STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey was conducted on 08/25/2020 through 09/08/2020 with onsite observations conducted on 08/25/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One (1) complaint was investigated during the survey. The census in this 65 certified bed facility was 53 at the time of the survey. The survey sample consisted of two (2) current resident record reviews and one (1) closed record review.	F 000	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion of set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws.	10/01/20
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and 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	F656 F 656	The nursing staff was in-serviced starting 9.2.2020 through 10.1.2020 by the Administrative Nursing Team regarding documenting meal and HS Snacks intake on the Activities of Daily Living (ADL) Sheet and the intake for resident #1 is now consistently being documented. Resident #3 no longer resides in the facility, thus, no corrective action can be completed for this resident. The Director of Nursing (DON) or designee will conduct an audit to verify	

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

Marsha Thomas — CED — 9/25/2020

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F 656	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement the comprehensive care plan in regards to nutrition for 2 of 3 residents, Residents #1 and #3. The findings included: 1. The facility staff failed to implement the nutrition care plan by failing to monitor intake at all meals for Resident #1. One surveyor reviewed Resident #1's clinical record on multiple days between 08/27/2020 and 09/05/2020. Resident #1's clinical record included the diagnoses: cerebral infarction (stroke), chronic kidney failure, moderate protein-calorie malnutrition, obesity, anemia, type 2 diabetes	F 656	that all resident's with nutritional care plans in regards to monitoring the intake at all meals are implemented with the required monitoring documentation on residents' Activities of Daily Living (ADL) sheet with corrective action upon discovery to be completed by 10.01.2020. The DON or designee will re-educate nursing staff to ensure the residents nutritional care plans are implemented by ensuring the accurate documentation for monitoring intake at all meals is completed in the residents ADL Records and the Certified Nursing Assistant (CNA) is to report off to a licensed nurse to verify completion of the Resident ADL Record. The re-education will include a posttest to validate understanding. New hires, including agency staff, will be provided education and posttests during orientation	10/01/2020

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F 656	Continued From page 2 mellitus with diabetic neuropathy, systolic (congestive) heart failure, hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting right dominant side, and acquired absence of left leg above knee. Section C (cognitive patterns) of the resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/03/2020 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (1/1) to indicate the resident required supervision (oversight, encouragement or cueing) with set up help only for eating. The comprehensive care plan developed for Resident #1 included the intervention "Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake." The facility's staff documented Resident #1 weighed 248.2 pounds on 03/01/2020. On 04/26/2020, the staff documented the resident weighed 217 pounds. A review of Resident #1's ADL (activities of daily living) Record sheets for the months of March, April, and May 2020 revealed that the facility staff had not documented all of the meal percentages. For March there were 29 missing meal percentages, for April there were 10 missing meal percentages and for May, there were 25 missing meal percentages. The bedtime snack percentages were missing for 11 days in March, 9 days in April, and 19 days in May 2020. Resident	F 656	by DON /Designee. Education to be completed in entirety by 10.01.2020. CNAs will be required to report off to a licensed nurse at the end of their shift to verify completion of the Resident's ADL records. The DON or designee will audit the ADL Records weekly X 4 then monthly X 2 to ensure the residents' individual nutrition care plan is implemented by ensuring the ADL documentation of monitoring of their intake of all meals is completed with corrective action upon discovery to be completed by 10.01, 2020. Outcomes of those audits will be presented to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	10/01/2020

