administered. R2's MAR dated April 2022, indicated on 4/4/22, at 7:30 a.m. R2 received Novolog 10 units scheduled and 14 units per sliding scale for a blood sugar before breakfast of 341. R2's nurse PN dated 4/4/22, at 2:49 p.m. indicated Resident's finger stick glucose level at 11 am was 37 mg/dl. Resident had symptoms like tremors, cold clammy skin, diaphoresis, increased heart rate and respiratory rate and resident was not alert. Paramedics were notified and arrived at 11:25 a.m. IV dextrose was administered. Writer updated NP about the incident. Resident was later educated about safety measured, importance of eating regular meals and snacks, causes of hypoglycemia and importance of maintaining a normal blood glucose level. Nursing will continue to monitor. R2's provider PN dated 4/8/22, indicated R2 was seen by nurse practitioner (NP) by request of staff for review of multiple orders for R2's blood sugar management. R2's PN indicated R2 had two episodes in the last week of unresponsiveness due to low blood sugars. During interview on 5/2/22, at 8:18 a.m. family member (FM)-A stated she had concerns regarding the care provided by facility of the diabetes management of R2. FM-A further stated R2 had multiple hospital and emergency room visits due to hypoglycemia which could be avoided with proper management of insulin, meals, education, and follow up assessment to ensure R2 was eating his meals. During interview on 5/3/22, at 11:45 a.m. family member (FM)-A stated R2 had been sent to the emergency room two to three times related to going into a diabetic coma and hypoglycemia. FM-A further stated the staff would administer R2 insulin, and not follow-up to make sure he had eaten, or he had side symptoms of hypoglycemia. FM-A stated she was concerned for R2 and the frequent hypoglycemic events. During interview on 5/3/22, at 9:20 a.m. LPN-B when asked about the incident on 3/3/22, responded what did my progress note state, that is what I did. LPN-B further stated, I gave the medications when I documented. LPN-B further stated he got busy with providing blood sugar checks for other residents, and did not provide an explanation why there were no interventions for 45 minutes following first finding R2's unresponsiveness episode on 3/3/22 at 10:45 a.m (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During interview on 5/2/22, at 3:00 p.m. nurse practititioner (NP)-B stated R2 had bottomed out twice. NP stated she was not aware R2 was not assessed by nursing staff for his blood sugar at 10:45 a.m. on 3/3/22, when he was first found unresponsive. During interview on 5/3/22, at 10:06 a.m. nurse practitioner (NP)-A stated R2 is a type one diabetic with history of hypoglycemia, and R2's insulin should be administered within 15 minutes before or 15 minutes after a meal. NP-A further stated she was also concerned regarding R2 was observed unresponsive at 10:45 a.m. and was not checked on again until 45 minutes later, when R2's blood sugar was taken. NP-A stated she expected staff to check R2's blood sugar at 10:45 a.m., administer glucagon, and continue to check a blood sugar every 15 minutes until R2's blood sugar was up to 80 or higher. During interview on 5/3/22, at 12:30 consulting pharmacist (CP) stated Novolog is a rapid acting insulin and becomes active within the bloodstream as soon as 15 minutes and peaks in one hour. CP stated nursing staff should have assessed and treated R2 for hypoglycemia when he was first found not responding and had a full uneaten meal tray on 3/3/22, at 10:45 a.m. and should not of waited. Additionally, CP stated nursing staff need education on diabetes management, monitoring a resident who is diabetic and receives insulin, monitoring intake, blood sugars, and when to use glucagon. During interview on 5/2/22, at 3:15 p.m. acting director of nursing (DON) verified R2's blood sugar was 344 when checked on 3/3/22, 6:58 a.m. and R2 was given his scheduled 10 units of Novolog. DON further stated R2 was given 14 units of Novolog for his sliding scale insulin at 7:03 a.m. Additionally, DON stated R2 was sent to the emergency roiagnom on [DATE], when he was found unresponsive with a blood sugar of 45. DON stated R2 had multiple hypoglycemic events since the beginning of this year which required treatment. DON further stated the nurse should have assessed and treated R2 on 3/3/22 at 10:45 a.m. when R2 was found unresponsive and not waited to recheck R2 45 minutes later. DON stated all staff need education on diabetes, insulin, and diabetes