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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Bay Terrace Rehabilitation & Healthcare Ctr DATE SURVEY COMPLETED: December 2, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility beginning November 26, 2024, through December 2, 2024. The facility census on the entrance day of the survey was seventy-three (73). The survey sample totaled nine (9). The survey process included observations, interviews, review of resident clinical records, facility policies and procedures and other facility documents as indicated.		
3201	**Regulations for Skilled and Intermediate Care Nursing 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 code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey completed December 2, 2024: F561, F578, F677, F684, F690.	See plan of correction cross refer to CMS 2567 for F561, F578, F677, F684, F690	1/20/25

Provider's Signature Anne M. Studd Title Administrator Date 12/27/24

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Title 16 Chapter 11 **Subchapter VII** **§ 1162. Nursing staffing**	**(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury... Every residential health facility employee shall wear a nametag prominently displaying his of her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.** This requirement was not met as evidenced by: Based on interviews and observations, it was determined that on 11/21/24 while caring for R2, the facility did not ensure that all staff were wearing a nametag prominently displayed with their name and title. Findings include: 10/8/24 Tuesday – R2 was admitted to the facility with diagnoses, including but not limited to, S/P right hip fracture repair and cognitive deficit. 11/21/24 6:32 PM – R2's Prehospital care report documented EMTs arrive at R2's bedside. 11/27/24 2:48 PM – During a telephone interview, C10 (EMT), "Myself and my partner [C9] went to [facility] for this run. I was met in the room with a nurse about 5 foot, 4 inches African American with a thick Haitian accent, in blue scrubs with no badge. She stated that she was the nurse. When I asked her, 'what is your name?' She stated, 'I cannot give that out.' I asked her twice. You can call my	A. The facility cannot retroactively correct the issue. B. A full audit/sweep will be completed to ensure all staff have a name badge. All staff will be educated by NHA or designee of the regulation and understand compliance is not optional. C. The root cause was staff's lack of understanding of the regulation and lack of oversight by management to ensure staff are wearing their name badges while on duty. D. Daily audit by all managers will be conducted to ensure name badge compliance x 5 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is 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.	1/20/25

Provider's Signature Anne M Budd Title Administrator Date 12/27/24

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	partner, [C9] and confirm that this is what she told me." 12/1/24 2:22 PM – During a telephone interview, C9 (EMT) stated, "[C10] and I have been regular partners for months... For this run, we walked into the room and see [R2] in her nursing home bed. There was a black female in blue scrubs. The clinician did not give us her clinical level. This person just kept saying, 'I just got here. I normally don't have this patient.'... I did not get her name...cannot remember her having a name tag on...". 12/2/24 2:10 PM – The surveyor observed E13 (LPN) on B wing without a nametag. When questioned about it, E13 stated that she had just moved and it got lost in the move. She stated that she was going to request a new one. On C wing, E14 (CNA) was noted to have a nametag on. E14 stated, "I just got my badge today. I have been here for years but when the facility changed owners, we were told we would get new badges. I have been asking for months." 12/2/24 3:10 PM – The findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RCC) and E5 (RDO) at the exit conference.	Audit findings will be reported to QA committee monthly x 3 months.	
Title 16 Health and Part II Chapter 25 2503 Advance Health-Care directives	**(e) A determination that an individual lacks or has recovered capacity that affects an individual instruction, or the authority of an agent must be made by the primary physician or other physician(s) as specified in a written health-care directive; ...** **(f) An agent shall make a health-care decision to treat, withdraw or withhold treatment on behalf of the patient after**		

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	consultation with the attending physician... Based on record review and interviews, it was determined that for one (R2) out of three residents reviewed for advanced directives, the facility failed to have the primary physician make R2's capacity determination and identify R2's surrogate in accordance Delaware code prior to executing R2's advanced directive. Findings include: 6/12/18 – R2 formulated an Advanced Health Care Directive in the presence of a lawyer stating, "I, [R2]... being over eighteen (18) years of age and of sound mind,..." named her daughter, [F2], with her other children, as her "attorneys-in-fact to make health and/or personal care decisions... Declarant's Health Care Instructions to Physicians – 2.01 If I am incapacitated and in a terminal condition... I direct that I DO NOT want my life prolonged...I do not want used cardiopulmonary resuscitation...". 10/8/24 Tuesday – R2 was admitted to the facility with diagnoses, including but not limited to, S/P right hip fracture repair and cognitive deficit. 10/8/24 – E22 (Guest Services) completed with F2 (R2's daughter/POA) the facility Resuscitation Policy form marking R2 as a DNR (Do not resuscitate) (No CPR) (cardiopulmonary resuscitation). F2's signature was witnessed by both E22 and E3 (ADON). 10/9/24 approximately 10 AM– E20 (NP) documented in R2's EMR initial consult note, "... History of present illness: 88 y.o		

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	(year old) with history of dementia... Patient was found resting in bed with patient's daughter at bedside...Code status: Full code (current and verified 10/8/2024) ... Physical exam: Neurological: no focal deficit present. Mental Status: She is alert. Mental status is at baseline...Advance Care Planning- Details: I spent 20 minutes (start time: 1017 Stop time: 1037) in advanced care plan activities. Advance care planning services were explained to the patient and family/persons present as above... The patients' (sic) values and overall goals of future treatments/care were discussed. The patient has the following goals- full code...". Review of this note lacked evidence of any documentation of R2's capacity determination. 10/11/24 – E22 (Guest Services) scanned into R2's EMR the copy of the facility Resuscitation Policy form, which stated, "In signing this document, you are acknowledging that you have been given a choice to make your own decision regarding the resuscitation and that you are requesting the following decision be enacted...". The form was signed by F2 (R2's daughter/POA) stating R2 wanted a DNR order. The witnesses to F2's signature were E22 (Guest Services) and E3 (RN/ ADON). Review of this form and R2's EMR progress notes from 10/8/24 to 10/11/24 lacked evidence that there was any consultation with the attending physician prior to completing this form. 10/12/24 – R2's admission Minimum Data Set (MDS) documented R2's Basic Inventory of Mental Status (BIMS) score		

