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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: October 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 Annual and Complaint survey was conducted at this facility from September 19, 2024 through October 2, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was (one hundred twenty-eight) 128. The investigative sample totaled (forty-six) 46 residents.		
3201			
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **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 the CMS 2567-L survey completed October 2, 2024: F552, F641, F656, F657, F684, F686, F688, F689, F690, F0692, F693, F695, F697,	3201.1.2 Cross Refer to the CMS 2567-L survey completed October 2, 2024: F552,	11/18/2024

Provider's Signature _____Renee Boyer____Title_ NHA_____Date _10/28/2024_____

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	F732, F757, F760, F807, F812, F842, F849, F880, F883, F887 and F921.	F641, F656, F657, F684, F686, F688, F689, F690, F0692, F693, F695, F697, F732, F757, F760, F807, F812, F842, F849, F880, F883, F887 and F921. Date of compliance: 11/18/2024	
16 Del. C., Ch. 11, §1162	**Nursing Staffing:** **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum shift ratios:** **Day 1 nurse per 15 res. 1 aide per 8 res.** **Evening 1:23 1 :10** **Night 1:40 1:20** ***or RN, LPN, or NAIT serving as a CNA.** **(g) The time period for review and determining compliance with the staffing ratios required under this chapter shall be (1) week.**	**16 Del. C., Ch. 11. SubChapter VII** 1. No residents were identified. 2. All residents have the potential to be affected. 3. Staff Scheduler was educated by Administrator on requirements for daily PPD. Facility utilizes agency staffing, shift pick-up bonuses and overtime pay to fill any gaps in the schedule. 4. An audit of daily PPD will be conducted weekly by the scheduler to ensure PPD minimums are met daily. The	11/18/2024

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	A staffing audit was conducted by the State of Delaware, Division of Long-Term Care Residents Protection on October 4, 2024. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. **Based on review of facility documentation it was determined that for fifteen days out of 91 days, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per patient day (PPD). Findings include:** **Review of the facility staffing worksheets from 1/1/24 through 3/31/24, completed and sent by the Nursing Home Administrator to the surveyor via email, revealed the following:** 1/7/24 PPD = 3.20 2/11/24 PPD = 3.13 2/18/24 PPD = 3.17 2/25/24 PPD = 3.06 2/26/24 PPD = 3.23 3/1/24 PPD = 3.24 3/3/24 PPD = 3.24 3/4/24 PPD = 3.21 3/6/24 PPD = 3.16 3/10/24 PPD = 3.19 3/16/24 PPD = 3.15	results of the audit will be brought to the QAPI Committee for further review and recommendations. 5 Date of compliance: 11/18/24	

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	3/17/24 PPD = 3.21 3/23/24 PPD = 3.23 3/24/24 PPD = 3.07 3/31/24 PPD = 3.13 **Findings were communicated with E1 (NHA) via email on October 7, 2024.**		

Provider's Signature _____Renee Boyer____Title_ NHA_____Date _10/28/2024_____

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	085028	A. BUILDING _____ B. WING _____	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 from September 19, 2024 through October 2, 2024. The facility census was 128 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from September 19, 2024 through October 2, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 128. The investigative sample totaled 46 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; DON - Director of Nursing; DOR - Director of Rehab; FM - Family Member; LPN - Licensed Practice Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner;	F 000		

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

Electronically Signed | 10/28/2024

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F 000	Continued From page 1 Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; O2 - Oxygen; PT - Physical Therapist; RCD- Regional Clinical Director; RN - Registered Nurse; SS - Social Services; SLP - Speech Language Pathologist; UM - Unit Manager; VPO - Vice President of Operations; WCC - Wound Care Consultant; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact. 8-12: Moderately impaired. 0-7: Severe impairment. AKI - acute kidney injury/ kidneys suddenly can't filter waste products from the blood; ADLs - activities of daily living/tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Aphasia - neurological condition affecting language; Aspiration Pneumonia - lung infection from inhaling food, fluid or vomit; BID - twice a day; Blanchable - skin becomes white or pale in appearance when pressed down upon; BMP - Basic Metabolic Panel/set of lab tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balance; BUN - blood urea nitrogen/lab test that determines how effectively kidneys filter out nitrogen. high BUN levels may indicate kidney problems, dehydration, or other conditions;	F 000		

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F 000	Continued From page 2	F 000		

Cerebral Vascular Accident (CVA) - stroke;
CHEM-7 - blood panel lab test;
cm - centimeters/metric measurement of length;
CMP - comprehensive metabolic panel/blood test that measures 14 different substances, like proteins and electrolytes, in the blood;
COPD - chronic obstructive pulmonary disease;
CPR - cardiopulmonary resuscitation/emergency procedure when someone's breathing or heart has stopped;
Creatinine - waste product in the urine; lab test that measures how well the kidneys are filtering waste from the blood;
Diffuse - spread over a wide area;
Dx - diagnosis;
Dysphagia - difficulty swallowing;
eMAR - Electronic Medical Administration Record;
EMS - emergency medical services;
Epithelial - new skin that is light pink and shiny. In Stage 2 PUs, it is seen in the center and at the edges of the ulcer. If full thickness Stage 3 and 4 PUs, it advances from the edges of the wound;
ER - emergency room;
Eschar tissue - dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound;
Exudate - accumulation of fluids in a wound;
Fall Risk Scoring Tool - assessment used to assess risk of falls;
High Risk- greater than or equal to 12;
Moderate Risk- 10-11;
Low Risk- less than 9;
Full code - a medical term that indicates a patient's preference for resuscitation and all life-saving measures during a medical

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F 000	Continued From page 3	F 000		

emergency;
GDR - gradual dose reduction;
Granulation - red tissue with "cobblestone" or bumpy appearance;
Hypodermoclysis - method of administering fluids under the the skin as opposed to intravenously;
Hypovolemia - condition that occurs when your body loses fluid (blood or water);
Ibuprofen - medication to treat pain;
Intravascular - within the blood vessel;
Kardex - form that instructs the CNA on care and interventions needed for each particular resident;
Medication Administration Record (MAR) - list of daily medications to be administered;
Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist;
Metabolic encephalopathy - change in how your brain works due to an underlying condition;
Metastatic/metastasis/mets - spread of cancer from one part of the body to another;
Metformin - oral medication to treat diabetes;
MDRO - multidrug-resistant organism;
MDS - standardized assessment form used in nursing homes;
MG - milligram/unit of mass;
Necrosis/necrotic - death of tissue;
Nephrologist - medical physician that focuses on diseases of the kidneys;
Percutaneous Endoscopic Gastrostomy (PEG) - tube placed through the abdominal wall into the stomach;
Pneumonia - lung infection;
PO - oral/by mouth;
Prerenal - inadequate blood flow to the kidney tissue;
PRN - As needed;
Pt - patient;

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F 000	Continued From page 4 PU - pressure ulcer/sore area of skin that develops when blood supply is cut off due to pressure; PVD - peripheral vascular disease/common circulatory problem in which narrowed arteries reduce blood flow to your limbs; q - every; RAI - Resident Assessment Instrument; Renal - kidney; Restorative Nursing Program (RNP) -nursing interventions promote residents ability to adjust to living as independently and safely as possible; Sacrum - large triangular bone at base of spine; Serosanguineous - drainage containing serum and blood; Slough - non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture; may be adherent to the base of the wound or present in clumps throughout the wound bed; SPO2 < (less than) 90% - blood oxygen saturation level is below the desired range of 94% - 100%; TID - three times a day; 2567 - Statement of deficiency's report generated from identified deficient practice during the survey; Skin Conditions, including pressure ulcers (PUs), defined according to the October 2023 CMS RAI Manual: MASD - Moisture Associated Skin Damage with skin erosion/superficial/partial thickness skin loss. The tissue is blanchable and diffuse and has irregular edges. Necrosis is not found in MASD. Stage I (1) PU - non-blanchable reddened area of tissue that does not turn white or pale when pressed firmly with a finger or device; Stage II (2) PU - partial thickness loss of dermis	F 000		

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F 000	Continued From page 5 presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister; Stage III (3) PU - full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling; Stage IV (4) PU - full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling; Unstageable - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black). Eschar is worse than slough. Suspected Deep Tissue Injury (sDTI or DTI) - Purple or maroon intact skin or blood-filled blister. May start as tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than surrounding tissue.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in	F 552		11/18/24

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F 552	Continued From page 6 advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined for one (R118) out of the survey sample reviewed for planning and implementing care, the facility failed to provide R118 the right to be informed of and participate in her treatment. Findings include: Delaware Medical Orders for Scope of Treatment (DMOST) is a form, that when completed and signed by the patient and a medical provider, documents the medical orders that indicate the level of life sustaining care a person wishes to have performed on them if they have no pulse or stop breathing. Review of R118's clinical record revealed: 8/28/24 - R118 was admitted to the facility with a physician order "Do Not Resuscitate". 9/4/24 - A Minimum Data Set (MDS) assessment indicated that R118 had a BIMS of 15, meaning that R118 was cognitively intact. 9/20/24 2:30 PM - A review of R118's electronic medical record (EMR) contained a document titled "Delaware Medical Orders for Scope of Treatment" (DMOST) form which was signed by	F 552	F552: Right to be Informed/Make Treatment Decisions 1. R118 still resides at the facility. R118 orders were updated to reflect their wishes. 2. All residents have the potential to be affected by the deficient practice. The DON or administrative nurse will review current residents completed DMOST to ensure wishes expressed on the DMOST match the order in their medical record. Any errors found will be corrected immediately. 3. Root cause has been identified as medical records lacked knowledge to ensure nurse sees DMOST prior to uploading it into the chart. Director of Nursing or administrative nurse will educate medical records staff to have nurse review DMOST and initial it prior to uploading it into the chart 4. The Director of Nursing or administrative staff will audit 10 residents' DMOST form and orders to ensure they match weekly x 4 weeks until 100% consecutively and then monthly x 3 months until 100% consecutively. The results of these audits will be reviewed	

