DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
Cambridge Building, 263 Chapman Rd, Suite 200
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Coral Springs Rehabilitation at Brandywine **DATE SURVEY COMPLETED:** November 8, 2023

STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES		COMPLE-TION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A recertification and complaint survey was conducted by Healthcare Management Solutions, LLC, on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/24/23-11/08/23 Survey Census: 147 Sample Size: 38 Supplemental Residents: 67 Findings are as follows: F561, F578, F580, F584, F641, F646, F655, F656, F657, F684, F689, F690, F692, F693, F695, F711, F729, F760. F761, F812, F842, F880, F908.	Please cross reference all tags on the 2567 POC submitted via Aspen on 12/9/23		
3201	**Regulations for Skilled and Intermediate Care Facilities**			
3201.1.0	**Scope**			
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable**			

Provider's Signature _____ Title NHA Date 1/31/24

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	code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. **Title 16 Chapter 25 Health-Care Decisions** **2507. Surrogates** **1. A surrogate may make a health-care decision to treat. withdraw or withhold treatment for an adult patient if the patient has been determined by the attending physician to lack capacity and there is no agent or guardian, or if the directive does not address the specific issue. This determination shall be confirmed in writing in the patient's medical record by the attending physician. Without this determination and confirmation, the patient is presumed to have capacity and may give or revoke an advance healthcare directive or disqualify a surrogate.** Based on record review, it was determined that the facility failed to provide appropriate documentation of R50's cognitive assessment or capacity that is required by statue in order to invoke Title 16 Chapter 25 Health-Care Decisions 2507 Surrogates of The Delaware Code. Findings include: 2/16/16 – R50 completed Durable Personal Power of Attorney designating his son as financial agent. "This power of attorney does not authorize your Agent to make health care decisions for you". 6/4/22 – R50 was admitted to the facility with diagnoses including but not limited to diabetes, stroke with left sided weakness and severe vision impairment. 6/4/22 – E2 (DO) ordered a full code status on R50's electronic medical record (EMR).	**2507. Surrogates** A. R50 competency will be reviewed by providers to determine cognitive ability. R50 has been hospice as of 12/22. R50s advance directive will be pending competency determination. B. Active residents admitted within the last 14 days will be reviewed for advance directives preference upon admission. Advance directives preferences will be reviewed as applicable based on BIMs score. C. The root cause is determined to be due to lack of understanding on the importance of determining capacity to make determination related to advance directives preference upon admission. D. Daily audit by Medical Director/Designee will be conducted to ensure cognitive capacity determined when determining advance directives preferences on admission x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.		

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES		COMPLE-TION DATE
	6/6/22 7:45 AM –A nurse's note documented," ...Resident code status confirmed to be FULL code by resident. Witnessed by 2 nurses. [NP] made aware." 6/6/22 9:46 AM – A NP's progress note documented," ...Past medical history significant for legal blindness, DM (diabetes), falls, CVA (stroke) with left hemiparesis (weakness)... is able to attend to most of his ADLs (activities of daily living) independently...". This note did not document any assessment of R50's cognitive status. 6/8/22 3:09 PM - R50's admission Minimum Data Set (MDS) documented R50's Basic Inventory of Mental Status (BIMS) score of 8, which was reflective of moderate cognitive impairment. 6/9/22 – E2 (DO) Admission History & Physical (H&P) documented, "... He (R50) is very limited with his vision. Physical Exam: Alert and awake...". Record review revealed the 6/8/22 BIMS score as the only standardized assessment of R50's cognitive status. 11/29/22 9:12 AM - R50's quarterly MDS documented R50's BIMS score of 8, which was reflective of moderate cognitive impairment. 12/7/22 – FM3 (R50's son) completed and signed a Resuscitation Policy designating R50 as a DNR (Do Not Resuscitate). 12/7/22 – MD (DO) discontinued the Full code order and placed a DNR (Do Not Resuscitate)/ DNI (Do Not Intubate) order in R50's EMAR. Record review of R50's EMAR revealed no documentation of any conversation about			

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	code status with R50 or FM3 around the time of this paperwork being completed. There was no documentation of any competency assessment of R50 or written documentation by R50's attending physician that R50 lacked capacity so it was unclear why the facility invoked the Delaware Surrogacy Provision 2507 under Title 16 Chapter 25 Health-care decisions of the Delaware Code. 11/3/23- 9:15 PM - Findings were reviewed with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).			

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	085004	A. BUILDING _____ B. WING _____	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(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 annual and complaint survey was conducted at this facility beginning 10/24/23 through 11/08/23. The facility census the first day of the survey was 147. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS REPORT REVISED POST IDR A recertification and complaint survey was conducted by Healthcare Management Solutions, LLC, on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/24/23-11/08/23 Survey Census: 147 Sample Size: 38 Supplemental Residents: 67 Abbreviations/definitions used in this report are as follows: CNA- Certified Nurse's Aide; DAL- Director of Assisted Living;	F 000		

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

Electronically Signed | 01/13/2024

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F 000	Continued From page 1	F 000		

DON- Director of Nursing;
ED- Executive Director;
LPN- Licensed Practical Nurse;
MA- Maintenance Assistant
NHA- Nursing Home Administrator;
NP- Nurse Practitioner;
RN- Registered Nurse;
REG- Regional Nurse;

abatement - to eliminate, decrease or remove;

acute hypoxemic respiratory failure - a condition where the blood in the body is not receiving enough oxygen due to inadequate oxygen exchange in the lungs;

advance directive- a written document that states who should be the decision maker and what medical decisions they should make if a person becomes unable to speak for themselves;

amputations- removal of a limb;

anemia - a condition in which there is a deficiency of healthy red blood cells in the blood;

anticonvulsant - medication to prevent seizure related shaking;

atelectasis - a condition where the lungs collapse partially or completely;

atrial fibrillation (Afib) - a disease of the heart characterized by irregular and often faster heartbeat;

AV Fistula - Abnormal connection between a vein and an artery;

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F 000	Continued From page 2 bilateral - both; BIMS (Basic Inventory of Mental Status) - a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility. A score of 0 to 7 reflects severe cognitive impairment, 8 to 12 reflects moderate cognitive impairment and 13 to 15 indicates intact cognitive response; BMI (Body mass Index) - a medical screening tool that measures the ration of a person's height to their weight to estimate the amount of body fat; CEA (carcinoembryoni antigen) - a protein that increases in the blood with certain cancers; cecum - the lower abdominal cavity; CHF - congestive heart failure; CNA - certified nursing assistant; colorectal - the area that begins at the colon and ends at the anus; continence - voluntary control of urinary bladder and bowel function; COPD (chronic obstructive pulmonary disease) - a progressive disease characterized by persistent respiratory symptoms such as breathless ness and cough; dehydration - a condition of abnormal water loss from the body; delusional disorder - a fixed false conviction in something that is not real or shared by other	F 000		

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F 000	Continued From page 3	F 000		

people;

dementia - a medical condition that affects memory, thinking and interferes with daily life;

designee - a person chosen to do something;

dysphagia - a condition with difficulty in swallowing food or liquid;

ecchymosis - medical term for a bruise, skin discoloration from damaged, leaking blood vessels underneath the skin;

edema - develops secondary to excess fluid accumulation between the cells of the body or within the various body cavities. Systemic factors such as serum protein, hydrostatic pressure and permeability of vessel walls impact the development of edema. Often this fluid accumulates into the extravascular (the space that surrounds the cells of a given tissue) space. In medicine, the term "third spacing" is utilized with regard to the loss of fluid into interstitial (surrounding the cells) spaces, such as with burn or edema. Patients can have edema and still be intravascularly (the space within the blood vessels) depleted. (Pathophysiology- Clinical Concepts of disease Processes, 6th Ed. Price & Wilson, 2022

encepaholopathy - a disease that affects brain structure or function causing an altered mental status and confusion;

etiology - the cause of a disease or abnormal condition;

EMR- electronic medical record;

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F 000	Continued From page 4 exacerbation - the worsening of a disease or an increase in its symptoms; feeding tube/gastric tube - a tube inserted into the abdomen to provide nutrition to the body; glucometer - a machine for testing the amount of glucose [sugar] in the blood; hematochezia - bleeding from the anus, sometimes mixed with stool; hematology - the study of blood and blood disorders; hydration - the process of treating with water; hypernatremia - an electrolyte problem characterized by increased sodium concentration in the blood which causes lethargy, confusion and excessive thirst; hyperventilation - "respiratory depression", a state when breathing is inadequate to perform needed respiratory gas exchange; hypoxemic - having levels of oxygen in the blood that are lower than normal; incontinence- involuntary loss of control of urinary bladder and bowel function; jejunostomy tube - a tube inserted into the small intestine; lethargic - an unusual decrease in consciousness;	F 000		

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F 000	Continued From page 5	F 000		

malignancy - a medical condition that is considered dangerous or likely to cause death if untreated;

MDS (Minimum Data Set) - a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes;

melena - dark, tarry stools containing decomposing blood that is usually an indication of bleeding in the digestive tract;

metastatic - a condition in which cancer has spread to a different part of the body than where it started;

mg - milligram;

nasal cannula - tube for administering oxygen through the nose;

nebulizer machine - a vaporizer machine for administering breathing medications;

neuropathic pain - nerve pain;

oncologist - a medical doctor qualified to diagnosis and treat cancers/tumors;

oxygen concentrator - a machine for the delivery of oxygen to the body;

oxygen cylinder - a circular canister attached to the oxygen concentrator to provide moisture;

osteopathy - a system of medical practice that emphasizes a holistic and comprehensive approach to patient care and utilizes the manipulation of musculoskeletal tissues along

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F 000	Continued From page 6	F 000		

with other therapeutic measures to prevent and treat diseases;

Parkinson's disease - a chronic, progressive movement disorder that initially causes a tremor in one hand, stiffness or slowing of movement;

PASARR- Preadmission Screening And Resident Review- a federally required evaluation used to ensure that individual's are not inappropriately placed in nursing homes for long term care;

p/f - potential for;

phlebotomy - the act of for drawing or removing blood from the circulatory system;

physiologic- a vital process or function of a living organism;

PO - "per os" (Latin), by mouth;

POA (Power of Attorney) - person legally designated to make decisions on a person's behalf;

practicable - able to be done or put into practice;

protein calorie malnutrition - a type of under-nutrition that occurs when a person does not consume enough protein and calories;

psychosis - a state of mind that results in the inability to determine what is real and what is not; loss of touch with reality;

psychotic- being in a state of mind that is not in touch with reality;

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pulse - a short term duration of a medication to achieve a quick, peak action;

renal - kidney;

s/s - signs and symptoms;

sundown - a medical condition characterized by the appearance of confusion,a agitation and other severely disruptive behaviors coupled with the inability to remain asleep, occurring solely or markedly worsening at night;

surrogate - a substitute, someone who is legally responsible for making decisions;

tachycardia - having a heart rate of greater than 100 beats per minute;

tracheostomy - a surgical hole placed in the throat to assist with breathing;

thromboembolic - a condition in which a blood clot that has formed inside a blood vessel breaks off, travels through the blood stream and plugs another blood vessel causing organ damage;

type 1 diabetes - a chronic condition in which the body's immune system destroys the insulin-producing beta cells of the pancreas, causing severe deficiency in insulin secretion;

unintentional - not done on purpose, committed accidentally or carelessly;

vascular - blood vessels;

vascular dementia - a condition caused by lack of blood that carries oxygen nd nutrients to a part of

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F 000	Continued From page 8 the brain, which results in problems with reasoning, planning judgment and memory; X - times.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record	F 561	A. R101's out of bed schedule as per	1/3/24

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F 561	Continued From page 9 reviews, the facility failed to ensure three of 34 sampled residents (Resident (R) 101) was given the right to self-determination when the resident was not able to be assisted out of her bed when she chose to. Additionally, (Resident's (R) 249 and R251 were not given the right to self determination when their preferences for showers were not completed. Findings include: 1. Review of R101's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/28/23, located in the resident's electronic medical record (EMR) under the "MDS" tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The MDS also revealed the resident was totally dependent on staff for bed mobility and transferring. Interview with R101 on 10/24/23 at 2:50 PM revealed she was bed bound and was unable to get out of bed on her own. R101 stated she usually got up into her wheelchair three times a week. Observation on 10/26/23 at 8:45 AM revealed the resident was in bed eating breakfast. Observation on 10/27/23 at 11:30 AM revealed the resident was in bed watching TV. Observation on 10/28/23 at 10:05 AM revealed the resident was in bed watching TV. Observation on 10/30/23 at 8:30 AM revealed the resident was in bed watching TV. Observations from 10/26/23 through 10/3/23 the resident had not been observed out of her bed and up in her wheelchair on any shift.	F 561	preference had been clarified. Plan of care revised as per preference. R249 no longer resides in the facility. Unable to correct the deficiency. R251 no longer resides in the facility. Unable to correct the deficiency. B. Active residents who need assistance with getting out of bed will be reviewed by IDT. Out of bed preference will be discussed and plan of care will be revised as per preference. Active residents shower schedule will be reviewed in the last week. Residents will be offered/provided shower as applicable. C. Root cause was determined to be due to staff not documenting resident preferences when getting out of bed and shower preferences honored or refusals. IDT will be in-serviced by Staff Development/Designee on the process in obtaining preferences with getting out of bed and showers. This will be reviewed during the new admission baseline care plan meetings or comprehensive care plan meetings. Staff will also be in-serviced on appropriate step when a resident refuses. D. Daily audit of 5 residents by Unit Manger/Designee of shower schedules and resident preferences with getting out of bed will be conducted to ensure staff is following the schedule as per resident preference x 7 days and documents if there are refusals until 100% compliance	

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F 561	Continued From page 10 Interview with RN4 nursing unit manager on 10/30/23 at 10:20 AM revealed that R101 liked to get out of bed on Monday, Wednesday and Friday during day shift only. RN4 stated she had worked day shift each day of the week and indicated that R101 had not been out of bed since last Wednesday or 10/25/23. During an interview on 11/03/23 at 9:30 AM, RN4 stated the facility did not have any documented evidence or to her knowledge that R101 had been out of bed all week. Interview with Certified Nursing Assistant (CNA) 13 on 10/24/23 at 2:55 PM, who was regularly assigned to R101, stated the resident had not been out of bed recently. A subsequent interview on 11/03/23 at 9:20 AM with CNA13 revealed R101 had not been out of bed the days she had worked since last week. 2. Review of R249's clinical record revealed: 8/28/21 - A significant change MDS documented R249 as cognitively intact and having a very important preference to choose between bath, shower, bed bath, and sponge bath. R249's care plan for ADL deficit last updated 3/8/22 included the intervention to assist in showering and/or bathing needs with extensive to total assist of one person and needs extensive assist with personal hygiene with one person. 2/18/22 - A quarterly MDS assessment documented R249 as cognitively intact and in need of extensive assistance of one staff person for hygiene and needing physical help of one staff	F 561	is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(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 561	Continued From page 11 person for bathing. January 2022 - March 2022 - Review of documentation of showers completed for R249 revealed the resident was to be offered a shower on each Sunday and Wednesday during the day shift. R249 received showers the following dates: January no showers received, February two showers received, and March one shower received. There were no documented refusals of showers in R249's clinical record. During an interview on 10/27/23 at 11:09 AM, Certified Nurse Aide (CNA)15 stated, that residents "are supposed to get a shower twice a week". CNA15 did remember R249 but did not recall the resident refusing showers, or why the resident may not have received showers. 2. Review of R251's clinical record revealed: 12/15/22 - R251 was admitted to the facility. 12/22/22- An admission MDS assessment documented R251 as cognitively intact. R251 found it somewhat important to choose between bath and showers and required physical help of one person with bathing. December 2022 - March 2023 - Review of documentation of showers completed for R251 revealed the resident was to be offered a shower on each Saturday and Wednesday during the day shift. R249 received showers the following dates: December no showers received, January four showers received, February four showers received, and March one shower received. There were no documented refusals of showers on the scheduled days in R249's clinical record.	F 561		

