AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 8, 2023

Mr. Travis Bergeron, Administrator
Maple Lane Nursing Home
60 Maple Lane
Barton, VT 05822-9494

Dear Mr. Bergeron:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 1, 2023.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475042	A. BUILDING ______ B. WING ______	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE NURSING HOME	60 MAPLE LANE BARTON, VT 05822

(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
E 000	Initial Comments An unannounced on-site survey of the facility's emergency preparedness program was conducted by the Division of Licensing and Protection on 1/30/23 - 2/1/23 at Maple Lane Nursing Home as part of the facility's recertification survey. The following regulatory violation was identified:	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.	E 039	E 039 1. No residents were negatively impacted as a result of the alleged deficient practice. 2. Residents residing in the facility have the potential to be impacted by the alleged deficient practice. 3. Facility administration is aware of the requirement to record the responses to emergency exercises and analyze the facilities response. 4. The exercise noted in the deficiency statement has been analyzed and responses recorded as required. The analysis and documentation have been included in the emergency plan for the facility. 5. The administrator will monitor for continued compliance with the plan as needed with emergency response exercises. 6. The administrator of the facility will report results of the compliance monitoring at QAA meetings x3 months and the committee will determine further frequency of compliance reports at that time. 7. Corrective action to be complete by 4/3/2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Travis B. [signature] TITLE: Administrator (X6) DATE: 3/1/23

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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E 039	Continued From page 1 (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years,	E 039	**Tag E 039 POC accepted on 3/7/2023 by T. Dougherty/P. Cota**	

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E 039	Continued From page 2 opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a	E 039		

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E 039	Continued From page 3 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant	E 039		

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E 039	Continued From page 4 emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency	E 039		

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E 039	Continued From page 5 scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 6 (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 7 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 8 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the	E 039		

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E 039	Continued From page 9 facility failed to document and analyze the facility's response to emergency drills and to incorporate the response and analysis into the emergency plan. Findings include: Per interview and record review with the facility's Administrator [ADM] on 2/1/23 at 2:21 PM, the ADM reported that the facility had participated in a community based, individual, facility based, or table top exercise on 10/27/22. The ADM confirmed that there was no record of the facility's response to the emergency response exercise, and that there was no analysis of the facility's response to the exercise. The ADM stated "We didn't do that."	E 039		
F 000	INITIAL COMMENTS An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection on 1/30/23 - 2/1/23 at Maple Lane Nursing Home. The following regulatory violations were identified:	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584	F 584 1. No residents were negatively impacted by the alleged deficient practice. 2. Residents residing in the facility have the potential to be impacted by the alleged deficient practice. 3. The carpets have been cleaned to address the urine odor identified during survey and the flooring throughout the building will be replaced throughout 2023. 4. The identified fraying in the carpet will be temporarily secured pending floor replacement throughout the year.	

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F 584	Continued From page 10 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of documentation, the facility failed to establish a well maintained, safe, clean and odor free environment throughout the building including some resident rooms, bathrooms, and halls. Findings include: 1. Observation on day one of survey (01/30/23 at 10:00 AM), upon entrance there was an intense foul urine odor, noted mainly on the West	F 584	5. The identified areas noted in the elevator will be repaired. 6. The issues in room #19 have been addressed. 7. Identified missing end caps to baseboard heating have been replaced. 8. The identified splintered door and bathroom vent in room #9 have been addressed. 9. The Maintenance Director and facility administration are aware of the requirements related to a safe/clean/ comfortable/homelike environment. 10. The Maintenance Director and facility administrator will utilize environmental rounds check sheets weekly to document findings of environmental rounds weekly as well as corrective actions taken. 11. Weekly environmental rounds will take place weekly x 3 months and monthly thereafter to monitor effectiveness of the plan. 12. The results of the environmental rounds and corrective action will be reported to the QAA committee x3 months at which time the committee will determine further frequency of reports. 13. Corrective action will be complete by 4/3/2023.	