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F 552	Continued From page 7 R118 and E50 (Nurse Practitioner) on 9/3/24. R118's DMOST form indicated that she wished to have full treatment (Full Code) administered to her if she was ever found to have no pulse or stop breathing. 9/20/24 2:40 PM - During an interview, E2 (DON) confirmed that R118's EMR chart contained her DMOST form, signed and dated by R118 and E50, that indicated that R118 wished to be a Full Code to her if she was ever found to have no pulse or stop breathing. 10/2/24 3:00 PM - Finding was reviewed during the exit conference with E1(NHA), E2 (DON), E3(ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 552	with the Quality Assurance and Assessment Committee (QAA) monthly meeting x 3 months. The committee will determine the need for additional audits. 5. Date of completion: 11/18/24	
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 interview and record review, it was determined that for one (R26) out of five residents reviewed for pressure ulcers, the facility failed to accurately reflect R26's medical status in the annual MDS assessment. Findings include: The October 2023 RAI Manual stated the following under Section M: Skin Conditions: - Moisture Associated Skin Damage defined, "... superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration... MASD with skin erosion has superficial/partial thickness skin	F 641	F641: Accuracy of Assessments 1. R26 still resides at the facility. The annual MDS was corrected. 2. All residents who have an open area to their skin have the potential to be affected. The DON or administrative nurse will a skin sweep of all current residents with open areas was completed to ensure the Wound Care Consultant documentation accurately reflected the skin condition. Any corrections needed were completed and correlating MDS□s were checked and updated appropriately.	11/18/24

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F 641	Continued From page 8 loss... the tissue is blanchable and diffuse and has irregular edges. Inflammation of the skin may be present. Necrosis is not found in MASD. If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300. If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300...". R26's clinical record revealed: 8/13/24 - The Wound Assessment Report by C1 (WCC) revealed: -Location: sacrum -Measurements: 1 cm x 2 cm x 0.30 cm -Etiology: MASD (Moisture Associated Skin Damage) -Stage/severity: Full Thickness -50% epithelial -30% granulation -20% slough -Wound edges: attached. -Exudate Amount: moderate -Exudate Description: Serosanguineous. 8/18/24 - The annual MDS assessment documented that R26 had no unhealed pressure ulcer and had MASD. Review of the 8/18/24 annual MDS assessment under Section M0300 revealed the following: -Stage 2 was defined as "Partial Thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising...". -Stage 3 was defined as "Full Thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be	F 641	3. Root cause has been identified as the wound care consultant lack of knowledge on the RAI definitions of skin conditions. The Regional Director of MDS or Nursing home administrator will educate the wound care consultant on the RAI definition of skin conditions and the need for their documentation to be accurate. 4. The Director of Nursing or administrative nurse will audit 5 residents with open areas to their skin to ensure their wound care consultant documentation is accurate weekly x 4 until 100% consecutively and then monthly x 3 months until 100% consecutively. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA) monthly meeting x 3 months. The committee will determine the need for additional audits. 5. Date of completion: 11/18/24	

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F 641	Continued From page 9 present but does not obscure the depth of tissue loss...". 10/1/24 at 10:48 AM - During an interview, the Surveyor and E47 (MDS Coordinator) reviewed the annual MDS assessment. E47 stated that they code the MDS based on the Wound Care Consultant's documentation. The Surveyor confirmed with E47 that C1 was not staging R26's sacral pressure ulcer. Review of C1's documentation, E47 stated that for the 8/18/24 assessment R26's sacrum was documented as MASD. The facility failed to accurately reflect R26's sacral skin condition as a Stage 3 sacral pressure ulcer. 10/2/24 at 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 641		
F 656 SS=E	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 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	F 656		11/18/24

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F 656	Continued From page 10 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 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for six (R26, R81, R89, R103, R326 and R328) out of 46 residents reviewed for care plans, the facility failed to develop and implement a comprehensive person-centered care plans for each resident. For	F 656	F656: Development/Implement Comprehensive Care Plan 1. For R26, a 3-day voiding dairy to determine continence status was completed by CNA staff and reviewed by the DON or administrative nurse to	

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F 656	Continued From page 11 R81, R89, R103 and R328, the facility failed to develop care plans based on assessment to restore and maintain their bladder and bladder continence to the extent possible. For R326, the facility failed to develop a person-centered care plan for R326 despite a high fall risk assessment. For R26, the facility failed to develop a pressure ulcer care plan. Findings include: Cross refer F690. 1. Review of R81's clinical records revealed: 1/19/23 - R81 was admitted to the facility with diagnoses including dementia and difficulty walking. 9/13/24 - R81's annual MDS documented a BIMS score of 15, indicating an intact cognitive status. R81's annual urinary MDS assessment documented, "Occasionally incontinent of urine..." 9/13/24 - R81's toileting care plan documented, "Occasional incontinent of bladder and continent of bowels." The care plan interventions included, "Check and change briefs frequently and provide toileting hygiene with brief changes." The facility failed to conduct a bowel and bladder assessment to forumlate a person centered bowel and bladder care plan. 9/13/24 - R81 was readmitted to hospital with diagnoses including internal bleeding. 9/20/24 - R81 was readmitted to the facility with a new diagnoses of urinary tract infection. The facility failed to conduct a bowel and bladder	F 656	determine continence status. R26 also had a head to toe skin check by the DON or ADON to ensure appropriate interventions were in place and were care planned. For R81 a 3-day voiding dairy to determine continence status was completed by CNA staff and reviewed by the DON or administrative nurse to determine continence status. For R89, a 3-day voiding dairy to determine continence status was completed by CNA staff and reviewed by the DON or administrative nurse to determine continence status. For R103, a 3-day voiding dairy to determine continence status was completed by CNA staff and reviewed by the DON or administrative nurse to determine continence status. R326 and R328 no longer reside in the facility, unable to correct. All diaries and status-updates were care- planned for these residents by the DON or administrative nurse. 2. All residents have the potential to be affected. The Director of Nursing/designee will audit residents care plans of residents with bladder diaries and/or contractures and/or adaptive equipment to ensure it is included in their person-centered care plan. Any missing will be corrected upon discovery. The DON or designee will audit all residents with pressure ulcers to determine continence status and need for any other intervention. Any identified will be initiated and care plan as applicable. 3. DON/designee will educate nursing staff on creating resident centered care plans and three-day-voiding diaries and/or	

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F 656	Continued From page 12 assessment to formulate a person centered bowel and bladder care plan. 2. Review of R89's clinical records revealed: 2/28/24 - R89 was admitted to the facility with diagnoses including lung disease, and acute kidney failure. R89's admission bladder and bowel assessment documented, "Continent." 3/6/24 - R89's admission MDS documented a BIMS score of 15, indicating an intact cognitive intact status. The MDS also documented, "Frequently incontinent of bladder." 3/7/24 - R89's toileting care plan documented, " ... Incontinent of bladder and bowel ..." The interventions included, "Check and change briefs frequently as needed, provide toileting hygiene with brief changes." The facility failed to conduct a bowel and bladder assessment to formulate a person centered bowel and bladder care plan. 6/10/24 - R89's quarterly MDS assessment documented, "Frequently incontinent of bowel and bladder." The facility failed to conduct a bowel and bladder assessment to forumlate a person centered bowel and bladder care plan. 9/17/24 - R89's quarterly MDS assessment documented, "Frequently incontinent of bowel and bladder." The facility failed to conduct a bowel and bladder assessment to formulate a person centered	F 656	pressure ulcers. The root cause identified as staff education for developing, revising and updating person-centered care plans. 4. The Director of nursing or administrative nurse will audit 5 residents care plans to verify accuracy of continence care plans and skin impairments weekly x4 until facility reaches 100% consecutively and then 5 residents monthly for 3 consecutive months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months 5. Date of completion: 11/18/24	

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F 656	Continued From page 13 bowel and bladder care plan. 9/26/24 - A review R89's flow sheets from 8/28/24 to 9/25/24 revealed 113 episodes of urinary incontinence 3. Review of R103's clinical records revealed: 4/19/24 - R103 was admitted to the facility with diagnoses including left femur (thigh bone) fracture and dementia. 5/2/24 - R103's admission MDS documented a BIMS score of 11, indicating a mild cognitive impairment. The MDS documented, "Frequently incontinent of bladder and bladder." R103's care plan interventions included, "Check and change ...provide toileting hygiene with brief changes." The facility failed to conduct a bowel and bladder assessment to formulate a person centered bowel and bladder care plan. 9/27/24 10:33 AM - During an interview, R103 stated that he was continent when he was at home, "I started peeing on myself after I broke my hip, but its healed now." R103 was observed ambulating independently. The surveyor asked if he would consider trying to regain some urinary continence. R103 stated, "That would be nice." 9/27/24 - A review of R103's flow sheets from 8/29/24 to 9/26/24 revealed 74 episodes of urinary incontinence. 4. Review of R326's clinical records revealed: 9/7/24 - R326 was admitted to the facility with diagnoses including dementia and fractures of	F 656		

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F 656	Continued From page 14 the pelvis. R103's admission fall assessment documented a score of 16 (indicating a high fall risk.) 9/7/24 - R326's fall care plan documented, " ... At risk/had a fall ... related to dementia ..." The interventions included, " ...Remind the resident to use the [call] light to ask for assistance ..." 9/17/24 - R326's admission MDS documented a BIMS score of 2, indicating severe a cognitive impairment. R326 was dependent on staff for activities of daily living. 9/17/24 9:48 AM - R326's clinical records documented that he was emergently sent to the hospital for evaluation after he sustained a fall from the bed to the floor. 9/27/24 10:30 - A review of R326's fall care plan revealed that even though he was identified as a high fall risk due to severe cognitive impairments, the care plan lacked person-centered interventions for fall preventions including but not limited to low bed, and non-skid socks. The facility failed to develop a person-centered fall care plan which included appropriate interventions for R103 despite a BIMS score of 2, and a fall score of 16. 5. Review of R328's clinical records revealed: 9/11/24 - R328 was admitted to the facility with diagnoses including urinary tract infection and difficulty walking. R328's admission fall assessment documented a fall score of 17 (high risk.) The bowel and bladder assessments were incomplete.	F 656		

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F 656	Continued From page 15 9/24/24 - R328's admission MDS documented a BIMS score of 10, indicating a mild cognitive impairment. The bowel and bladder documented, "Frequently incontinent." R328's toileting care plan interventions included, " ...Check and change briefs frequently as needed ..." 9/25/24 4:33 AM - R326's clinical records documented that she sustained a fall while going to the bathroom. This fall resulted in an emergent hospital visit. R326's fall was reviewed by the facility's interdisciplinary team, but no additional interventions were implemented. 9/27/24 9:00 AM - During an interview, R328 stated that she was continent of bladder and bladder prior to coming to the facility. R328 stated, "I am so angry about how I am doing. I don't think I will be able to go home if I don't get better." The surveyor asked R328 if she was offered to go to the bathroom by the staff. She stated, "No, I wear a diaper and I go in it." 10/2/24 1:30 PM - A review of R328's clinical records from 9/12/24 to 10/2/24 revealed 28 episodes of bladder incontinence and 12 episodes of bowel incontinence. The facility failed to formulate person centered toileting care plans with interventions to promote continency for R81, R89, R103 and R328. Additionally, the facility failed to formulate a person-centered fall care plan with interventions for R326. 6. Cross refer to F686, example 1 The October 2023 RAI Manual defined Stages 3 and 4 Pressures Ulcers as:	F 656		