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F 656	Continued From page 3 #1 was not in the facility between May 22, 2020 and May 27, 2020. The meals and bedtime snack counts for those days were not included in the May missing percentages totals. On 08/28/2020 at 3:35 p.m., during a phone call with the administrator and ADON (assistant director of nursing) the ADON informed the survey team it was the CNA's (certified nursing assistants) responsibility to complete the ADL Record sheets. On 09/04/2020 at 2:20 p.m., the facility's dietician was interviewed via conference call related to Resident #1's nutritional status and food intake documentation. The facility's administrator and ADON (assistant director of nursing) were present during the conference call. The ADON acknowledged the missing documentation for meal and snack percentages on the ADL record sheets and stated the expectation was for the percentages to be documented every day, every meal, every shift. No further information was provided prior to exit. 2. For resident #3, the facility staff failed to implement the nutrition care plan in regards to documenting PO (by mouth) intake. The clinical record was reviewed on 08/28/2020. Resident #3's clinical record included the diagnosis, failure to thrive, dementia, diabetes, benign neoplasm of adrenal gland, and gastroesophageal reflux disease. Section C (cognitive patterns) of the residents admission MDS (minimum data set) assessment	F 656	This page intentionally left blank.	

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F 656	Continued From page 4 with an ARD (assessment reference date) of 06/24/2020 included a BIMS (brief interview for mental status) summary score of 8 out of a possible 15 points. Section G (functional status) was coded (0/1) to indicate the resident was independent with set up help only for eating. The comprehensive care plan included the intervention "Monitor and document PO intakes." A review of the residents weights revealed that on 06/24/2020 the staff documented Resident #3 weighed 165.4 pounds. On 08/05/2020, the staff documented the resident weighed 129 pounds. A review of Resident #3's ADLs (activities of daily living) sheets for the months of June, July, and August 2020 revealed that the facility staff had not documented all of the residents meal percentages. For June there were 14 missing meal percentages, for July 67 missing meal percentages, and for August 20 missing meal percentages. These ADL sheets did not include any percentage of intake for a bedtime snack. On 08/28/2020 at 3:35 p.m., during a phone call with the administrator and ADON (assistant director of nursing) the ADON verbalized to the survey team that it was the CNA's (certified nursing assistants) responsibility to fill out the ADL sheets. On 08/31/2020, the facility provided the surveyor with a calorie count sheet that included documentation for 3 more meals for July. Changing the missing percentages for July to 64. No further information regarding the missing documentation was provided to the survey team.	F 656	This page intentionally left blank.	

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide care in accordance with the comprehensive care plan and physicians orders for 2 of 3 residents, Resident #1 and #3. The findings included: 1. The facility staff failed to provide wound care according to physician orders for Resident #1. One surveyor reviewed Resident #1's clinical record on multiple days between 08/27/2020 and 09/05/2020. Resident #1's clinical record included the diagnoses: cerebral infarction (stroke), chronic kidney failure, moderate protein-calorie malnutrition, obesity, anemia, type 2 diabetes mellitus with diabetic neuropathy, systolic (congestive) heart failure, hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting right dominant side, and acquired absence of left leg above knee. Section C (cognitive patterns) of the	F684 F 684	1) Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion of set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws. The licensed nurses were in-serviced by the Administrative Nursing Team 9.24.2020 through 10.1.2020 regarding the importance of following physician orders by completing and documenting ordered treatments. Treatments are now being completed and documented per physician orders for resident #3. DON or designee will conduct an audit on all current residents identified with wounds by 10.01.2020 to ensure all residents with wounds are being provided the wound care according to	10/01/2020

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F 684	Continued From page 6 resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/03/2020 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The comprehensive care plan developed for Resident #1 included a focus area that read, "Resident at risk for skin breakdown related to shear/friction, limited mobility, incontinence, morbid obesity, DM (diabetes mellitus), chronic fungal rash to back, excessive moisture" with one of many interventions that read, "Provide wound treatment as ordered." The Treatment Administration Record (TAR) contained a provider order that read, "Diabetic Ulcer of (R) outer ankle [sic] Cleanse with wound cleanser [sic] Pat dry [sic] Apply sure-prep to peri-wound [sic] Fill wound cavity with collagen powder [sic] Cover with dry dressing and place Optifoam pad over dressing and secure with gauze wrap daily and PRN (as needed) [sic] Optifoam pad only to be changed if soiled every day shift for wound care." That order had a start date of 05/28/2020 at 7:00 a.m. and a discontinue date of 06/10/2020 at 8:00 p.m. There was no documentation on the TAR that facility staff had provided wound care according to this order for the dates of May 28th, 29th, 30th, 31st, June 1st or 2nd. The wound care was documented June 3rd through June 10th. On 09/08/2020 at 11:07 a.m. during a conference call with the facility's administrator, the missing documentation of wound care as above was discussed. The administrator wanted to enlist input from the facility's infection preventionist (IP). At 12:00 noon on the same day, the administrator	F 684	physician orders with the Treatment Administration Record (TAR) documentation completed. Corrective action upon discovery to be completed by 10.01.2020. DON or designee to re-educate licensed nurses regarding the importance of following physician orders by completing and documenting wound treatments to ensure the residents wound care is provided per physician orders and the TAR documentation is completed. The re-education will include a posttest to validate understanding. New hires, including agency staff, will be provided education and posttests during orientation by DON /Designee. Education to be completed in entirety by 10.01.2020. The Administrative Nursing Team and the Interdisciplinary Team were in-serviced by the Regional Resource Nurse on 9.23.2020 regarding the	10/01/2020