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F 584	Continued From page 11 wing/upper level. This odor was constant, throughout the full survey process. The carpet throughout the building including in some resident rooms, was frayed at the edges where carpet on the wall meets the carpet on the floor and at areas of heavy traffic, where carpet seams are coming apart. There is duct tape noted to be covering a frayed seam outside the elevator door on the lower level of the building. In the elevator, on the back wall, there is brown panel that is broken with jagged pieces coming away from the wall and a missing piece of flooring. Review of Maintenance daily audit logs (red binder), indicate pages of listed items to check daily including, "Check for spots on carpets". These pages go back more than a year. There are no daily check marks for the past year regarding the carpet. Review of Maple Lane Maintenance Request Log (white binder) reveals many areas of concerns by staff and residents including that of frayed, and dirty carpet. (12/09/22 - "Carpet seaming strips at elevator east ends are lifted, needs secured" and 01/04/23 "Please carpet clean and vacuum rm 8's carpet, often has urine, drinks spilled. Resident requesting at least a vacuum." On 02/01/23 at 12:00 PM a tour of the interior building was conducted by the Maintenance Director in the Presence of two surveyors. H/she confirmed that there is a need for many repairs and that discussions had taken place sometime in the past regarding replacement of the carpet with new flooring throughout the building, but this had not been done. 2. During environmental observations between 1/30 and 2/1/23 there were several environmental	F 584	**Tag F 584 POC accepted on 3/7/2023 by T. Dougherty/P. Cota**	

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F 584	Continued From page 12	F 584		

concerns identified on the West and East Wings of the 2nd level.

On 2/1/23 at 12:00PM during an environmental walk through with the Environmental Services Director (ESD) and two surveyors, the concerns that had been identified during survey were confirmed by the ESD.

In Room #19 there two types of power strips that had multiple electronic devices connected in two separate outlets. One power strip had 5 devices plugged into it and one cord laying on the floor next to it not plugged in. The other power strip had three devices plugged in with 5 cords laying on the floor next to it that were not plugged in. One outlet by the head of the window bed had a three-outlet grounded wall tap strip that allows one electrical outlet to power three devices. When room #19 was entered the ESD stated "No, this is not allowed" when seeing the power strips and other power sources. S/he stated that s/he does require all devices be inspected by her/him and that s/he did not know that this room had these devices in it. There was also a missing endcap to the baseboard heat in the bathroom that exposed heating pipe and sharp edges. This was on the left wall when facing the toilet. This was also confirmed by the ESD.

In the dining/activity area there was a missing endcap of the baseboard heat to the right of the porch exit exposing the heating pipe and sharp edges. The ESD confirmed that this was a safety concern related to the exposure to heat and that the sharp edge could cause injury to a resident.

Room #3 there was carpet that was pulled up and frayed. There was a hole with raised edges in the

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F 584	Continued From page 13 tile in the bathroom near the toilet. The ESD stated that s/he was not aware of the flooring condition in this room. Room #9 the carpet was pulled up from floor under the bed that protruded out into the walkway. The bathroom door was splintered and the vent in the bathroom ceiling full of dust. When the ESD was shown the vent in this bathroom s/he stated that s/he would need to remove it to clean it. There was no sign that this vent had been removed for cleaning since it was last painted AEB paint on screws. The ESD did not recall when it was last painted. Room #15 the carpet in front of the resident's commode was torn and frayed with a large dark brownish stain. The ESD stated that it is "hard to get the stains out of the carpets at times." S/he stated that s/he had not been aware of the torn and frayed condition of the carpet or the stain. At the end of the West Hall 2nd level, the ESD was asked about the strong urine odor throughout the hall that was especially strong at the west end. S/he stated that s/he "had not been made aware that this was an issue." This surveyor informed her/him that nursing staff had explained that the resident in Room #1 often refused care causing the increase in odor. The ESD stated that s/he "was not aware of this, and there are things that can be done to decrease the odor that they have done in the past for similar situations."	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656	F 656 1. Resident #22 had no negative impact from the alleged deficient practice and hasn't required treatment for further infection.	

