STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065188	A. Building B. Wing	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Morrison	150 Spring St Morrison, CO 80465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and interviews, the facility failed to ensure three (#1, #3 and #2) of six out of eight sample residents received the care and services necessary to meet their nutrition needs to maintain their highest level of physical well-being. Resident #1 was admitted to the facility on [DATE]. Resident #1 had a diagnosis of traumatic subdural hemorrhage (brain bleed). Hypertension (high blood pressure), multiple fractures of ribs, history of traumatic brain injury and dementia. Upon admission on [DATE] Resident #1 weighed 178.2 pounds (lbs). On [DATE] Resident #1 weighed 170 lbs. This weight revealed, Resident #1 had a significant weight loss of 4.3% (7.6 lbs) in one week. The family began providing Ensure (nutritional supplement) on [DATE]. Speech therapy was involved in the resident's care, but no additional nutritional interventions were implemented. The only nutritional intervention provided was initiated by the family providing Ensure. The facility failed to implement a nutritional intervention to prevent further weight loss, for Resident #1. Therefore, Resident #1 sustained a 11% weight loss (19.6 lbs) in five months, which was considered significant. Resident #3 was admitted to the facility on [DATE]. Resident #3 had a diagnosis of type two diabetes mellitus, hypothyroidism (reduced thyroid function), hyperlipidemia (high cholesterol) and personal history of traumatic brain injury. Upon admission on [DATE] Resident #3 weighed 248 lbs. Resident #3 was hospitalized from [DATE] through [DATE]. During this time he was diagnosed with pneumonia related to a COVID-19 infection. The [DATE] discharge summary from the hospital documented the resident weighed 240 lbs and the resident was no longer on Hospice comfort care and the wife wanted to have the resident's medical issues treated. Upon Resident #3's readmission to the facility on [DATE], the facility failed to obtain a readmission weight to determine if the resident sustained weight loss while in the hospital and create a baseline for the resident after the hospitalization . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident #3 sustained a 10.4% (28.4 lbs) weight loss in one month from [DATE] through [DATE], which was considered significant. Although the resident spent six days in the hospital the facility failed to weigh the resident timely upon readmission to determine if nutritional interventions should be put into place. Resident #3 was not weighed for 22 days after being readmitted to the facility. The resident sustained a 8.5% (20.4 lbs) weight loss from his hospitalization until he was weighed again at the facility on [DATE]. Additionally, the facility failed for Resident #2 to: -Obtain an admission weight for Resident #2 and follow physician's orders to for weekly weights for the resident's first four weeks after admission; -Document attempts made to weigh the resident; and, -Provide clarification on documented weights in Resident #2's medical record. Findings include: I. Facility policy and procedure The Nutritional Management policy, revised February 2023, was provided by the nursing home administrator (NHA) on [DATE] at 4:38 p.m. It revealed in pertinent part, The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. A systematic approach is used to optimize each resident's nutritional status: identifying and assessing each resident's nutritional status and risk factors, evaluating/analyzing the assessment information, developing and consistently implementing pertinent approaches and monitoring the effectiveness of interventions and revising them as necessary. Identification/assessment: nursing staff shall obtain the resident's height and weight upon admission, and subsequently in accordance with facility policy, the dietary manager or designee shall obtain the resident's food and beverage preferences upon admission, significant change in condition, and periodically throughout his or her stay and a comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission, annually, and upon significant change in condition. Follow-up assessments will be completed as needed. Care plan implementation: the resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care, interventions will be individualized to address the specific needs of the residents, real food will be offered first before adding supplements and tube feeding or parenteral fluids will be provided in the context of the resident's overall clinical condition and resident goals/preferences. The care plan will be updated as needed, such as when a resident's condition changes, goals are met or the resident changes his or her goals, interventions are determined to be ineffective, or as new causes of nutrition-related problems are identified. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The physician will be notified of: significant changes in weight, intake, or nutrition status, lack of improvement toward goals and any complications associated with interventions. Informed consent: the resident/representative has the right to choose and decline interventions designed to improve or maintain nutritional or hydration status, the facility shall discuss the risks and benefits associated with the resident/representative decision and offer alternatives and the comprehensive care plan should describe any interventions offered, but declined by the resident or resident's representative. II. Resident #1 A. Resident status Resident #1, age 86, admitted on [DATE] and expired on [DATE]. According to the February 2023 computerized physician orders (CPO), the diagnoses included traumatic subdural hemorrhage (brain bleed), hypertension (high blood pressure), personal history of traumatic brain injury and dementia. The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) with a score of six out of 15. He required extensive assistance of one person for bed mobility, transfers, dressing, toileting and personal hygiene. He required supervision of one person assistance for walking in his room and in the corridor. He required supervision with no set-up or assistance for locomotion on and off the unit and he required supervision with set-up assistance for eating. The MDS assessment documented the resident did not have any swallowing difficulties. The resident weighed 167 lbs. The resident did not have any weight changes and was on a mechanically altered diet. -However, Resident #1's electronic medical record weight data documentation revealed the resident had sustained weight changes. B. Record review 1. Nutritional care plan The nutritional care plan, initiated on [DATE], revealed Resident #1 was at nutritional risk related to dysphagia (difficulty swallowing). He was tolerating a dysphagia advanced diet with nectar thick liquids. The interventions included: monitoring for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated, monitoring for signs or symptoms of aspiration, providing diet as ordered, weighing resident per protocol and alerting physician and RD (registered dietitian) of any significant weight loss or gain. -All interventions on the nutritional care plan were implemented on [DATE]. -Resident #1's comprehensive care plan was not updated after he had significant weight loss from [DATE] to [DATE] and from [DATE] through [DATE] (see below). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2. Resident #1's weights Resident #1's weights were documented in the resident's medical record as follows: -On [DATE], the resident weighed 178.2 lbs. -On [DATE], the resident weighed 178 lbs. -On [DATE], the resident weighed 176.4 lbs. -On [DATE], the resident weighed 177.6 lbs. -On [DATE], the resident weighed 170 lbs. -On [DATE], the resident weighed 163.8 lbs. -On [DATE], the resident weighed 166.6 lbs. -On [DATE], the resident weighed 158.6 lbs. -The resident had 4.3% (7.6 lbs) weight loss, which was considered significant from [DATE] to [DATE] in one week. -The resident had an 11% (19.6 lbs) weight loss, which was considered significant from [DATE] through [DATE] in five months. 3. Physician orders The [DATE] CPO revealed Resident #1 had the following physician orders related to nutrition: -Weigh weekly X4 (times four) weeks then monthly, ordered [DATE]. -Resident #1 was not weighed weekly upon admission for four weeks as ordered. (See above). The [DATE] CPO revealed Resident #1 had the following physician orders related to nutrition: -Dysphagia diet, dysphagia advanced texture, thin liquids, ordered on [DATE] and discontinued on [DATE]. The [DATE] CPO revealed Resident #1 had the following physician orders related to nutrition: -Family has provided Ensure (nutritional supplements) drinks in the fridge, please offer with breakfast and dinner, ordered [DATE] , discontinued on [DATE]. The [DATE] CPO revealed Resident #1 had the following physician orders related to nutrition: -Family has provided Ensure (nutritional supplement) drinks in the fridge, please offer with breakfast and dinner. Please make sure to thicken if not cold, ordered [DATE] and discontinued on [DATE]. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Regular/liberalized diet, dysphagia advanced texture, nectar consistency, ordered [DATE] and discontinued on [DATE]. -Hospice eval (evaluation) and treat (treatment), ordered [DATE], discontinued on [DATE]. 4. Nutritional assessments/progress notes The [DATE] admission nutritional assessment documented in part, the resident weighed 178 lbs on [DATE] and was 70 inches tall on [DATE]. The resident's body mass index (BMI) was 25.5. The resident was on a regular liberalized diet, dysphagia advanced texture (limit very hard, sticky or crunchy foods) and nectar thick liquids. The resident did not have any food allergies or cultural, ethnic or religious preferences with food. The nutrition history documented the RD met with the resident in the dining room and he was pleasant. The resident was tolerating his diet and was working with speech therapy. The resident was dining in the main dining room and the family requested him to eat there for supervision. The resident was able to feed himself and benefited from set-up assistance. The resident's family was unsure of his usual weight and his current weight was health. The goal was weight maintenance for the resident. The family frequently visited and brought in special foods for the resident. Resident #1 enjoyed smoothies and chili. The assessment documented the resident displayed coughing or choking during meals or when swallowing medications and was