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F 684	Continued From page 7 and IP called the surveyor back. The IP acknowledged the wound care was not documented on the TAR. The administrator indicated the wound care might be documented somewhere within the clinical record other than the TAR. At 12:36 p.m. the administrator called the surveyor to verbalize the wound care was not documented elsewhere in Resident #1's clinical record. No further information was provided prior to exit. 2. For Resident #3, the facility staff failed to follow a physician order in regards to the residents calorie intake. The clinical record was reviewed on 08/28/2020. Resident #3's clinical record included the diagnosis, failure to thrive, dementia, diabetes, benign neoplasm of adrenal gland, and gastroesophageal reflux disease. Section C (cognitive patterns) of the residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/24/2020 included a BIMS (brief interview for mental status) summary score of 8 out of a possible 15 points. Section G (functional status) was coded (0/1) to indicate the resident was independent with set up help only for eating. A review of Resident #3's weights revealed that on 06/24/2020 the staff documented a weight 165.4 pounds. On 08/05/2020, the staff documented the resident weighed 129 pounds. The "Order Recap Report" located in the clinical record included a physicians order dated	F 684	Customer At Risk (CAR) Meeting. The CAR Meeting will be established to meet weekly by 10.1.2020 and will review any resident identified with wounds. The TARs will be reviewed in the CAR meeting for treatment completion. Corrective action upon discovery of licensed nurses failing to complete and document treatments will be completed as necessary. DON or designee will audit the TARs weekly X 4 then monthly X 2 to ensure that the wound care ordered by the physician and the documentation in the TAR is being completed for all residents identified with wounds with corrective action upon discovery. Outcomes of those audits will be presented to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will	10/01/2020

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F 684	Continued From page 8 07/16/2020 for a "Calorie count X 72 hours." The residents comprehensive care plan included the focus area "Resident at nutrition risk r/t (related to) significant wt. (weight) loss, poor intakes, need for appetite stimulant." On 07/24/2020, the dietician documented that a calorie count was completed on 07/16, 07/20, and 07/21/2020. The surveyor was unable to locate the calorie count in the clinical record. On 08/28/2020 at approximately 3:35 p.m., the administrator and ADON (assistant director of nursing) were asked about the missing calorie counts. The ADON verbalized to the surveyor that this would be on paper. A copy of this was requested. On 08/31/2020, the facility provided the surveyor with a calorie count sheet. However, the dates on the sheet were documented as 07/16, 07/20, and 07/21/2020. On 08/31/2020 at approximately 12:10 p.m., the administrator and ADON were asked about the dates. The ADON stated the facility staff had missed the corresponding dates, had notified the physician, and were told to just pick it up starting the 20th. The surveyor requested any further information on this. The ADON stated they thought this was done verbally. No further information regarding this issue was provided to the surveyor.	F 684	direct further analysis and interventions based on reported outcomes and direct further investigations. 2) Resident #3 and no longer resides in the facility, thus, no corrective action can be completed for this resident. DON or designee will conduct an audit on all residents with a physician order in regards to the residents' calorie intake to ensure all residents with calorie intake orders are being completed and documented as ordered with corrective action upon discovery to be completed by 10.01.2020 DON or designee to re-educate nursing staff to ensure the physician orders in regards to resident calorie intake are completed per the physicians order and if the order is changed the	10/01/2020
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 9 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	physician must provide written documentation. The re-education will include a posttest to validate understanding. New hires, including agency staff, will be provided education and posttests during orientation by DON /Designee. Education to be completed in entirety by 10.01.2020. Physician orders will be reviewed daily in the Clinical Meeting to ensure physician orders are implemented and followed through. DON or designee will audit physician orders weekly X 4 then monthly X 2 to ensure that the calorie intake orders are completed as ordered and written documentation is provided for any physician changes with corrective action upon discovery. Outcomes of those audits will be presented to the Quality Assurance	10/01/2020