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F 656	Continued From page 14 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656	2. Resident #22 weight is stable. 3. Residents residing in the facility have the potential to be impacted by the alleged deficient practice. 4. The facility has provided education to staff on the requirements to follow the plan of care for all residents. 5. Audits will be conducted by the Director of Nursing or designee weekly x4 weeks and then bi-weekly x 3 months to monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAA committee x 3 months and further frequency of the audits will be determined by the committee. 7. Corrective action will be completed by 4/3/2023. **Tag F 656 POC accepted on 3/7/2023 by T. Dougherty/P. Cota**	

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F 656	Continued From page 15 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to evaluate resident goals and follow interventions for 1 of 20 residents, (#22) regarding comprehensive care plans. 1. Observation of meal distribution to resident rooms on 01/30/23 at approximately 11:55 AM, resident # 22 was observed to be sitting on the edge of her/his bed fully clothed, with a Foley catheter bag located on the floor. The bag contained urine. The bag was not hung at a level that prevented contamination and did not have a covering to protect the dignity of the resident. A Licensed Nurse Assistance (LNA) was observed to be delivering this resident's lunch meal tray and stated to the resident "I'll be back later to empty your catheter". The Plan of Care (01/16/23) for this resident indicates the need for a catheter due to urinary retention and status post urinary surgery and to keep catheter tubing placed below the bladder and cover drainage bag with cover. Per the Medication Administration Record (MAR), This resident was prescribed antibiotics for a Urinary Tract Infection and bacitracin ointment to penis suture line. Resident #22 is at risk for infection complications. The resident was observed again around 12:30PM to be resting in his/her bed with the meal tray untouched. The resident stated "someone needs to empty this. It's going to	F 656		

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explode". The Foley catheter at this time was still located on the floor and uncovered. The bag contained additional urine and was completely full. This surveyor notified the nurse who stated "I'll go take care of it. S/he always takes the cover off as soon as we put it on". This nurse confirmed that according to the plan of care, the Foley catheter should be off the floor, emptied and covered for dignity and to prevent further infection. Review of the facility policy Catheter Care, Urinary under the heading Infection Control indicates "2. Be sure the catheter tubing and drainage bag are kept off the floor." Follow up around 2:00PM revealed the catheter was empty, properly placed and covered. This citation is cross referenced to F690.

2. Review of a medical record for resident #22 reveals an admission to Maple Lane on 01/04/23. This is the resident's 6th admission. S/he has the following diagnoses: (not all inclusive) Constipation, Atherosclerotic Heart Disease, Stage III Chronic Kidney Disease, Type II Diabetes with polyneuropathy, Anemia, Dementia, Autoimmune Thyroiditis, History of malignant neoplasm of prostate, Osteoarthritis, Urogenital Implants, and recent COVID-19.

A Plan of Care (01/10/23) reveals resident #22 is at risk for altered nutrition status and the goal is to "Maintain weight within 3 pounds of baseline weight". A physician order indicates weekly weights for four weeks to start 01/09/23. Weight data is missing for the week of January 15 - 21st. The medical record reflects the following documented weights: (01/06/23) 183.6, (01/09/23) 204.4, and (01/27/23) 214.2. This is a significant weight gain of a 30.6 pounds with an increased Body Mass Index (BMI) of 16.67% in a

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F 656	Continued From page 17 matter of 3 weeks. Section K of the Minimum Data Assessment (MDS) and a weight graph indicates a weight of 226 on 01/12/23. Per interview on 02/01/23 at 10:37am with the Director of Nursing (DON), "there is a glitch in the system." On 02/01/23 at 09:30am an interview was conducted with all surveyors, the dietician, and the kitchen manager to discuss the process of gathering resident weight data, how it is reviewed for any discrepancies and reported by nursing staff. The assessment of resident information by the dietician was reviewed and how it relates to the goals and interventions of the Plan of Care. The Dietician, Kitchen Manager and Director of Nursing confirmed the weight discrepancies and the lack of reporting a fluxuation of 3 pounds of baseline weight per resident #22s Plan of Care. This citation is cross referenced to F692.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657	F657 1. Care plans for residents #30, 9, and 40 have been reviewed and revised to ensure they reflect the current care needs and risk factors for the residents. 2. Residents residing in the facility have the potential to be impacted by the alleged deficient practice. 3. Education has been provided to licensed staff regarding the requirement to review and revise care plans to ensure the needs of the resident are reflected. 4. Audits will be completed by the Director of Nursing and/or designee weekly x4 weeks and then bi-weekly x 3 months to monitor effectiveness of the plan.	