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F 656	Continued From page 16 -Stage 3: Full Thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. -Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. R26's clinical record revealed: 1/2/24 - R26 was care planned for at risk for pressure ulcers. 6/27/24 at 7:06 AM - A Skin Wound Note by C1 (WCC) documented, "... sacrum... full thickness... 3 cm x 1 cm x 0.10 cm, periwound fragile, moderate amount of serosanguineous exudate... debrided 100% removal of biofilm causing delayed wound closure. Removal of necrotic tissue...". Review of R26's clinical record lacked evidence of a person-centered sacral pressure ulcer care plan from 6/27/24 through 10/2/24. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		11/18/24

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F 657	Continued From page 17 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: Based on interview and record review, it was determined that for one (R116) out of seven residents sampled for incontinence and one (R26) out of one resident sampled for hospice, the facility failed to review and revise each residents' care plan. Findings include: 1. Cross refer F690, example 5 R116's clinical record revealed: 8/20/24 - R116 was admitted to the facility. 8/20/24 at 9:50 PM - The Admission Nursing	F 657	F657: Care Plan Timing and Revision 1.R116 no longer resides in the facility. Unable to correct Upon discovery, R26s care plan was updated by the administrative nurse to include to reflect hospice care services. 2. All residents have the potential to be affected. The DON or administrative nurse will complete a 30-day lookback audit of residents who are currently receiving hospice services to ensure care plans are updated. Any missing will be corrected upon discovery. 3. DON or designee will educate Licensed	

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F 657	Continued From page 18 Collection Tool documented that R116 was cognitively intact upon arrival, continent of bowel and bladder with an intervention to supervise or cue to toilet as needed and required partial/moderate assistance for toileting transfer and toileting hygiene. 8/26/24 - The admission MDS assessment documented that R116's BIMS was a 9 (moderate cognitive impairment), required partial/moderate assistance for toileting transfer and toileting hygiene and was frequently incontinent of bowel and bladder. 10/1/24 at 10:48 AM - During an interview, E47 (MDS Coordinator) stated that the MDS Coordinator was responsible for the resident's care plan. E47 confirmed that R116 was frequently incontinent of bowel and bladder in the 8/26/24 admission MDS assessment. The facility failed to review and revise R116's continence care plan to ensure it was person-centered and reflected interventions for her frequent incontinence. 2. Cross refer to F849 R26's clinical record revealed: 8/4/23 - R26 was admitted to hospice services. 8/14/23 (revised on 9/23/24) - R26 was care planned for hospice services and is not expected to improve in condition for diagnosis of: advanced age. The approaches included the following: -hospice to provide bath or shower aide (8/14/23); and -see hospice plan of care; [name of hospice]	F 657	nurses on updating care plans to reflect residents current status. Root cause identified as staff lack of knowledge of hospice care plan process and supervisor follow-up. 4. The Director of nursing or administrative nurse will audit residents currently receiving hospice care services weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with updating care plans. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	

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F 657	Continued From page 19 (revised on 9/7/23). 1/2/24 (revised on 1/3/24) - R26 was care planned for End of Life: the resident requires assistance with ADLs and is receiving end of life care related to advanced age and chronic disease. The approaches included: -medicate as needed to maintain residents comfort; -spiritual needs met as requested. The facility failed to review and revise R26's hospice care plan to establish who was responsible for her bathing needs as the hospice aid was not coming into the facility as of 1/1/24. In addition, the care plan did not establish what and how often hospice services were to be provided, including visits from nursing, chaplain and social work. The hospice care plan failed to address the medical equipment, supplies, and medications the resident was to be provided.	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 interview and record review, it was determined that for one (R116) out of two residents sampled for hospitalization and one	F 684	F684: Quality of Care 1. A. R116 no longer resides in the facility.	11/18/24

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F 684	Continued From page 20 (R127) out of seven residents sampled for falls, the facility failed to ensure each resident received treatment and care in accordance with the person-centered care plan. Findings include: 1. R116's clinical record revealed: 8/20/24 - For R116, the hospital interagency nursing communication record documented under the Follow-Up Care section to make an appointment with D1 (Nephrologist). 8/20/24 - R116 was admitted to the facility with diagnoses that included, but were not limited to, acute kidney injury. 8/21/24 - R116's family member, F1, signed the admission paperwork. The admission paperwork stated the following, "Appointments & Transportation. All follow-up appointments will be scheduled by our unit clerk...". 8/26/24 - The admission MDS assessment documented that R116 had a BIMS of 9, a moderate cognitive impairment; no rejection of care since admission; and had active diagnoses of renal insufficiency. 10/1/24 at 9:30 AM - During an interview, E48 (Unit Clerk/Scheduler) confirmed that the Nephrologist follow-up appointment was not scheduled. Review of R116's clinical record lacked evidence of facility staff discussions held with R116 and F1 regarding the follow-up appointment with the Nephrologist. 2. According to the Mayo Clinic, May 2022,	F 684	Unable to correct B. R127 no longer resides in the facility. Unable to correct 2. A. All new admissions have the potential to be affected. New admission for the last month will be reviewed to ensure any necessary follow up appointments were scheduled. Any missing will be corrected. B. All residents with orthostatic BP orders have the potential to be affected. A review of all residents with orthostatic BP orders will be completed to ensure they were done per order. Any missing will be brought to the providers attention for further follow-up 3. A. Root cause analysis identified the unit clerk failed to follow up on admission paperwork to ensure appointments were scheduled and nursing staff failed to review new admission appointments to verify completion due to lack of process. Facility implemented a new process where admission appointments are reviewed during morning clinical meetings to validate appointments is scheduled or changed and scheduled. Any appointment needed will be placed on the new Resident Appointment Form. This form will then be given to the appointment scheduler for completion. Once the appointment has been scheduled, a copy of the completed form is given to the UM/DON. DON/SDC or designee have educated the appointment schedulers (unit clerk, admission staff), ADON and unit manager on the new process B. DON/Designee nurses will educate	

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F 684	Continued From page 21 Orthostatic hypotension is a form of low blood pressure that happens when standing after sitting or lying down. Orthostatic hypotension can cause dizziness or lightheadedness and possibly fainting. A care provider might review medical history, medications and symptoms and conduct a physical exam to help diagnose the condition. A provider also might recommend orthostatic blood pressure monitoring. This involves measuring blood pressure while sitting and standing. A drop of 20 millimeters of mercury (mm Hg) in the top number (systolic blood pressure) within 2 to 5 minutes of standing is a sign of orthostatic hypotension. A drop of 10 mm Hg in the bottom number (diastolic blood pressure) within 2 to 5 minutes of standing also indicates orthostatic hypotension. Review of R127's clinical record revealed: 7/23/24 - R127 was admitted to the facility with multiple diagnoses including kidney disease, high blood pressure, and anemia. 7/31/24 - Physician's orders were written by E4 (Medical Director) for the following medications to be administered to R127 to treat his high blood pressure: -Amlodipine 10 mg, one tablet by mouth daily. -Doxazosin 2 mg, one tablet by mouth daily at bedtime. -Hydralazine 25 mg, one tablet by mouth twice daily. -Metoprolol Extended Release 100 mg, one tablet by mouth daily. -Valsarten 320 mg, one tablet by mouth daily. 8/8/24 7:09 AM - R127 had a fall without injury.	F 684	licensed nurses on following providers orders as written and notification to provider if they can□t be completed for some reason. Root cause analysis identified lack of knowledge on notification of provider when orders can□t be completed. 4. A. NHA, DON, or designee will audit admission paperwork for any appointments to ensure they are scheduled appropriately, are on the calendar, and appointment form is completed in its entirety daily x 4 weeks until 100% compliance is met, then weekly x 4 until 100% compliance is met and then monthly x 4 until 100% compliance is met. B. The Director of nursing or administrative nurse will audit residents with orthostatic BP order weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	

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8/13/24 5:50 AM - R127 had a fall without injury, E4 ordered R127 to be sent to the hospital for an evaluation; no injuries were assessed during the hospital evaluation.

8/14/24 3:30 PM - R127 had a fall without injury.

8/14/24 - A physician order was written for R127 to have orthostatic vital signs taken because of falls, once a day for three days starting 8/15/24. The orthostatic blood pressure results were be documented in the electronic medical record (EMR)

9/26/24 - A review of R127's vital signs in the EMR revealed the following:

-8/15/2024 2:16 PM 126/72 Lying
-8/15/2024 3:15 PM 126/72 Lying
-8/15/2024 3:27 PM 119/68 Lying
-8/16/2024 12:34 PM 138/84 Lying
-8/16/2024 1:39 PM 121/68 Lying
-8/16/2024 1:40 PM 127/63 Lying
-8/17/2024 9:10 AM 147/69 Sitting
-8/17/2024 12:26 PM 148/70 Lying

R127's orthostatic vital signs were not measured according to standards of practice, as evidenced by the following:

-8/15/24 - R127's blood pressure was measured three times, but all while R127 was lying down.

-8/16/24 - R127's blood pressure was measured twice, but while R127 was lying down both times.