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F 561	Continued From page 12 During an interview on 10/27/23 at 2:15 PM Director of Nursing (DON) confirmed the findings. These findings were reviewed during the exit conference on 11/8/23 at 1:18 PM with Nursing Home Administrator (NHA).	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		12/26/23

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F 578	Continued From page 13 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure six of 32 sampled residents (Resident (R) 38, R50, R398, R119, R123 and R118) or their surrogate decision maker were provided written information informing them of their right to formulate an advanced directive. Findings include: Review of the facility's undated policy titled, "Topic: Residents' Rights Regarding Treatment and Advance Directives," revealed, "Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Guideline: I. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated	F 578	A. R 38, R50, R398, R 119, R 123 and R118 have been offered the opportunity to complete Advance Directives. R50□s representative was also contacted and provided with Education on Advance Directives due to resident□s cognitive care needs. B. Residents and resident representatives will be offered are offered the opportunity to complete the Advance Directive Acknowledgement Form during the Admission Sign In process that indicates if the resident has or has not completed Advance Directives or would like more information on how to formulate one. C. The root cause was determined to be due to lack of consistent process with offering Advance Directives to new admissions. Social Services Regional Consultant/Designee will in-service Social	

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F 578	Continued From page 14 to the staff ..." The facility's policy failed to address providing advance directive information to the resident or resident representative in writing. 1. Review of R38's undated "Admission Record" located in R38's electronic medical record (EMR) under the "Profile" tab revealed R38 was admitted to the facility on 09/21/23. Review of R38's EMR revealed no documented evidence of an Advance Directive or that the facility provided written information to the resident or the resident's representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 10/27/23 at 11:25 AM, the Admissions Director (ADM) stated, "R38 admitted on 09/21/23, there is no documentation that he has an advance directive or that he was provided with written information regarding an advance directive." 2. Review of R398's undated "Admission Record," located in R398's EMR under the "Profile" tab revealed R398 was admitted to the facility on 10/18/23. Review of R398's EMR revealed no documented evidence of an Advance Directive or that the facility provided written information to the resident, or the resident's representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 10/27/23 at 11:25 AM, the ADM stated, "R398 admitted on 10/18/23, there is	F 578	Services/Designee and Admissions/Designee on the process of offering advance directives to new admissions. Admissions will provide the Social Services department with printed copies of the Advance Directive Acknowledgement form completed during the Admission Sign-In process. The Social Services staff or Designee will provide an Advance Directive example with instructions on how one is completed to residents and residents□ representatives as indicated on the Advance Directive Acknowledgement Form. D. NHA/Designee will audit all new admissions weekly to ensure Advance Directive paperwork is provided until a 100% compliance is achieved and sustained x 4 weeks. Following will be a monthly order x 3 months. Audit result will be submitted to QA committee monthly.	

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F 578	Continued From page 15 no documentation that he has an advance directive or that he was provided with written information regarding an advance directive." 3. Review of R119's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 09/14/23. Further review of R119's EMR revealed no documented evidence the resident and/or the resident's representative received written information of the resident's right to formulate an advance directive. 4. Review of R118's undated "Admission Record," located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 11/25/23. Further review of R118's EMR revealed no documented evidence the resident and/or the resident's representative received written information of the resident's right to formulate an advance directive. During an interview on 10/31/23 at 9:50 AM, the Director of Nursing (DON) verified there was documented evidence either resident was informed of their right to formulate an advanced directive prior to the start of the survey. 5. Review of R123's clinical record revealed: 9/1/23 - R123 was admitted to the facility. 9/7/23 - R123 signed the facility's Advance Directive Acknowledgement form, on which R123 checked the statement "I would like more information on Advance Medical Directive (if	F 578		

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F 578	Continued From page 16 checked, please complete below). A referral has been made to the Social Worker_____(name of Social Worker) on_____ (date of referral)." The two blanks on the form were not filled out. This form was signed by facility representative (Admission Director) and dated 9/7/23. 10/26/23 - During an interview, ADM (Admissions Director) stated that the process for advance directives involved the ADM going over the advance directive Acknowledgement paper with the resident and getting the resident to declare whether the resident had or did not have an existing advanced directive and then sign the form. Then the admission person alerts the social worker to follow up with the resident to obtain a copy of the advance directive or to give information to the resident about advance directives. ADM was unable to confirm if social work had been notified that R123 was interested in advanced directive information. Record review revealed that there were no social services notes regarding advance directives. 10/30/23 - During an interview, R123 confirmed that to date he still had not received any information (written or oral) regarding advance directives from any personnel of the facility. He stated that he was still interested in learning about advanced directives. 6. Cross refer F711 Review of R50's clinical record revealed: 2/16/16 - R50 completed a durable Personal Power of Attorney designating his son as financial	F 578		

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F 578	Continued From page 17 agent. "This power of attorney does not authorize your Agent to make health care decisions for you." 6/4/22 - R50 was admitted to the facility with diagnoses including, but were not limited to, diabetes, stroke with left sided weakness and severe vision impairment. 6/6/22 9:46 AM - A NP's progress note documented, "... Past medical history significant for legal blindness...". 6/8/22 3:09 PM - R50's Admission Minimum Data Set (MDS) documented R50's Basic Inventory of Mental Status (BIMS) score of 8, which was reflective of moderate cognitive impairment. 10/25/23 - The Surveyor requested a copy of R50's Advance Directive Acknowledgement paperwork. 10/26/23 - ADM (Admission Director) presented R50's Advance Directive Acknowledgement paperwork dated 10/26/23 with R50's illegible signature. At the time, R50's cognitive status was documented as a BIMS of 8 or moderate cognitive impairment. R50 also carried a diagnosis of legal blindness. There was no evidence that the facility reached out to R50's responsible party to discuss formulating an advanced directive. 11/3/23- 9:15 PM - Findings were reviewed with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		12/26/23

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F 580	Continued From page 18 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 19 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for one (R307) out of five residents reviewed for nutrition, the facility failed to consult the physician of the significant change in R307's weight. During the first nine months of R307's admission, R307 lost a documented 67.9 pounds. Findings include: 2/2/22 - R307 underwent bilateral above the knee (AKA) amputations. 2/17/22 - R307 was admitted to the facility with diagnoses including, but were not limited to stroke, diabetes and bilateral above the knee amputations. 2/17/22 10:59 PM - RN2 documented R307 as weighing 273.5 pounds. 3/18/22 2:21 PM - R307's weight was documented as 222 pounds. This reflected a 51 pound weight loss since R307's admission weight one month prior. Review of R307's clinical record revealed no evidence that the providers (MD/NP) were consulted about this significant weight loss.	F 580	A. R307 no longer resides in the facility. B. Dietician will review residents with significant weight loss in the last month and providers will be notified of the weight loss as indicated. C. Root cause was determined to be due to an oversight from the dietician in notifying the physician of the significant weight loss. Regional Dietician/Designee will in-service facility Dietician on the process of provider notification when there is a significant weight loss. D. Weekly audit by the Regional Dietician/Designee on significant weight loss. Audit will verify provider notification of change x 4 weeks until a 100% compliance is achieved and sustained. The following will be a monthly audit x 3 until a 100% compliance is achieved. In an event where compliance is consistently	

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F 580	Continued From page 20 4/13/22 2:23 PM - R307's weight was documented as 219 pounds. Review of R307's clinical record revealed no evidence that the providers were consulted about this significant weight loss. 8/11/22 2:55 PM - RD (Dietician) note documented, "... quarterly nutrition assessment. Weight for August 221. Weight triggers for 16.14% decrease x 6 mo (months)... No difficulties in diet noted. Appetite good. % meal completions 50-100%...". This note recognized the 16.14 % weight loss over 6 months but failed to document consulting the providers of the significant change in R307's weight. 11/9/22 7:38 AM - R307's weight was documented as 212.6 pounds. 1/25/23 1:30 PM - E10's (Surgical Oncologist) office visit note documented, "... He [R307] has had unintentional weight loss over the last 2 years of approximately 140 pounds, he states 50 of this was within the last year...". Review of R307's clinical record provided no evidence that the providers were aware of this significant weight loss. 11/3/23- 9:15 PM - Findings were reviewed with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).	F 580	below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit result will be submitted to QA committee monthly.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		12/26/23

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F 584	Continued From page 21 §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 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	F 584		

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F 584	Continued From page 22 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, the facility failed to ensure a clean and homelike environment for 13 resident rooms out of 89 sampled resident rooms. This failure had the potential for decreasing the independence and safety of the residents. Findings include: Review of the undated facility policy titled, "Cleaning Privacy Curtains" stated, " ... Curtains should be changed with every detailed cleaning or as needed ...Whenever a curtain is taken down, it should be replaced immediately with a clean one ..." Review of the facility's undated policy titled, "Cycle Cleaning," revealed, "It is the policy of this facility to identify the functional areas in the facility that require cleaning and to use cycle cleaning schedules to outline the frequencies and maintain regularly scheduled environmental service tasks ..." Review of the October 2023 "Housekeeping Deep Clean Schedule" provided by the Housekeeping Supervisor indicated deep cleaning began on 10/12/23. Review of the facility's undated policy titled, "Maintenance Inspection" stated, "It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public..."	F 584	A. Resident rooms B14, B-6, B-5, C-4, E-1, E-5, E-6, E-11, E-12, D5, D6, D7 privacy curtain replaced with clean curtains. All Curtain hooks were checked. The overbed table located in room E15 was cleaned. The commode in room B-6 was cleaned. The resident rooms located in E-2, E-6, E-14 beds were moved and cleaned. The AC cover in room D-7 was cleaned immediately. The outlet covers C-9B was replaced immediately. The base board cover was reinstalled in room C-4. The door in room D-5 was repaired. B. Inspection audit was completed for cleaning privacy curtains. Audit was completed for the privacy curtain hooks. An Audit was completed for all resident room detail cleaning. An Inspection audit was completed for facility electrical outlet covers. Inspection audit was completed for any loose or broken baseboard covers. Inspection audit for the resident corridor room doors was completed. 3. The root cause was determined to be due to lack of consistent oversight to ensure rooms are clean and homelike, and the room's equipment is properly	

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F 584	Continued From page 23 Review of the facility's undated policy titled, "Routine Cleaning and Disinfection" stated, " ...Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to ...toilet flush handles ...bed rails ...tray tables ...call buttons ...IV (intravenous) poles ...resident chairs ...Privacy curtains in resident rooms will be changed when visibly dirty by laundering or cleaning with an EPA registered disinfectant per the curtain and disinfectant manufacturer's instructions." Review of the facility's undated policy titled, "Safe and Homelike Environment," stated, "In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extend possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk ...Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment ..." Observation on 10/26/23 at 9:30 AM of the wall in room B14 revealed scattered dark brown circles on the wall. During an interview at the time of the observation, Certified Nursing Assistant (CNA) 10 stated, "I haven't noticed that this morning. But it doesn't look good because she [resident] will look at that all day the way the bed is turned, and it is right beside the bed."	F 584	installed. Housekeeping staff will be educated by the Director of Environmental /designee on policy and procedures on how to keep a Safe and Homelike Environment. Director of maintenance/designee to in-service maintenance staff on proper installation and safety of outlet covers. Director of maintenance or designee to in-service maintenance staff on proper installation and safety of base board heater covers. D. Environmental Director/Designee will conduct weekly audit to ensure home is clean and homelike, room equipment are properly installed and working x 4 then monthly X 3 months. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit result will be submitted to QA committee monthly.	

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F 584	Continued From page 24 During an observation and interview on 10/26/23 at 10:15 AM, Housekeeper Supervisor (HSK) stated, "I will get someone to clean this now." Observation on 10/26/23 at 1:00 PM of room E15 revealed an overbed table at the foot of a bed with large amounts of spilled dried food substances and rust. Observation on 10/26/23 at 1:05 PM of room E-2 revealed a very dirty, dusty area with heavy debris under a bed. Observation on 10/26/23 at 1:10 PM of room E-6 revealed a very dirty, dusty area with heavy debris under a bed. Observation on 10/26/23 at 1:15 PM of room E-14 revealed an area under a bed to have a large amount of dust and dirt with debris. Interview with the Housekeeping Supervisor (HSK) at the time of each observation verified the vents had not been cleaned and the bedrooms have not been cleaned properly. She stated she is new to the facility and is starting to evaluate the housekeepers working on each unit. Observations on 10/26/23 at 2:00 PM of the B Unit revealed the following: Room B5, a brown substance down below the bedside commode that was placed over the toilet in the bathroom and the privacy curtain had missing hooks and the curtain was not hanging correctly. Room B6, the privacy curtain had brown stains that were visible. On 10/26/23 at 2:20 PM, the Operations Maintenance Director (OMD) and Maintenance Director (MD) did a walking round on the B unit	F 584		

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F 584	Continued From page 25 where they were shown the areas of concern as documented above. OMD stated, "We will make rounds on all the units to look at this. Observation on 10/26/23 at 4:28 PM in Room C9-B noted a broken electrical outlet cover. Observation on 10/26/23 at 4:30 PM in Room C4-B noted a broken baseboard heater cover and the privacy curtain was dirty with white spots of an unknown substance on it. Observation on 10/26/23 at 4:54 PM in Room E11-A noted with brown stains on the privacy curtain. Observation on 10/26/23 at 4:58 PM in Room E12-B noted with brown stains on the privacy curtain. Observation on 10/26/23 at 5:05 PM in Room E6-A revealed the privacy curtain was soiled with a hard white substance stuck to it. Observation on 10/26/23 at 5:08 PM in Room E5-B noted a privacy curtain with large brown stains on it. Observation on 10/26/23 at 5:15 PM in Room E1-B revealed the privacy curtain had brown and white stains on it. The following observations were made on 10/26/27 from 5:24 PM to 6:06 PM on the D Unit: D5, the resident's door on the left upper corner had wood exposed. The privacy curtain was noted to have white debris on it. The privacy curtain had a pink dried substance on it. D6, the privacy curtain had hooks missing letting	F 584		

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F 584	Continued From page 26 the curtain not hang properly. The AC unit cover was dirty with a brown substance and dust. D7, the privacy curtain had food debris on it. On 10/27/23 beginning at 11:00 AM and ending at 1:15 PM, the OMD conducted a walking tour of Units B, C, D, and E. At this time, they were shown the areas of concern in the resident's rooms.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R123, R200) out of twenty-nine residents reviewed for assessments, the facility failed to accurately reflect the residents' status in their admission MDS assessments. Findings include: 1. R123's clinical record revealed: 8/22/23 - R123's hospital admission History & Physical stated, "Problem list/Past Medical History Ongoing: ...tobacco use...". 9/1/23 - R123 was admitted to the facility. 9/10/23 5:22 PM - E2's (DO) admission History & Physical documented, "...Past Medical History...tobacco use...Social History : + tobacco/marijuana use...". 9/14/23 10:42 PM - R123's admission Minimum	F 641	A. R123 tobacco use as per preference had been clarified. Plan of care revised as per tobacco usage. R200 no longer resides in the facility. B. MDS Coordinator will review all residents in house to determine accuracy of resident□s tobacco use in the last 14 days and MDSs will be updated if resident is currently using tobacco during the look-back period. MDS Coordinator will review all residents voiding diaries for accuracy in the last 14 days and MDS will be updated with correct continence coding. C. Root cause was determined to be due to MDS staff not discussing with resident	1/3/24