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F 657	Continued From page 18 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to review and/or revise the care plans for 2 residents in a sample of 20 [#30, & #9] regarding falls, and for 1 resident [#40] regarding nutrition and weight loss. Findings include: 1.) Per record review, Res. #30 was admitted to the facility in November 2022 with diagnoses that include muscle weakness, delirium due to a known physiological condition, and repeated falls. The resident's Care Plan identified the resident as having "Actual falls related to cognitive loss, restless leg syndrome, muscle weakness, Osteo-Arthritis of the knee, psychophysiological insomnia, anxiety, sleeps in recliner per his preference, unable to rest in bed, noncompliance with proper recliner positioning, noncompliance with proper footwear." Per interview with the facility's Director of Nursing [DON] on 2/1/23 at 10:29 AM, the DON stated that all resident falls are documented in Progress Notes in the resident's medical record. Per review of Res. #30's medical record, the	F 657	5. Results of the audits will be reported to the QAA committee x 3 months as which time the committee will determine further frequency of the audits. 6. Corrective action to be completed by 4/3/2023. **Tag F 657 POC accepted on 3/7/2023 by T. Dougherty/P. Cota**	

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resident suffered 10 falls beginning 12/1/22 to 1/10/23:

12/1/22 Title: Fall
"Resident observed sitting on the floor in front of his recliner. Resident stated, "I was just turning, and I slide out of the chair"."
12/18/22 Title: Assess s/p fall
"[Res. #30] had a witnessed fall at approx. 0915 AM."
12/20/22
"No c/o pain or complaints of injury post fall when slid out of recliner. States he did that himself slid himself to the floor as he couldn't get his bottom back in his recliner so he slid himself off as he couldn't reach his call light."
12/21/22
"Resident rang call light and was found sitting on floor leaned up against recliner. States "I slid out of the recliner again"."
12/23/22 Title : MD notification
"MD notified of new orders from ER visit and 2 falls since return"
12/24/22
"found sitting on floor in front recliner"
12/28/22
"found sitting on floor in front of recliner"
1/6/23 Title : unwitnessed fall
"Resident observed sitting on the floor in front of his chair with both legs extended".
1/10/23
"Range of motion within normal limits post fall".

Review of the facility's "Fall and Fall Risk, Managing" policy includes "A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., patient pushes another patient). An episode where a patient lost

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their balance and would have fallen if not for another person or if they had not caught themselves is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, a fall is considered to have occurred when a patient is found on the floor." Under the policy's "Resident-Centered Approaches to Managing Falls and Fall Risk" section is "If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant." Additionally, under "Monitoring Subsequent Falls and Fall Risk" is "If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions."

Review of Res. #30's Care Plan and of Progress Notes listing falls reveals no new interventions added to prevent future falls after falls on 12/1, 12/20, 12/21, 12/28, and 1/6.
Per interview with the facility's Director of Nursing [DON] on 2/1/23 at 10:29 AM, the DON confirmed that despite the 5 documented falls listed above, the facility did not add new interventions to Res. #30's Care Plan to prevent future falls, which then subsequently occurred.

2.) Per record review, Res. #9 was admitted to the facility in 2/15/21 with diagnoses that included Muscle weakness, Spinal stenosis, and Unsteadiness on feet.
The resident's Care Plan identified the resident as having "Actual Falls- Potential for Injury: related to Unsteady gait, Impaired safety awareness, Weakness, Polypharmacy, Use of psychotropic medications, Impaired mobility, Balance problem, Risky behaviors- As evidenced by: History of falls, Unable to ambulate without