tolerating his current diet texture. There was coughing with thin liquids, which promoted the recommendation of nectar thick liquids. The resident had no significant weight weight changes and his BMI was less than 19 or greater than 25. The intake observation said the resident had variable intakes and accepted an average of ,d+[DATE]%. The assessment documented he had no skin issues and was not appropriate for diet education. The assessment summary documented an [AGE] year old male was admitted for long term care after a hospitalization for traumatic subdural hematoma (brain bleed). His prior medical history included hypothyroidism (overactive thyroid) and hypertension (high blood pressure). Resident #1 was tolerating his diet. Medications and labs were reviewed. The assessment documented further assessment was needed. The resident's nutritional needs were 1950 calories, 81 grams protein and 2430 fluid ounces. The assessment documented the resident's intake was meeting his nutritional needs compared to his calculated needs and had generally good meal intakes and the family was also providing snacks. The nutritional evaluation and plan section documented the resident was admitted for long term care and was on a texture modified for dysphagia. He was eating generally well at this time. There were no nutrition related concerns to address at this time. There was no identified nutrition problem. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The [DATE] nutritional assessment documented the resident weighed 166.6 lbs on [DATE] and his BMI was 23.9. The resident was on a regular/liberalized diet with dysphagia advanced and nectar thick liquids. The nutrition history section documented the resident was being seen due to a change in condition by admitting to hospice services. Resident #1 was tolerating his diet and his meal intakes were variable and accepted partial bottles of Ensure brought in by family. The resident was no longer eating in the main dining room and the family was requesting to offer that he eat in the main dining room if able. Resident #1 was able to feed himself independently, but benefited from set-up assistance. The family was unsure of his usual weight. His current weight was within a healthy BMI range. Weight maintenance was an appropriate goal for the resident moving forward, but had seen a 6% weight loss in the last three months. The swallowing section documented the resident was tolerating current diet texture and thickened liquids. The resident lost 6% weight in three months. It documented the resident had not had any significant/severe loss or gain, the resident had weight loss and the resident did not have a BMI that was less than 19 or greater than 25. The resident had variable intakes that average about ,d+[DATE]%. The resident's skin was intact and was not appropriate for diet education at that time. The assessment summary documented an [AGE] year old male was admitted for long term care status post hospitalization for traumatic subdural hematoma. He was admitted to hospice per power of attorney decision. The resident tolerated his diet and the family provided Ensure which he usually accepted at least 25%. The resident's medication and labs were reviewed. The evaluation and nutrition plan documented Resident #1 was seen for a change in condition due to family opting hospice services. The resident consumed at least half of his meals most days. The assessment documented the staff will continue to encourage intake as able and offer Ensure at least twice a day. Comfort was the goal. The assessment documented to continue to monitor the resident per protocol and make changes as needed. The nutrition assessment documented there was not a nutrition problem. -However, Resident #1 had a 4.3% (7.6 lbs) weight loss, which was considered significant from [DATE] to [DATE] in one week. -The assessment mentioned the resident was tolerating his prescribed diet at that time and was accepting nutritional supplements. The assessment did not document the families desire to not provide nutritional interventions (see interview below). In addition, the assessment did not document the resident's wishes for nutritional interventions. -A request was made for the at risk meeting notes (see interview below) for Resident #1 on [DATE] and they were not provided by the facility. III. Resident #3 A. Resident status Resident #3, admitted on [DATE] and readmitted on [DATE]. According to the [DATE] CPO, the diagnoses included type two diabetes mellitus without complications, hyperlipidemia (high cholesterol, personal history of traumatic brain injury, viral pneumonia, pneumonia due to coronavirus disease 2019 and history of malignant neoplasm of prostate (prostate cancer). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The [DATE] MDS assessment documented the resident was moderately impaired with inattention per staff interview for cognitive impairment. He required supervision with one person assistance for bed mobility, walking in the corridor, locomotion on and off the unit, eating and personal hygiene. He required extensive assistance of two people for transfers, supervision with set-up assistance for walking in his room, extensive assistance of one person for dressing and limited assistance of one person for toileting. The MDS assessment documented the resident did not have any swallowing difficulties. The resident weighed 219 lbs. Resident #3 had weight loss of 5% or more in the last month or loss of 10% or more in the last six months and was not on a prescribed weight loss regimen. He was on a therapeutic diet. B. Record review 1. Nutritional care plan The nutritional care plan initiated on [DATE] and revised on [DATE] revealed Resident #3 was at nutritional risk related to type two diabetes. Resident #3 had significant weight loss over six months consistent with overall decline. Resident #3 was overweight per his BMI, but weight loss was not a goal of care. The interventions included: encourage 100% consumption of all fluids provided, encouraging the resident to sit up for meals as tolerated, providing supervision and cueing at meals, monitoring for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicted, monitoring for signs and symptoms of hyper/hypoglycemia (high or low blood sugars) and report abnormal findings to physician, offering Boost (nutritional supplement) or house supplement three times a day, providing diet as ordered and encouraging to dine in restorative dining and weighing resident per protocol, alerting RD and physician of any significant weight loss or gain. 2. Resident #3's weights Resident #3's weights were documented in the resident's medical record as follows: -On [DATE], the resident weighed 248 lbs. -On [DATE], the resident weighed 243.4 lbs. -On [DATE], the resident weighed 237 lbs. -On [DATE], the resident weighed 244.4 lbs. -On [DATE], the resident weighed 219.6 lbs. -On [DATE], the resident weighed 217.6 lbs. The resident had a 10.2% (24.8 lbs) weight loss in one month, which was considered significant from [DATE] to [DATE]. The resident had not been weighed in [DATE], at the time of the survey ([DATE]). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	3. Physician orders The February 2023 CPO revealed the following physician orders related to nutrition: -House supplement three times a day for supplemental nutrition. Give with meals, ordered [DATE] and discontinued on [DATE]. The [DATE] CPO revealed the following physician orders related to nutrition: -Sugar free house supplement PO (by mouth) BID (twice a day) after meals for DMII (diabetes type two), ordered [DATE] and discontinued on [DATE]. -House supplement three times a day for ongoing supplementation ordered [DATE] and discontinued on [DATE]. -Offer three times a day; offer resident Boost or Premier Protein (nutritional supplement) (provided by family, located in the fridge). If these supplements are unavailable please offer a house supplement, ordered [DATE] and discontinued on [DATE]. -The nutritional supplement orders failed to document how much of the supplement to provide to the resident. The [DATE] CPO revealed the following physician orders related to nutrition: -Sugar free house supplement PO, BID after meals for DMII, ordered [DATE] and discontinued on [DATE]. -Offer three times a day; offer resident Boost or Premier Protein (provided by family located in the fridge). If these supplements are unavailable please offer a house supplement, ordered [DATE] and discontinued on [DATE]. -The nutritional supplement orders failed to document how much of the supplement to provide to the resident. The [DATE] CPO revealed the following physician orders related to nutrition: -Weigh weekly x4 (times four) weeks then monthly, ordered [DATE]. -Offer three times a day offer resident Boost or Premier Protein(provided by family located in the fridge). If these supplements are unavailable please offer a house supplement, ordered [DATE] and discontinued on [DATE]. -House supplement, three times a day offer resident 4 oz (four ounces) house supplement. Please assist with completion as needed. Document % (percent) completed in the MAR (medication administration record), ordered [DATE]. -Upon readmission [DATE], the resident was not weighed for 14 days, per physician's orders. The resident was not weighed weekly after readmission, per physician's orders. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	4. Nutritional assessments/progress notes The [DATE] admission/readmission nutritional assessment documented the resident weighed 243.4 lbs on [DATE] and was 72 inches. The resident's BMI was 33 and he was [AGE] years old. The resident received a consistent carbohydrate diet with no food allergies. The resident had no cultural, ethnic or religious preferences. The nutrition history section documented the resident was on a consistent carbohydrate diet and was eating in the dining room for most meals. Resident #3 was consuming ,d+[DATE]% of his meals and enjoyed meat. The resident reported no strong dislikes. The resident was unsure of his weight history, but currently weighed 243.3 lbs and his admission weight was 248 lbs. The resident had no recent labs and received Lasix (diuretic). The resident had no swallowing concerns or had any significant weight changes. The residents BMI was less than 19 or greater than 25. The intake section documented the resident's BMI was 33 (sic) and his oral intake was ,d+[DATE]% for three meals a day. The resident's skin was intact. Diet education was not provided to the resident as he was not interested at that time, but the RD was available upon request. The assessment summary documented the resident had a history