management. During interview on 5/3/22, at 1:58 p.m. acting DON stated he had provided education to nursing staff on hypoglycemia, where to locate the glucagon and when to administer. DON further stated he provided the education because of the incident with R2 who had a hypoglycemic event and nursing staff were not aware of where to find the glucagon which delayed the administration. A facility policy titled Management of Hypoglycemia, dated 9/30/21, indicated symptoms of hypoglycemia included weakness, restlessness, tachycardia, excessive perspiration, irritability, blurred vision, headaches, unconsciousness, or coma. Level three hypoglycemia was classified when altered mental and or physical status required assistance for treatment of hypoglycemia. The facility policy directed staff if a resident had a level three hypoglycemia and is unresponsive, to call 911, administer glucagon, notify the provider immediately, remain with the resident, place resident in a comfortable and safe position and monitor vital signs. R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 was cognitively intact and had diagnoses of diabetes (diseases that result in too much sugar in the blood), hypertension (high blood pressure), and renal insufficiency (poor function of the kidneys). Further, the MDS identified R5 had moisture associated skin damage and required staff to provide application of nonsurgical dressings and ointments. R5's MDS lacked indication R5 had behaviors of refusing cares. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R5's care plan, revised date 3/14/22, identified R5 had skin alteration, a fluid filled blister on his right lower leg and fluid leakage from both legs. R5's care plan directed staff to administer treatments as ordered and monitor for effectiveness. R5's Wound Evaluation and Management Summary dated 4/26/22, indicated R5 had four wounds which incorporated his right and left lower extremity and recommended for R5 to elevate his legs and wound care to be completed daily. R5's dressing treatment plan included applying Eucerin cream to intact skin, cover lower legs with xeroform gauze, absorbant pad, and wrap with secondary gauze dressings. - Site one was described as a full thickness lymphedemic (tissue swelling caused by an accumulation of protein-rich fluid) wound of the right distal anterior leg which measured 1 centimeter (cm) x 1 cm x 0.1 cm with serous exudate (clear, thin, watery fluid). - Site two was described as a full thickness lymphedemic wound of the right distal medial (lower inside) leg which measured 1 cm x 1 cm x 0.1 cm with light serosanguinous exudate (composed of red blood cells and serous fluid, known as blood serum), 50 percent slough (dead tissue), 50 percent granulation (healing) tissue, and a fluid filled blister. R5's wound was described as in an inflammatory stage and unable to progress to a healing phase because of presence of a biofilm (can affect the healing). R5's wound was noted as unchanged and required surgical excisional debridement to establish viable tissue margins and remove necrotic tissue. - Site three was described as healed. - Site Four: lymphedemic wound of the left shin which was full thickness which measured 0.3 cm x 0.3 cm x 0.3 cm with light serosanguinous exudate, 50 percent slough and 50 percent granulation tissue. R5's wound was described as in an inflammatory stage and was unable to progress to a healing phase because of presence of a biofilm, had no change in healing status and required surgical excisional debridement to remove necrotic tissue and establish the margins viable tissue. R5's treatment administration record (TAR) dated 5/22, indicated R5's daily wound care orders for the right distal and anterior leg, left calf and shin included: - Cleanse wounds with normal saline. - Apply Eucerin cream to intact skin on lower legs. - Apply xeroform gauze over lower legs, cover with absorbent dressing and wrap in gauze. On 5/2/22, at 11:30 p.m. R5 stated each nurse would complete the wound care differently or not at all. He further stated, some staff will not use all the supplies or apply the cream to my legs, and the wound care is not consistent. R5 stated his bandages fall off after a few hours and the nurses do not reapply them. He stated he had significant swelling in his legs and his legs would leak fluid out of them causing further skin irritation. (continued on next page)

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Victory Health & Rehabilitation Center	512 49th Avenue North Minneapolis, MN 55430