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F 657	Continued From page 21 assistance, Unable to transfer without assistance, and desire to be independent." Per review of Res. #9's medical record, the resident suffered 5 falls between 11/13/22 and 1/30/23: 11/13/22 Title : Fall "found resident on floor laying on her left side" 12/29/22 "Resident found laying on her right side on floor next to bed." 1/12/23 "Resident found sitting on the floor next to bed." 1/19/23 "discovered her on the floor beside her bed on her back with her head towards the foot end of the bed." 1/30/23 "At approximately 1430 resident found lying on floor mat beside her bed." Review of Res. #9's Care Plan reveals no new interventions added to prevent future falls after falls on 11/13/22, 12/29/22, 1/12/23, 1/19/23. Additionally, interventions added after the fall on 1/30/23 were previously in place or are repeated from interventions added when the resident was first admitted in 2021. Intervention #1, dated 1/30/23 lists "Encourage and remind [Res.# 9] to use call light and wait for assistance to arrive". Interventions dated 2/15/21 include "Remind resident to call when needing assistance" and "Keep call light within reach". Additionally, Intervention #2 dated 1/30/23 lists "Place fall mat on left side of bed as this side is what she uses for bed to commode transfers". Review of Progress Notes reveal the fall mat intervention was already implemented previously	F 657		

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and Progress Notes for the fall on 1/30/23 record "resident found lying on floor mat beside her bed." Per interview with the facility's Director of Nursing [DON] on 2/1/23 at 10:29 AM, the DON confirmed that despite the 5 documented falls listed above, the facility did not add new interventions to Res. #9's Care Plan to prevent future falls, which then subsequently occurred.

3. Per record review Resident #40 was admitted to the facility on 9/21/2022 with diagnoses that include Transient ischemic attack (TIA), Diabetes myelitis type 2 (DM2), Chronic obstructive pulmonary disease (COPD), bipolar, Post traumatic stress disorder (PTSD), depression, Gastroesophageal reflux disorder (GERD), hypothyroid, obstructive sleep apnea (OSA). Documentation reflects that the Resident has experienced both a significant weight gain, a significant weight loss, and an increase in fluid volume excess over a 4 month period with no updated interventions made to the Resident's plan of care.

Review of Resident #40's documented weekly weights as follows.
9/28/22 - 134.8bs
10/5/22 - 163lbs (significant weight gain of 20.9% over a 7-day period).
10/17/22 - 162lbs
11/4/22 - 164lbs
11/18/22- 164.2lbs.
12/7/22- 151.2lbs This is a significant weight loss of 7.92% in less than 30 days.
12/16/22 - 182.4lbs indicating a 20.63% weight gain in 9 days.
1/2/23 - 196lbs 7.57% weight gain in 17 days.
1/6/23- 188.6lbs this reflects an 8.6lb - 3.87% weight loss in 4 days.

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F 657	Continued From page 23 1/24/23 - 157lbs a weight loss of 16.76% in 18 days. On 1/9/23 an order was written for Lasix 40mg daily x 4 days and Prednisone 40mg x 4 days A physicians progress note written on 1/19/2023 states "PVD [Peripheral Vascular Disease] /edema Progressively worsened. Will increase furosemide to 40 mg 3 times daily. CKD [chronic kidney disease]" A care plan focus initiated on 01/09/2023 and reviewed by staff on 01/16/2023 states "altered urinary output requiring foley catheter [a tube that enters and remains in the bladder to allow the passage of urine] placement during diuresis of fluid." A physicians progress note written on 1/19/2023 reveals instruction to continue with foley catheter until more diuresis [an increase in urine production due to an increase in dosage of diuretic] can be completed, Lasix increased 1/12/2023." A Nutrition care plan created on 10/04/2022 and reviewed by staff with no changes on 01/16/2023 reflects no changes or updates related to the Resident's weight gain or weight loss over the 4 months since admission. The Resident care plan also reflects that the Resident has the "Potential for fluid Volume Deficit related to medication side effects" Interventions include Monitor for sudden weight loss, encourage fluids as ordered, provide several beverages with each meal, Keep fluids at bedside, staff to assist / cue resident to drink all fluids, monitor lab reports, discuss with resident choices of beverages, identify preferred fluids, and offer frequently. The care plan was not updated to reflect any additional nutritional needs. Nor was it updated to reflect the Resident's actual	F 657		