-8/17/24 - R127's blood pressure was measured twice, from a lying position to a sitting position,

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F 684	Continued From page 23 three hours apart. 9/26/24 1:45 PM - During an interview, E16 (RN) confirmed that the orthostatic vital signs listed above, and as shown in R127's Emr were not obtained according to E4's order and the standards of practice to obtain orthostatic vital signs. R127 was on five different blood pressure medications to treat his high blood pressure at the time that he experienced three falls in six days. The facility failed to ensure that R127's orthostatic vital signs were obtained according to according to physician order and standards of practice. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		11/18/24

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F 686	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of clinical record and other documentation as indicated, it was determined that for three (R26, R105, R228 and R533) out five residents sampled for pressure ulcer, the facility failed to provide the necessary treatment and services consistent with professional standards of practice to promote healing and prevent new ulcers from developing. For R26, the facility failed to initiate and implement a sacral pressure ulcer care plan with appropriate interventions and hospice involvement and appropriately Stage her sacral pressure ulcer that started as MASD. As a result of multiple failures, R26 was harmed. For R105, R228 and R533, the facility failed to provide pressure ulcer wound care as ordered. In addition, the facility failed to complete weekly skin audits. Findings include: A facility policy entitled, "Pressure Ulcer Monitoring & Documentation" (initiated 11/1/2019) included, "A licensed nurse will assess patients for the presence of pressure ulcers/injuries." A facility policy entitled, "Skin Assessments" (initiated 11/1/2019) included, "A licensed nurse will ensure that the skin risk assessment is done upon admission and quarterly thereafter. The weekly skin assessment will be completed thereafter." 1. Cross refer to F641, F656, F657, F697, F849 R26's clinical record revealed: 12/23/23 - R26 was care planned for requiring assistance with ADLs (activities of daily living)	F 686	F686: Treatment/Svcs to Prevent/Heal Pressure Ulcer F686 1A. 105, R228, R533 no longer reside in the facility. Unable to correct. R26 still resides at the facility. R26 had a head to toe skin check by the DON or ADON to ensure appropriate interventions were in place and being completed. 2A. All residents have the potential to be affected by this practice. A skin sweep of all current residents will be reviewed to ensure the Wound Care Consultant documentation accurately reflects the skin condition. Any corrections will be made, and MDS□s will be updated accordingly. 3A. Root cause has been identified as the wound care consultant's lack of knowledge on the RAI definitions of skin conditions. The Clinical Director of Healing Partners will provide mandatory education for wound care consultants on the RAI definition of skin conditions and the need for their documentation to be accurate. The Director of Nursing/Administrator will validate mandatory education of all Wound Care Consultants/NPs assigned to facility. 4A. The Director of Nursing or administrative nurse will audit 5 residents with open areas to their skin to ensure their wound care consultant documentation is accurate weekly x 4 until 100% consecutively and then monthly x 3 months until 100% consecutively. The results of these audits will be reviewed with the Quality Assurance and	

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F 686	Continued From page 25 related to physical limitations with an intervention for one person assist for bed mobility and transfers. 1/1/24 - R26 was readmitted to the facility from the hospital and remained on hospice services. 1/2/24 - R26 was care planned for at risk for pressure ulcers related to chronic diseases, PVD, incontinence episodes and decreased mobility. The approaches included: -assess resident for risk of skin breakdown; -assist the resident to turn and reposition often; -encourage to turn and reposition often; -keep skin clean and dry as possible; -offload heels while in bed as tolerated; -skin assessments as indicated; -Treatment per TAR (Treatment Administration Record). From 1/1/24 through 3/17/24, R26's nurse's notes documented that that she was being turned and repositioned every 2 hours and oral intake monitored. From 2/15/24 through 2/29/24, R26 was diagnosed and treated for a Stage 2 pressure ulcer on the sacrum. Per C1's (WCC) progress note on 2/29/24, the sacral pressure ulcer was resolved. 3/9/24 at 3:09 PM - E8 (LPN, Wound Nurse) documented that R26's Braden scale for predicting pressure sore risk was 13, a moderate risk. 3/18/24 at 11:48 PM - A nurse's note documented that R26's room was changed to another floor.	F 686	Assessment Committee (QAA) monthly meeting x 3 months. The committee will determine the need for additional audits. 1B. 105, R228, R533 no longer reside in the facility. Unable to correct. R26 still resides at the facility. R26 had a head to toe skin check by the DON or ADON to ensure appropriate interventions were in place and being completed. 2B. All residents have the potential to be affected by this practice. All residents who are at risk for skin impairment will be assessed to ensure care plans are updated, skin assessments in the past 7 days have been documented, TAR for the last 24 hours is completed/documented, any ordered equipment is present and in good working order, any wound care is completed/documented, resident is assessed for pain medication need with wound care and any nutritional supplements were administered/documented. Any issues will be corrected. 3B. Root cause determined to be failure to update care plans, failure to accurately document findings of skin assessments, failure to complete tasks as indicated in the TAR to prevent skin breakdown, failure to ensure equipment used to prevent skin breakdown is in working order, failure to provide wound care as ordered, failure to provide medication for pain prior to wound care as ordered, failure to ensure nutritional supplements were administered according to order/recommendation. All nursing staff will be educated by the SCD or nursing designee on updating care plans with	

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F 686	Continued From page 26 4/19/24 - A hospice nurse's note documented that a Stage 1 pressure ulcer on the sacrum, painful. Review of the facility's nurse's notes lacked evidence that R26's sacrum pressure ulcer was being assessed and monitored. 4/28/24 - A facility Skin Assessment documented no issues. Review of R26's clinical record lacked evidence that weekly skin assessments were completed by nursing staff from 4/29/24 through 6/5/24. 5/20/24 - The quarterly MDS assessment documented that R26 was moderately impaired for daily decision making; no rejection of care; required supervision or touching assistance for eating and toileting hygiene; required partial/moderate assist with rolling left to right in bed; always incontinent of bladder and bowel; active diagnoses but were not limited to, coronary artery disease, dementia, adult failure to thrive, malnutrition; weight loss; at risk for pressure ulcers; no unhealed pressure ulcers at the present time; no other skin problems; and current skin treatments were pressure reducing device for bed and applications of ointments/medications. 5/22/24 at 12:09 PM - A nutrition note documented, "... significant weight loss ... Resident is on comfort care so wt (weight) loss is anticipated. PO (oral) intake is variable 25-75%. Pt (Patient) receives Magic cup q (every) day which she accepts. Family is aware and NP made aware... Monitor... po intake...". 5/28/24 at 2:45 PM - E8 (LPN, Wound Nurse)	F 686	appropriate interventions, performing wound care as ordered, use of equipment to prevent breakdown and how to report said equipment needs to be replaced and/or repaired, communicating with hospice providers and ensuring care is received as per hospice care plan, and referring to the hospice binders located at the nurses station. CNAs will receive education on referring to the Kardex aide task list documenting compliance of tasks completed. 4B. The Director of Nursing or administrative nurse will audit 5 residents records with skin impairment to ensure their wound care consultants and equipment is documented accurately weekly x 4 until 100% consecutively and then monthly x 3 months until 100% consecutively. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA) monthly meeting x 3 months. The committee will determine the need for additional audits. 5. Date of compliance 11/18/24	

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F 686	Continued From page 27 documented that R26's Braden scale for predicting pressure sore risk was 13, a moderate risk. 5/30/24 at 11:04 AM - A skin note by C1 (WCC) documented, "... new skin and wound consult... location: sacrum primary etiology: MASD stage/severity: partial thickness... size: 2cm x 2 cm x 0.1 cm... treatment: apply collagen, zinc oxide paste to base of the wound, leave open to air, BID (twice a day)... Recommend washing area with soap and water and pat dry thoroughly...". 5/31/24 - R26 was care planned for MASD to the sacrum with interventions to: -notify MD as indicated; -observe for signs and symptoms of worsening or improvement; -supplement to aid in wound healing; and -treatments as ordered. 6/5/24 at 2:43 PM - A skin note by C1 (WCC) documented, "...Location: sacrum ... Stage/severity: partial thickness... size: 1 cm x 2 cm x 0.2 cm, stable... treatment... medical grade honey fiber to base of the wound... bordered gauze. Change daily, and prn... The patient was noted to have incontinence associated dermatitis... Recommend washing area with soap and water and pat dry thoroughly...". 6/5/24 at 9:43 PM - E8 (LPN, Wound Nurse) documented that R26's Braden scale for predicting pressure sore risk was 13, a moderate risk. 6/13/24 at 9:51 AM - A skin note by C1 (WCC)	F 686		

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F 686	Continued From page 28 documented, "... Location: sacrum... Stage/severity: partial thickness... improving without complications, Size: 1 cm x 1.5 cm x 0.2 cm... Treatment...medical grade honey fiber to base of the wound... bordered gauze. Change daily, and prn... reviewed treatment plan with nursing staff." 6/20/24 at 8:15 AM - A skin note by C1 (WCC) documented, "... Location: sacrum ... Stage/severity: partial thickness... stable... Size: 1.5 cm x 2.2 cm x 0.1 cm... moderate amount of serosanguineous exudate... Treatment... Apply calcium alginate to base of the wound... Change daily and PRN... noted to have incontinence associated dermatitis... Continue with turning and repositioning schedule per protocol for pressure prevention. Position patient side to side as tolerated. Recommend an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus." 6/25/24 at 2:30 PM - A nutrition note documented, "... hospice... magic cup q day... po intake: variable, typically 50-75%... weight loss is anticipated with decline and advanced age/hospice status... Recommend: continue with Magic Cup q day, honor pt preferences, comfort over satiety...". 6/27/24 at 7:06 AM - A skin note by C1 (WCC) documented, "... Location: sacrum ... Stage/severity: full thickness, stable, Size: 3 cm x 1 cm x 0.1 cm, periwound fragile, moderate amount of serosanguineous exudate... debrided 100% removal of biofilm causing	F 686		

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F 686	Continued From page 29 delayed wound closure. Removal of necrotic tissue... topical lidocaine... Treatment... Apply medical grade honey fiber to base of the wound... bordered gauze... Change daily, and PRN... Continue with turning and repositioning schedule...". The facility lacked evidence of R26's pressure ulcer stage as the severity increased to full thickness and removal of necrotic tissue was completed by debridement. In addition, there was no evidence in the clinical record of turning and repositioning R26. 7/2/24 at 7:14 AM - A skin note by C2 (WCC #2) documented, "... Location: sacrum ... Stage/severity: full thickness, improving without complications... Size: 2.5 cm x 1.2 cm x 0.1 cm, wound base 100% epithelial, attached wound edges, periwound fragile, intact, moderate amount of serosanguineous exudate... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change daily, and prn... continue with turning and positioning schedule per protocol for pressure prevention. Position patient side to side as tolerated...". Review of R26's clinical record lacked evidence that R26 sacral pressure ulcer was staged and R26 was being turned and repositioned. 7/11/24 at 10:13 AM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness... stable... Size: 1.5 cm x 2 cm x 0.3 cm, 75-99% granulation, 1-24% slough,	F 686		