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	as a three, which reflected a severe cognitive impairment. 10/28/24 – E23 (MD) documented in R2's EMR follow up note, "History of present illness: 88 y.o (year old) with history of dementia...Physical exam... Neurological: No focal deficit present. Mental Status: she is alert. Mental status is at baseline...Code Status List: AD: Full code-other directive (current and verified) 10/8/2024... Advanced Care Planning details: full code from records". Review of the note revealed no capacity determination nor any description of R2's "baseline mental status". The note also erroneously documented the "current" advance directive was "verified" when in fact, R2's 2018 Advanced Health Care directive scanned into her EMR and clearly stated that R2' wishes were to have a do not resuscitate order. 12/2/24 3:10 PM – The findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RCC) and E5 (RDO) at the exit conference.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY TERRACE REHABILITATION AND HEALTH CENTER	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Revised Post Informal Dispute Resolution (IDR). An unannounced complaint survey was conducted at this facility from November 26, 2024 through December 2, 2024. The deficiencies contained in this reeport are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census was seventy-three (73) on the first day of the survey. The survey sample totaled nine (9) residents. Abbreviations/definition used in this part are as follows: ADLs - activities of daily living; ADON - assistant director of nursing; BIMS- Basic Interview of Mental Status- a test to measure thinking ability with score ranges from 00 to 15. 13 to 15 - cognitively intact 08 to 12 - moderate impairment 00 to 07 - severe impairment; BM - bowel movement; BMP- basic metabolic panel, a lab draw BP - blood pressure; bpm- beats per minute; CBC with diff- complete blood count, a lab draw; cc- cubic centimeter; a unit of capacity; cm - centimeters; CNA- certified nurse aide; CPR - cardiopulmonary resuscitation; CVA - cerebral vascular accident, stroke; disimpaction - (digital disimpaction) - a procedure using the finger to remove trapped stool from the rectum; DNR - do not resuscitate; DON - director of nursing;	F 000		

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

Electronically Signed | 12/27/2024

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

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F 000	Continued From page 1	F 000		

dtr - daughter;
EMR- electronic medical record;
EMS - emergency medical services;
EMT- emergency medical technician;
fecal - stool;
FNE- forensic nurse examiner- a specialized nurse who provides care to victims of trauma and collects evidence for legal purposes;
gm - grams;
HR - heart rate;
ileus - a partial or complete non-mechanical blockage of the intestines;
IM - intramuscular;
in-situ - in place;
L- liters;
LTC - long-term care;
MDS- Minimum Data Set- standardized assessment forms used in nursing homes;
mg - milligrams;
ml - milliliters;
NC- nasal cannula;
NHA - nursing home administrator;
N.O. - new order(s);
NP- nurse practitioner;
O2 - oxygen;
PCC - point click care, facility's EMR platform;
pmhx - past medical history;
POA - power of attorney;
pt - patient;
q - every;
Rp - representative;
RSV- respiratory syncytial virus;
s/s - signs/symptoms;
suprapubic catheter- a medical device, a thin, flexible tube that is surgically inserted through abdominal access into the bladder to drain urine;
UTL - laboratory nomenclature for" unable to obtain";
X- times.

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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 record review and interview, it was determined that for one (R1) out of three reviewed for quality of care , the facility failed to provide services for hygiene that met with R1's stated preference of a shower for personal hygiene. Findings include:	F 561	A. R1's shower schedule was reviewed. The facility is unable to retroactively correct the issue B. Active residents will be reviewed to ensure showers are provided as per preference.	1/20/25

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F 561	Continued From page 3 Cross refer F677 and F684. Review of R1's clinical record revealed: 8/14/15 - R1 admitted to the facility with diagnoses, including but not limited to, diabetes, stroke with left-sided weakness, constipation, dementia and PEG feeding tube in-situ. 10/14/24 - R1's annual Minimum Data Set (MDS) assessment documented in Section F-Preferences for Customary Routine and Activities that it was "very important" for R1 "to choose between a tub bath, shower, bed bath or sponge bath". Due to R1 being nonverbal, F1 (R1's wife) was documented as the primary respondent who answered the MDS questions. Review of R1's care kardex revealed, "Bathing: Showers preferred Sundays and Thursdays 3-11 (evening shift) (bed bath all other days unless otherwise specified)". 11/3/24 10:43 PM - On Sunday, E8 (CNA) documented on R1's care Kardex that R1 was totally dependent for bathing with a two+ person physical assist and had been given a bed bath. 11/7/24 8:28 PM - On Thursday, E6 (CNA) documented on R1's care Kardex that R1 was totally dependent for bathing with a two+ person physical assist and had been given a bed bath. 11/10/24 10:12 PM - On Sunday, E9 (CNA) documented on R1's care Kardex that R1 was totally dependent for bathing with a two+ person physical assist and had been given a bed bath. 11/14/24 10:55 PM - On Thursday, E6 (CNA)	F 561	C. The root cause was determined to be due to lack of oversight to ensure staff provided showers as per the plan of care. Shift Supervisor/Designee will monitor each shift to ensure showers are provided as per plan of care. DON/Designee will educate nursing staff to ensure showers are provided as per plan of care and documented. D. Daily audit by ADON/Designee will be conducted to ensure showers are provided as per preference and per plan of care x 5 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is 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. Audit findings will be reported to QA committee monthly x 3 months.	