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(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 657	Continued From page 24 fluid volume excess rather than fluid volume deficit. A Quarterly Nutrition Assessment completed on 12/29/2022 states "Nutrition care plan reviewed with no changes at this time. Will follow resident course." Per interview on 2/1/23 at 9:40AM with the Registered Dietician (RD) and Dietary Manager the RD stated that s/he did not participate in the care plan process and reviewed the Care Plans on a quarterly basis [every 3 months]. The RD also stated that they were "not vigilant" about keeping up with the weight changes. S/he confirmed that Resident #40's significant fluctuations in weight should have been addresses in the Resident's care plan.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690	F 690 1. The identified residents have had no complications related to the alleged deficient practice. 2. Residents requiring the use of foley catheters have the potential to be impacted by the alleged deficient practice. 3. Education and competency assessments have been completed for staff caring for residents with foley catheters. 4. Audits will be conducted by the Director of Nursing or designee weekly x 4 weeks and then bi-weekly x 3 months to monitor effectiveness of the plan. 5. The results of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be complete by 4/3/2023.	

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	475042	A. BUILDING ______ B. WING ______	02/01/2023

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F 690	Continued From page 25 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure 2 residents [#30 & #22] of 13 residents with urinary catheters received appropriate treatment and services to prevent urinary tract infections. Findings include: 1.) Per record review, Res. #30 was admitted to the facility in November 2022 with diagnoses that include Benign prostatic hyperplasia with lower urinary tract symptoms and retention of urine, which require the resident to use a foley catheter for urinary elimination. Per record review on 12/23/22 Res. #30 was transferred to the North Country Hospital Emergency Room due to an acute change in mental status. A report was later received from North Country Hospital diagnosing Res. #30 with a Urinary Tract Infection [UTI], and the resident was started on antibiotics, which continued upon his return to the nursing home.	F 690	**Tag F 690 POC accepted on 3/7/2023 by T. Dougherty/P. Cota**	

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F 690	Continued From page 26 Review of Res. #30's Care Plan reveals the resident is identified as "requires the use of urinary catheter related to medical diagnosis ... and is at risk of complications including infection from the use of a urinary catheter, Hisotry of recurrent UTIs". Per observation on 1/30/23 at 10:48 AM, Res.# 30's foley catheter tubing was observed connected to the resident and lying on the floor underneath Res. #30's feet. The tubing was connected to a drainage bag, which was uncovered and hung on a dresser on the bottom drawer to the right of the resident. On 2/01/23 at 12:24 PM, an identical observation was made, with the foley catheter tubing again on the floor beneath the resident's feet and the drainage bag uncovered. A staff Licensed Nurse's Aide confirmed that the resident's foley catheter tubing was lying on the floor and at risk for infection and confirmed that per Res. #30's care plan, the drainage bag should have been covered but was not. 2.) Observation of meal distribution to resident rooms on 01/30/23 at approximately 11:55 AM, resident # 22 was observed to be sitting on the edge of her/his bed fully clothed, with a Foley catheter bag located on the floor. The bag contained urine. The bag was not hung at a level that prevented contamination and did not have a covering to protect the dignity of the resident. A Licensed Nurse Assistance (LNA) was observed to be delivering this resident's lunch meal tray and stated to the resident "I'll be back later to empty your catheter". The care plan (01/16/23) for resident #22 indicates the need for a catheter due to urinary	F 690		

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F 690	Continued From page 27 retention and status post urinary surgery and to keep catheter tubing placed below the bladder and cover drainage bag with cover. Per the Medication Administration Record (MAR), This resident was prescribed antibiotics (Cefuroxime Axetil) for a Urinary Tract Infection and Bacitracin ointment to penis suture line. Resident #22 is at risk for infection complications. Resident #22 was observed again around 12:30 PM to be resting in his/her bed with the meal tray untouched. The resident stated "someone needs to empty this. It's going to explode". The Foley catheter at this time was still located on the floor and uncovered. The bag contained additional urine and was completely full. This surveyor notified the nurse who stated "I'll go take care of it. S/he always takes the cover off as soon as we put it on". This nurse confirmed that the Foley catheter should be off the floor, emptied and covered for dignity and to prevent further infection. Review of the facility policy Catheter Care, Urinary under the heading Infection Control indicates "2. Be sure the catheter tubing and drainage bag are kept off the floor." Follow up around 2:00 PM revealed the catheter was empty, properly placed and covered.	F 690		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692	F 692 1. Residents #22, 30, and 40 nutritional care plan and weights have been reviewed and revisions made to care plans as needed.	