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	During observation on 5/2/22, at 12:46 p.m. R5 was observed with no bandages on his lower extremities. R5's bilateral lower extremities from the knees down to toes were edematous, found to have areas of a thick build-up of skin scaling in areas, and slight red color to his lower legs. Additionally, R5's was found to have wounds located on his right anterior lower leg, right distal lower leg and at R5's left shin. During wound care registered nurse (RN)-B sprayed each leg with a wound cleanser and patted tehm dry. RN-B proceeded with applying xeroform directly onto the skin covering the wounds and non-affected skin. RN-B then covered R5's lower extremities with highly absorbent dressings and wrapped them with a secondary dressing of gauze rolls. During observation of R5's wound care, RN-B did not apply the ordered Eucerin cream. During interview on 5/2/22, at 1:10 p.m. RN-B stated R5 had wounds on both of his lower legs which required daily wound care. RN-B did not respond when asked why he did not apply Eucerin cream to R5's legs prior to application of the xeroform gauze as directed by the R5's physician orders During interview on 5/3/22, at 2:30 p.m. acting director of nursing (DON) stated his expectation for nursing staff would be to follow the physician's order to provide wound care and any ointments as ordered for R5's wound care. Acting DON further stated if RN-B did not apply the Eucerin cream as ordered, he did not follow the wound care as ordered. A facility policy on wound care was requested but was not provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure assessed and care planned nutritional interventions for meal intake monitoring were completed to reduce the risk of complication for 1 of 1 resident (R1) reviewed who was subsequently hospitalized with a cachectic appearance (a loss of body weight and muscle mass). Findings include: R1's significant change Minimum Data Set (MDS), dated [DATE], identified R1 had severe cognitive impairment, was independent with eating after set-up, had diabetes mellitus, and admitted to the nursing home on 11/8/21. Further, the MDS identified R1 weighed 98.0 pounds (lbs) and had sustained no substantial weight loss or weight gain in the previous six months. On 5/2/22 at 8:09 a.m. R1's family member (FM)-B was interviewed. FM-B explained R1 admitted to the nursing home in November 2021, and while focused on palliative (non-curative) care was not considered to be terminal or at the end of her life. FM-B expressed she visited R1 at the nursing home on 12/19/21, and found R1 appearing severely dehydrated and malnourished so R1 was subsequently transferred to the hospital where she passed away. FM-B stated R1's usual body weight was typically between 102 to 105 pounds; however, the appearance and condition she found R1 to be in when she visited caused her significant concern as it appeared R1 had sustained a significant weight loss. R1's corresponding ED (Emergency Department) Provider Note, printed 1/7/22, identified R1 was seen in the acute hospital ED on 12/19/21, where she was non-verbal and had, Cachectic appearance with extensive mottling. R1's Dietary / Nutrition Assessment, dated 11/12/21, identified R1 consumed a regular consistency, consistent carbohydrate diet, was 60 inches tall, and weighed 98.0 lbs at the time of the assessment. The assessment outlined, Resident feels she has lost some wt. [weight] over the past few months but is uncertain just how much, and identified R1's ideal body weight (IBW) to be 100 lbs. with an estimated daily caloric intake needed of 1260-1575 calories. R1 demonstrated independence with eating and the assessment recorded R1 as having regular-sized portions for meals with, Good (50-100%), appetite. Further, the assessment determined R1 was at risk for impaired nutritional status and listed interventions to help ensure adequate nutrition was maintained including, . Encourage resident to eat 75% or more at meals. Monitor appetite and weights per facility policy. R1's care plan, closed 12/20/21, identified R1 was at risk for impaired nutrition due to a history of alcohol use, dementia, and medication non-compliance. R1 was recorded as being able to feed herself independently and several goals were listed for R1 including maintaining a stable weight of 90 - 100 lbs. and eating 75% or more at a majority of her meals. There were several interventions listed to help R1 meet these goals including, . Monitor appetite and weight per facility policy. Observe for any difficulty chewing or swallowing or for any change in eating habits. R1's Weight Summary, dated 11/8/21 to 12/20/21, identified two weights were obtained on R1 during her admission to the nursing home. This included on 11/8/21 (98.0 lbs.) and on 12/3/21 (98.6 lbs.). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 5/2/22 at 11:52 a.m., nursing assistant (NA)-A recalled R1 would repeatedly refuse cares and was not a big eater but could not recall much else about her due to R1 being discharged several months prior. NA-A explained meal intakes were supposed to be tracked for each meal and should be recorded in the computer by the NA staff who provide and pick-up the trays to rooms. R1's Follow Up Question Report NUTRITION - Amount Eaten, dated 11/8/21 to 12/19/21, identified R1's recorded meal intakes with a percentage (%) consumed. This report identified each date with one to three recorded entries supporting R1's meal intake. The recorded amounts identified R1 typically consumed 50% or more of the provided meals. However, the following date(s) had only one (out of three provided meals) recorded meal intakes: 11/13/21, 11/15/21, 11/20/21, 11/23/21, 11/24/21, 11/25/21, 11/26/21, 11/27/21, 11/28/21, 12/1/21, 12/2/21, 12/3/21, 12/6/21, 12/8/21, 12/12/21, 12/14/21, 12/17/21. Further, the following date(s) lacked any recorded meal intakes for the entire day: 11/12/21, 11/17/21, 11/18/21, 11/19/21, 11/22/21, 11/29/21, 12/5/21, 12/9/21, 12/20/21, 12/11/21, 12/13/21, 12/15/21, 12/16/21, 12/18/21. R1's medical record was reviewed and lacked any recorded evidence of R1's intakes for the remaining date(s), nor any evidence if she had been offered and/or refused meals on those dates, despite having diabetes mellitus and being identified as at risk for impaired nutritional status through her assessment and care planning process. When interviewed on 5/2/22 at 2:15 p.m., registered nurse (RN)-B stated meal intakes were supposed to be recorded for each meal to his knowledge; however, expressed he did not think anyone was supposed to monitor or ensure these were being recorded for each shift or day. RN-B added, Are we trained to go in [and check to ensure recorded], I don't think so. On 5/3/22 at 11:26 a.m., the registered dietitian (RD)-A was interviewed. RD-A stated the nursing home typically weighed people only on a monthly basis unless there existed a specific rationale or directions from the physician to implement more frequent monitoring. RD-A explained resident's appetites were monitored through the recorded meal intakes which were to be completed and documented for each meal. RD-A reviewed R1's medical record and stated while R1 seemed to maintain her weight, she did notice there were some gaps in the documentation. RD-A verified meal intakes should have been recorded and expressed she noticed the lack of recorded meal intakes continued to be noticed as of today. RD-A stated it was important to ensure meal intakes were recorded as the information helps them monitor the patient and help determine what's going on[?] if they decline. Further, RD-A stated she had not completed any education or inservice with nursing staff on meal intake recording, despite noticing they continued to not be recorded as they should, but was unsure if nursing had completed any such education or not. When interviewed on 5/3/22 at 1:56 p.m., the acting director of nursing (DON) stated meal intakes were to be monitored and recorded on every shift as that was the expectation. This was important to do as the nutritional information and assessment process was used for the well being of the resident, and it helped to quickly identify if someone was not eating enough. The DON stated there had only been some very informal education with staff on this issue in the past months he could recall despite it continuing to be a concern as identified by RD-A. During the onsite abbreviated survey, from 5/2/22 to 5/3/22, documentation or evidence was requested demonstrating what, if any, education was completed with direct care staff on meal intake recording. However, none was ever received. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provided Recording Percent of Meal Consumed policy, dated 2010, identified staff were to document the percentage of each meal consumed for each resident on a daily basis. The policy continued and outlined there were several ways this record could be completed and the RD would provide which method to be used.