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F 641	Continued From page 27 Data Set (MDS) documented no current tobacco usage. 10/25/23 1:39 PM - During an interview, R123 stated that he was an active smoker. He does not have cigarettes here at this building as it was a non-smoking facility. But when he leaves the building almost daily, he smokes. He keeps his smoking material (cigarette and lighter) at his Mom's house. 2. R200's clinical record revealed: 9/6/23 - R200 was admitted to the facility. 9/6/23 5:01 PM - R200's voiding diary documented resident voided in the toilet. All other documentation in the voiding diary from 9/6/23 stated, "resident was found dry." 9/7/23 6:27 AM - R200's voiding dairy documented resident voided in the toilet. 9/10/23 6:01 PM - R200's voiding diary documented resident voided in the toilet. However, the rest of the day, R200 is documented as having four incontinence episodes. 9/12/23 - R200's admission MDS documented always incontinent (no episodes of continent voiding) for urinary continence. The facility failed to accurately reflect R200's incontinence. 11/3/23 9:15 PM - Findings were reviewed with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).	F 641	preferences when out of facility during 7-day look back period. Root cause was determined by MDS staff oversight of voiding diary when coding continence question on MDS. Regional MDS Consultant will review with MDS Coordinators RAI Manual coding guidance on J1300 and H0300. D. Weekly audit by the Regional MDS Consultant on tobacco usage and continence coding x 4 weeks until 100% compliance is achieved and sustained. The following will be a monthly audit x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the MDS Team will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	
F 646 SS=D	MD/ID Significant Change Notification	F 646		1/3/24

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F 646	Continued From page 28 CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R50) out of two residents reviewed for PASARR (Preadmission Screening and Assessment Resident Review), the facility failed to refer R50 for a PASARR Level II after R50 was diagnosed with delusional disorder. Findings include: Review of R50's clinical record revealed: 6/3/22 - The PASARR, which was completed while R50 was hospitalized, documented, "PASARR Level 1 Determination: No Level II Required...". 6/4/22 - R50 was admitted to the facility with diagnoses including, but were not limited to, diabetes and stroke with left sided weakness. 11/29/22 - R50's quarterly Minimum Data Set (MDS) assessment documented that R50 did not have a diagnosis of psychosis. 12/8/22 - R50's medical diagnoses in the electronic medical record (EMR) added delusional disorder with the classification diagnosed "during stay." 12/15/22 - E2 (MD) ordered R50 "Risperidone 0.5	F 646	A. R50□s PASRR was sent for review regarding new DX relating to SMI, 10/31/2023. Assessment created on Assessment Pro. Level 2 evaluation to be scheduled onsite by PASRR. B. All residents with that require a Level II or have a significant change could be affected by this deficient practice. C. The root cause was determined to be due to lack of consistent oversight related to PASSR requirement when there is a significant change. D. Social Services will complete a full-house Audit of all residents to ensure all DX are correctly updated on residents PASRR□s and Care Plans. Regional Social Services/Designee will Audit new admission PASRR□s weekly x1, then Monthly x1.	

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F 646	Continued From page 29 mg by mouth two times a day for major depression recurrent, severe psychotic symptoms." 12/19/22 - R50's significant change MDS assessment documented R50 as having a diagnosis of psychotic disorder (other than schizophrenia). 10/30/23 - The facility requested a PASARR Level II onsite referral after the Surveyor brought this issue to their attention. 11/3/23- 9:15 PM - Findings were reviewed with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).	F 646		
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		1/3/24

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F 655	Continued From page 30 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three Residents (R) 248, R250 and R314) out of three new admissions reviewed the facility failed to ensure that a baseline care plan summary was provided to the resident/responsible party (RP). Findings include: The facility policy for baseline care plans, last updated 7/2023, indicated, "A written summary of the baseline care plan shall be provided to the resident and representative...". Review of R248, R250 and R314's clinical records revealed:	F 655	A. R248 no longer resides in the facility. R250 no longer resides in the facility R314 no longer resides in the facility. B. All residents admitted are affected by the deficient practice. Active residents admitted in the last 14 days will be reviewed to ensure the baseline care plan summary sheet is appropriately filled out and signed during the meeting. C. The root cause was determined to be due to lack of oversight and consistent	

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F 655	Continued From page 31 1. 6/23/22 - R250 was admitted to the facility. 6/24/22 - Baseline care plans were created for R250. The signature section for acknowledgment of summary received by resident/RP was blank. 2. 7/20/22 - R314 was admitted to the facility. 7/22/22 - Baseline care plans were created for R314. The signature section for acknowledgment of summary received by resident/RP was blank. 3. 5/10/23 - R248 was admitted to the facility. 5/10/23 - Baseline care plans were created for R248. The signature section for acknowledgment of summary received by resident/RP was blank. During an interview on 10/30/23 at 12:30 PM MDS Coordinator (MDSC)2 provided copies of the unsigned baseline care plans and confirmed that signatures were not completed as evidence of the baseline care plan summary provided to the residents or their responsible party's. MDSC2 stated,"it may be provided later when we sit down and do the care plan meeting". These findings were reviewed during the exit conference on 11/8/23 at 1:18 PM with Nursing Home Administrator (NHA).	F 655	process in obtaining signatures during baseline care plan meetings with resident or responsible party. Staff Development/Designee will in-service IDT team responsible for baseline care plan completion to ensure summary sheet is signed during meetings. D. Weekly audit by the Regional Social Services Consultant on baseline care plan completion and summary sheet completion x 4 weeks until 100% compliance is achieved and sustained. The following will be a monthly audit x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	
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 implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		12/26/23

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F 656	Continued From page 32 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656		

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F 656	Continued From page 33 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to develop a comprehensive care plan for three of 38 sampled residents (Resident (R) 140, R308 and R309). This failure had the potential to leave the resident with unmet care needs. In, additon the facility failed to create a person-centered care plan for R308 a resident that had a dialysis access in both arms. Findings include: Review of the facility's policy titled, "Comprehensive Care Plans," revised 04/2023, indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment ..." 1. Review of R140's undated "Admission Record" located in the resident's EMR under the "Profile" tab indicated the resident was admitted on 09/20/23 diagnoses which included unspecified intracapsular fracture of left femur (broken leg). Review of R140's " Admission/Readmission Screener," dated 09/20/23 located in the resident's EMR under the "Assessment" tab included the use of a left wrist splint. Review of R140's document from an orthopedic	F 656	A. R140's Splint order was clarified on 11/2/23. Splint use was added on CP on R303 is no longer in the facility. R309 is no longer in the facility. B. Active residents with splints will be reviewed. Order will be clarified to ensure a specific timeframe for use is in place. CP will be reviewed to include splint use. Active residents with AV fistula will be reviewed. Plan of care will be updated to include AV fistula. Active residents with CHF will be reviewed. Residents' plan of care will be reviewed to ensure CHF protocol intervention is reflected in the plan of care as indicated. C. The root cause is determined to be due to lack of oversight from nursing management team in ensuring splint, AV fistula and CHF protocol are reflected in the plan of care. Licensed staff will be in-service by Staff Development/Designee on splint use with appropriate timeframe for use, AV fistula use is in the plan of care and CHF protocol interventions are reflected in the plan of care. Review of new admission chart will	

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F 656	Continued From page 34 physician, dated 09/22/23, indicated R140 had a closed fracture of distal end of left radius and required the use of a "sugar-tong brace [splint for the lower arm]." The document did not indicate how long the resident was to wear the brace, or if she was able to remove it at any time. Review of R140's "Order Summary Report" dated 09/21/23, located in the resident's EMR under the "Orders" tab, included "check sensation circulation and movement of left hand qshift (every shift) for left wrist splint." Review of R140's "Care Plan" initiated on 09/20/23, located in the resident's EMR under the "Care Plan" tab did not include the resident's use of a splint. During an observation and interview on 10/24/23 at 11:56 AM, R140 was wearing a splint on her left wrist. During an observation on 10/27/23 at 11:50 AM, R140 was wearing a splint on her left wrist. During an interview on 10/28/23 at 10:30 AM, based on the review of R140's occupational therapy notes, Physical Therapist (PT) 2 confirmed R140 wore a splint. Due to the splint not being addressed by the therapy department, PT2 stated the splint must have been ordered by the orthopedic specialist due to a fall with fracture in September 2023, which was prior to the resident's admission to the facility. During an interview on 10/28/23 at 11:16 AM, Licensed Practical Nurse (LPN) 8 confirmed that R140 wore a splint to her left wrist and was being followed by an orthopedic specialist. LPN8 also	F 656	include review of splint use and timeframe, AV fistula and CHF protocol to ensure care plan is updated. D. Daily audit by ADON/Designee on splint use, AV fistula and CHF protocol x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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F 656	Continued From page 35 stated the resident did not have an order for the splint usage but should have. Additionally, LPN8 confirmed that R140's care plan did not include splint usage but should have. During an interview on 10/31/23 at 2:05 PM, Minimum Data Set Coordinator (MDSC) 2 stated that she was not aware of R140 wearing a splint. MDSC2 stated had there been coding in place for the certified nursing assistants (CNAs) to document under the tasks tab, then it would have been tracked and then triggered to be included in the MDS assessment. MDSC2 also stated the Resident Assessment Instrument (RAI) manual indicated to code splint usage as part of a restorative nursing program. Continued interview revealed R140 did not receive restorative nursing services. MDSC2 confirmed there was not an order in place for the splint to indicate how long R140 was to wear the splint or how often it could be removed. 2. Review of R308's clinical record revealed: 6/8/22 - R308 was admitted to the facility. 6/8/22 8:01 pm - An admission progress note documented R308 had an active left AV fistula (an abnormal connection between an artery and a vein for dialysis) and a non-active AV fistula in the right upper arm. 10/30/23 12:35 PM - The DON confirmed that the care plan for R308 had not been developed to identify that R308 had an AV fistula in both arms." The facility failed to develop a care plan that identified R308 had AV fistulas in both arms.	F 656		

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F 656	Continued From page 36 3. The facility protocol for congestive heart failure [CHF- a condition of excess fluid around the heart] management, undated, directed staff to do the following daily monitoring: weigh resident, administer medications as prescribed, assess for swelling in feet, ankles, legs, or stomach. Encourage low salt diet, monitor fluid volume intake, assess for cough wheezing changes in breathing. Review of R309's clinical record revealed: 11/9/21 - R309 was admitted to the facility with multiple diagnosis including a history of congestive heart failure. 11/9/21 - A physician's order was written for R309 to have no extra fluids at the bedside except for fluids from meal tray, med pass fluids or ordered supplements. R309 was also on a diuretic twice a day for thirty days for a diagnosis of CHF. 11/15/21- An admission MDS assessment documented R309 as having an active diagnosis of heart failure. Review of care plans for R309 lacked evidence of a care plan or interventions for CHF monitoring as indicated in the facility protocol. R309 had a care plan for fluid volume deficit. During an interview on 11/6/23 at 9:29 AM, Director of Nursing (DON) confirmed the finding and stated that, "there should have been a care plan for potential fluid volume excess not deficit." During an interview on 11/7/23 at 10:30 AM, Nurse Practitioner (NP) confirmed a care plan for fluid volume excess was expected with	F 656		

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F 656	Continued From page 37 interventions such as "lung sounds, and other monitoring". These findings were reviewed during the exit conference on 11/8/23 at 1:18 PM with the Nursing Home Administrator (NHA).	F 656		
F 657 SS=D	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). 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:	F 657		12/26/23

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F 657	Continued From page 38 Based on record review and interviews, it was determined that for three (R73, R95 and R123) out of six residents reviewed for care plans, the facility failed to ensure that the residents or the resident's representative was invited to participate in their care plan meetings. Findings include: 1. Review of R73's clinical record revealed: 4/25/19 - R73 completed a Power of Attorney (POA) for Healthcare in which R73 named FM1 as "Healthcare Representative with the power to make decisions with regard to my health care if and when I am unable to make my own health care decisions." 6/28/21 - R73 was admitted to the facility with diagnoses including, but were not limited to, Parkinson's disease, dementia and depression with psychotic symptoms. 7/6/21 3:31 PM - R73's admission Minimum Data Set (MDS) assessment documented R73's Basic Inventory of Mental Status (BIMS) as 9, which reflected moderate cognitive impairment. FM1 was listed in R73's electronic medical record (EMR) as R73's representative, responsible person, POA financial, POA health care, care conference person and emergency contact. 3/1/23 1:45 PM - R73's quarterly care plan meeting sign in sheet documented FM1 as attending via phone. This was a Wednesday. 5/8/23 11:10 AM - R73's quarterly MDS documented R73's BIMS as 3, which reflected severe cognitive impairment.	F 657	A. R73's family was called, and family meeting scheduled. R95 will have CP meeting scheduled. R123 will be invited to care plan meeting scheduled. B. Residents and families are able to participate in care plan meetings as offered by the facility in person or by phone. Active resident's care conferences will be reviewed, and care conferences will be scheduled as applicable. C. The root cause was determined to be due to lack of consistent approach and follow through with scheduling and process followed during care conference. Regional Social Services/Designee will in-service Social Services department/Designee on care conference timing and process. Residents are provided with an Invitation by Social Services or Designee that is also mailed to Residents Representatives within 2 weeks of the prospective care plan meeting. D. Audits will be completed monthly by the Regional Social Services Coordinator/Designee to ensure proper coordination is offered and compliant with care conference process x 4 months until a 100% compliance is achieved or sustained. Audit report will be submitted to QA committee monthly.	

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F 657	Continued From page 39 5/23/23 11:30 AM - R73's quarterly care plan meeting sign in sheet documented that no family representative participated in this meeting. 8/4/23 10:37 AM - R73's quarterly MDS documented R73's BIMS as 3, which reflected severe cognitive impairment. 8/8/23 11:30 AM - R73's quarterly care plan meeting sign in sheet documented that no family representative participated in this meeting. 8/8/23 2:50 PM - SSA2 (social work assistant) documented in R73's EMR "... Participated in Comprehensive Care Plan with goals based on orders, medication orders, dietary orders, and any services or treatment to be administered by the facility and offered copies to resident and representative." 8/9/23 8:22 AM - SSA1 (social work assistant) documented in R73's EMR, "... SS (social services) has offered multiple days and times for the family to attend care plan meetings. everything that has been offered the family has been unable to attend as they "are busy" and "schedules are hectic." Received a message that they are busy the entire month of August and not available by phone. All attempts and efforts have been given by SS but they are not satisfied. Care plans will be emailed going forward." 10/25/23 3:35 PM - During a telephone interview, FM1 stated, "... since [R73]'s admission, I have participated in her care plans via phone. We have an adult son who is disabled and mornings are tough trying to get him organized for the day. In the past, [R73]'s care plan meetings were on Wednesday afternoons after 3 pm, which worked	F 657		

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F 657	Continued From page 40 well ... now they won't accommodate our schedule. We need afternoons after 3 PM... do not receive any written reports ... they have not mailed the last two care plans after the meetings... you would think they would be happy that someone was engaged and interested in R73's care." 10/30/23 1:35 PM- During an interview, SSA1 stated that the long term care residents' care plan meetings are scheduled "weeks in advance... The process is the resident or representative person gets a letter by email. They then call to schedule a time based on the times offered in the letter. The person can participate by phone or in person. The care plan is then sent to them. There are set days and times for each unit: Greenbank unit is on Wednesdays, Cedar Unit is on Tuesdays, BW unit is on Mondays. The times are from 10:30 AM to 3 PM. We try not to go past 2:30 PM as some of the disciplines are leaving that need to be at the meeting." 2. Review of R95's clinical record revealed: 11/18/99 - R95 completed an Advanced Directive that designated FM2 as her "surrogate to make medical decisions for me if I should be incompetent...". 5/22/12 - R95 completed a Durable Power of Attorney paperwork naming FM2 as her "lawful Attorney-in-fact/Agent." 7/2/21 - R95 was admitted to the facility with diagnoses including, but were not limited to, vascular dementia and stroke with left sided weakness.	F 657		