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F 686	Continued From page 30 attached wound edges, fragile/intact periwound, moderate amount of serosanguineous exudate... debrided 100% removal of biofilm causing delayed wound closure, removal of necrotic tissue, topical lidocaine... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change BID and PRN... continue with turning and repositioning...". The facility lacked evidence of R26's pressure ulcer stage as the severity was full thickness and removal of necrotic tissue was completed by debridement. In addition, there was no evidence in the clinical record of turning and repositioning R26. 7/18/24 at 6:23 AM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness, stable... Size: 1.5 cm x 2.5 cm x 0.2 cm, 75-99% granulation, 75-99% slough... moderate amount of serosanguineous exudate... A sharp debridement was not performed today due to patient is palliative and/or under hospice care and debridement is not recommended at this time... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change BID and PRN... continue with turning and repositioning." The facility lacked evidence of the sacral PU stage and turning and repositioning of R26 in the clinical record. 7/24/24 at 11:18 AM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness...	F 686		

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F 686	Continued From page 31 Size: 1.5 cm x 2 cm x 0.4 cm, 1-24% epithelial, 75-99% granulation... moderate amount of serosanguineous exudate. A sharp debridement was not performed today due to patient is palliative and/or under hospice care and debridement is not recommended at this time... Treatment... calcium alginate to base of wound... bordered gauze... Change daily, and prn... Continue with turning and repositioning schedule...". The facility lacked evidence of the sacral PU stage and turning and repositioning of R26 in the clinical record. 7/26/24 - A progress note by E4 (MD) documented, "... po intake has been relatively stable...". 7/30/24 - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness, stable... Size: 1.5 cm x 2 cm x 0.4 cm, 1-24 % epithelial, 75-99% granulation... moderate amount of serosanguineous exudate... A sharp debridement was not performed today due to patient is palliative and/or under hospice care and debridement is not recommended at this time... Treatment... calcium alginate to base of the wound... bordered gauze... Change daily, and PRN... Continue with turning and repositioning... for pressure prevention. Position patient side to side as tolerated... The patient was seen today for evaluation and management of a chronic ulcer. Despite individual interventions in place in accordance with the standards of care for patient's needs and goals... It is this provider's opinion that the ulcer is unavoidable due to the	F 686		

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F 686	Continued From page 32 patient's chronic medical/comorbid conditions... The patient has the following risk factors and/or co-morbities that delay, impair, or impede wound healing: age, bladder incontinence, bowel incontinence, fragile skin." The facility lacked evidence of the sacral PU stage and turning and repositioning of R26 in the clinical record. 7/31/24 at 5:15 PM - A nutrition note documented, "...She often refuses wts (weights), but past month was agreeable to obtaining wt... has gained significant amount of wt which is favorable considering her underweight status... Some wt loss and decline may be unavoidable due to medical condition. PO (oral intake) appears to be stable with most meals at 50-100% and good acceptance of supplements. Per wound notes, sacral wound is stable...". 8/9/24 at 1:53 PM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness, improving without complications... Size: 2 cm x 2 cm x 0.1 cm, 100% epithelial, no exudate... Treatment... zinc oxide paste to base of the wound... leave open to air... (every) shift... continuing turning and repositioning...". The facility lacked evidence of the sacral PU stage and turning and repositioning of R26 in the clinical record. 8/13/24 at 7:37 AM - A skin noted by C1 (WCC) documented, "... Location: sacrum...	F 686		

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F 686	Continued From page 33 Stage/severity: full thickness, stable... Size: 1 cm x 2 cm x 0.3 cm, 50% epithelial, 30% granulation, 20% slough, moderate amount of serosanguineous exudate... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change daily... continue with turning and repositioning... The patient is currently under hospice services. Goals of care remain to minimize pain and risk of infection. Continue palliative wound management." The facility lacked evidence of R26's sacral PU stage and turning/repositioning in the clinical record. 8/14/24 at 1:24 PM - E8 (LPN, Wound Nurse) documented that R26's Braden scale for predicting pressure sore risk was 14, a moderate risk. Despite having a full thickness, unstaged sacral PU, the facility assessed R26's pressure sore risk as moderate. 8/18/24 - The annual MDS assessment documented that R26 was moderately impaired for daily decision making; no rejection of care; required supervision or touching assistance for eating and was dependent for toileting hygiene; required substantial/maximal assist with rolling left to right in bed; always incontinent of bladder and bowel; active diagnoses but were not limited to, coronary artery disease, peripheral vascular disease, dementia, adult failure to thrive, malnutrition; at risk for pressure ulcers; no unhealed pressure ulcers at the present time; other skin problem was MASD; and current skin treatments were pressure reducing device for bed	F 686		

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F 686	Continued From page 34 and applications of nonsurgical dressing and ointments/medications. Despite R26 having a full thickness, unstaged sacral PU with 20% slough on 8/13/24, the MDS assessment was coded that R26 had MASD and no pressure ulcer. In addition, under current skin treatments, turning and repositioning was not checked as being completed nor was the nutrition or hydration intervention. 8/20/24 at 12:27 PM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness, stable... Size: 2 cm x 2 cm x 0.3 cm, 50% epithelial, 30% granulation, 20% slough, moderate amount of serosanguineous exudate... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change daily... continue with turning and repositioning...". 8/23/24 - A nutrition note documented, "... Supplements: magic cup...daily... active liquid protein... BID (twice a day)... Supplements in place to assist w/ (with) weight gain and also for healing of MASD to sacrum which is stable per recent wound report... MD notified of significant weight gain...". Despite R26 having a full thickness, unstaged sacral PU with 20% slough, the facility's dietician documented MASD on the sacrum. 8/28/24 at 10:55 AM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness, stable, Size: 1 cm x 3 cm x 0.3 cm,	F 686		

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F 686	Continued From page 35 100 % granulation, moderate amount of serosanguineous exudate... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change daily... continue with turning and repositioning...". 9/6/24 at 10:24 AM - A skin note by C2 (WCC #2) documented, "... Location: sacrum... Stage/severity: full thickness, worsening... Size: 4 cm x 5 cm x 0.3 cm, 50% granulation, 50% slough, periwound evolving DTI, moderate amount of serosanguineous exudate... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change daily... continue with turning and repositioning... Patient with worsening sacral wound to sacrum due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin: Kennedy ulcer." 9/11/24 at 10:45 AM - A skin noted by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness, worsening... Size: 4 cm x 5 cm x 0.3 cm, 10% epithelial, 50% slough, 40% eschar, evolving DTI periwound, moderate amount of serosanguineous exudate... continue turning and repositioning... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change daily... Patient with worsening sacral wound to sacrum due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin to Kennedy ulcer." 9/17/24 at 11:02 AM - A nutrition note	F 686		

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F 686	Continued From page 36 documented, "... wound sacral... presenting with a favorable weight gain... Per wound records, pt wound has "worsening". Will increase pro liquid from BID to TID for optimal wound healing. Continue with magic cup QD (every day)...". 9/17/24 - A physician's orders documented, "Active Liquid protein three times a day for wound healing 30ml... po, supplement...". 9/18/24 at 9:37 AM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/Severity: Full Thickness... worsening... Size: 4 cm x 7.5 cm x 0.2 cm... 10% epithelial, 50% granulation, 40% eschar... Periwound: Fragile, intact, evolving DTI. Exudate: Moderate amount of serosanguineous... A sharp debridement was not performed today due to patient is palliative and/or under hospice care and debridement is not recommended at this time... Treatment... medical grade honey fiber to base of the wound... bordered gauze... Change daily, and PRN... Continue with turning and repositioning... Position patient side to side as tolerated. The patient has the following risk factors that delay, impair, or impede wound healing: age, bladder incontinence, bowel incontinence, fragile skin. NEW RECOMMENDATIONS: The patient is currently under hospice services. Patient with worsening sacral wound to sacrum due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin to Kennedy ulcer. Goals of care remain to minimize pain and risk of infection. Continue palliative wound management." 9/24/24 - Observations of R26 revealed:	F 686		

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F 686	Continued From page 37 -at 9:00 AM, R26 laying on her left side facing doorway; -at 10:31 AM, R26 laying on her left side facing doorway; -at 12:02 PM, R26 sitting up in bed eating lunch with assistance of staff; -at 2:07 PM, R26 laying on her left side facing doorway. 9/25/24 at 8:11 AM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness... worsening... Size: 4.2 cm x 6.5 cm x 0.2 cm... 10% epithelial, 50% granulation, 40% slough... Periwound: fragile, intact, evolving DTI Exudate: moderate amount of serosanguineous... Treatment... medical grade honey fiber to base of the wound... bordered gauze... change daily, and PRN... continue with turning and repositioning... position patient side to side as tolerated... Patient with worsening sacral wound... due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin to Kennedy terminal ulcer... can be present up to 6 weeks...". 9/25/24 at 8:00 AM - An observation of wound care with C1 (WCC) and E8 (LPN) revealed the following: -observed R16 moaning when R26 was being repositioned in bed and during the dressing change; -observed the saturated wound dressing dated 9/23 in black ink on R26's sacrum. The Surveyor asked if this was a daily dressing and E8 confirmed that it was and the dressing was not changed yesterday. -no enhanced barrier precautions were in place	F 686		

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F 686	Continued From page 38 for R26's chronic wound and thus no gowns were worn during the dressing change; -observed that the low air loss mattress device at the foot of the bed was on standby; -observed C1 state 6 cm x 4 cm as she measured and took a picture of the wound; Immediately following the wound dressing change, the Surveyor asked C1 if she believed that the area was a Kennedy ulcer, which C1 replied no. C1 stated that her colleague, C2, filled in for her once about two weeks ago and believed it to be a Kennedy ulcer, but it has gone on too long. C1 stated that she believes R26 has rebounded. When the Surveyor asked about the black area on the sacrum, C1 stated that it was slough and that slough can be black in color. When the Surveyor asked about debridement, C1 stated that she does not do debridement because the resident was on hospice. When the Surveyor asked if she spoke to R26's hospice nurse, C1 stated no and that she would only talk to them if he/she are here in the facility when she was present. It should be noted that R26's daily sacral wound treatment was signed off on the September 2024 eTAR as completed on 9/24/25. 9/25/24 at 8:17 AM - During an interview, E26 (LPN) stated that she did not administer any medications to R26 this morning. 9/25/24 at 8:45 AM - Observed E26 administer two Tylenol tablets for pain to R26. 9/25/24 at 11:00 AM - During an interview, the Surveyor asked C3 (Hospice Nurse) if hospice would prohibit debridement of a wound. C3 replied no, being on hospice does not prevent	F 686		