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F 561	Continued From page 4 documented on R1's care Kardex that R1 was totally dependent for bathing with a two+ person physical assist and had been given a bed bath. 11/17/24 10:27 PM - On Sunday, E10 (CNA) documented on R1's care Kardex that R1 was totally dependent for bathing with a two+ person physical assist and had been given a bed bath. 11/21/24 10:45 PM - On Thursday, E6 (CNA) documented on R1's care Kardex that R1 was totally dependent for bathing with a one person physical assist and had been given a bed bath. Review of R1's entire month of November 2024 care Kardex revealed there was no evidence that R1 was given his preferred shower at any point during the month. 12/2/24 3:10 PM - The findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RCC) and E5 (RDO) at the exit conference.	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,	F 578		1/20/25

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F 578	Continued From page 5 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 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 and interview, it was determined that for one (R2) out of three residents reviewed for Advanced Directives, the facility failed to have a process for documenting and communicating R2's code status decision to the staff. Findings include: The facility's "Residents' Rights Regarding Treatment and Advanced Directives Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or	F 578	A. R2's advance directive preference had been clarified. B. Active residents code status and advance directives will be reviewed to ensure it is consistent with the resident/responsible party's wishes. C. Root cause was determined to be due to lack of a clear process related to code status and advance directives	

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F 578	Continued From page 6 discontinue medical or surgical treatment and to formulate an advance directive ...9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care ..." revised 5/2024 6/12/18 - R2 formulated an Advanced Health Care Directive in the presence of a lawyer that named her daughter, [F2], with her other children, as her "attorneys-in-fact to make health and/or personal care decisions ... Declarant's Health Care Instructions to Physicians - 2.01 If I am incapacitated and in a terminal condition ... I direct that I DO NOT want my life prolonged ...I do not want used cardiopulmonary resuscitation ...". 10/8/24 - R2 was admitted to the facility with diagnoses, including but not limited to, S/P right hip fracture repair and cognitive deficit. 10/8/24 - E21 (Guest Services) completed with R2 the facility Resuscitation Policy form marking R2 as a Full Code (start CPR) (cardiopulmonary resuscitation). On the line for R2's signature, R2 wrote "Restudent". The back of the form contained the Consent to treatment, here R2 signed only her first name and failed to date the document. Both of R2's signatures were witnessed by E21. 10/8/24 - E20 (NP) ordered in R2's EMR, "Full code". 10/8/24 - E22 (Guest Services) completed with F2 (R2's daughter/POA) the facility Resuscitation Policy form marking R2 as a DNR (Do not	F 578	responsibility. DON/Designee will educate Licensed Nurses and the Social Services department regarding a clear process to honor advance directive and code status upon admission. Daily in morning meetings, code status will be reviewed to ensure it is consistent with the resident/responsible party's wishes. D. Daily audit by ADON/Designee will be conducted to ensure code status are consistent with resident/responsible party's wishes x 5 days until 100% compliance 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% is 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. Audit findings will be reported to QA committee monthly x 3 months.	

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F 578	Continued From page 7 resuscitate) (No CPR) (cardiopulmonary resuscitation). F2's signature was witnessed by both E22 and E3 (ADON). The facility Resuscitation Policy form documented R2's wishes regarding life-sustaining treatment as DNR. 10/8/24 8:41 PM - E19 (RN) documented in R2's EMR, "Nurses note ... patient new admission from [hospital] ...The on-call from [medical practice] [E20] (NP) notified, confirmed all the orders, Rp (representative) [F2] (R2's daughter/POA) notified of patient arrival at the facility ...". 10/9/24 - E21 scanned into R2's EMR the copy of the facility Resuscitation Policy form that R2 signed, stating R2 wanted a Full code order. 10/9/24 - E21 scanned into R2's EMR a copy of R2's Advanced Directive (dated 6/12/2018), which the daughter had provided and stated R2 did not CPR. 10/9/24 approximately 10 AM- E20 (NP) documented in R2's EMR initial consult note, " ... History of present illness : 88 y.o (year old) with history of dementia ... Patient was found resting in bed with patient's daughter at bedside ...Code status: Full code (current and verified 10/8/2024) ... Advance Care Planning- Details: I spent 20 minutes (start time : 1017 Stop time: 1037) in advanced care plan activities. Advance care planning services were explained to the patient and family/persons present as above ... The patients' (sic) values and overall goals of future treatments/care were discussed. The patient has the following goals- full code ...".	F 578		

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F 578	Continued From page 8 10/11/24 - E22 scanned into R2's EMR the copy of the facility Resuscitation Policy form that F2 signed, stating R2 wanted a DNR order. The facility failed to provide evidence of a process that ensured that the providers were notified that R2's family had requested a change to R2's code status. 10/12/24 - R2's admission Minimum Data Set (MDS) documented R2's Basic Inventory of Mental Status (BIMS) score as a three, which reflected a severe cognitive impairment. 10/15/24 - E20 (NP) documented in R2's EMR follow up note, " ...History of present illness: patient found resting in bed with patient's daughter at bedside ...Daughter request for foley to be removed ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 10/16/24 - E20 (NP) documented in R2's EMR follow up note, " ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 10/22/24 3:00 PM - E20 (NP) documented in R2's EMR follow up note, " ... History of present illness: ... patient seen today for follow up ... Daughter at bedside ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 10/23/24 - E20 (NP) documented in R2's EMR follow up note, " ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...".	F 578		

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F 578	Continued From page 9 10/28/24 - E23 (MD) documented in R2's EMR follow up note, " ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ... Advanced Care Planning details: full code from records". This was the first physician encounter that R2 had at the facility, which occurred 20 days after her admission. The facility failed to produce evidence that the physician attempted to contact the family to discuss goals of care and code status. E23's 10/28/24 note documented that the "full code" order was confirmed from the records; however, R2's Advanced Health Care Directive (dated 6/12/18) was uploaded into R2's facility EMR and stated that R2's wishes were DNR. 10/29/24 - E20 (NP) documented in R2's EMR follow up note, " ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 11/5/24 - E20 (NP) documented in R2's EMR follow up note, " ... Chief Complaint/ Nature of presenting problem: low BP (blood pressure) ... BP 103/60 11/5/24 8:16 PM ... Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 11/6/24 - E20 (NP) documented in R2's EMR follow up note, " ... Chief Complaint/ Nature of presenting problem: low BP (blood pressure) ...BP 111/68 11/6/24 11:11 AM ... Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 11/12/24 - E20 (NP) documented in R2's EMR follow up note, " ...Code Status List: AD: Full code- other directive (current and verified)	F 578		