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F 657	Continued From page 41 FM2 was listed on R95's EMR profile as R95's representative, responsible person, POA financial, POA health care, care conference person and emergency contact. 2/16/23 11:50 AM - R95's quarterly MDS assessment documented a BIMS score as 3, which reflected severe cognitive impairment. 3/8/23- The facility's care plan schedule had R95 scheduled to have a care plan meeting at 2:30 PM; however, the facility was not able to produce a care plan sign in sheet or any note documenting this meeting. There are no social work services notes in R95's chart from 9/23/22 to 5/8/23. 5/23/23 - R95's quarterly care plan meeting sign in sheet documented that no family representative participated in this meeting. 10/25/23 1:20 PM - During a telephone interview, FM2 stated, "... the communication is poor. RN1 (unit manager) is the only one who calls. When you call, the phone just rings and rings... they change the meeting dates and times...". 3. Review of R123's clinical record revealed: 9/1/23 - R123 was admitted to the facility with diagnoses including, but were not limited to, type 1 diabetes, chronic obstructive pulmonary disease (COPD) and severe protein calorie malnutrition. 9/7/23 - R123's admission MDS assessment documented a BIMS score as 14, which reflected normal cognitive function.	F 657		

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F 657	Continued From page 42 9/13/23 1:00 PM - R123's admission care plan meeting sign in sheet documented that the resident "did not schedule to attend." 10/26/23 11:10 AM - During an interview, R123 stated, [he] "did not even know there was such a thing as a care plan meeting." 10/26/23 1:12 PM - SSA2's (social work assistant) progress note documented, "... Late entry: Resident and RP (responsible person) were invited to care plan on 9/13/23. No one called to attend." 11/3/23- 9:15 PM - Findings were reviewed at the exit conference with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).	F 657		
F 684 SS=D	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 record review and interview, it was determined that for one (R307) out of seven residents reviewed for hospitalization, the facility failed ensure follow-up appointments and diagnostic tests were scheduled timely after a	F 684	A. R307 no longer resides in the facility. B. Active residents admitted within the last two weeks will be reviewed to ensure appointments post hospitalization and	12/26/23

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F 684	Continued From page 43 hospital stay. Findings include: Cross refer F580 and F842 1. Review of R307's clinical record revealed: 2/17/22 - R307 was admitted to the facility with diagnoses including, but were not limited to, stroke, diabetes and bilateral above the knee amputations. 12/7/22 - R307 was admitted to the hospital with abdominal pain. 12/12/22 - The Hospital Discharge Summary stated, "Discharge Diagnoses: cecum mass, large bowel obstruction, hepatic (liver) lesion... Follow Up Providers: Follow up with Radiology within 2-7 days for a CT chest scan, Follow up with Hematology/Oncology Service within 2-7 days for further management, Follow up with Colorectal Surgery Service within 2-7 days for colonoscopy and Follow up with VIR (Vascular Interventional Radiology) within 2-7 days for liver biopsy...". 12/12/22 - R307 was readmitted to the facility. 12/13/22 - E2 (Doctor of Osteopathy [DO]) Readmission History & Physical Note documented, "... Plan: Mass of cecum Concerning for malignancy... Patient also has numerous lesions on his liver most likely metastatic from his cecum.... Anemia- Monitor CBC. Most likely secondary to colonic mass He will need follow-up with oncology and interventional radiology for biopsy and colonoscopy...".	F 684	diagnostic testing were scheduled in a timely manner. C. The root cause was determined to be due to lack of oversight to ensure post hospitalization appointments and diagnostic testing are scheduled timely. New admissions chart review will include post hospitalization appointment and diagnostic testing are scheduled timely. Licensed staff and unit secretaries will be in-service by Staff Development/Designee on timely scheduling of appointments and diagnostic testing post hospitalization. D. Daily audit by ADON/Designee on new admissions to ensure post hospital follow up appointments and diagnostic testing are scheduled timely x 7 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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F 684	Continued From page 44 12/20/22 10:28 AM - UC1's (Unit clerk) Appointment Note documented, "... Called to schedule resident a follow up colorectal oncology appointment. Left message for called (sic) back. Also left message for vascular interventional radiology appointment." This note documented the first attempt to schedule any of the follow up appointments which occurred 8 days after R307 was discharged from the hospital. 12/27/22 11:03 AM - UC1's (Unit clerk) Appointment Note documented, "...Scheduled resident a colorectal oncology appointment for January 25th at 1:30 PM. Left message for hematology. Also, for vascular interventional radiology their (sic) asking for orders to schedule resident appointment." This note documented that the colorectal oncology appointment was successfully scheduled 15 days after R307's discharge from the hospital and that the actual appointment was to occur 44 days after discharge from the hospital. The hospital discharge instructions stated the appointment should occur within 2 -7 days. 1/10/23 3:13 PM - UC1's (Unit clerk) Appointment Note documented, "... Called over to see if Radiology received the fax I send (sic), they received it and stated they will call me to schedule biopsy appointment." Record review revealed no evidence that Radiology/CT chest scan was scheduled or performed prior to R307's readmission to the hospital in February 2023.	F 684		

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F 684	Continued From page 45 10/30/23 3:00 PM - During an interview, UC2 (Unit clerk) stated, "The unit clerks schedule the appointments. They obtain the necessary information from the hospital discharge instruction paperwork that comes with the resident from the hospital. The clerk then calls and attempts to schedule the follow up appointment." 10/30/23 4:20 PM - During a telephone interview, FM5 (R307's sister) stated, "...With regard to his follow up appointments, he just fell through the cracks... no one saw any urgency in making his appointments. It was terrible. When I questioned the facility NP about his appointments, she told me that she had no control over appointment setting at the facility, that was the facility's responsibility." 11/3/23 9:15 PM - Findings were reviewed with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and other facility documentation it was	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 46 determined that for one (R313) out of one resident reviewed for wandering and elopement the facility failed to provide adequate supervision that contributed to the elopement of R313 and put the resident at immediate jeopardy and risk of a serious adverse outcome. R313 was able to elope from the facility on 9/17/22 and wander to a neighborhood behind the facility, fell in a driveway and was taken to the hospital by ambulance. An immediate jeopardy (IJ) was identified starting on 9/17/22. Due to the facility's corrective measures following the incident, this is being cited as immediate jeopardy, past non-compliance with an abatement date of 9/19/22. Findings include: A facility policy titled Elopements and Wandering Residents documented ... "This facility ensures that residents who exhibit wandering behavior and or are at risk for elopement receive adequate supervision to prevent accidents and receive in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk ... 1. The facility is equipped with door locks/alarms to avoid elopements ... 2. Alarms are not replacements for necessary supervision. Staff are vigilant in responding to alarms in a timely manner." 1. Review of R313's clinical record revealed: 7/19/16 - R313 was admitted to the facility with a diagnosis of depression, anxiety and later diagnosed with Alzheimer's disease and dementia. 5/2/22 11:30 AM - The elopement evaluation documented "1. Resident is exit seeking ... 2. Wanting to go home ... 3. Watching others go out the door ... 3. Independent with ambulation ... 4.	F 689		

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	085004	A. BUILDING _____ B. WING _____	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

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F 689	Continued From page 47 Elopement attempted in the last 30 days ... 5. Resident is at risk for elopement. 5/2/22 - A nursing progress note documented, "[R313] had increased behaviors and had wandered to the front door to leave the facility." 5/2/22 - Review of R313's care plan for elopement risk documented, "[R313] is at risk for elopement related to cognitive deficits and exit seeking. Resident is observed to remove ID (Identification) bracelet frequently... 1. Resident will have no significant injury related to wandering for 90 days... 2. Engage resident in activity as needed... 3. Give fluids as needed... 4. Give food as needed... 5. Redirect as needed." 7/1/22 - Review of R313's MDS Assessment for a significant changed documented R313 was severely cognitively impaired. The facility investigation documented the following timeline for R313's elopement on 9/17/22. -4:45 PM - 5:00 PM - R313 was toileted and later observed ambulating in a hallway in the facility. -5:15 PM - Resident was offered dinner and did not eat. -5:20 PM - Camera footage showed R313 was wandering in and out of resident rooms on the F-hallway. -5:28 PM - Camera footage showed R313 wandering into room F8. -5:43 PM - Resident wandered off the facility	F 689		

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F 689	Continued From page 48 property to a neighborhood behind the facility. The resident was seen by a homeowner walking across a driveway, the homeowner asked the resident it they needed help. The resident started walking and tripped on the sidewalk and fell face first on to the grass. -5:47 PM - The neighbor called 911 and the resident was transported to the hospital emergency room by EMS (Emergency Medical Services). -7:00 PM - A statement written by C15 (CNA) revealed, the resident was not in their room. -8:00 PM - 9:00 PM - E1 (NHA) and E2 (DON) were notified R313 was missing and 911 had been called. -10:05 PM - The ADON received a call from the Police to notify the facility that the resident had been taken to the hospital emergency room and that the facility to call the hospital. -10:10 PM - The ADON contacted the hospital and verified the resident was in the emergency room. 9/18/22 7:10 AM - The resident returned to the facility. The facilty provided the following corrective measures: 9/18/22 - Review of R313's revised care plan documented 1:1 supervision. 9/18/22 - All windows and potential exits were checked and secured on 9/18/22.	F 689		

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F 689	Continued From page 49 9/18/22 - R313 was placed on 1:1 supervision and was treated for a urinary tract infection. Care plan reviewed and updated by the DON/designee to reflect current wandering and elopement risk. 9/18/22 - Windows were checked by maintenance director daily for one week. Then weekly for four weeks and then monthly for the next quarter, and increased checks based on any renovations occurring in the facility. 9/18/22 - NHA/designee in-serviced maintenance department to monitor windows and doors to assure that they are secured. 9/18/22 - Elopement drill done to validate compliance with the facility policy and procedures and education provided. NHA/designee did random audits of five rooms in each unit to ensure windows are secured weekly for four weeks then monthly for the next quarter, and then routine checks every three months. In addition, findings are reviewed in the QAPI (Quality Assurance Process Improvement) meetings monthly for three months. 9/20/22 - Review of R313's revised care plan documened [R313] will not elope from the facility for 90 days... 1. ID bracelet as resident allows. 9/28/22 - Review of R313's revised care plan documented ambulate resident through the building as a redirection tool. 5/12/23 - Additionally, the facility installed a wander guard program system as a preventative measure for residents that are at risk for elopement from the facility.	F 689		

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F 689	Continued From page 50 11/3/23 2:45 PM - During an interview, the DON revealed, "[R313] came down the hall looked in room F8 and never came out of the room and that the window was open in the room." 11/6/23 12:48 PM - A telephone interview with C15 (CNA) revealed, "[R313] is always walking around in the building and on 9/17/22 after dinner C15 had checked in [R313's] room and [R313] was not in the room." In addition, C15 revealed R313 had climbed out of the window in room F8. 11/6/23 2:00 PM - During an interview MA2 (Maintenance Assistant) said, "yellow caution tape had been placed across the doorway of room F8 (a room under maintenance) before MA2 exited the building on Friday 9/16/22." Additionally, MA2 revealed that on 9/18/22 after R313 had eloped, "maintenance checked all the windows in the facility and had secured the latches on the windows with screws." 11/6/23 2:27 PM - During another interview MA2 said, "I really can't tell you how R313 managed to get out of the window." 11/8/23 11:38 AM - Another interview with MA2 revealed, "MA2 had returned to the facility on 9/17/22 after (R313's) elopement and checked the window in room F8 and found that the latch on the left side of the window was broken. 11/8/23 - Staff interviews with LPN7, CNA9, and MA2 confirmed staff educations and elopment drills had been conducted. In addition, education for elopement, drills, audits, 1:1 supervison for R313 and safety checks for the facility had been completed. It has been determined that the facility	F 689		

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F 689	Continued From page 51 abated the IJ on 9/19/22. 11/8/23 1:18 PM - Findings were reviewed with NHA, Interim DON and REG at the Exit Conference.	F 689		
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 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	F 690		1/3/24

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F 690	Continued From page 52 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 on record review and interview, it was determined that for two (R200, R248) out of two reviewed for bladder continence, the facility failed to ensure that the residents received appropriate treatment and services to maintain highest practicable urinary function. Findings include: 1. Cross refer F641, example 2. Review of R200's clinical record revealed: The facility's Incontinence Policy and Procedure, undated, stated, "Purpose- A resident who is continent of bladder will receive appropriate care and services to maintain as much bladder function as possible as determined by the IDT (Interdisciplinary team). Each incontinent resident will be assessed in an effort to improve or maintain bladder function as indicated. Bladder and bowel continence is defined as voluntary control of urinary bladder and bowel function. Incontinence is defined as involuntary loss of these functions. Habit Training/Scheduled Toileting- Habit training or timed voidings (sic), is scheduled toileting on a planned basis. The goal is to keep the resident dry by encouraging them to void at regular intervals. Attempts are made to match the voiding intervals to the resident's natural voiding schedule." (from Springs at Brandywine Incontinence Policy and Procedure) 9/6/23 - R200 was admitted to the facility with diagnoses, including but were not limited to,	F 690	A. R200 no longer resides in the facility. R248 no longer resides in the facility. B. All active residents continence status will be reviewed, and if a pattern of incontinence exist then a toileting program will be initiated as indicated. Active residents with suprapubic catheter will be reviewed to ensure supra pubic catheter size is consistent with physician's order. C. The root cause was determined to be due to the lack of consistent oversight in reviewing and evaluating voiding diaries. Staff Development/Designee will re-in-service licensed nurse on how to appropriately evaluate bowel and bladder status and toileting program on new admissions. The root cause was determined to be due to unavailability of the specific suprapubic size for the resident. Staff Development/Designee will be re-in-service licensed nurse to ensure appropriate suprapubic catheter is used	

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F 690	Continued From page 53 congestive heart failure (CHF), chronic kidney disease stage 4 and gait dysfunction. 9/6/23 5:01 PM - R200's voiding diary documented resident voided in the toilet. All other documentation in the voiding diary from 9/6/23 stated "resident was found dry." 9/6/23 9:33 PM - RN2's daily skilled note documented, "... Resident is alert and responsive, able to make her needs/concerns known...". 9/7/23 6:27 AM - R200's voiding dairy documented resident voided in the toilet. 9/7/23 - NP's progress note documented, "... 94 year old admitted for acute rehab status post hospital for CHF exacerbation with melena and ambulatory dysfunction... Plan:... 3. Ambulatory dysfunction-continue with physical therapy for range of motion and strengthening with overall goal to discharge home when stable...". 9/7/23 8:45 PM - R200's voiding diary documented resident voided in the toilet. 9/8/23 - R200's voiding diary documented this as the first day where R200 did not successfully toilet in the bathroom all day. R200 was documented as having three episodes of incontinence in a 24 hour period. 9/9/23 - R200's voiding diary documented nine incontinence episodes all day with no successful toileting. 9/10/23 6:01 PM - R200's voiding diary documented that the resident voided in the toilet. However, the rest of the day, R200 was	F 690	as ordered. Admissions/ DON/Designee will communicate with central supply regarding new admission's needs such as suprapubic catheter as applicable to ensure supplies are available. D. Daily audit by ADON/Designee on new admissions to ensure voiding diaries are appropriately reviewed and toileting program initiated as applicable x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly with 10% sample size of new admissions x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Weekly audit by ADON/Designee on new admissions to ensure appropriate size of suprapubic catheter is available in-house x 4 weeks until 100% compliance is achieved and sustained. The following will be a monthly audit x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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F 690	Continued From page 54 documented as having four incontinence episodes. 9/10/23 3:51 PM - E2's admission History and Physical documented, "... Her discharge plan is to return home with her daughter... bowel and bladder function are at baseline...". 9/11/23 - R200 ' s care plan documented, "[R200] had decreased ADL (activities of daily living) performance (sic) has the potential to restore function for toileting hygiene as evidenced by declines from PLOF (predicted loss of function) related to recent illness. Interventions- CNA assist as needed for task after resident has the time to do as much for themselves as they can. [R200] had decreased ADL performance has the potential to restore function for chair to bed transfers as evidenced by declines from PLOF related to recent illness. Goal: [R200] will be able to do chair to bed transfers at partial mod assist level X 90 days." 9/11/23 - R200's voiding diary documented R200 as having four episodes of incontinence in the 24 hour period. 9/12/23 - R200's admission Minimum Data Set (MDS) evaluation documented R200 as requiring "extensive assistance one person assist for toilet use and personal hygiene." The MDS also documented that no trial of a toileting program (eg. scheduled toileting, prompted voiding or bladder training) had been attempted with R200 on admission. The admission MDS inaccurately documented that R200 was "always incontinent" with regard to urinary continence.	F 690		