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F 686	Continued From page 39 debridement. 9/25/24 at 12:26 PM - Observed R26's low air loss mattress device on the footboard still on Standby. 9/25/24 at 12:34 PM - During an interview, E52 (Maintenance) was asked if he could confirm if the low air loss mattress device on the footboard was working as the Standby green light was on. E52 stated no, it was not on and then he pushed the On button and the device turned on. Review of the September eTAR lacked evidence that R26's prescribed daily wound treatment to her sacrum was completed on 9/11/24, 9/16/24 and 9/18/24. 10/1/24 at 1:48 PM - Reviewed findings with E1 (NHA), E2 (DON), E3 (ADON), E53 (Regional), E46 (VPO). No further information was provided to the Surveyor. 10/2/24 at 9:44 AM - A skin note by C1 (WCC) documented, "... Location: sacrum... Stage/severity: full thickness... worsening... Size: 4 cm x 6.7 cm x 0.2 cm... 10% epithelial, 40% slough 50% eschar ... Periwound: fragile, intact, evolving DTI Exudate: moderate amount of serosanguineous ... Treatment... medical grade honey fiber to base of the wound... bordered gauze... change daily, and PRN... continue with turning and repositioning... position patient side to side as tolerated... Patient with worsening sacral wound... due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of	F 686		

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F 686	Continued From page 40 the skin to Kennedy terminal ulcer...". Review of R26's progress notes from 5/31/24 through 9/25/24 lacked evidence of any documentation of turning and repositioning R26 or monitoring her pressure ulcer on the sacrum by the nursing staff. With respect to R26's sacral pressure ulcer, the facility failed to do the following: - failed to develop a pressure ulcer care plan with appropriate interventions as of 6/27/24; - failed to implement turning and repositioning from 5/31/24 through 9/25/24; - failed to complete weekly skin assessments during the month of May 2024, August 2024 and September 2024; - failed to complete four daily sacral wound treatments on 9/11/24, 9/16/24, 9/18/24 and 9/24/24; - failed to ensure that wound care was not signed off on the eTAR as completed on 9/24/24 when it wasn't done; - failed to ensure that on 9/25/24 R26's air loss mattress device on the footboard was turned on; - failed to collaborate with R26's hospice provider from 6/27/24 through 9/25/24 on sacral wound care and treatment; and - failed to Stage R26's sacral PU from 6/27/24 through 10/2/24 on weekly wound assessments. 2. Review of R533's clinical record revealed: 9/10/24 - R533 was admitted to the facility with multiple diagnoses including CVA, right sided paralysis, aspiration pneumonia, aphasia and dysphagia. R533 had a PEG tube for nutrition. 9/10/24 11:30 PM - A nursing admission progress	F 686		

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F 686	Continued From page 41 note revealed that R533's skin assessment included that he had a scar on his sacrum. 9/10/24 - A Braden Scale Assessment revealed R533 had a moderate risk for pressure ulcer development. 9/11/24 - A nursing skin assessment was completed on R533 that revealed that he had no skin impairments. 9/16/24 - MDS Assessment, section M Skin Conditions: R533 had no unhealed pressure ulcers/injuries. 9/17/24 - A Braden Scale Assessment for R533 revealed a high risk for pressure ulcer development. 9/18/24 - A progress note was written by E10 (Nurse Practitioner) that R533 had a new wound to the sacrum: "Wound: 1 Location: sacrum Primary Etiology: Incontinence Associated Dermatitis (IAD) Stage/Severity: Partial Thickness Wound Status: New Size: 2.7 cm x 5 cm x 0.1 cm. Calculated area is 13.5 sq cm. Wound Edges: Attached." 9/18/24 - A physician order was written to apply collagen particles/zinc oxide paste to sacrum incontinence associated dermatitis (IAD) twice a day and as needed for incontinence care. 9/23/24 - A Braden Scale Assessment revealed a	F 686		

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F 686	Continued From page 42 very high risk for pressure ulcer development. 09/24/24 10:33 AM - During an observation, wound care was performed on R533 by E8 (LPN wound care). The wound on R533's sacrum was observed to be a stage II pressure ulcer wound. The following electronic medical record documents were reviewed on 9/24/24: -9/11/24 care plan revealed: "The resident is at risk for pressure ulcers related to chronic health conditions, cognitive impairment, inability to turn and reposition independently, incontinence". - The kardex aide task list revealed the lack of a regular timed turning and repositioning task for R533. The Resident Care section of the Kardex documented for the aide to "encourage to turn and reposition often". Additionally, the kardex directed that R533's should roll left and right. R533 was dependent on staff to reposition him while he was in bed. R533 was not repositioned for six out of forty-two opportunities from 9/17/24-9/25/24. Additionally, the times that R533 was repositioned in bed from 9/17/24-9/25/24 was not consistent, and the times were documented anywhere between two hours apart to fourteen plus hours apart, meaning R533 was left in one position for ten to fourteen hours on several occasions. 9/24/24 10:45 AM - During an interview E11 (LPN) confirmed that R533's Kardex documented to "encourage to turn and reposition often", but that R533 could not turn himself in bed. 9/24/23 - A physician order was written to cleanse	F 686		

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F 686	Continued From page 43	F 686		

sacrum with wound cleanser, apply medical grade honey fiber and cover with bordered gauze, every day shift AND as needed for incontinence care.

9/25/23 - A review of a September Medication Administration report revealed that collagen particles/zinc oxide paste was applied once a day 9/19/24 thru 9/23/24, and not twice a day as ordered.

9/26/24 2:30 PM - During an interview, E9 (RN UM) confirmed that collagen particles/zinc oxide paste was applied once a day to R533 on 9/19/24 thru 9/23/24, and not twice a day as ordered.

R533's stage II sacral wound was acquired after he was admitted to the facility. R533 entered the facility with a scar on his sacrum, but eight days later, that scar was a stage II 2.7 cm x 5 cm x 0.1 cm. pressure ulcer wound. The wound required changes to wound care management; the orders were not followed by nursing as written by the physician. R533 did not have bed turning and prepositioning as an aide task, which made it difficult to determine how often he was turned and repositioned in bed.

3. Review of R105's clinical record revealed:

4/30/24 - R105 was admitted to the facility with a diagnosis of a stroke and had two existing pressure ulcers to her buttock area.

7/23/24- A review of the care plan revealed that R105 had a chronic wound or pressure ulcer: stage 4 on the right buttock and stage 4 on the left buttock.

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F 686	Continued From page 44 8/21/24 - A physician's order was written by E4 (MD) to cleanse the left buttock wound with wound cleanser, apply collagen/ hydrogel, and to cover the wound with bordered gauze, every day shift. The same treatment order was written for the right buttock wound. 9/25/24 - A review of the treatment administration record (TAR) revealed the lack of dressing changes to both the left and the right buttock on 9/17/24 and 9/23/24. 9/25/24 - During an interview with E8 (LPN), she verbally confirmed the dressing changes were not documented on 9/17/24 and 9/23/24. 4. Review of R228's clinical records included: 10/24/22 - R228 was admitted to the facility with diagnoses including muscle weakness and stroke affecting the left side. 4/8/24 - 4/12/24 - R228 was hospitalized. 4/13/24 - R228 was readmitted to the facility. The admission skin assessment documented open areas on her groin and sacrum. R228's physician's orders included, "Weekly skin audits." An undated Kardex entry included, "Daily skin audits." 6/5/24 - R228's clinical records documented, "Clean sacral MASD... and cover with hydrocolloid dressing...". 10/1/24 - A review of R228's clinical records lacked evidence that the daily or weekly skin audits were completed for 4/17/24, 4/24/24, 5/8/24, 5/15/24, 5/22/24 and 6/12/24. R228's	F 686		

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F 686	Continued From page 45 clinical records lacked evidence of treatment for the groin and sacral area from 4/13/24 through 6/4/24. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that for one (R105) out of two residents reviewed for mobility, the facility failed to provide assistance to maintain or improve mobility. For R105, the facility failed to ensure the resident's therapy devices were applied per physician orders. Findings include:	F 688	F688: Increase/Prevent Decrease in ROM/Mobility F688 1. R105 no longer resides in the facility. Unable to correct 2. All residents requiring the use of adaptive equipment for range of motion	11/18/24

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	085028	A. BUILDING _____ B. WING _____	C 10/02/2024

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F 688	Continued From page 46 Review of R105's clinical record revealed: 4/30/24 - R105 was admitted to the facility with a diagnosis of a stroke. 7/29/24 - A care plan for R105 indicated that "the resident requires assistance with ADLs (activities of daily living) related to having a previous stroke and is dependent with self-care and mobility." A care plan intervention was to apply a therapy carrot to the left hand and wear it as tolerated during the day. 8/8/24 - An additional intervention to the ADL care plan was created to "apply the palm guard to the right hand and wear it as tolerated during the day". A review of R105's orders revealed a physician's order to "apply palm guard to right hand and wear as tolerated during the day," as well as "apply therapy carrot to left hand and wear as tolerated during the day." A review of the Kardex, revealed the instruction of the therapy device applications to R105's right and left hands during the day was present. 9/19/24 10:44 AM - During an observation, the resident had contractures to both of her hands, with no therapy devices in use, or by the bedside. 9/20/24 11:30 AM - During an observation, the resident was observed not wearing the therapeutic devices on either of her hands. 9/23/24 2:03 PM - During an observation, the resident was observed not wearing the	F 688	have the potential to be affected. An audit of all residents with orders for adaptive equipment will be conducted by the Director of Rehab. Audit will include listing of adaptive equipment on resident Kardex and ensuring adaptive equipment is in good working order and present in residents' room, as well as ensuring care plan is up to date 3. Nursing Staff will be educated on the use of adaptive equipment and checking resident Kardex for adaptive equipment by SDC / designee. Unit Managers will be educated on purposeful rounding including but not limited to checking for adaptive equipment being used as ordered by the Director of Nursing. The use of adaptive equipment will be added to Unit Manager Daily rounds sheets. Unit Managers will complete rounds on 100% of residents M-F and Weekend Supervisors will complete rounds on 100% of residents Saturday and Sunday to ensure adaptive equipment is being used as ordered. Rounds sheets will be submitted to the DON daily for review. Root cause identified as supervisor rounding and follow-up as well as Kardex use. 4. The Director of nursing or administrative nurse will audit residents with orders for adaptive equipment weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success on adaptive equipment order compliance. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will	