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F 578	Continued From page 10 10/8/2024 ...". 11/13/24 - E20 (NP) documented in R2's EMR follow up note, " ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 11/19/24 - E20 (NP) documented in R2's EMR follow up note, " ...History of present illness: ... Patient daughter at bedside. Daughter had concerns on patient's right foot ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 11/20/24 - E20 (NP) documented in R2's EMR follow up note, " ... History of present illness: ... Patient daughter at bedside. I reviewed medication changes with daughter ...Code Status List: AD: Full code- other directive (current and verified) 10/8/2024 ...". 11/21/24 2:21 PM - E23 (MD) ordered in R2's EMR, "DNR" (do not resuscitate) that was entered into R2's EMR by E18 (RN). There were twelve (12) provider encounters, often with the daughter/POA at the bedside, that provided the opportunity to affirm the code status directly with the POA. The facility failed to have a process that communicated to the providers responsible for R2's care that a second and changed facility resuscitation form had been filled out and uploaded into R2's EMR. This form reflected R2's wish to have a DNR order. 11/21/24 4:38 PM - E18 (RN) documented in R2's EMR, "Nurses note- resident has low oxygen level 77% on room air but improved with oxygen therapy to 95% @2 liter/min. Physician made	F 578		

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F 578	Continued From page 11 aware and chest xray, cbc, bmp and urinalysis were ordered. At this time, no s/s (signs/symptoms) of acute distress. Family made aware." 11/21/24 6:32 PM - R2's Prehospital care report documented EMTs arrived at R2's bedside. The report narrative written by C10 stated, "EMS (emergency medical services) noted that the patient had a hospital band from [hospital] on her wrist from an admittance date of September 2, 2024. The wrist band had a DNR sticker on it. When EMS asked if the patient had a DNR, the nurse left the room after saying, 'I don't know' ...EMS then started to move the patient out of her room when the pulse oximeter gave a reading that the patient's heart rate had brady (heart rate slowing to a dangerous level) down to 20. EMS palpated the patient's pulse and it correlated on the way out of the nursing home. EMS asked if they could get a copy of the DNR, nursing staff was rude towards EMS and said, 'I don't know if I can find it. I will get you a copy ...". 11/25/24 10:10 AM - C8 (hospital palliative NP) completed R2's Palliative medicine Inpatient consult which stated, "Pt (patient) wishes no aggressive resuscitation in thee event of a cardiopulmonary emergency ...once a LTC (long-term care) bed is found, they would like to have hospice services involved. Her current code status (hospital record) orders reflect her wishes ...Code status: DNAR - dtr (daughter) brought paperwork for paper chart at desk." 11/27/24 11:35 AM- During an interview, E22 (Guest Services) stated, "I have been here since May 2024. The old social worker left in August. She had been doing the DNR paperwork. After	F 578		

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F 578	Continued From page 12 she left in August, it got assigned to me ... I knew from the language on the form that I should not be filling it out ... As of yesterday (11/26/24), the admitting nurse is responsible for getting the code status paperwork done. Guest services gets the admission paperwork completed 9with the resident) and then uploads it in the EMR. Guest services will upload the DNR/Advanced directive paperwork into the system if the nurse gives it to me." 11/27/24 2:05 PM - During an interview with E2 (DON) and E4 (RCC), E2 stated, "The process for advanced directives and code status- the nurse and supervisor on the floor got to the newly admitted resident and ask about code status. They have the resident sign the facility's Resuscitation Policy paperwork. If the resident is confused or has a low BIMS, they call the family or RP (representative person). If we cannot contact them, then the resident defaults to a full code. Both the nurse and the supervisor must sign the form. Then they call the provider to verify the order. We document orders in the EMR and on the ribbon on the PCC dashboard." E4 stated, "We self-identified there was an issue and had E2 write a new process for obtaining code status orders." 11/27/24 2:48 PM - During a telephone interview, C10 (EMT) stated, "Myself and my partner [C9] went to [facility] on this run ...She still had the DNR wrist band on from her hospitalization in September. The wrist band was blue and said DNR ... At this point, [R2] had bradied down (heart rate had dropped) to 18 on our monitor. I asked about her code status. The nurse brought me a copy of an inhouse Resuscitation policy form that stated she [R2] was a full code. We	F 578		

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F 578	Continued From page 13 knew the paramedics were coming so we wanted to get her to the ambulance quickly for them to work on her there. On our way out, we were met by the paramedics who assisted with her care in the ambulance. " 11/27/24 3:37 PM - During a telephone interview, F2 (R2's daughter/POA) stated that on 10/8/24, the hospital told her that her mom [R2] would be transferring to [facility]. F2 stated, "I went home to get some things and it was during that time, that my mom was transported to [facility]. The facility did try to call to let me know my mom had arrived at the building, but they were calling my mom's landline, not my cell number. E21 and E22 from Guest Services had my mom sign all the paperwork ...my mom can have a conversation, but she shouldn't be signing paperwork ... anyway, my mom checked the box for full code on the facility form. When I came to the facility, I brought mom's advanced directive and power of attorney paperwork and gave a copy to them. I remember speaking with the social worker about code status. Not sure if I spoke to the nurse practitioner or doctor. There have been a lot of people with all my mom's transfers. I really don't remember ..." When asked about her mom's transfer back to the hospital on 11/21/24, F2 stated, "Last Thursday [11/21/24], I came in and found my mom in distress. She was having trouble breathing. Two nurses came in to help her; they had trouble getting a pulse ox reading on my mom. They put her on oxygen. The one male nurse pointed to her bracelet (hospital DNR bracelet) and asked, 'what is this?' I replied that is her DNR bracelet. He then said that she was not marked in the system as a DNR. I told him that I gave the facility of her advanced directive and filled out the resuscitation form stating that was	F 578		