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F 690	Continued From page 55 9/12/23 - R200's voiding diary documented four incontinence episodes with no successful toileting documented in the 24 hour period. 9/13/23 - R200's voiding diary documented six incontinence episodes with no successful toileting documented in the 24 hour period. R200's record lacked evidence of an assessment and an individualized toileting plan to restore and maintain bladder continence. 9/14/23 - R200 was sent to the hospital after a fall and diagnosed with a urinary tract infection (UTI). 9/14/23 - E21's ED (Emergency Department) physician record documented, "... She (R200) tells me that she had to urinate and pressed her call bell but the staff did not come promptly and she attempted to get herself out of bed...". 10/31/23 12:40 PM - During a telephone interview, FM6 stated, "They told my mom to go in her brief... they weren't toileting her. That is how she ended up with a UTI that put her in the hospital." 2. The facility policy on suprapubic catheterization last updated 7/2023, indicated, "The orders shall specify the type and size of the catheter and frequency of catheter changes. Suprapubic catheters shall be changed by licensed nurses under the orders of the attending physician." Review of R248's clinical record revealed: 5/10/23 - R248 was admitted to the facility with an existing suprapubic catheter.	F 690		

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F 690	Continued From page 56 5/10/23- R248's care plan for suprapubic catheter care had the intervention to change the catheter monthly with a size 22 catheter. 5/10/23- R248 had a physician order for changing of suprapubic catheter using a size 22 catheter, every month and as needed. 5/13/23 4:22 AM - A nurses note documented, " ... Resident has pulled out suprapubic catheter during fall. Catheter replaced with an [size] 18 French [catheter] ..." During an interview on 10/30/23 at 10:25 AM, Registered Nurse (RN) 9 confirmed that she changed R248's catheter with a size different than ordered. During an interview on 10/30/23 at 2:41 PM with Director of Nursing (DON) it was confirmed that Registered Nurse (RN) 9 was expected to replace R248's catheter with the same size catheter, as ordered. These findings were reviewed during the exit conference on 11/8/23 at 1:18 PM with Nursing Home Administrator (NHA).	F 690		
F 692 SS=G	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		1/3/24

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F 692	Continued From page 57 §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 interviews, it was determined that the facility failed to recognize, evaluate and address R198's hydration status to ensure R198 maintained proper hydration and health. This failure caused harm to R198 as evidenced by R198's insufficient fluid intake and diminished hydration status which resulted in R198's hospitalization with a critically high sodium level and a diagnosis of dehydration. Findings include: The U.S. National Academies of Sciences, Engineering, and Medicine determined that an adequate daily fluid intake is about 3700 cc (cubic centimeter) of fluids a day for men and 2700 cc of fluids a day for women. These recommendations cover fluids from water, other beverages and food. About 20% of daily fluid intake usually comes from food and the rest from drinks. Nutrition Calculation Reference Sheet- "Determining fluid needs can be based on calorie intake OR weight ...Calculation: weight in kgs	F 692	A. R198 no longer resides in the facility. B. Active residents with poor p.o. intake will be reviewed by the dietician/designee and appropriate intervention will be initiated as applicable. C. The root cause was determined to be due to lack of oversight when a resident has poor p.o. intake on a regular basis to evaluate intervention. Staff Development/Designee will educate dietician and nursing staff on the process to follow when a resident is determined to have poor intake. Regional Dietary Consultant/Designee will educate facility Dietician/Designee on monitoring and re-evaluation of fluid and meal intake and on-going coordination with interdisciplinary team (IDT) of the	

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F 692	Continued From page 58 (kilograms) X (times) fluid factor ... Fluid factors: 25 ml (milliliters) X kg body weight for 75 year old or inactive ..." (University of California, Davis, 10/7/2023) R198's clinical record revealed: 11/25/22 2:41 PM - The hospital History and Physical documented, " ...labs notable for elevated creatinine 1.3 with no known h/o (history of) CKD (chronic kidney disease) or baseline creatinine ...". 12/1/22 12:04 PM - The hospital discharge summary stated, " ...Patient (R198) was found to have acute kidney injury which improved with IV (intravenous) fluid hydration ...". 12/1/22 - R198 was admitted to the facility with diagnoses including but not limited to dementia, acute kidney failure, hypertension and falls. 12/1/22 6:13 PM - R198's weight documented as 198 pounds (90 kilograms). Based on the UC Davis Nutrition calculation reference sheet, R918 required 2250 mls of fluid intake per day. 12/1/22 - E2 (DO) ordered a no added salt diet, regular texture, regular consistency for R198. 12/1/22 - E2 (DO) ordered, "Administer a minimum of 120 cc of appropriate fluid per shift with medication administration unless ordered otherwise. Every shift if resident consumes less than 120 cc document per shift in progress note." 12/1/22 - R198's care plan stated, "resident has	F 692	resident's hydration status. D. Daily audit by Regional Dietary Consultant/Designee on residents identified as having poor intake to ensure evaluation of fluid intake is reviewed and appropriate intervention as indicated x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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F 692	Continued From page 59 ADLs (activities of daily living) care deficit" and listed an intervention of "staff to assist with ADLs as needed". 12/7/23 - R198's admission Minimum Data Set (MDS) documented her functional status for eating (how resident eats and drinks, regardless of skill) as limited assistance, one person physical assist. Limited assistance is defined in the MDS for this skill as the "resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance." R198's Minimum Data Set (MDS) documented a Basic Inventory of Mental status (BIMS) score of 8, which was indicative of moderate cognitive impairment. 1/3/23 11:48 AM - RD documented, "Per SLP (Speech therapy) recommendations, liquids (for R198) downgraded on this day to NTL (nectar thick liquids). Diet : regular/NTL. Will continue to monitor nutritional parameters and update CP (care plan)". 1/3/23 - E2 (DO) changed diet order to regular diet, regular texture, nectar thick consistency (liquids downgraded to nectar thick). Nectar thick fluids are thicker than water, fall slowly from a spoon and can be sipped through a straw. 1/3/23 11:48 AM - NP evaluated R198 for new onset difficulty swallowing and ordered CBC (complete blood count) and BMP (basic metabolic panel) on 1/4/23. NP documented in the Progress Note. " ...Physical exam: Edema- +1 edema R (right) > L (left) ...". 1/3/23 (revised) - R198's care plan, initiated 12/2/22, stated "[R198] has p/f (potential for)	F 692		

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F 692	Continued From page 60 Nutritional Risk and p/f fluid volume deficit r/t (related to) advanced age, cognitive impairment/dementia, varying to poor intake, AKI (acute kidney injury), hypothyroidism, edema" with interventions that included: "Monitor for s/s (signs & symptoms) of diet intolerance, Monitor s/s of fluid volume deficit (i.e. change in mental status, poor skin turgor, decreased urinary output, dry mucous membranes, dizziness when standing /sitting) and report abnormal findings to MD (medical doctor)." R198's care plan was revised on 1/3/23 to include the intervention of "adaptive equipment needed as ordered: divided plate and teaspoon". 1/4/23 - R198 evaluated by NP and was diagnosed with probable aspiration pneumonia. A CXR (chest X-ray) was ordered. 1/4/23 3:04 PM - The laboratory reported R198's serum Na 141 mmol/L (normal range 137-145), chloride 10.7 (normal range 98-107) and creatinine 1.3 mg/dL (normal range 0.52-1.04). 1/5/23 12:56 PM - NP evaluated R198 and documented in Progress Note, " ...CXR last evening revealed mild CHF ... Plan: 1. Hypertensive heart disease with CHF- will add pulse dose of lasix 20 mg daily X 3 days, continue to monitor blood pressure and fluid status ...". Record review of CNA task and Electronic Medical Administration Record (EMAR) documentation revealed R198's daily fluid intake and percentage of meal eaten as: 1/1/23 - 2520 cc and 76-100% (all three meals) 1/2/23 - 2520 cc and 51-75% (breakfast), 76-100% (lunch and dinner)	F 692		

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F 692	Continued From page 61 1/3/23 - 1960 cc and 26-50% (breakfast), 51-75% (lunch and dinner) 1/4/23 - 2040 cc and 76- 100% (breakfast and lunch), 26-50% (dinner) 1/5/23 - 2280 cc and 76-100% (breakfast and lunch), 51-75% (dinner) 1/6/23 - 2280 cc and 76-100% (breakfast and lunch), 26-50% (dinner) 1/7/23 - 1800 cc and 26-50% (breakfast and lunch), 51-75% (dinner) These fluid intake numbers included extra fluids given at medication pass as well as documentation by the CNAs of fluids consumed during meals and at the bedside. Multiple nurse notes between 1/5/23 and 1/10/23 documented "fluids encouraged", "encouraged extra fluids" along with "refused dinner" and "had a good appetite". 1/8/23 - R198 tested positive for COVID-19 virus and was placed in isolation per the facility's COVID-19 infection control policy for 10 days. 1/9/23 - R198's weight documented as 164 pounds (74.5 kilograms). Based on the UC Davis Nutrition calculation reference sheet and this significant weight change, R918 now required 1863 mls of fluid intake per day. 1/10/23 1:33 PM - NP evaluated R198 after being diagnosed with COVID-19. NP documented in R198's progress note," ... Plan: 1. Hypertension with CHF- resident recently completed Lasix pulse dose, continue verapamil 240 mg, continue to monitor blood pressures, may trend down if	F 692		

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F 692	Continued From page 62 resident not drinking (sic), will closely follow." Despite documenting that R198 will be "followed closely", this was the last evaluation/ note written by a provider about R198 and her care until 1/20/23, the morning R198 is sent to the hospital with a mental status change. 1/11/23 2:43 PM - RD documented, " ...Had resident care conference on this day ...Questioning weights currently ...Weight fluctuations to be expected with CHF and edema. Pending reweigh ...Discussed labs, diet, PO (per oral) intake. Intake does seem decreased the last few days, mainly 25-50%...Will add supplementation at this time. Will continue to monitor nutritional parameters". 1/11/23 - E2 ordered "Mighty shakes two times a day for decreased PO intake, with lunch and dinner, prefers chocolate." Mighty shakes contain 250 cc of fluid. Record review of CNA task documentation revealed R198's daily fluid intake and percentage of meal eaten after her COVID infection diagnosis as: 1/8/23 - 1320 cc and 51-75% (breakfast and lunch), 26-50% (dinner) 1/9/23 - 1080 cc and 26-50% (breakfast), refused lunch, 0-25% (dinner) 1/10/23 - 2000 cc and breakfast not documented, 26-50% (lunch), 0-25% (dinner) 1/11/23 - 2040 cc and 26-50% (breakfast and lunch), refused dinner 1/12/23 - 1020 cc and breakfast and lunch not documented, 26-50% (dinner) 1/13/23 - 840 cc and 76-100% (breakfast), refused lunch and dinner	F 692		

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F 692	Continued From page 63 1/14/23 - 1260 cc and "not applicable" (breakfast and lunch), 26-50% (dinner) 1/15/23 - 1740 cc and 26-50% (breakfast), refused lunch, 26-50% (dinner) 1/16/23 - 1380 cc and 0-25% (breakfast, lunch and dinner) 1/17/23 - 1380 cc and 51-75% (breakfast and lunch), 0-25% (dinner) 1/18/23 - 1200 cc and 51-75% (breakfast and lunch), 0-25% (dinner) 1/19/23 - 1020 cc and 0-25% (breakfast), lunch not documented, 0-25% (dinner). Various nursing notes from 1/12/23 to 1/19/23 documented "p/t has poor meals intake", "resident ate about 25% of meal", "PO fluid and food intake encouraged", "refused dinner, tolerated PO medications and sips of fluids", "Refused dinner, tolerated 3 spoonful's of pudding" and "tolerated meds and consumed approx ...75% of ensure clear, however she refused to eat dinner." None of the notes contained statements that the providers were notified regarding R198's poor intake. Abrupt weight changes, change in food intake or altered level of consciousness are some of the clinical manifestations of fluid and electrolyte imbalances (Journal of American Dietetic Association 2003; 103(8) 1061-1072). Despite documentation of poor PO intake, the facility failed to produce evidence that staff recognized R198's impaired hydration status and escalated the problem to the providers for further interventions such as labs or IV (intravenous) fluids. In the 12 day span in which R198 was diagnosed and being treated for COVID-19, R198 only had 2	F 692		

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F 692	Continued From page 64 days (1/10/23 & 1/11/23) out of 12 in which she met her required fluid intake per day (1863 mls/day). The facility failed to recognize, evaluate and address that R198 was experiencing decreased PO intake and impaired hydration. The last time R198 had lab work to check her fluid status (BMP) was on 1/4/23, which was 16 days prior to her 1/20/23 admission to the hospital. 1/20/23 9:13 AM - RN5's nurse note documented, "Resident noted with decreased responsiveness, responds to name, eyes opened on and off, skin color is pale. VS 97.7 96 20 150/78, pox (pulse oximetry) 91% RA (room air). NP called and N/O (new order) to send out to the ER (emergency room) for further evaluation and tx (treatment). RP (representative person) made aware. Resident transported via stretcher". 1/20/23 - NP documented in Progress Note, " ... HPI (history of present illness): Resident lying in bed lethargic and not arousable ... Physical Exam: General - Resident lying in bed unresponsive, pallor ...Ears/Nose/Mouth/Throat - mucous membrane moist ...Edema - +1 edema R>L (right greater than left) ... Plan: 1. Increased lethargy, resident unresponsive, however vital signs remained stable, heart rate is irregular resident is a full code. We will send to the ER for evaluation ...". This note on 1/20/23 was the first evaluation by a provider in 10 days; the last previous provider note was dated 1/10/23. 1/20/23 9:10 AM - E13's (MD) ED (Emergency Department) Physician Record documented, "	F 692		

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F 692	Continued From page 65 ...86 yo (year old) F (female) with history of hypertension, atrial fibrillation on Coumadin, dementia who is typically alert and oriented x 1 or 2 per nursing home staff. History is obtained from independent historian [facility] nurse who gives the entire history as patient is altered and unable to contribute to her history. Nurse relates that she came in for a morning shift today and found the patient to be decreased responsiveness and very generally weak ...Exam reveals an elderly female who appears ill, tachycardic, irregularly irregular, diminished and coarse breath sounds bilaterally, ... extremely dry mucous membranes ... HR (heart rate) 125 bpm (beats per minute) pulse ox 100% Source 3L/min (supplemental oxygen) ...Assessment and Plan: Broad differential ... electrolyte derangements given her significant dehydration on clinical exam, hypernatremia considered, intracranial hemorrhage versus ischemic stroke ..." 1/20/23 9:41 AM - The hospital laboratory reported R198's serum Na (sodium) level was 165 mmol/L; this was a CRITICAL value as the normal range for serum Na is 136- 145 mmol/L. R198's serum chloride (Cl) level was 123 mmol/L, which was a high value. (normal Cl range is 98-107) and creatinine 2.53. 1/20/23 2:54 PM - E15's (Renal MD) Consult Note documented, " ...Labs showed sodium 165 mmol/L creatinine of 2.53 mg/dL and elevated INR of 6.2 ...Assessment and Plan: Hypernatremia: presentation sodium was 165. This is due to dehydration. Serum sodium is improved by 4 mmol with lactated Ringer (intravenous fluid) X 1 L (liter)." 1/20/23 3 PM - E16's Admission History &	F 692		