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F 842	Continued From page 10 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (I) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete an accurate clinical record for 3 of 3 residents, Residents #1, #2 and #3. The findings included: 1. For resident #1, the facility staff failed to ensure the resident's meal and bedtime snack intake percentages were documented on the ADL (activities of daily living) Record sheets.	F 842	Performance Improvement (QAPI) committee monthly. The QAPI committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	10/01/2020

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F 842	Continued From page 11 The clinical record was reviewed on multiple days between 08/27/2020 and 09/05/2020. Resident #1's clinical record included the diagnoses: cerebral infarction (stroke), chronic kidney failure, moderate protein-calorie malnutrition, obesity, anemia, type 2 diabetes mellitus with diabetic neuropathy, systolic (congestive) heart failure, hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting right dominant side, and acquired absence of left leg above knee. Section C (cognitive patterns) of the resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/03/2020 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The comprehensive care plan included the intervention "Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake." A review of Resident #1's ADLs (activities of daily living) sheets for the months of March, April, and May 2020 revealed that the facility staff had not documented all of the meal percentages. For March there were 29 missing meal percentages, for April there were 10 missing meal percentages and for May, there were 25 missing meal percentages. The bedtime snack percentages were missing for 11 days in March, 9 days in April, and 19 days in May 2020. Resident #1 was not in the facility between May 22, 2020 and May 27, 2020. The meals and bedtime snack counts for those days were not included in the May missing percentages totals.	F 842	F842 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion of set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws. The nursing staff was in-serviced starting 9.2.2020 through 10.1.2020 by the Administrative Nursing Team regarding documenting meal and HS Snacks intake on the Activities of Daily Living (ADL) Sheet and the meal intake for resident #1 is now consistently being documented. Residents #2 and #3 no longer reside in the facility, thus, no corrective action can be completed for these residents	10/01/2020

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	495200	A. BUILDING _____ B. WING _____	C 09/08/2020

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F 842	Continued From page 12 On 08/28/2020 at 3:35 p.m., during a phone call with the administrator and ADON (assistant director of nursing) the ADON verbalized to the survey team that it was the CNA's (certified nursing assistants) responsibility to fill out the ADL Record sheets. On 09/04/2020 at 2:20 p.m., the facility's dietician was interviewed via conference call related to Resident #1's nutritional status and food intake documentation. The facility's administrator and ADON (assistant director of nursing) were present during the conference call. The ADON acknowledged the missing meal and snack percentages documentation on the ADL Record sheets and stated the expectation was for the percentages to be documented every day, every meal, every shift. No further information was provided to the survey team prior to exit conference. 2. For Resident #2, the facility staff failed to ensure the staff documented the residents meal intake and bedtime snack(s) on the ADL (activities of daily living) sheets. The clinical record was reviewed on 08/28/2020. Resident #2's clinical record included the diagnosis, Alzheimer's disease, dementia, gastroesophageal reflux disease, feeding difficulties, and dysphagia. Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of	F 842	The Director of Nursing (DON) or designee will conduct an audit to verify that all resident's Activities of Daily Living (ADL) Records are complete including documentation of the resident's meal and bedtime snack intake percentages per policy with corrective action upon discovery to be completed by 10.01.2020. The DON or designee will re-educate nursing staff regarding the regulation for maintaining complete and accurate medical records and ensuring the residents' meal and bedtime snack intake percentages are documented on ADL Record and the Certified Nursing Assistant (CNA) is to report off to a licensed nurse to verify completion of the Resident ADL Record. The re-education will include a posttest to validate understanding. New hires, including agency staff, will be	10/01/2020