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F 578	Continued From page 14 her wish ... I typically visit my mom in the early afternoon and my sister comes in the evening. Both of us are there almost every day ...My mom and our family went to the effort to get her an advanced directive back in 2018. Those are her wishes and we as a family support that. It was my family's intention that my mom be a DNR the entire time that she was in the facility." 12/1/24 2:22 PM - During a telephone interview, C9 (EMT) stated, "When I asked her [R2's] code status. The nurse replied that she was a DNR. I asked her to get me a copy. After we loaded R2 on the ambulance for the paramedics to work on her, I went back in the facility and the clinician handed me a DNR policy sheet that the daughter had signed stating that R2 was a DNR." 12/2/24 10:35 AM - During an interview, E24 (Social Work) stated, " ...During the Social work assessment, the daughter [F2] stated that she was not sure and wanted to check her mom's advanced directive regarding code status. So we entered a full code status on the assessment Then the daughter brought in paperwork that said she was a DNR later that day." E24 confirmed that she as a social worker does not enter the order in R2's EMR regarding code status. E24 stated, "That would be done by a provider." 12/2/24 3:10 PM - The findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RCC) and E5 (RDO) at the exit conference.	F 578		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		1/20/25

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F 677	Continued From page 15 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for quality of care, the facility failed to provide the necessary services to R1 to maintain good grooming and oral hygiene. Findings include: Cross refer F561 and F684. Review of R1's clinical record revealed: 8/14/15 - R1 admitted to the facility with diagnoses, including but not limited to, diabetes, stroke with left-sided weakness, dementia, PEG feeding tube and supra- pubic catheter in-situ. 10/14/24 - R1's annual Minimum Data Set (MDS) assessment documented in Section GG-Functional Abilities documented R1 as dependent for oral hygiene, shower/bathe self, and personal hygiene. The MDS defined dependent as "helper does all of the effort. Resident does none of the effort to complete the activity". Oral hygiene was defined in the MDS as "the ability to use suitable items to clean teeth." The task of "shower/bathe self" was defined in the MDS as "the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment." "Personal hygiene" in the MDS assessment was defined as "the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene)."	F 677	A. No adverse effect related to the deficiency. R1 was provided with shower and staff ensured grooming and oral hygiene was provided. B. Active residents who are dependent on staff ADL will be reviewed to ensure shower, grooming and hygiene needs are provided. Shower beds will be reviewed to ensure it is available for use in each unit. C. The root cause was determined to be due to the staff's lack of oversight to ensure shower, grooming and oral hygiene is provided to dependent residents and lack of understanding of the process of notification when equipment is not available for use. DON/Designee will educate nursing staff regarding provision of showers, grooming and oral hygiene to dependent residents. Staff will also be educated regarding the process when an equipment is not available for use D. Daily audit by ADON/Designee will be conducted to ensure showers, grooming and oral hygiene are provided as per plan of care x 5 days until 100% compliance 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% is achieved	

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F 677	Continued From page 16 Review of R1's care kardex for the month on November 2024 revealed multiple CNA's documented in the task section, "Oral hygiene, personal hygiene and shower/bathe self - dependent. The helper does all of the effort. Resident does none of the effort to complete this activity". 11/23/24 6:24 PM - [Ambulance transport] Emergency medical technicians (EMTs) arrived at the facility to transport R1 to the hospital for respiratory distress. 11/23/24 8:56 PM - C4 (RN, hospital forensic nurse) photographed R1's appearance upon his admission to [hospital] emergency room. Review of R1's [hospital] forensic photos and documents revealed, " ...Photograph #4 [IMG_1740] Patient [R1] suprapubic cath, dried drainage around cath ...". The surveyor noted photo to have crusty, dark debris surrounding the insertion site of R1's suprapubic catheter. " ...Photograph #7 [IMG_1744] Patients (sic) pillow, linen dirty ...". The surveyor noted R1 with greasy hair and pillowcase with yellowish, brown stain where R1's head was on the pillow. " ...Photograph #10 [IMG_1747] inside of patients (sic) mouth, poor dental care ...". The surveyor noted R1's lips were cracked and flaking, R1 's tongue had dry, white patches on it, which can be a sign of bacteria build up and discolored, dull teeth with plaque buildup. " ...Photograph #11 [IMG_1748] Patient rolled to right side. Image of patients (sic) back, dried skin,	F 677	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. Audit findings will be reported to QA committee monthly x 3 months.	

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F 677	Continued From page 17 yellowing, scabs ...". The surveyor noted the majority of R1's back was covered with patches of skin that are hyperpigmented, scaly and rough due to poor hygiene (dermatitis neglecta) with underlying inflamed, pink skin. 11/27/24 11:05 AM - During an interview when asked about the facility's shower beds for bedbound residents, E2 (DON) stated, "Yes we have one but I am not sure it is available for the staff to use." E11 (RN Supervisor/Unit manager) piped in, "no there are no shower beds in the facility." To which , E4 (RCC) responded, "What do you mean there aren't any shower beds?" 11/27/24 12:01 PM - During an interview, E7 (NP) stated, " ... [R1] has contact dermatitis and he sweats a lot so the derm [consult] ordered the hibclens wash." After being shown photograph #11 [IMG_1748], E7 stated, "[R1] is not being properly cleaned. That (pointing at the dry flaky skin patches) should all come off with water and a washcloth ...". When asked if she or the other providers had been notified that the facility had no functional shower beds, E7 stated that she was not aware of that. 12/2/24 2:10 PM - The surveyor toured each unit and requested to see the unit's shower rooms. On D wing, during an interview, E12 (LPN) stated, "We have a brand new shower bed. It has never been used. It can't fit into the shower room." The surveyor observed there was a cement tiled half wall that made it impossible to maneuver the shower bed into the shower area in the shower room. On B wing, E13 (LPN) stated that the unit did have a shower bed and it could fit in the shower area, if the CNAs moved the wheelchair tub out of the way. She stated there were issues	F 677		