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F 692	Continued From page 66 Physical (H&P) documented, " ...86 year old female ...admitted for acute encephalopathy (altered mental state/confusion) and AKI (acute kidney injury) ...Assessment/Plan: 1- AKI (acute kidney injury)- with creatinine of 2.53 from a baseline of approximately 1.2 ...etiology from significant dehydration ...2-Acute hypoxemic respiratory failure- ...Suspect hypoventilation from encephalopathy resulting in atelectasis ...3 - encephalopathy- Likely in the setting of significant dehydration ...4 - Hypernatremia - Significantly hypernatremic likely in setting of dehydration/poor fluid intake ...". 2/8/23 6:21 PM - R198's Discharge Summary documented, " ...Patient medically stable for discharge to inpatient hospice." 10/30/23 2:55 PM - During a telephone interview, E2 (DO) stated that the practice of obtaining labs on a resident, "varies from patient to patient. For some residents, it can be weekly or even biweekly (typically residents on Coumadin) but it is a provider decision." 10/30/23 3:50 AM - During an interview, CNA15 stated, "I took care of her (R198) a few times. She did not have the best appetite but would eat what her family brought into her. When she was sick with COVID, her appetite went down." 11/3/23 8:23 AM - During a telephone interview, FM4 (R198's daughter) stated, "Prior to the COVID isolation, we would bring in food and drinks- milkshakes, for my Mom to make sure that she was eating enough. But with the isolation, we were not allowed in and all that stopped ... The doctors in the ER told me this did not happen in day ...Her mouth was so dry and	F 692		

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F 692	Continued From page 67 she was begging ... 'water, orange juice, soup' ...I still hear her in my dreams. She never recovered from all this ...". 11/3/23- 9:15 PM - Findings were reviewed at the Annual Survey Exit conference with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure appropriate care of a gastrostomy	F 693	A. R30 has no adverse effect. LPN 21 will be educated regarding PEG tube placement and proper	1/3/24

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F 693	Continued From page 68 (g-tube) during medication administration for three residents (Resident (R) 30, R43 and R95) of three residents during medication administration with gastric tubes. Specifically, Licensed Practical Nurse (LPN) 14 and LPN17 failed to check for proper g-tube placement, did not flush the g-tube before and after medication administration, and administered medication via push method rather than by gravity administration for R43. LPN23 failed to check for proper g-tube placement, administered water flush via push method, and administered medications via push method rather than by gravity method for R95. This failure increases the risk for nausea, vomiting, or aspiration. Findings include: Review of facility's policy titled "Verifying Placement of Feeding Tube" revised 07/2023 stated, "It is the practice of this facility to ensure proper placement of feeding tubes prior to beginning a feeding, flushing the tube, or before administering medications via feeding tube ...Before beginning a feeding, flushing the tube, or administering a medication via feeding tube, proper placement and functioning will be verified ...Verify tube placement: i. For gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. Notify supervisor and/or physician of abnormal findings, OR ii. Measure length of tube from insertion site to tip upon new admission to facility or with a new/change in tube and record the length ...d. Flush feeding tube with 30ml [milliliters] of water after residual measurements to maintain tube patency ..."	F 693	technique with medication administration via PEG tube. R43 has no adverse effects. LPN 17 was educated on 10/31/23 by Staff Development on checking of placement, flushing of PEG tube proper technique when administering medication via PEG tube. R95 has no adverse effect. Licensed nurses will be educated on administration of medications via PEG tube. B. Active residents with medications administered via PEG tube will be reviewed. Staff Development/Designee will observe medication administration on residents with PEG tube and education will be provided as indicated. C. The root cause was determined to be due to licensed nurses lack of understanding of the steps when administering medications via PEG tube and checking of placement prior to medication administration. Staff Development/Designee will re-educate licensed nurses on appropriate process when administering medications via PEG tube via return demonstration based on current professional standards. Staff competency for tube feeding will be reviewed annually or as needed. Consultant pharmacist/designee will be performing random medication	

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F 693	Continued From page 69 1. Review of "Validation Checklist- Feeding Tube" provided by Staff Development, indicated to check placement of feeding tube in accordance with facility policy ...Check residual as ordered ...Administered gravity feeding appropriately, as ordered ..." Review of R30's undated "Admission Record" located in Electronic Medical Record (EMR) under the "Profile" tab revealed R30 was admitted to the facility on 07/16/13 with diagnoses including gastrostomy status, hydrocephalus, dysphagia, aphasia, gastro-esophageal reflux, macrocephaly, and paraplegia. Review of R30's "Care Plan" revised on 11/04/22, located in EMR under the "Care Plan" tab revealed R30 had a feeding tube with the need for checking tube placement prior to administration, monitor bowel sounds, abdominal distention, provide enteral feedings and flushes as ordered. Review of R30's "Physician Orders" located in EMR under the "Orders" tab, included NPO (nothing by mouth) diet dated 01/20/16, enteral feed order every three hours, verify Peg Tube (percutaneous endoscopic gastrostomy tube) length (17cm [centimeter]) marking prior to each feeding, flush or medication administration for proper placement. If marking is not visible measure peg tube to confirm, every shift (09/12/23), enteral feed orders every six hours flush peg tube with 300mL water (10/08/21), check g-tube placement. Check residual prior to administration, if greater than 150cc push back tube feed into stomach and hold feeding for one hour (07/27/23), and levothyroxine tab 50 mcg (micrograms) tablet via peg-tube once daily for	F 693	administration observations via PEG tube. Daily random observation by Staff D. Staff Development/Designee on medication administration via PEG tube on all shifts to ensure licensed staff are following the process when administering medication via PEG tube x 7 days until 100% compliance is achieved and sustained. The following will be a random weekly audit x 4 on all shifts then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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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 693	Continued From page 70 hypothyroidism (04/18/21). Flush tube with 30ml before and after meds every shift (06/22/23). During an observation and interview on 10/30/23 at 5:55 AM, LPN21 prepared R30's levothyroxine medication, paused the feeding pump, disconnected the feeding tube from the feeding pump, did not check for feeding tube placement prior to flushing the tube with water, flushed tube with 30ml water via push method, administered crushed levothyroxine mixed with 10cc water via push method. LPN21 stated she did not check the placement of the tube because she had checked it at the start of her shift. When asked if she should check prior to each medication administration, she stated probably so. LPN21 stated she was not aware that she was not supposed to administer water and medications via push method. 2. Review of R43's undated "Admission Record" located in the EMR under the "Profile" tab revealed R43 was admitted to the facility on 08/08/15 with diagnoses including gastrostomy, encephalopathy, dysphagia, tracheostomy, and gastro-esophageal reflux. Review of R43's "Care Plan" revised on 07/26/23, located in EMR under the "Care Plan" tab revealed R43 had a tube feeding G/J combination related to dysphagia. Review of R43's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/13/23, confirmed R43 had a "Brief Interview for Mental Status (BIMS)" score of 99 indicating the resident had severe cognitive impairment. Continued review of the MDS did not include feeding tube status.	F 693		

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	085004	A. BUILDING _____ B. WING _____	C 11/08/2023

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F 693	Continued From page 71 Review of R43's "Physician Orders" located in EMR under the "Orders" tab, included NPO diet dated 08/04/23, liquid protein supplements two times a day for low albumin 30ml via PEG, enteral feed order every two hours flush Jtube (jejunostomy) 120ml (milliliters), enteral feed order every shift flush with 15ml before and after medications, Diabetisource AC 1.2 at 75ml/hour x 20 hours infuse 1500ml via jtube and valproic acid oral solution 250mg/5ml give 15ml by mouth [sic] three times a day for seizure disorder. During an observation and interview on 11/01/23 at 12:14 PM, LPN17 flushed R43's g-tube with 15ml of water via push method. LPN17 stated she could see "17cm [centimeters]" on the g-tubing, confirmed that she flushed the g-tube with 15ml water through the g-tube port, and that she had been educated by the Staff Development on 10/31/23 to use gravity method for flushing g-tube. LPN17 also stated it was okay to look at the number on the g-tubing to verify placement. LPN17 confirmed that she did not auscultate or check residual prior to flushing R43's g-tube but should have. 3. Review of R95's undated "Admission Record" located in the EMR under the "Profile" tab revealed R95 was admitted to the facility on 07/02/21with diagnoses including vascular dementia, hemiplegia, and dysphagia. The Admission Record did not include g-tube status. Review of R95's "Care Plan" revised on 07/26/23, located in EMR under the "Care Plan" tab revealed R95 had a tube feeding related to dysphagia.	F 693		

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F 693	Continued From page 72 Review of R95's quarterly "MDS" with an ARD of 10/02/23, revealed the facility assessed R95 to have a BIMS score of one out of 15 which indicated the resident was severely cognitive impaired. Continued review of the MDS did not include feeding tube status. Review of R95's "Physician Orders" located in EMR under the "Orders" tab, included liquid protein supplement twice daily 30ml via PEG (10/20/23), gabapentin (anticonvulsant used to relieve pain) oral solution 250mg/5ml give two ml three times (TID) daily for neuropathic pain (07/28/23), and guaifenesin 100mg/5ml- give 10ml for seven days TID for cough (10/26/23). During an observation and interview on 10/28/23 at 11:17AM, LPN14 prepared R95's valproic acid (anticonvulsant medication) 250mg (milligrams) per 5ml (milliliters). LPN14 entered the room, did not check placement of the feeding tube, did not flush the feeding tube, and then administered 15ml of valproic acid via push method with difficulty. Continued observation revealed R43's g-tube was noted to have hardened formula in the g-tube and at that time, the surveyor the observation out to the LPN. LPN14 stated he had previously flushed the g-tube and he did not know why the tube had thickened formula or why he had difficulty administering the medication. No reason was given as to why he did not flush the g-tube prior to medication administration. LPN14 stated that he had not been educated to use gravity method versus push method. During an observation and interview on 10/30/23 at 1:01 PM, LPN23 prepared R95's medications (liquid protein supplement, gabapentin 250mg/5ml- give two ml TID) daily for neuropathic	F 693		

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F 693	Continued From page 73	F 693		

pain, and guaifenesin 100mg/5ml- give 10ml for seven days TID for cough), used push method to flush g-tube with 30ml prior to medication administration, and did not check for g-tube placement prior to water flush/medication administration. LPN23 stated that she confirmed placement of the g-tube by visualizing the tube marking at 15mm (millimeters), that she had checked residual earlier this morning, but not before current water/medication administration. She stated she normally checks residual prior to water/medication administration but was not sure why she did not do it now, but she should have.

During an interview on 10/28/23 at 11:30AM, LPN8 stated LPN14 should have been notified by CNA2 prior to bathing/activities of daily living (ADL) care for g-tube patients so that the tube could be flushed, and the feeding placed on pause during care. LPN8 also confirmed he was not aware that LPN14 had not checked placement of R95's g-tube, had not flushed the g-tube, and administered medications via push method. LPN8 confirmed it was the facility policy to measure the g-tube with a paper measuring tape to verify placement, and this should be done prior to every water flush or medication administration. Additionally, LPN8 stated all nurses should use gravity method for medication and water flushes. LPN8 confirmed that R95's medications were via gtube, not mouth as indicated on valproic acid order.

During an interview on 10/31/23 at 3:57 PM, Regional Nurse (REG) stated each nurse should check placement for all g-tube residents by measuring the peg tube with a tape measure which was available on each medication cart. The REG also stated the g-tube should be checked

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F 693	Continued From page 74 for residual prior to all water and medication administrations. All medication and water flushes should be via gravity method and not via push method.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to properly maintain clean filters on oxygen concentrators for six of eight residents sampled for respiratory care (Resident (R) 403, R402, R93, R103, R38, and R43). The facility also failed to properly administer nebulizer treatments for two residents (R43, and R121) two residents sampled. The facility failed to maintain supplemental oxygen for one of one dependent residents (R30). Findings include: Review of the facility's policy titled, "Oxygen Administration" dated 2/2023 revealed, "Policy: Oxygen is administered to residents who need it consistent with professional standards of practice, comprehensive person-centered care plans, and the resident's goals and preferences ... 7. Cleaning and care of equipment shall be in	F 695	A. R40 no longer resides in the facility. No adverse effect. R38's oxygen concentrator filter was replaced. Routine filter replacement in place. R403 no longer resides in the facility. No adverse effect. R103 no longer resides in the facility. No adverse effect. No adverse effect to R43. Nurse immediately in-serviced appropriate steps when administering medication via nebulizer. R93 no longer resides in the facility. No adverse effect R121 no longer require oxygen therapy and no adverse effect noted. R30's oxygen was re-applied and no adverse effect. Resident was placed on frequent monitoring for mask placement.	1/3/24

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F 695	Continued From page 75 accordance with facility policies for such equipment." 1. Review of R402's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed R402 was admitted to the facility on 10/26/23 Review of R402's "Physician Order" dated 10/27/23 located in the resident's EMR under the "Orders" tab revealed an order for "O2 [oxygen] at 2 lpm [liters per minute] via nasal canula." Further review of the physician's order revealed an order dated 10/28/23 of "clean oxygen filter every Friday on 11-7 shift dated 10/28/23." Observation and interview on 10/28/23 at 10:35 AM revealed R402's concentrator located next to her bed to have a dirty air intake filter. Licensed Practical Nurse (LPN) 8 was present during the observation and stated, "the filter is dirty and needs to be cleaned." 2. Review of R38's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed R38 was admitted to the facility on 9/21/23 with diagnoses which included chronic respiratory failure with hypoxia and obstructive sleep apnea. Review of R38's "Physician Order" dated 9/21/23 located in the resident's EMR under the "Orders" tab revealed an order for "O2 [oxygen] at 2 lpm via nasal canula." Further review of physician orders revealed no orders for the cleaning of the concentrator filter. Observation and interview on 10/28/23 at 10:39	F 695	B. All residents with oxygen concentrator, nebulizing treatment, utilizing oxygen tank in rooms and with behaviors could potentially be affected. Active residents with oxygen concentrators will be checked to ensure filters are clean. Licensed staff will be educated on proper administration medication via nebulizer. Licensed staff will be educated to utilize oxygen concentrator for room use. Active residents with oxygen therapy order will be reviewed for new behaviors to ensure oxygen tubing is in place while in room. Appropriate intervention will be in place as applicable. C. The root cause was determined to be due to lack of oversight and process related to oxygen concentrator's filter cleaning. Staff Development/Designee will educate licensed staff/maintenance on process update related to oxygen concentrator filter changes. The root cause was determined to be due to lack of understanding on the importance of monitoring while providing nebulizer treatment.	