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F 688	Continued From page 47 therapeutic devices on either of her hands. 9/24/24 9:15 AM - During an observation, the resident was observed to be not wearing the therapeutic devices on either of her hands. During an interview, E43 (LPN) confirmed that "[R105] should have the therapeutic mobility devices in place, but they are not on." E43 found the left palm guard in R105's closet but could not find the therapy carrot for her right hand. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 688	determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	
F 689 SS=D	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, it was determined that for one (R64) out of two residents reviewed for accidents, the facility failed to ensure that R64 received supervision to prevent accidents. Findings include: 9/3/24 - R64 was admitted to the facility with diagnoses including dementia and muscle weakness. R64's admission assessment documented a fall score of 18, which indicated a	F 689	F689: Free of Accident Hazards/Supervision/Devices 1. Incident relating to R64 was from a facility self-reported incident and R64 continues to reside in the facility. Unable to correct 2. All residents have the potential to be affected. 3. The Director of Nursing or Staff Development Coordinator will provide	11/18/24

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F 689	Continued From page 48 high fall risk. 9/4/24 - R64's fall care plan included, "At risk for falls related to cognitive impairment, poor balance, and muscle weakness." The interventions included, "Low bed, and place items within reach of resident." 9/9/24 - R64's admission MDS assessment documented a BIMS score of "00," indicating severe cognitive impairment. R64's ADLs (Activities of Daily Living) documented, "Dependent for bed mobility/turning and repositioning." 9/12/24 10:30 AM - R64's clinical records documented, "... Notified that resident [R64] fell out of bed while receiving care... A scrape and hematoma were located separately on the right upper forehead... Sent to the hospital for evaluation... Staff education on body positioning techniques to use while performing personal care in bed to resident when alone...". 10/1/24 10:15 AM - During an interview, E18 (CNA) stated, "The resident [R64] was lying on her side, and I placed a clean brief under her. I turned to get some lotion from the table behind me and she rolled out of the bed." The facility failed to provide enough supervision to R64, a dependent resident which resulted in a fall and an emergent transfer to the hospital. R64 did not sustain any signigicant injuries. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 689	education on safe positioning and turning of residents while in bed during care and on reviewing transfer status of the Kardex. This education will be added to all new hires. Root cause identified as facility needing to provide education on prevention of falls and keeping resident safe when providing care in bed. (CNA) E18 received one on one education on turning residents safely in bed and not turning away from resident during care. Corrective action was also taken. 4. The Director of Nursing or designee will audit 10 random residents' position during care to ensure they are safely positioned weekly x 4 until 100% consecutively and then monthly x 2 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of Completion: 11/18/24	

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F 690 SS=E	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 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 observations, interviews, and record	F 690	F690: Bowel/Bladder Incontinence,	11/18/24

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F 690	Continued From page 50 reviews, it was determined that for five (R81, R89, R103, R116 and R328) out of seven residents reviewed for bowel and bladder assessments, the facility failed to conduct bowel and bladder assessments to develop an individualized care plan to restore and maintain their bladder and bladder continence to extent possible. Findings include: 11/1/19 - A facility document titled, "Assessment for Bowel and Urinary Toileting Program" documented, "Licensed nurse will perform a bowel and/or urinary assessment on admission, readmission, annually, and PRN using the RAI process ...Bowel and urinary toileting approaches will be documented in the care plan ...evaluation of the toileting program will be documented in the Nurses Progress Notes." 1. Review of R81's clinical records revealed: 1/19/23 - R81 was admitted to the facility with diagnoses including dementia and difficulty walking. 9/13/24 - R81's annual MDS documented a BIMS score of 15, indicating an intact cognitive status. R81's annual urinary MDS assessment documented, "Occasionally incontinent of urine..." R81's toileting care plan documented, "Occasional incontinent of bladder and continent of bowels." The care plan interventions included, "Check and change briefs frequently and provide toileting hygiene with brief changes." 9/13/24 - R81 was admitted to hospital with diagnoses including internal bleeding. 9/20/24 - R81 was readmitted to the facility with a	F 690	Catheter, UTI 1. R81, R89, R103 continue to reside in the facility. R89 has completed a 3-day bowel and bladder diary. R81 and R103 completed a 3-day bowel and bladder diary. R389 no longer resides in the facility. Unable to correct. R116 no longer resides at the facility. Unable to correct. 2. All residents have the potential to be affected. The Director of Nursing/designee will audit residents POC of incontinent episodes, complete a 3- day voiding diary and review for implementation of toileting plan as indicated. Results will be reviewed, and interventions implemented at that time based on results. 3. DON/designee will educate nurses and CNA□s on completing a 3-day bladder diary and review of completed documentation for implementation of a toileting plan as indicated. Root cause identified as lack of knowledge of the process of completing a 3-day voiding diary and the development of a toileting plan. Unit Managers will be educated by the Director of Nursing on reviewing 3-day bladder diary and implementing toileting plan as indicated. 4. The Director of nursing or administrative nurse will audit residents that are on a 3-day bladder diary daily until completion of the diary and audit the development of a toileting plan as indicated until 100% consecutively and then weekly for 4 consecutive weeks until facility reaches 100% success. Then monthly until the facility reaches 100% success for 2 consecutive months. The	

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F 690	Continued From page 51 new diagnoses of a urinary tract infection. R81's readmission nursing assessment lacked evidence of a bladder and bowel reassessment for the new diagnoses of a urinary tract infection. 9/27/24 8:58 AM - During an interview, R81 stated, "I used to be able to go to the toilet. I really don't like when I pee on myself." 9/29/24 - A review of R81's flow sheets from 9/5/24 to 9/28/24 revealed 18 episodes of urinary incontinence out of 60 opportunities for bowel and bladder continence. 2. Review of R89's clinical records revealed: 2/28/24 - R89 was admitted to the facility with diagnoses including lung disease, and acute kidney failure. R89's admission bladder and bowel assessment documented, "Continent." 3/6/24 - R89's admission MDS documented a BIMS score of 15, indicating an intact cognitive intact status. The MDS also documented, "Frequently incontinent of bladder." R89's clinical records lacked evidence of assessments to restore bladder continence. 3/7/24 - R89's toileting care plan documented, " ...ncontinent of bladder and bowel ..." The interventions included, "Check and change briefs frequently as needed, provide toileting hygiene with brief changes." 6/10/24 - R89's quarterly MDS assessment documented, "Frequently incontinent of bowel and bladder." R89's clinical records lacked evidence of assessments to restore bladder and bowel continence.	F 690	results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	

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F 690	Continued From page 52 9/17/24 - R89's quarterly MDS assessment documented, "Frequently incontinent of bowel and bladder." R89's clinical records lacked evidence of assessments to restore bladder and bowel continence. 9/25/24 11:00 AM - During an interview, R89 stated, "I used the toilet and stayed dry when I was at home. I am wet all the time now. I pee in the diaper and the aides change me." The surveyor asked R89 if she would like to use the toilet to void and have a bowel movement, stated, "I would really like to use the toilet. I don't like that I must go in a diaper. It's not good for me to think that this is how I am." 9/26/24 10:12 AM - During an interview, E19 (CNA) stated, "I did not receive any information on toileting this resident. The Kardex says, "check and change." I change her when she asks me to change her." 9/26/24 - A review R89's flow sheets from 8/28/24 to 9/25/24 revealed 113 episodes of urinary incontinence, and 24 episodes of bowel incontinence out of 175 opportunities for bowel and bladder continence. 3. Review of R103's clinical records revealed: 4/19/24 - R103 was admitted to the facility with diagnoses including left femur (thigh bone) fracture and dementia. 5/2/24 - R103's admission MDS documented a BIMS score of 11, indicating a mild cognitive impairment. The MDS documented, "Frequently incontinent of bladder and bladder." R103's care	F 690		

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F 690	Continued From page 53 plan interventions included, "Check and change ...provide toileting hygiene with brief changes." R103's clinical documents lacked evidence of bladder and bowel assessments to restore continence. 9/27/24 10:33 AM - During an interview, R103 stated that he was continent when he was at home, "I started peeing on myself after I broke my hip, but its healed now." R103 was observed ambulating independently. The surveyor asked if he would consider trying to regain some urinary continence. R103 stated, "That would be nice." 9/27/24 - A review of R103's flow sheets from 8/29/24 to 9/26/24 revealed 74 episodes of urinary incontinence out of 90 opportunities for urinary continence. 4. Review of R328's clinical records revealed: 9/11/24 - R328 was admitted to the facility with diagnoses including urinary tract infection and difficulty walking. R328's admission fall assessment documented a fall score of 17 (high risk.) The bowel and bladder assessments were incomplete. 9/24/24 - R328's admission MDS documented a BIMS score of 10, indicating a mild cognitive impairment. The bowel and bladder documented, "Frequently incontinent." R328's toileting care plan interventions included, " ...Check and change briefs frequently as needed ..." 9/25/24 4:33 AM - R328's clinical records documented that she sustained a fall while going to the bathroom. This fall resulted in an emergent hospital visit. The fall was reviewed by the	F 690		

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F 690	Continued From page 54 facility's interdisciplinary team but lacked evidence of assessment or additional interventions for R328's toileting needs. 9/27/24 9:00 AM - During an interview, R328 stated that she was continent of bladder and bladder prior to coming to the facility. R328 stated, "I am so angry about how I am doing. I don't think I will be able to go home if I don't get better." The surveyor asked R326 if she was offered to go to the bathroom by the staff. She stated, "No, I wear a diaper and I go in it." 10/2/24 1:30 PM - A review of R328's clinical records from 9/12/24 to 10/2/24 revealed 28 episodes of bladder incontinence and 12 episodes of bowel incontinence out of 80 opportunities for bladder and bowel continence. 10/2/24 2:30 PM - During an interview with E2 (DON), the Surveyor asked if the residents are assessed for bladder and bowel, E2 stated, "PCC [eMAR] does not have the set up for bladder and bowel assessments." The facility failed to conduct bladder and bowel assessments for R81, R89, R103 and R328 to restore their bladder and bowel continence to the extent possible. 5. Cross refer to F657, example 1 R116's clinical record revealed: 8/20/24 at 2:00 PM - The Interagency Nursing Communication Record from the hospital documented that R116 was continent of bladder and incontinent of bowel.	F 690		

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F 690	Continued From page 55 8/20/24 - R116 was admitted to the facility with diagnoses that included, but were not limited to, urinary tract infection (UTI). 8/20/24 at 9:50 PM - The Admission Nursing Collection Tool documented that R116 was cognitively intact upon arrival, continent of bowel and bladder with an intervention to supervise or cue to toilet as needed and required partial/moderate assistance for toileting transfer and toileting hygiene. 8/20/24 - R116 was care planned for continent of bladder and bowel with approaches that included: -one persion assist with toileting; -provide with toileting supplies and incontinence supplies as needed; -record bowel movements; -refer to Occupational Therapy (OT) as indicated; and -supervise or cue to toilet as needed. The above approaches were also listed on the CNA Kardex. 8/26/24 - The admission MDS assessment documented that R116's BIMS was a 9 (moderate cognitive impairment), required partial/moderate assistance for toileting transfer and toileting hygiene and was frequently incontinent of bowel and bladder. Despite the admission MDS assessment capturing that R116 was frequently incontinent of bladder and bowel, the facility failed to comprehensively assess and update R116's continent care plan to ensure it was person-centered. Review of the CNA Documentation Survey	F 690		