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F 677	Continued From page 18 with draining the shower bed because there was a drain in the shower so when they use the shower bed, they have to run a tube from the shower bed into the wheelchair tub to drain the dirty water from the shower bed. On C wing, E14 (CNA) stated, " We don't have a shower bed. Ours is broken. That is why [R1] does not get showers. And even if it works, it really does not fit in the shower are because of that wall (pointing to the tiled half wall)." 12/2/24 3:10 PM - The findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RCC) and E5 (RDO) at the exit conference.	F 677		
F 684 SS=G	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 for one (R1) out of three residents reviewed for hospitalization, the facility failed to provide services to maintain R1's bowel function. The facility's failure to initiate the bowel protocol resulted in harm to R1 as it resulted in R1 undergoing a fecal disimpaction procedure during his 11/23/24 hospitalization. Additionally, the facility failed to obtain ordered blood work, to provide neb treatment due to "machine not	F 684	FTAG690- Bowel and Bladder SS=G A. The facility cannot retroactively correct the issue B. Residents with no bowel movements for 3 days will be reviewed to ensure licensed staff are following the bowel protocol.	1/21/25

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F 684	Continued From page 19 available" and failed to obtain peripheral access for intravenous fluid infusion and supplemental oxygen order. Findings include: Cross refer F561 and F677. Review of R1's clinical record revealed: 8/14/15 - R1 was admitted to the facility with diagnoses, including but not limited to, diabetes, stroke with left-sided weakness, constipation, dementia and PEG feeding tube in-situ. a. The facility's "Bowel Protocol- Laxative: Milk of Magnesia 30 cc after 3rd day without BM (bowel movement) (3-11) (signifies given on the 3 PM to 11 PM shift) - if no BM, then bisacodyl suppository (7-3) (signifies 7 AM to 3 PM shift) - if no BM, then fleets enema (3-11) (signifies 3 PM to 11 PM shift)" 2/1/18 - R1 was ordered senna syrup (a medication used to treat constipation) 8.8. mg/5 ml - give 10 ml via PEG tube two times a day related to constipation. 1/31/21 - R1 was started on Lactulose solution (a medication used to treat constipation by increasing water absorption and pressure in the colon) 20 gm/30 ml- give 30 ml via PEG two times a day for ileus (a partial or complete non-mechanical blockage of the intestine). It should be noted that R1 was ordered to be administered the two above- mentioned laxative medications twice a day every day as part of his routine medications.	F 684	C. The root cause was determined to be due to facility's current bowel protocol regimen clarity and the resident's change in condition resulting in resident's transfer to the hospital The facility's bowel protocol for no bowel movement for 3 days will be revised. DON/Designee will educate nursing staff on revised bowel protocol and importance of documenting bowel movements The supervisor on each shift will monitor compliance of the bowel protocol D. Daily audit by ADON/Designee will be conducted to ensure licensed nurses are compliant with following the bowel protocol x 5 days until 100% compliance 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% is 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. Audit findings will be reported to QA committee monthly x 3 months. Follow bowel protocol from other facility (it will be standard PRN order auto	

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F 684	Continued From page 20 11/19/24 9:54 PM - E6 (CNA) documented in R1's electronic medical record (EMR) that R1 was incontinent of a large, putty-like stool. Review of R1's EMR progress notes revealed no documentation by nursing or the providers regarding R1's lack of bowel movement from 11/19/24 night shift to 11/23/24 evening shift. Any notes during this time period lacked evidence of assessment of R1's abdomen and documentation of bowel sounds. Review of R1's EMR revealed no additional bowel/laxative medication was ordered after nine shifts (3 days) with no documentation of R1 having a bowel movement. 11/22/24 12:51 PM - E7 (NP) documented in R1's EMR progress notes, " ...71 year old male with pmhx (past medical history) of CVA (cerebral vascular accident/stroke) with hemiplegia and dependent for all ADLs (activities of daily living) ...Notified this morning that patient is hypoxic, tachypneic, rhonchorus (sic) and febrile ... Physical exam: Gastrointestinal: soft: positive; Tender: negative; Distended; negative; Dysphagia; positive; Bowel sounds Present: X 4 Quadrants; PEG tube; positive ...". This note lacked evidence of any documentation regarding R1's lack of bowel movement in three days or any interventions to alleviate his constipation. R1's last documented bowel movement (BM) was 11/19/24 at 9:54 PM. From 11/19/24 at 9:54 PM until 11/23/24 at 6:24 PM ,which was a total of eleven and a half shifts, R1 did not have a bowel movement. 11/23/24 6:24 PM - [Ambulance transport]	F 684	create on admission BM log (nurses) Process for running report, list given to each nurse and supervisor monitoring each shift's compliance before the endo f the shift	