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F 692	Continued From page 28 §483.25(g)(1) Maintains 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; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain accurate weight monitoring for acceptable parameters that influence the nutritional and hydration status of 3 residents (#22, #30, and #40) in a sample size of 20. Findings include: 1.) Review of a medical record for resident #22 reveals an admission to Maple Lane on 01/04/23. This is the resident's 6th admission. S/he has the following diagnoses: (not all inclusive) Constipation, Atherosclerotic Heart Disease, Stage III Chronic Kidney Disease, Type II Diabetes with polyneuropathy, Anemia, Dementia, Autoimmune Thyroiditis, History of malignant neoplasm of prostate, Osteoarthritis, Urogenital Implants, and recent COVID-19. A care plan (01/10/23) reveals the resident is at risk for altered nutrition status and the goal is to "Maintain weight within 3 pounds of baseline weight". A physician order indicates weekly weights for four weeks to start 01/09/23. Weight data is missing for the week of January 15 - 21st.	F 692	2. Residents at risk for alteration in nutritional and hydration have the potential to be impacted by the alleged deficient practice. 3. Education has been provided to staff regarding the facility policy related to obtaining and monitoring weights as well as notification requirements. 4. Audits will be conducted by the Director of Nursing or designee weekly x 4 weeks and bi-weekly x 3 months to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by 4/3/2023. **Tag F 692 POC accepted on 3/7/2023 by T. Dougherty/P. Cota**	

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F 692	Continued From page 29 The medical record reflects the following documented weights: (01/06/23) 183.6, (01/09/23) 204.4, and (01/27/23) 214.2. This is a significant weight gain of a 30.6 pounds with an increased Body Mass Index (BMI) of 16.67% in a matter of 3 weeks. Section K of the Minimum Data Assessment (MDS) and a weight graph indicates a weight of 226 on 01/12/23. Per interview on 02/01/23 at 10:37am with the Director of Nursing (DON), "there is a glitch in the system." On 02/01/23 at 09:30am an interview was conducted with all surveyors, the dietician, and the kitchen manager to discuss the process of gathering resident weight data, how it is reviewed for any discrepancies and reported by nursing staff. The assessment of resident information by the dietician was reviewed and how it relates to the goals and interventions of the plan of care. The Dietician, Kitchen Manager and Director of Nursing confirmed the weight discrepancies and the lack of reporting a gain greater than 3 pounds per the patient plan of care. 2.) Per record review, Res. #30 was admitted to the facility in November 2022 with diagnoses that include anemia, diabetes, Gastro-esophageal reflux disease, and irritable bowel syndrome with diarrhea. A Comprehensive Nutritional Assessment was conducted on the day after Res. #30's admission by the Registered Dietician. The Dietician noted that the resident's current nutritional plan does not meet 100% of the resident's needs and recorded "Diet order is regular with poor po intake of most meals. Admit weight of 189 lbs. Nutrition care plan created. Trial house shakes twice a day". Res. #30's Care Plan under 'Nutrition'	F 692		