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F 695	Continued From page 76 AM revealed R38's concentrator located next to her bed to have a dirty air intake filter. LPN8 was present during the observation and stated, "the filter is dirty and needs to be cleaned." 3. Review of R403's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed R403 was admitted to the facility on 10/19/23 with diagnoses which included mild persistent asthma and acute respiratory failure with hypoxia. Review of R403's "Physician Order" dated 10/19/23, located in the resident's EMR under the "Orders" tab revealed an order for "O2 [oxygen] at 2 lpm via nasal cannula. . . "Further review of physician orders revealed no orders for the cleaning of the concentrator filter. Observation and interview on 10/28/23 at 10:40 AM revealed R403's concentrator located next to her bed to have a dirty air intake filter. LPN8 stated "the filter is dirty and needs to be cleaned." 4. Review of R103's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed R103 was admitted to the facility on 7/26/23 with diagnoses which included acute respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Review of R103's "Physician Order" dated 7/26/23 located in the resident's EMR under the "Orders" tab revealed an order for "O2 [oxygen] at 3 lpm via nasal cannula. . ." Continued review of physician orders revealed an order dated 10/30/23 of "clean oxygen filter every Friday on 11-7 shift."	F 695	Staff Development/Designee will re-in-service licensed staff on monitoring process when administering medication via the nebulizer machine. The root cause was determined to be due to lack of clear direction when a resident is started on oxygen and use of oxygen concentrator while in the room. Staff Development/Designee will in-service licensed staff and therapy to utilize oxygen concentrator when the resident is in the room. The root cause was determined to be due to resident's behavior and staff anticipating the need for a change in the plan of care. Staff Development/Designee will in-service nursing staff on intervention to initiate when residents manifest behavior and a need for frequent monitoring of resident while on oxygen use. D. Daily audit by Unit Manager/Designee to ensure oxygen concentrator filters are clean x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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F 695	Continued From page 77 Observation and interview on 10/28/23 at 10:41 AM revealed R103's concentrator located next to her bed to have a dirty air intake filter. LPN8 stated "the filter is dirty and needs to be cleaned." 5. Review of R43's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed R43 was admitted to the facility on 8/8/15 and readmitted on 8/3/23 with diagnoses which included chronic respiratory failure, chronic emphysema, and tracheostomy. Review of R43's "Physician Order" dated 10/27/23 located under the "Orders" tab in the EMR revealed an order for "titrate O2 [oxygen] to keep [saturation] 92% or above up to 5 lpm. . ." Further review of physician orders revealed an order dated 10/23/23 of "clean oxygen filter every Friday on 11-7 shift dated 10/28/23." Review of R43's "Care Plan" revised on 9/16/20, located in the resident's EMR under the "Care Plan" tab revealed R43 had a tracheostomy, requiring nebulizer treatments and oxygen administration via tracheostomy mask as needed. Interventions included administration of medication/nebulizer treatments as ordered and to monitor for effectiveness. Review of R43's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 9/13/23, located in the resident's EMR under the "MDS" tab revealed the facility assessed R43 to have a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident had severe cognitive impairment. Continued review of the MDS included shortness of breath; however, it did not include oxygen or tracheostomy status.	F 695	Daily audit by Unit Manager/Designee to ensure residents are utilizing the oxygen concentrator when while in the room x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Daily audit by Staff Development/Designee to ensure licensed staff are following the process when administering medication via a nebulizer machine x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Daily audit by Unit Manager/Designee to ensure residents oxygen cannula are in place for residents requiring oxygen therapy x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be	

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F 695	Continued From page 78 Review of R43's "Physician Orders" dated 8/3/23, located in the resident's EMR under the "Orders" tab, included albuterol sulfate nebulization solution (2.5mg (milligrams)/3ml milliliters) 0.083% (percent) 3ml inhale orally via nebulizer four times a day for abnormal lung sounds. During an observation and interview on 10/30/23 at 6:12 AM, R43 was lying in bed with nebulizer machine running, oxygen administration via tracheostomy collar, and no staff monitoring nebulizer treatment. The surveyor located Licensed Practical Nurse (LPN18) who confirmed he was providing care to R43. LPN18 stated he started the nebulizer treatment for R43, exited the room, and confirmed that he should have stayed with the resident during the nebulizer treatment. LPN18 did not give a reason as to why the resident was left unattended during medication administration. 6. Review of R93's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 9/9/23 with diagnoses which included chronic obstructive pulmonary disease (COPD). Review of R93's "Physician Order" dated 9/11/23, located in the resident's EMR under the "Orders" tab revealed an order for "O2 at 2 lpm via nasal cannula. . ." Further review of the physician orders revealed an order dated 9/11/23 of "clean oxygen filter every Friday on 11-7 shift." Observation and interview on 10/28/23 at 10:46 AM with LPN8 revealed R93's concentrator located next to her bed to have a dirty air intake filter. LPN8 stated "the filter is dirty and needs to	F 695	made to maintain and sustain compliance.	

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F 695	Continued From page 79 be cleaned." 7. Review of R121's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed R121 was admitted to the facility on 12/30/22. The Admission Record did not indicate a diagnosis related to the need for supplemental oxygen. Review of R121's "Care Plan" revised on 7/12/23, located in the resident's EMR under the "Care Plan" tab revealed no identified problems or interventions related to the use of supplemental oxygen. Review of R121's quarterly "MDS" with an ARD of 7/21/23, located in the resident's EMR under the "MDS" tab revealed the facility assessed R121 to have a BIMS score of 10 indicating the resident was moderately cognitively impaired Continued review of the MDS did include a diagnosis of orthostatic hypotension. Review of R121's "Physician Orders" located in EMR under the "Orders" tab did not include oxygen therapy. During an observation and interview on 10/30/23 at 12:26PM, R121 was lying in bed with a large oxygen tank next to her bed set to two liters per minute via nasal cannula. Upon inspection of the oxygen cylinder, the tank was empty and was not administering any supplemental oxygen to R121. Resident was resting with eyes closed upon observation. LPN23 was standing at the medication cart upon this surveyor's observation of R121. LPN23 was asked to go to R121's room for observation. LPN23 noted R121 to be in bed with eyes closed, stated that the resident had	F 695		

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F 695	Continued From page 80 been in therapy that morning and that her oxygen levels started to decrease so the morning nurse applied oxygen. LPN23 was not aware that the oxygen tank was empty and was not sure when staff had last checked the tank to ensure supplemental oxygen was being administered. LPN23 then checked R121's oxygen saturation level with a reading of 96%. LPN23 stated she would determine if oxygen was still needed and if so, provide a full oxygen tank or oxygen concentrator. LPN23 confirmed that staff should have monitored the oxygen tank for oxygen availability. 8. Review of Resident (R)30's undated "Face Sheet" located in the resident's Electronic Medical Record (EMR) under the "Profile" tab revealed R30 was admitted to the facility on 4/17/21 with diagnoses which included coronary artery disease, profound intellectual disabilities, seizure disorder, and diabetes mellitus. Review of R30's quarterly "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of 9/26/23, located in the resident's EMR, revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of 99 which represents R30 was unable to complete the interview. The facility assessed R30 to have short- and long-term memory problems and was severely impaired in making decisions regarding tasks of daily life. Review of section "G0400" in the quarterly MDS, the facility assessed R30 as having impairment of both sides for upper and lower extremities. R30 was total dependence of two or more persons for transfers and was total dependence of one person assist for personal hygiene and bathing.	F 695		

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F 695	Continued From page 81 Review of R30's physician's orders located in the resident's EMR under the "Order" tab, revealed orders for "Continuous O2 (oxygen) face mask @ (at) 4L (4 liters) to maintain Sats (saturation) at > (greater than) 93%". This order was dated for 10/30/23 at 3:00 PM. The observation was made on 11/1/23 at 5:13 PM, as passing R30's room, it was noted the face mask was off the resident's face and laying on the right side beside the resident's pillow. Registered Nurse (RN)8 was observed with the medication cart administering medications to residents on C unit in rooms up from R30's room. At 5:23 PM, RN8 obtained the oxygen saturation (O2 sat), and it was 79% without oxygen. The nurse immediately increased the oxygen to deliver 5 liters/minute and placed the face mask on R30's face. RN8 attempted to obtain another oxygen saturation level but R30 started shaking her hand very lightly at the nurse. RN8 stated, "R30 is non-verbal, and she is refusing." At 5:28 PM, RN8 attempted to auscultate R30's lungs and again the resident started shaking her hand at the nurse very lightly. RN8 stated, "R30 is refusing." At 5:29 PM, RN8 stated, "I don't see any distress right now, she has the right to refuse. I'm going to call the Supervisor and doctor." At 5:31 PM, RN5 accompanied RN8 back to R30's room. RN5 decreased the oxygen to 4 liters/minute while RN8 attempted to check R30's oxygen saturation. RN8 was able to obtain the O2 saturations which was 94% before R30 started shaking her hand at the nurse as before.	F 695		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)	F 711		12/26/23

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	085004	A. BUILDING _____ B. WING _____	C 11/08/2023

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F 711	Continued From page 82 §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R50) out of three residents reviewed for Physician services, the facility failed to ensure that R50's total program of care, including R50's advanced directives, was reviewed by the providers at the time of his admission. Findings include: Cross refer F578, example 6 Review of R50's clinical record revealed: Advance Care Planning is a process of communication between individuals and their healthcare agents to understand, reflect on, discuss and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. An Advance Directive is a written instruction, such	F 711	A. R50s advance directive will be discussed with family. B. Active residents admitted within the last 14 days will be reviewed for advance directives preference upon admission. Advance directives preferences will be reviewed as applicable. C. The root cause is determined to be due to lack of understanding on the importance of advance directives preference review upon admission. Medical Director/Designee will provide in-service to providers regarding advance directives preference discussion upon admission. D. Daily audit by Medical Director/Designee will be conducted to	

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F 711	Continued From page 83 as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. 2/16/16 - R50 completed Durable Personal Power of Attorney designating his son (FM3) as financial agent. "This power of attorney does not authorize your Agent to make health care decisions for you." 6/4/22 - R50 was admitted to the facility with diagnoses including, but were not limited to, diabetes, stroke with left sided weakness and severe vision impairment. 6/4/22 - E2 (DO) ordered a Full code status on R50's electronic medical record (EMAR). Record review revealed no documentation of conversation with R50 or his family regarding code status. 6/6/22 7:45 AM - RN1 (unit manager) documented in his Nurse's note, "... Resident code status confirmed to be Full code by resident. Witnessed by 2 nurses. [NP] made aware." 6/6/22 9:46 AM - NP documented in R50's Progress Note, "... Code Status: Full Scope of Treatment." In the Quality Measurement Documentation of this note, NP documented, "... I confirmed today that the patient's Advance Care Plan is documented in the medical record either by discussing and documenting the patient's Advance Care Plan, confirming that the patient's surrogate decision maker is documented in the medical record, or confirming that the patient's	F 711	ensure advance directives preferences are discussed on admission x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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F 711	Continued From page 84 Advance Care Plan is presently documented." This note speaks to code status with R50's desire to have full scope of treatment. However, the NP failed to address in the 6/6/22 progress note whether R50 had an Advanced Directive and if the facility had a copy of that document. 6/8/22 3:09 PM - R50's Admission Minimum Data Set (MDS) assessment documented R50's Basic Inventory of Mental Status (BIMS) score of 8, which was reflective of moderate cognitive impairment. 6/9/22 - E2's (DO) Admission History & Physical (H&P) documented, "... History of Present Illness:... patient presented to hospital for altered mental status... Physical Exam:... general_ alert & awake...Code Status: Full scope of treatment...". In the Quality Measurement Documentation of this note, E2 (DO) documented, "... I confirmed today that the patient's Advance Care Plan is documented in the medical record either by discussing and documenting the patient's Advance Care Plan, confirming that the patient's surrogate decision maker is documented in the medical record, or confirming that the patient's Advance Care Plan is presently documented." This note speaks to code status with R50's desire to have full scope of treatment. However, E2 failed to address in the 6/9/22 progress note whether R50 had an Advanced Directive and if the facility had custody of a copy of that document. E2 failed in the 6/9/22 progress note to document R50's current cognitive condition and assess the appropriateness of R50's ability to make decisions regarding his medical regimen in order to maintain his highest practicable physical,	F 711		

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F 711	Continued From page 85 mental and psychosocial well-being. Record review revealed R50's facesheet documented FM3 (R50's son) as "resident representative, POA (power of attorney) financial, and resident responsible party." 11/3/23 9:15 PM - Findings were reviewed with E1 (NHA), DON, REG, E4 (Regional Clinical Director) and E5 (Director of Operations).	F 711		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of	F 729		12/26/23

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F 729	Continued From page 86 a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (CNA6) out of five certified nursing assistants (CNA) reviewed for Registry verification, the facility failed to ensure that CNA6, who successfully completed an out of state CNA competency evaluation program, went on to register with the State of Delaware. Findings include: 10/19/10 - CNA6 obtained her certified nursing assistant license from the State of Maryland. 6/28/22 - CNA6 was hired as an employee at the facility during the COVID-19 Public Health Emergency (PHE) when CMS waived the nurse aide training requirement. 5/11/23 - CMS ended all waivers for the Public Health Emergency. 8/21/23 - CNA6 renewed her Maryland Nursing Assistant certification. 10/23/23 3:58 PM -Delaware Division of Health Care Quality (DHCQ) verified that there are no current CNA waivers in place in Delaware. 11/7/23 - During an interview, E1 (NHA) stated that CNA6 was covered by the "waiver" and did	F 729	A. Employee was immediately taken off the schedule. Verified license for state of DE was submitted. B. Active staff's licenses will be audited to verify licenses are current. C. The root cause was determined to be due to lack of consistent monitoring and checking of licenses by the staff in charge. Regional Human Resources Consultant/Designee will educate facility HR/Designee process for license verification process, waiver protocol and expiration, application for license, waivers and on-going monitoring of license renewal and special exception waivers. D. Weekly audit by HR Consultant/Designee will be conducted to ensure licenses of new hires and active staff are current x 4 until 100% compliance is achieved and sustained. The following will be a monthly x 3. In an event where compliance is consistently below the goal, the Interdisciplinary Team	

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F 729	Continued From page 87 not require a Delaware license. The facility failed to ensure that CNA6 was certified to work in Delaware.	F 729	(IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (resident (R) 251) out of one resident reviewed for insulin use, the facility failed to prevent significant medication errors when R251 received insulin greater than one hour after the ordered time repeatedly from December 2022 through May 2023. Findings include: The facility policy on medication administration, undated, indicated "Administer medication as ordered in accordance with manufacturer specifications." Insulin Detemir, sold under the brand name Levemir, among others, is a long-acting insulin used to treat diabetes. It is used by injection under the skin. It is effective for up to 24 hours. https://www.drugs.com/levemir.html. Review of R251's clinical record revealed: 12/15/22 - R251 was admitted to the facility. 12/15/22 - A physician's order was written for R251 to receive insulin Detemir, inject 40 units two times a day for diabetes.	F 760	A. R251 no longer resides in the facility. B. Active residents with routine long-acting insulin orders will be reviewed to assure plan of care is followed . The provider will be notified of any issues and will be reviewed for appropriate intervention as applicable. C. The root cause was determined to be due to the staff's lack of understanding of the importance of timely insulin administration. Staff development/designee will re-educate staff on allowed timeframe for insulin administration. Any deviation from the allowed timeframe will be documented and physician notified, D. Daily audit by Unit Manager/Designee to ensure long-acting insulins are administered timely x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4	12/26/23

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F 760	Continued From page 88 12/27/22 - A care plan was implemented for diabetes with the intervention to administer medications, as ordered. December 2022 MAR [Medication Administration Record] - Review of insulin Detemir administrations ordered to be given at 8:00 AM and 6:00 PM revealed 23/32 administrations given late, greater than one hour past the ordered time. Late administrations ranged from one hour and nine minutes late to five hours and forty-five minutes late. January 2023 MAR- Review of insulin Detemir administrations ordered to be given at 8:00 AM and 6:00 PM revealed 25/62 administrations given late, greater than one hour past the ordered time. Late administrations ranged from one hour and thirty-six minutes late to six hours and thirty-six minutes late. February 2023 MAR- Review of insulin Detemir administrations ordered to be given at 8:00 AM and 6:00 PM revealed 14/56 administrations given late, greater than one hour past the ordered time. Late administrations ranged from one hour and thirty minutes late to five hours and four minutes late. March 2023 MAR - Review of insulin Detemir administrations ordered to be given at 8:00 AM and 6:00 PM revealed 16/62 administrations given late, greater than one hour past the ordered time. Late administrations ranged from one hour and twenty minutes late to four hours and thirty-five minutes late. April 2023 MAR - Review of insulin Detemir	F 760	then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	

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F 760	Continued From page 89	F 760		

administrations ordered to be given at 8:00 AM and 4:00 PM revealed 23/60 administrations given late, greater than one hour past the ordered time. Late administrations ranged from one hour and twenty-three minutes late to seven hours and forty-five minutes late.