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F 684	Continued From page 21 Emergency medical technicians (EMTs) arrived at the facility to transport R1 to the hospital for respiratory distress. 11/24/24 2:02 AM - C1 (hospital emergency room physician) documented in R1's Hospitalist History and Physical Note, " ...Physical Exam-Abdominal: General: Abdomen is flat. Tenderness: There is generalized abdominal tenderness ...". 11/24/24 5:28 PM - C3 (hospital general surgery resident/MD) documented in R1's medical record, " ...diagnostic workup for his sepsis shows large fecal stool burden in rectum, general surgery consulted for fecal disimpaction ...Physical Exam-Abdomen: mildly distended ...CT of abdomen and pelvis ...There is moderate fecal retention, especially within the rectum, which is distended up to 8 cm (centimeters) ...will evaluate patient at bedside and perform digital rectal exam and fecal disimpaction. Will also order soap suds enema. After his disimpaction, recommend resident be placed on a bowel regimen ...". C2 (hospital general surgeon attending/MD) documented in R1's medical record a consult note, " 71 year old male bedbound, previous stroke, contractures, PEG tube dependent for feeding, suprapubic cystostomy catheter in place, admitted for urosepsis. General surgery consulted for fecal (stool) disimpaction (a procedure to remove trapped stool from the rectum). Will perform a fecal disimpaction at bedside. Continue enemas." Review of R1's EMR CNA (certified nurses aide) tasks revealed various CNAs documented, "DN-No bowel movement" from Tuesday, 11/19/24 night shift to Saturday, 11/23/24 day shift. This	F 684		

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F 684	Continued From page 22 confirmed that R1 went a total of eleven 8-hour shifts without having a bowel movement. 12/2/24 2:45 PM - During an interview with E2 (DON) and E4 (RCC), E2 reiterated the facility's bowel protocol for when a resident goes three days without a bowel movement. "We run the report from the EMR. It is called a complex alert documentation report. Usually it is the day shift supervisor who runs the report. Then we discuss the residents on the BM list at the morning clinical meeting. Then an order is entered to start the protocol with milk of magnesia to be given on evening shift (3-11 PM) as a one-time order so it flags red in the MAR for the nurse to administer and sign off the medication." The facility was unable to provide evidence of the complex alert documentation report for 11/22/24 and 11/23/24 when requested. The facility was unable to provide evidence of the one-time order for milk of magnesia for R1 that was to be entered on 11/23/24 and administered on 11/23/24 evening shift. It should be noted that, per the facility's protocol, day three (9 shifts) without a bowel movement for R1 would flag in the report system on Friday, 11/22/24 after evening shift. The first complex alert documentation report that would reflect this information was Saturday, 11/23/24. There were no morning clinical meetings on weekends and therefore no complex alert documentation report. b. The facility's "Oxygen Administration Policy: ...Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In	F 684		

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F 684	Continued From page 23 such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control ...8. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen." Revised 5/2024 11/22/24 Friday 10:29 AM - E15 (LPN) documented in R1's Electronic medical record (EMR), " ...On assessment @approx. (sic) 0830, resident appear (sic) to be struggling to breathe, lung sounds assessed resident has coarse and crackling lung sounds. O2 (oxygen) assessed, resident at 77 %, O2 @2L (liters) applied, rose to 93% via NC (nasal cannula), B/P (blood pressure) - 133/81, HR (heart rate) 120 (normal adult heart rate is 60 to 100 beats per minute), Temp 98.9, 42 breaths per minute (normal adult respiratory rate is 12 to 20 per minute). On-call NP contacted with no answer, [E16] (MD) contacted with no answer, NP later called back with N. O (new order) ceftriaxone (antibiotic) 1 gm, guaifenesin liquid (cough medicine) 100 mg/5 ml, CBC w/diff (blood work- complete blood count with differential), BMP (blood work- basic metabolic panel). [E16] applied to N.O. for Xray. Resident emergency contact #1 contacted to make aware of the resident condition." 11/22/24 Friday 12:51 PM - E7 (NP) documented in R1's EMR progress notes, " ...71 year old male with pmhx (past medical history) of CVA with hemiplegia and dependent for all ADLs ... Notified this morning that patient is hypoxic, tachypneic, rhonchorus (sic) and febrile ... Plan: Ceftriaxone 1 gm IM (intramuscular) q (every) 24 hours X (times) 5 days, Normal saline @ 50 ml/hr for 3	F 684		

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F 684	Continued From page 24 days. Antitussive, antipyretics as needed, suction q 2 hours ...". 11/22/24 - E7 (NP) ordered in R1's EMR, " ...BMP one time only for febrile illness ...CBC with Diff one time only for febrile illness ... flu, COVID, RSV one time only for viral panel swab ...please place peripheral IV, if unable to obtain, consider external IV team to come and place midline ...vital signs q shift x 3 days ...Ipratropium-Albuterol solution (inhaled bronchodilator medication) 0.5-2.5 (3) mg/ 3 ml - 1 dose inhale orally four times a day for congestion; Start date - 11/23/2024 0000 ...Sodium chloride solution 0.9% - use 50 ml/hr intravenously x 24 hours for IV infusion for hydration X 3 days." 11/22/24 Friday 2:13 PM - E15 (LPN) documented in R1's EMR, "Nurses Note -NP notified and confirmed N.O ... Use 50 ml/hr intravenously X 24 hours for IV infusion for hydration for 3 days. Please place peripheral IV (intravenous access). Flu, COVID, RSV (respiratory syncytial virus) (swabs). Vital signs q shift for 3 days. BMP, CBC with diff, Chest X-ray-crackles heard during assessment. Resident RP (representative) made aware of all N.O, is ok with treating resident in house." 11/22/24 Friday 7:35 PM - E11 (RN supervisor) documented in R1's EMR, "Nurses note - NP called for update on patient. Gave her the vitals, pts (sic) heart rate is 110, orders received, informed her that his labs will not be drawn until 7:00 AM 11-23-24, she verbalized understanding." 11/22/24 Friday 8:10 PM - E11 documented in R1's EMR, "Nurses note - Called [facility	F 684		