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F 692	Continued From page 30 includes the goal of "Weight maintenance", and interventions that include "Monitor weights weekly". Review of Res. #30's medical record reveals the resident was weighed once upon admission on 11/22/22, at 189.4 lbs., then again 6 weeks later. Res. #30's weight 6 weeks later on 1/06/23 was 165.4 lbs.: a loss of 24.0 lbs. (-12.6%). Review of the Comprehensive Nutritional Assessment includes a definition of "Significant Weight Loss" as greater than or equal to 5% over 1 month or greater than or equal to 10% over 6 months. An interview was conducted with the facility's Dietician on 2/1/23 at 9:32 AM. The Dietician stated that h/she spends about "3 hours a week" at the facility and "relies upon staff ("nursing, anyone, a variety of people") to communicate weight changes" to h/her. The Dietician reported that the facility and h/her "were not vigilant" regarding weight loss and there was "clearly need" for a change. The Dietician also stated that h/she did not participate in the Care Plan process, and reviewed the Care Plans on a quarterly basis [every 3 months]. The Dietician confirmed he was not aware of Res. #30's significant weight loss of 12.6% over a period of 6 weeks. 3.) Per record review Resident #40 was admitted to the facility on 9/21/2022 with diagnoses that include Transient ischemic attack (TIA), Diabetes myelitis type 2 (DM2), Chronic obstructive pulmonary disease (COPD), bipolar, Post traumatic stress disorder (PTSD), depression, Gastroesophageal reflux disorder (GERD), hypothyroid, obstructive sleep apnea (OSA). Documentation reflects that the Resident has experienced both a significant weight gain, and a significant weight loss over a 4-month period.	F 692		

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F 692	Continued From page 31	F 692		

An Admission Nutrition Assessment dated 10/4/2022 states "Diet order is regular with good po intake of most meals. Admit weight of 135#... Unable to review mediations or labs at this time. Resident is able to feed [her/himself] on most occasions. Ambulates with walker and staff assist becoming short of breath on exertion. Nutrition care plan created. Will follow resident course. This assessment completed remotely." The assessment also states, "resident's current nutritional plan does not meet 100% of the resident's needs."

A Nutrition care plan created on 10/04/2022 and reviewed on 01/16/2023 reflects that the Resident is at risk of poor nutrition status. Care plan goals include "Weight maintenance. Average meal intakes of 50% or greater. No s/s of dehydration" with an Intervention of "Monitor weights weekly." Review of Resident #40's weekly weights reveals that weights were not monitored weekly, and that the Resident experienced a significant weight gain and a significant weight loss in less than 30 days over a 4-month period. Documented weights as follows; 9/28/22 - 134.8, 10/5/22 - 163lbs (significant weight gain of 20.9% over a 7-day period).
10/17/22 (12 days later) the resident's weight was documented as 162lbs. There are no further documented weights obtained for 18 days.
11/4/22 - 164.0 then 14 days later on 11/18/22 a weight was documented as 164.2lbs.
The Residents weight was not documented again until 12/7/22 (19 days later) at 151.2. This is a significant weight loss of 7.92% in less than 30 days.
12/16/22 - 182.4 indicating a 20.63% weight gain in 9 days. There are no further documented

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F 692	Continued From page 32 weights for 17 days. 1/2/23 - 196lbs - a 7.57% weight gain in 17 days. 1/6/23- 188.6 this reflects an 8.6 3.87% weight loss in 4 days. 1/24/23 - 157 a weight loss of 16.76% in 18 days. A Nutrition Assessment completed on 12/29/2022 states "the resident's current weight is 162lbs with BMI [body mass index] of 36. Weight 30 days ago: 164# (11%) and 90 days ago on admission: 134# (36%) revealing significant increase over this review period. Nursing notes refer to edema/fluid status changes, presumably contributing to the resident's significant weight increase. Diet order is regular with good po intake of most meals...Medications reviewed. Resident is able to feed her/himself on most occasions. Ambulates with walker and staff assist becoming short of breath on exertion. Nutrition care plan reviewed with no changes at this time. Will follow resident course." On 2/1/23 at 9:40AM during an interview with the Registered Dietician (RD) and the dietary manager, the dietary manager was asked to explain the process of monitoring and communicating significant weight changes. S/he reported that s/he looks at the daily weight sheets indicating who has more than 5% or 10 % of weight loss. Residents are weighed during the first week of the month. If the weights don't look right they are reweighed. The Residents are discussed in the standard in care meeting. The RD stated that that they were not as vigilant about [weight changes] as they could be.	F 692		