5/5/23 - A progress note written by Nurse Practitioner (NP) documented, Resident's blood sugars continue to range in the 300's and 400's. Resident seen lying bed in no acute distress. Plan: 1. Diabetes, increase [long-acting insulin] to 44 units twice daily, continue diabetic diet, continue Accu-Checks and sliding scale insulin, titrate meds as needed." Review of R251's MAR revealed the long acting insulin was given one hour and nineteen minutes late. The progress note lacked evidence that the NP was aware of any late administrations of insulin to R251.

May 2023 MAR - Review of insulin Detemir administrations ordered to be given at 8:00 AM and 4:00 PM revealed 21/48 administrations given late, greater than one hour past the ordered time. Late administrations ranged from one hour and nineteen minutes late to eight hours and nineteen minutes late.

5/24/23 - R251 was discharged from the facility.

During an interview on 11/1/23 at 3:39 PM, Director of Nursing (DON) confirmed that the facility was unaware that R251 received ordered insulin late from December 2022 - May 2023. DON stated, "It may have been due to late mealtimes, that is something identified this survey."

During an interview on 11/7/23 at 10:07 AM

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F 760	Continued From page 90 Medical Director (MD), it was reported that R251's non-compliance with her diet was the contributor to the residents elevated blood sugars. MD did confirm she was not made aware that R251 was receiving insulin later than ordered from December 2022 through May 2023. MD stated, "If it was ongoing, we would have expected to be contacted." During an interview on 11/7/23 at 10:22 AM Nurse Practitioner (NP) was unable to recall whether the facility made her aware that R251's insulin was frequently administered outside the ordered timeframe. NP then stated, "For long acting [insulin] I would not be concerned. For short acting [insulin] yes, it's a concern but it is given in conjunction with meals. I would at least want a recheck of the blood sugar if it had been too long." During an interview on 11/7/23 at 1:24 PM Registered Nurse (RN)5 who was the unit manager on R251's unit, was unable to recall any reason why R251 received insulin an hour past the ordered time. RN5 also reported she was unaware of delay in insulin administration. Findings were reviewed during the exit conference on 11/8/23 at 1:18 PM with Nursing Home Administrator (NHA).	F 760		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		12/26/23

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F 761	Continued From page 91 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents' expired and discontinued medications were removed from medication carts for six of six medication carts. Resident (R) 12, R18, R23, R47, R116, R138, R299, R448, R87, R22, R32, R62, R109, R121, R34, R56, R65, R118, R128, R122, R124, R125, R301, R302, R13, R103, R129, R140, R457, and R458 had expired or discontinued medications on the medication carts. This created the potential for medications to be diverted or for residents to receive medications with no current physician order. Additionally, it was determined that the facility failed to permit only authorized personnel to have access to the keys to locked compartments containing medications.	F 761	A. R12's discontinued medications were removed on 10/27/23. No adverse effect to resident. R18's discontinued medications were removed on 10/27/23. No adverse effect to resident. R23 discontinued medications were removed on 10/27/23. No adverse effect to resident. R47 discontinued medications were removed on 10/27/23. No adverse effect to resident. R116's discontinued medications were removed on 10/27/23. No adverse effect to resident. R138's discontinued medications were removed on 10/27/23. No adverse effect	

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F 761	Continued From page 92 Registered Nurse (RN)10 , unauthorized personnel due to being off shift, entered the facility and was given access to locked medications. The medications RN 10 gained access to were not witnessed as wasted. Findings include: Review of the facility's policy titled "Disposal of Medications and Medication-Related Supplies" dated 1/1/16 indicated "Discontinued medications and medications left in the facility after a resident's discharge that are not returned to the pharmacy are destroyed ...Controlled substances cannot be returned to the pharmacy and are retained in a securely locked area with restricted access until destruction ...Medication destruction occurs only in the presence of 2 (two) licensed individuals ...The medication disposition record is placed in the resident's medical record." Review of the facility's policy titled "Medication Storage" dated 7/2023 stated, " ...Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels." Observation on 10/27/23 from 2:27 PM to 4:45 PM, with Licensed Practical Nurse (LPN) 2, of the Unit B medication cart revealed R12, R18, R23, R47, R82, R116, R138, R299 and R448 had medications in the medication cart with no current order for the medications. LPN3 confirmed the residents' medications were in the medication cart with no current order in place for the medications. LPN3 stated the medications should have been removed from the cart.	F 761	to resident. R299 no longer resides in the facility. Discontinued medications for this resident were removed from the med cart on 10/27/23. R448's discontinued medications were removed on 10/27/23. No adverse effect to resident. R87 discontinued medications were removed on 10/27/23. No adverse effect to resident. R22's discontinued medications were removed on 10/27/23. No adverse effect to resident. R32's discontinued medications were removed on 10/27/23. No adverse effect to resident. R62's discontinued medications were removed on 10/27/23. No adverse effect to resident. R109's discontinued medications were removed on 10/27/23. No adverse effect to resident. R121's discontinued medications were removed on 10/27/23. No adverse effect to resident. R34's discontinued medications were removed on 10/27/23. No adverse effect to resident. R56's discontinued medications were removed on 10/27/23. No adverse effect to resident. R65's discontinued medications were removed on 10/27/23. No adverse effect to resident. R118's discontinued medications were removed on 10/27/23. No adverse effect to resident. R128's discontinued medications were	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(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 761	Continued From page 93 Review of R12's undated "Admission Record" located in the resident's Electronic Medical Record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 5/31/19. Review of R12's "Order Summary Report" located in the EMR under the "Orders" tab revealed an order dated 3/28/23 for ondansetron hydrochloride tablet (used to treat nausea and vomiting) 4mg (milligram), give one tablet by mouth every six hours as needed for nausea and vomiting for three days. The order was discontinued on 3/31/23. R12 had ondansetron hydrochloride tablets dispensed on 03/29/23. No doses had been administered from blister pack and the medication was still in the medication cart. Review of R18's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 6/29/22. Review of R18's "Clinical Physician Orders" located in the resident's EMR under the "Orders" tab revealed an order dated 10/11/23-10/16/23 for metronidazole vaginal gel (an antifungal cream) 0.75% to be inserted vaginally once a day for bacterial vaginosis for five days. R18 had metronidazole vaginal gel 0.75%, two applicators remaining with mostly full tubes filled on 10/10/23. Review of R23's undated "Admission Record" located in the resident's EMR under the "Profile"	F 761	removed on 10/27/23. No adverse effect to resident. R22's discontinued medications were removed on 10/27/23. No adverse effect to resident. R124's discontinued medications were removed on 10/27/23. No adverse effect to resident. R125's medication was clarified on 10/28/23 to match the physician's order and what is available in the blister pack. No adverse effect. R301's discontinued medications were removed on 10/27/23. No adverse effect to resident. R302's discontinued medications were removed on 10/27/23. No adverse effect to resident. R13's discontinued medications were removed on 10/27/23. No adverse effect to resident. R103's discontinued medications were removed on 10/27/23. No adverse effect to resident. R129's discontinued medications were removed on 10/27/23. No adverse effect to resident. R140's discontinued medications were removed on 10/27/23. No adverse effect to resident. R457's discontinued medications were removed on 10/27/23. No adverse effect to resident. R458's discontinued medications were removed on 10/27/23. No adverse effect to resident. B. All medication carts will be checked to ensure all discontinued and discharged	

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F 761	Continued From page 94 tab revealed the resident was admitted to the facility on 8/14/22. Review of R23's "Clinical Physician Orders" located in the EMR under the "Orders" tab revealed an order dated 6/26/23-9/28/23 for oxycodone hydrochloride (narcotic pain medication) 5mg capsule, give half tablet by mouth every four hours as needed for pain. R23 had 18 oxycodone hydrochloride 5mg half tablets remaining in a blister pack. Review of R47's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed the resident was admitted on 12/17/15. Review of R47's "Clinical Physician Orders" located in the EMR under the "Orders" tab revealed an order dated 9/16/23-9/21/23 for hydrochlorothiazide (a diuretic medication used to treat hypertension) 25mg tablet, give one tablet by mouth once a day for hypertension. R47 had a blister pack with hydrochlorothiazide 25mg tablet filled on 9/19/23 with five tablets remaining. Review of R116's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 7/1/22. Review of R116's "Clinical Physician Orders" located in the resident's EMR under the "Orders" tab revealed an order dated 03/28/23-08/31/23 for ondansetron hydrochloride 4mg tablets to be given one tablet by mouth every eight hours as	F 761	residents medications are removed from the cart and appropriately disposed as applicable. C. The root cause was determined to be due to the recent change with the pharmacy process of delivery and accounting of medications on a regular basis. Pharmacist Consultant/Designee will in-service nursing management team on process when a medication is discontinued or with an order change and when a resident is discharged from the facility. In-service also focused on linking orders to ensure medication on hand matches the physician's order. Staff Development/Designee will educate staff on disposition when a medication is discontinued or with an order change and when a resident is discharged from the facility. In-service will also focus on linking orders to ensure medications on hand matches the physician's order. D. Daily audit by Unit Manager/Designee to ensure discontinued, order change and discharged residents' medications are removed from the medication cart and disposed of appropriately x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 until a 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT)	

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F 761	Continued From page 95 needed for nausea/vomiting. R116 had a blister pack with ondansetron hydrochloride 4mg tablets filled on 3/28/23 with five out of eight tablets remaining. Review of R138's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed she was admitted on 9/8/23. Review of R138's "Clinical Physician Orders" located in the resident's EMR under the "Orders" tab revealed an order dated on 9/9/23 and discontinued 9/19/23 for hydrochlorothiazide 12.5mg tablets to be given one tablet by mouth once daily for hypertension. R138 had hydrochlorothiazide 12.5mg capsules filled on 9/19/23 with seven out of seven capsules remaining. No doses had been administered from blister pack. Review of R299's "Admission Record" located in the resident's EMR under the "Profile" tab revealed the resident was admitted on 4/11/19 and discharged from the facility 8/02/23. Review of R299's "Order Summary Report" located in the resident's EMR under the "Orders" tab revealed an order dated 12/27/22 and discontinued upon discharge (8/2/23) for glucagon (used to treat low blood sugar) 1mg to be injected intramuscularly as needed for hypoglycemic episode for blood glucose levels less than 60. May repeat in 15 minutes if needed. R299 had one glucagon kit 1mg filled on 12/27/22. Unknown if any doses had been administered.	F 761	will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. The Pharmacist Consultant will check medication carts monthly x 3 months. Daily audit by Unit Manager/Designee to ensure medications on hand matches the physician's order x 7 days until 100% compliance is achieved and sustained. The following will be a weekly audit of new orders against stock on hand x 4 then monthly x 3 until 100% compliance is achieved. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. The Pharmacist Consultant will check medication carts monthly x 3 months.	

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F 761	Continued From page 96 Review of R448's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed she was admitted to the facility on 7/12/23. Review of R448's "Clinical Physician Orders" located in the resident's EMR under the "Orders" tab revealed an order dated 7/17/23 and discontinued on 10/5/23 for doxycycline monohydrate (an antibiotic) oral tablet 100mg tablets to be given one tablet by mouth twice daily for MRSA (methicillin-resistant staphylococcus aureus) prophylactic. R448 had doxycycline monohydrate oral tablet 100mg tablets filled 9/26/23 with 28 tablets remaining. No doses had been administered from blister pack. During an interview on 10/27/23 at 7:30 PM, the Director of Nursing (DON) confirmed residents R12, R18, R23, R47, R116, R138, R299 and R448 had medications on hand with no current order. The DON stated the medications should have been pulled from the medication cart and sent back to the pharmacy. Observation on 10/27/23 from 3:00 PM to 4:30 PM of the Unit C medication cart revealed R87 had medication on hand with no current order and the medication was expired. Review of R87's undated "Admission Record" located in the resident's EMR under the "Profile" tab revealed he was admitted on 03/09/20. Review of R87's "Order Summary Report" located in the EMR under the "Orders" tab revealed an	F 761		

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F 761	Continued From page 97 order started on 6/21/22 and discontinued 8/17/22 for ondansetron tablets 4 mg (milligram) one tablet by mouth every six hours as needed for nausea and vomiting. R87 had a blister pack for ondansetron tablets 4 mg tablets filled on 6/21/22 for a quantity of 30 tablets. There were six tablets remaining. The blister pack for this medication had an expiration date of 6/21/23. During an interview on 10/27/23 at 9:00 PM, the Director of Nursing (DON) confirmed that R87 had a medication on hand with a discontinued date of 8/17/22 and an expiration date of 6/21/23. The DON also confirmed that the medications should have been pulled from the cart and sent back to the pharmacy. Observation on 10/27/23 from 4:40 PM to 5:40 PM, with LPN12, of the Unit D medication cart revealed R22, R32, R62, R95, R109, and R121 had medications on hand with no current orders. Review of R22's discharge "MDS" with an ARD of 04/12/23, located in the resident's EMR under the "MDS" tab, revealed the resident was admitted on 8/3/21. Review of R22's "Order Summary Report" located in the resident's EMR under the "Orders" tab revealed an order started on 4/24/23 and discontinued 9/21/23 for ibuprofen tablet (an over-the-counter pain medication) 400 mg one tablet by mouth every six hours as needed for pain. R22 had a blister pack for ibuprofen tablet 400	F 761		

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F 761	Continued From page 98	F 761		

mg tablets filled on 4/24/23 for a quantity of 30 tablets. The blister pack for this medication had 30 tablets remaining. There were no doses given.

Review of R32's quarterly "MDS" with an ARD of 9/11/23, located in the resident's EMR under the "MDS" tab revealed the resident was admitted on 2/25/22.

Review of R32's "Order Summary Report" located in the resident's EMR under the "Orders" tab revealed an order started on 4/6/23 with an end date of 4/9/23 for ondansetron tablet 4 mg one tablet every six hours as needed for nausea and vomiting for 3 days.

R32 had a blister pack for ondansetron 4 mg tablets filled on 4/6/23 for a quantity of 12 tablets. The blister pack for this medication had nine tablets remaining.

Review of R62's significant change in status " MDS" with an ARD of 7/14/23, located in the resident's EMR under the "MDS" tab revealed the resident was readmitted to the facility on 6/30/23.

Review of R62's "Order Summary Report" located in the resident's EMR under the "Orders" tab revealed an order started on 6/30/23 and discontinued on 7/5/23 for Seroquel oral tablet (an antipsychotic medication) 25 mg give one tablet by mouth every 12 hours as needed for agitation for 14 days.

R62 had a blister pack for Seroquel oral tablet 25 mg filled on 6/30/23 for a quantity of 28 tablets. The blister pack for this medication had 17 tablets remaining.

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F 761	Continued From page 99 Review of R109's discharge " MDS" with an " ARD of 12/23/22, located in the resident's EMR under the "MDS" tab, revealed the resident was admitted on 4/1/22. Review of R109's "Order Summary Report" located in the resident's EMR under the "Orders" tab revealed an order started on 4/8/23 with end date of 4/11/23 for ondansetron tablet 4 mg one tablet by mouth every six hours as needed for nausea and vomiting for 3 days. R109 had a blister pack for ondansetron tablet 4 mg filled on 4/8/23 for a quantity of nine tablets. The blister pack had seven tablets remaining. Review of R121's discharge "MDS" with an ARD of 1/4/23, located in the resident's EMR under the "MDS" tab, revealed the resident was admitted on 4/1/22. Review of R121's "Order Summary Report" located in the resident's EMR under the "Orders" tab revealed an order started on 4/1/23 with end date of 4/8/23 for "ondansetron tablet 4 mg one tablet by mouth every eight hours as needed for nausea for 7 days." R121 had a blister pack was labeled for "ondansetron tablet 8 mg ½ tablet (4 mg) by mouth every eight hours as needed for nausea for 7 days. Qty (Quantity) 8." This prescription was filled on 4/1/23. The blister pack had 13 half tablets remaining. During an interview on 10/27/23 at 9:00 PM, the DON confirmed residents R22, R32, R62, R109, and R121 had medications on hand with no current orders. Continued interview revealed the	F 761		