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F 684	Continued From page 25 contracted laboratory] lab to get STAT labs ordered, left message on voice mail, will pass on in report. " 11/22/24 Friday 9:21 PM - E11 documented in R1's EMR, "Administration note - Sodium chloride solution 0.9% use 50 ml/hr intravenously x 24 hours for IV infusion for hydration for 3 days, no IV access." 11/23/24 Saturday 11:34 AM - E11 documented in R1's EMR, "Nurses note - call placed to [medical practice] awaiting call back, can't get IV in patient." 11/23/24 Saturday 1:05 PM - E11 documented in R1's EMR, "Nurse note - spoke to NP [E17] informed her pts. (sic) vitals, breathing at a rate of 28 on 5 liters nasal cannula, expiratory wheezes, 112/72, 107, 98.3. Unable to get IV access several attempts, facility does not have outside company to insert IV venous access. Phlebotomist unable to draw labs ...". Review of R1's clinical records lacked evidence of the facility's plan for obtaining peripheral access after several failed attempts and having no external company to come insert a midline. 11/23/24 Saturday 2:00 PM - E11 documented in R1's EMR, "Nurses note - spoke with NP [E17] she reordered labs, station called the lab. I was informed unable to send phlebotomist out until Monday." Review of R1's clinical records lacked evidence of the facility's plan for obtaining STAT labs in a timely fashion after [laboratory] was unable to obtain the lab draw and allegedly informed the	F 684		

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F 684	Continued From page 26 facility of a delay in another attempt until Monday, 11/24/24, which was close to seventy-two hours after the STAT labs were ordered. 11/23/24 Saturday 3:36 PM - E15 (LPN) documented in R1's EMR, "Orders administration note - Ipratropium- Albuterol solution 1 dose inhaled orally four times a day for congestion ... Machine not available per supervisor." Review of R1's clinical record lacked evidence of the facility's plan for the administration of the ipratropium- albuterol medication in light of the lack of a nebulizer machine availability. This medication was ordered to start on 11/23/24 at 0000 (midnight) so R5 missed four doses of the medication by the time R5 was sent to the hospital. Review of R1'S clinical record revealed a lack of any documented vital signs or nurses notes for the entire 11/22/24 night shift (from 11 PM on 11/22/24 to 7 AM 11/23/24). There were vitals signs documented for day and evening shifts on 11/22/24 and day and evening shifts on 11/23/24. 11/23/24 Saturday 6:26 PM - From R1's [Emergency transport company] Prehospital Care Report, the emergency medical technicians (EMTs) arrived in R1's room and increased his supplemental oxygen to 6 L NC. 11/23/24 Saturday 6:59 PM - R1 arrived at [hospital] emergency room. 11/23/24 Saturday 7:09 PM - E18 (RN) documented in R1's EMR, "Nurses note - With the resident's spouse agreement and provider, sent to ED (emergency room) for increased	F 684		

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F 684	Continued From page 27 respiratory distress and lethargy. Spouse disallowed labs work pending until Monday. Resident sent to ED for further evaluation and treatment." 11/24/24 Sunday 2:02 AM - C1 (hospital ER physician) documented in R1 's hospital EMR, "Hospitalist History and Physical- In the ED, patient meets sepsis criteria with fever, tachypnea, tachycardia ...labs 11/23/24 7:07 PM- WBC (white blood count) 13.8 (normal range 4.5-11.0), glucose 1359 (normal range 70-140), BUN 190 (normal range 7-20), creatinine 4.3 (normal range 0.7-1.3), sodium 153 (normal range 137-145) and potassium 5.9 (normal range 3.5-5.1)...Plan: 1. Admit to ICU (intensive care unit), consult critical care team. Manage hyperglycemia with insulin drip. Received IV sepsis bolus ...". 11/27/24 8:28 AM - During a telephone interview, C5 (laboratory supervisor) stated, "For STAT labs, we come out our next availability. We have a phlebotomist available on weekends from 5 AM to 12 noon. It is limited ...[laboratory] lab did have staff available on Sunday 11/24/24 to draw lab work." 11/27/24 9:44 AM - During an interview, E15 (LPN) stated, "A guy from [laboratory] lab did come out on Saturday to draw labs. I think his name was [C7] and he was unsuccessful at getting the labs." 11/27/24 9:59 AM - During a telephone interview, C6 (lab personnel) confirmed that their company has a lab tech named [C7], who was sent to [facility] on Saturday morning to obtain labs. C6 also stated, "No on came out on Friday (11/22/24)	F 684		

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F 684	Continued From page 28 after the morning run ... During weekdays, if a STAT lab order is called in prior to 3 PM, we have the availability to send a phlebotomist out that day. If the order comes in after 3 PM, the STAT lab order is added to the next morning's lab run ... There were STAT labs called in on Saturday (11/23/24). There was a message on the voicemail. I was here on Saturday and checked the answering machine. [C7] came to the facility on Saturday 11/23/24 for the STAT labs. I am not seeing any labs in the system for [R1] on that day, probably put in as a UTL (unable to obtain)." Of note, the order for the STAT was documented by E15 (LPN) on Friday 11/22/24 at 2:13 PM. 11/27/24 12:11 PM - During an interview, E2 (DON) confirmed that R1's EMR orders did not have an order entered for supplemental oxygen on 11/22/24 or 11/23/24. E2 also confirmed that the facility was not able to provide evidence of R1's STAT lab results as the lab was not successful at obtaining the ordered lab work. E2 also stated, "We don't have the swabs results (flu, COVID, RSV)." E2 confirmed the facility had the ability to perform a COVID swab in house. The facility failed to enter a supplemental oxygen order from its initiation during R1's respiratory crisis on 11/22/24 at 10:29 AM until R1's transfer to the hospital thirty-two hours later. During these thirty-two hours, R1's supplemental oxygen was titrated from 2L NC to 5L NC. 12/2/24 3:10 PM - The findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RCC) and E5 (RDO) at the exit conference.	F 684		