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F 842	Continued From page 13 08/04/2020 was coded 1/1/2 to indicate the resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Section K (swallowing/nutritional status) was coded 7/2 for eating to indicate this activity only occurred once or twice in the look back period. This MDS had been coded to indicate the resident had a weight loss and was not on a physician prescribed weight loss regimen. On 08/28/2020 at 11:15 a.m., the surveyor contacted the administrator and asked to speak with the MDS nurse. The administrator verbalized to the surveyor that the MDS nurse was not at the facility. The surveyor asked for information in regards to the MDS being coded 7/2 for eating. On 08/28/2020 at 11:30 a.m., the administrator verbalized to the surveyor that the MDS nurse had resigned and was not available for interview. The administrator stated that she had spoken with the MDS nurse via phone and they stated they had coded the MDS with a 7/2 due to the lack of documentation on the ADL sheets. A review of the ADL sheets for the months of July and August 2020 revealed that the facility staff had not documented all of the residents meal percentages. For July, there were 42 missing meal percentages and 19 bedtime snack percentages. For August, there were 59 missing meal percentages and 24 bedtime snack percentages. The residents comprehensive care plan included the intervention "Monitor intake at all meals...alert dietitian and physician to any decline in intake."	F 842	provided education and posttests during orientation by DON /Designee. Education to be completed in entirety by 10.01.2020. CNAs will be required to report off to a licensed nurse at the end of their shift to verify completion of the Resident's ADL records. The DON or designee will audit the ADL Records weekly X 4 then monthly X 2 to ensure complete and accurate medical records maintained and ensuring the residents' meal and bedtime snack intake percentages are documented on ADL Record with corrective action upon discovery to be completed by 10.01, 2020. Outcomes of those audits will be presented to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will	10/01/2020

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F 842	Continued From page 14 On 08/28/2020 at 3:35 p.m., during a follow-up call with the administrator and ADON (assistant director of nursing), these staff were asked if the MDS coordinator could have asked the staff that worked with the resident for this information. The administrator verbalized to the survey team that she could have spoken with the CNAs (certified nursing assistants). No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For resident #3, the facility staff failed to ensure the staff documented the residents meal and bedtime snack intake on the ADL (activities of daily living) sheets. The clinical record was reviewed on 08/28/2020. Resident #3's clinical record included the diagnosis, failure to thrive, dementia, diabetes, benign neoplasm of adrenal gland, and gastroesophageal reflux disease. Section C (cognitive patterns) of the residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/24/2020 included a BIMS (brief interview for mental status) summary score of 8 out of a possible 15 points. A review of the ADL sheets for the months of June, July, and August 2020 revealed that the facility staff had not documented all of the residents meal percentages. For June there were 14 missing meal percentages, for July 67 missing meal percentages, and for August 20 missing meal percentages. These ADL sheets did not	F 842	direct further analysis and interventions based on reported outcomes and direct further investigations.	10/01/2020

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F 842	Continued From page 15 include any percentage of intake for a bedtime snack. The residents comprehensive care plan included the intervention "Monitor and document PO (by mouth) intakes." On 08/28/2020 at 3:35 p.m., during a phone call with the administrator and ADON (assistant director of nursing) the ADON verbalized to the survey team that it is the CNA's (certified nursing assistants) responsibility to fill out the ADL sheets. On 08/31/2020, the facility provided the surveyor with a calorie count sheet that included documentation for 3 more meals for July. Changing the missing percentages for July to 64. No further information regarding the missing documentation was provided to the survey team.	F 842	This page intentionally left blank	