of hypertension (high blood pressure), hyperlipidemia (high cholesterol, diabetes type two, hypothyroidism (overactive thyroid), anemia (low blood count), prostate cancer, benign prostatic hyperplasia (enlarged prostate gland), traumatic brain injury and obstructive sleep apnea. The resident was admitted from home for respite care and was currently on a carbohydrate diet with adequate oral intakes. The [DATE] admission/readmission nutritional assessment documented the resident weighed 244.4 lbs on [DATE] and was 72 inches. His BMI was 33.1. The resident was on a consistent carbohydrate diet with no food allergies. The nutrition history documented the RD attempted to meet with the resident, but the resident was sleeping during the visit. The resident remained on a consistent carbohydrate diet with generally good meal intakes. The resident had been eating in his room due to COVID-19 precautions. The resident was able to feed himself independently and enjoyed meat. The resident had not been weighed upon admission although the RD suspected that the resident lost weight when he was hospitalized for COVID-19. The resident had no significant weight changes and had a BMI less than 19 or greater than 25. The residents' meals intakes were generally good and he consumed ,d+[DATE]% of his meals per the documentation. The assessment summary documented the resident was recently hospitalized for COVID-19. The resident remained on a consistent carbohydrate diet with good intakes. The resident's medications were reviewed and there were no recent labs to review. The resident's nutritional needs were calculated, ,d+[DATE] calories, 88 grams of protein and ,d+[DATE] milliliters of fluid per day. The assessment evaluation and plan documented the resident was recently hospitalized . Weight loss may be anticipated when the residents monthly weight was obtained related to hospitalization . The RD was to continue to monitor and make changes as needed. -The RD suspected weight loss, but did not recommend obtaining a weight to confirm suspected weight loss or implement a nutritional intervention to prevent further weight loss. The [DATE] interdisciplinary (IDT) note documented the IDT team discussed the resident's 11.5% weight loss, which was significant in three months. The resident was requiring more assistance with food and fluid intake. The resident was offered Boost after meals. The resident's fluid intake appeared to be adequate, but the resident was frequently declining food. The resident sustained a general functional decline after having COVID-19. The resident was receiving therapy services to restore previous function. The physician and wife were made aware. The RD was to evaluate and make recommendations for further interventions. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The [DATE] weight change note documented, Resident #3 was reviewed by the RD for significant weight loss of 11.2% in three months. The resident's weight loss was discussed with the interdisciplinary team and the wife. The resident's current weight was 219.6 lbs. The resident's estimated nutrition needs were calculated at 2495 calories, 99 grams protein and 2495 milliliters of fluid. He was on a carbohydrate diet with overall poor oral intakes. The resident recently had COVID-19, which required a hospitalization . Resident #3 was occasionally offered Boost by his wife. A new intervention was to implement a house supplement three times a day and encouraging the resident to join restorative dining to receive one-on-one observation, cueing and encouragement during meals. The resident was receiving physical, occupational and speech therapy services. The resident was having ongoing diarrhea since the hospitalization . The RD reviewed the resident's medications list and discontinued the magnesium supplement, which could contribute to loose stools. The note documented there were no new or recent nutrition related labs to review. The resident's stool sample was negative for clostridium difficile (C. Diff, a bacterium that causes diarrhea and inflammation of the colon). The RD was to continue to monitor the resident's weight and meal intakes to determine if further interventions were needed. The [DATE] IDT note documented the IDT team discussed that the resident continued to have poor oral intake. The resident was offered a house supplement twice a day. The resident had a functional decline since having COVID-19. -However, the IDT team noted the resident had poor oral intake, but did not recommend new nutritional interventions to help promote oral intake. The [DATE] nursing progress note documented the resident was now receiving hospice care. -The resident sustained significant weight loss prior to admission to hospice services. The [DATE] IDT note documented the IDT team discussed the residents' continued poor appetite. The resident accepted supplements intermittently. The [DATE] IDT note documented the IDT team discussed the wife's concerns over the resident's poor oral intake. The wife requested a notebook with concerns and challenges to be available for staff to use as a communication aide for daily struggles with intakes, which was provided and nursing staff was made aware of the process. The resident continued with a poor appetite and was encouraged to eat and offered hands-on assistance with meals. The resident tested positive for C. Diff. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The [DATE] comprehensive MDS nutritional assessment documented the resident weighed 217.6 lbs on [DATE] and was 72 inches tall. His BMI was 29.5 and he was on a consistent carbohydrate diet with no food allergies. The nutrition history documented the resident had not been weighed in the month of May (2023). The resident's weight in April (2023) suggested the resident's weight had stabilized following a significant weight loss trend. The resident remained overweight per BMI, though weight loss was not a goal of his care. Weight loss was likely inevitable with the diagnosis progression. The resident remained on the same diet and had generally poor intakes. The resident often did not get up for meals even when encouraged. The resident had been dining in his room due to C. Diff. The IDR felt the resident required assistance with meals. Nursing staff was to assist the resident with meals in his room until he was off isolation. The resident had no swallowing difficulties. The resident had 8.2% weight loss in three months. The resident had significant/severe loss or gain, had a weight loss/gain trend and had a BMI less than 19 or greater than 25. The resident had variable intakes and was less than 50% at most meals. The resident's skin was intake and he was not appropriate for diet education. The resident nutritional labs were reviewed. The evaluation and plan section of the assessment documented the resident was recently admitted to hospice with comfort as an overall goal of care. The resident had significant weight loss since admission, which appeared to be stabilizing. The resident had inadequate oral intake related to sleeping through meals and poor appetite as evidenced by poor documented meal intakes. The nutrition prescription was to continue with the consistent carbohydrate diet. The nutrition interventions included encouraging the resident to sit up for meals and offer one on one assistance as tolerated and continuing to offer the resident Boost or house supplement three times a day. The nursing staff was to obtain weights and provide assistance with meals. The care plan goals were for the resident to safely consume food and beverages that bring comfort. The [DATE] IDT note documented the IDT team discussed the residents' continued poor oral intakes. The resident was sleeping often. Staff continued to document activities of daily living and nutrition assistance attempts in a notebook which was helpful for the wife. The resident was being followed by hospice services. IV. Resident #2 A. Resident status Resident #2, age 88, admitted on [DATE]. According to the [DATE] CPO, the diagnoses included displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing (left hip fracture), dementia unspecified severity with agitation and cerebral infarction (stroke). The [DATE] MDS assessment revealed the resident had moderate cognitive impairment with a BIMS with a score of eight out of 15. He required limited assistance of one person for bed mobility, walking in room and walking in the corridor, locomotion on and off the unit, toileting and personal hygiene. He required extensive assistance from one person for transfers and dressing. He required supervision with set-up assistance for eating. The MDS assessment documented the resident had coughing or choking during meals or when swallowing medications; but did not have loss of liquids or solids from his mouth when eating or drinking, did not hold food in his mouth or cheeks or have residual food in his mouth after meals or had complaints of difficulty or pain when swallowing. The resident weighed 175 lbs. The resident did not have any weight changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065188	A. Building B. Wing	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Morrison	150 Spring St Morrison, CO 80465

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	B. Record review 1. Nutritional care plan The nutritional care plan, initiated on [DATE], revealed Resident #2 was at nutritional risk related to dementia and a left femur fracture. The interventions included: encouraging 100% consumption of all fluids provided and providing the diet as ordered. 2. Resident #2's weights -On [DATE], the resident weighed 175 lbs. -On [DATE], the resident weighed 161.6 lbs. -On [DATE], the resident weighed 166.4 lbs. -The resident sustained a 7.7% (13.4 lbs) weight loss, which was considered significant in two months from [DATE] through [DATE]. 3. Physician orders The [DATE] CPO revealed Resident #2 had the following physician orders related to nutrition: -Regular/liberalized diet, regular texture, thin consistency, ordered [DATE]. -Weigh weekly X4 (times four) weeks then monthly, ordered [DATE]. -However, the resident was not weighed until [DATE] which was 19 days after the resident was admitted to the facility (see interviews below). 4. Record review The [DATE] admission nutritional assessment documented the resident weighed 175 lbs on [DATE] and was 72 inches. The resident had a BMI of 23.7. The resident was on a regular/liberalized diet and had no food allergies or cultural, ethnic or religious preferences with food. The nutrition history section documented the resident was reviewed by the RD for a new admission and was on a re[TRUNCATED]