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F 690	Continued From page 56 Reports revealed: - from 8/20/24 through 8/31/24 revealed that R116 had 23 episodes of urinary incontinence and 7 episodes of bowel incontinence out of 55 opportunities; and - from 9/1/24 through 9/15/24 revealed that R116 had 37 episodes of urinary incontinence and 2 episodes of bowel incontinence out of 76 opportunities. 10/1/24 at 10:48 AM - During a combined interview, E47 (MDS Coordinator) stated that the MDS Coordinator was responsible for the resident's care plan. E47 confirmed that R116 was frequently incontinent of bowel and bladder in the 8/26/24 admission MDS assessment. E51 (MDS Coordinator 2) stated that when a resident triggers on the MDS assessment for incontinence, she reviews the resident's diagnoses, how the resident communicates, BIMS score, and mobility. When asked by the Surveyor if she initiates a 3 day voiding diary after the MDS triggers an incontinence care issue, she replied no. E51 acknowledged that the care plan may not be person centered. When asked by the Surveyor if the facility initiates a voiding diary upon a resident's admission, both E47 and E51 were not sure. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		11/18/24

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F 692	Continued From page 57 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)(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 interviews and record review, it was determined that for one (R83) out of four residents reviewed for nutrition, the facility failed to maintain acceptable parameters of nutrition. Findings include: Review of a facility policy titled, "Weight Monitoring and Tracking", effective 1/29/24, indicated "Policy: The center has a system in place to weigh, monitor, and track patient's weights. Weights are tracked, monitored, and analyzed by the Interdisciplinary Team. Procedure ... 2. Patients will be weighed on admission/readmission and weekly x 4 weeks thereafter, or until the Interdisciplinary Team determines weight is stable, then monthly thereafter ... 6. Weekly weights should continue greater than 4 weeks if one or more of the	F 692	F692: Nutrition/Hydration Status Maintenance F 692 1A. R83 no longer resides in the facility. Unable to correct 2A. All residents have the potential to be affected. 3A. Root cause analysis determined that there was a lack of knowledge of the remote dietitian for order entry into the EHR system. The NHA or DON will educate the dietitian that they are to put their orders into PCC for residents that require nutritional supplements or specific weight that need to be obtained. Nursing staff will confirm the orders and push providers for signature. 4A. DON / designee will audit dietician	

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F 692	Continued From page 58 following criteria are met: ...Patients < 100 pounds ... . Review of R83's clinical chart revealed: 7/19/24 - R83 was admitted to the facility with multiple diagnoses including pneumonia, malnutrition, swallowing disorder, and dementia. R83's weight was 96.6 pounds (lbs). 7/23/24 - Review of a dietary progress note revealed that R83's BMI was 14.7, indicating that he was severely underweight, and that his food intake was highly varied, ranging from 0-100%. The dietician recommended adding a nutritional supplement Magic Cup to R83's meal plan. 8/2/24 - An order was written for Magic Cup 4 oz daily with lunch by E4 (Medical Director), 10 days after R83's dietary recommendation. 9/25/24 - A review of R83's weights revealed the following: -8/5/24 - 97.2 lbs. -9/4/24 - 86.8 lbs. -9/13/24 - 89.2 lbs. -9/20/24 - 85.6 lbs. 09/26/24 10:42 AM - During an interview, E13 (Dietician) stated that in the presence of significant weight loss, the facility policy is to weigh a resident weekly. R83 had an 11% loss of weight in two months, July thru September 2024. The facility policy for obtaining weights was not adhered to when weights were not obtained for R83 when he was below 100 lbs. at admission thru his discharge on	F 692	goals and recommendations and notes weekly to ensure there are appropriate orders in place for those recommendations x 4 weeks until 100% consecutively and then monthly x 2 months until facility reaches 100% success on residents flagging for weight loss. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion:11/18/24 1B. R83 no longer resides in the facility. 2B. All new admissions have the potential to be affected. 3B. Root cause analysis determined that the resident did not have weekly weights obtained to determine a baseline or to monitor a significant decrease in weight loss. 4B. SDS / designee will educate clinical staff on policy regarding obtaining baseline weights. DON and/or designee will audit weekly weights for new admissions x4 weeks until 100% consecutively then monthly x 2 months until facility reaches 100% success. Weekly weights to be continued to greater than 4 weeks if significant weight loss continues. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3	

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F 692	Continued From page 59 9/26/24. R83 should have had weekly weights to monitor his declining nutritional status. Additionally, R83 was not ordered the nutritional supplement Magic Cup for almost two weeks after the dietician made the initial recommendation. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 692	months. 5. Date of completion: 11/18/24	
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:	F 693		11/18/24

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F 693	Continued From page 60 Based on observation and interview, it was determined that for one (R105) out of four residents reviewed for tube feeding, the facility failed to ensure that the standard of care for the proper labeling and dating of tube feeding bottles was followed. A review of R105's clinical record revealed: 4/30/24 - R105 was admitted to the facility with a diagnosis of a stroke, and difficulty swallowing food and liquids. 9/19/24 10:40 AM - During an observation, the tube feeding bottle was being administered at R105's bedside. No date was written on the tube feeding bottle. 9/20/24 11:30 AM - During an observation, the tube feeding bottle was administered at R105's bedside. No date was written on the tube feeding bottle. 09/20/24 11:54 AM - During an interview, E24 (RN) confirmed that the tube feed bottle had no date written on it. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 693	F693: Tube Feeding Management/Restore Eating Skills F693 1. Upon discovery, the hung date was written on the tube feeding bottle. R105 no longer resides in the facility. 2. Residents with orders for tube feeding have the potential to be affected. The Director of Nursing/designee will audit all residents with orders for tube feeding to ensure the proper labeling of tube feed bottles. 3. SDC will educate licensed nurses on the proper dating and labeling of tube feedings. Unit Managers will be educated by DON/ ADON on checking the tube feed bottles when completing their rounds. Root cause identified as purposeful supervisor rounds to identify missing dates on tube feeding bottles. 4. DON /designee will audit those who are NPO weekly x 4 weeks until 100% consecutively and then monthly x 2 months until facility reaches 100% success to ensure the proper labeling of tube feeding bottles. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	
F 695 SS=D	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	F 695		11/18/24

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F 695	Continued From page 61 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 record review, it was determined that for one (R3) out of three sampled residents reviewed for respiratory care, the facility failed to ensure that R3 was provided respiratory care consistent with her physician orders and comprehensive person-centered care plan. Findings include: Review of R3's clinical record revealed: 4/22/24 - R3 was readmitted to the facility. 5/28/24 - R3 had a physician's order for oxygen therapy at 2 liters per minute via nasal cannula (a medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels). 5/28/24 11:09 PM - A nurse progress note documented that R3 had a new physician's order for oxygen therapy for SOB (shortness of breath). 6/30/24 - R3's quarterly MDS (Minimum Data Set) assessment revealed that R3 was receiving oxygen therapy during the review period. 7/30/24 (created 5/12/21) - R3 was care planned for cardiac disease related to...and SOB. R3's interventions including but not limited to administering oxygen as ordered.	F 695	F695: Respiratory/Tracheostomy Care and Suctioning F695 1. R3 continues to reside in the facility. Upon discovery, the physician was notified that residents saturation levels being above 95%. Order to discontinue was put in place 10/2/24. 2. Residents with orders for oxygen have the potential to be affected. The Director of Nursing/designee will audit all residents with orders for oxygen and ensure residents receive oxygen per the physician's order, all orders are up to date for resident's current health status and include parameters for PRN use. Any issues identified will be corrected. 3. The DON or SDC will educate licensed nurses to ensure the physician orders are followed for residents with oxygen. The DON or designee will be educated on checking for oxygen use as ordered while completing rounds. Root cause identified as purposeful supervisor rounds to identify oxygen usage per physician orders. 4. The Director of nursing / designee will complete oxygen audit sheets to ensure appropriate orders, health status and PRN use are in place as applicable weekly x 4 weeks until 100% consecutively and then	

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F 695	Continued From page 62 During multiple random observations, R3's oxygen concentrator and tubing were noted set up at R3's bedside but R3 was observed not receiving oxygen therapy on the following dates and times: - 9/20/24 at 10:30 AM; - 9/23/24 at 9:40 AM; - 9/23/24 at 1:48 PM; - 9/30/24 at 9:10 AM. 9/30/24 9:15 AM - Review of R3's September 1-28, 2024 MAR (Medication Administration Records) revealed that licensed nurses had signed off R3's oxygen therapy as administered via nasal cannula every shift. 9/30/20 9:20 AM - During interview, E26 (LPN) confirmed that R3 had an active order for oxygen therapy every shift. E26 further confirmed that R3's oxygen was not administered "... because R3's oxygen saturation level is high above 95%." E26 further stated, "I will need to let the physician know so that [R3]'s oxygen therapy order can be changed to PRN (as needed)." 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 695	monthly x 2 months until facility reaches 100% success to ensure oxygen orders are being followed. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		11/18/24

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F 697	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R26) out of five residents reviewed for pressure ulcers, the facility failed to ensure R26's pain management during wound care was consistent with her care plan and professional standards of practice. Findings include: According to the Lippincott Manual of Nursing Practice, 11th Edition, Chapter 2 entitled, "Standards of Care and Ethical and Legal Issues... Nonmaleficence. 1. The principle of nonmaleficence... obligates the professional nurse not to harm the patient directly... it is common for the nurse to cause pain or expose the patient to risk of harm when such actions are justified by the benefits of the procedures or treatments...". Cross refer to F686, example 1 R26's clinical record revealed: 4/11/24 revised - R26 was care planned for at risk for pain related to advanced age, osteoarthritis pain in right shoulder, right leg, back, neck, buttocks, knee pain, left foot, being more sedentary/bedbound related to poor prognosis. The approaches included, but were not limited to, observe for physical indicators of pain and administer medications as ordered. 9/25/24 at 8:00 AM - An observation of wound care rounds with C1 (Wound Care Consultant) and E8 (LPN) revealed that R26 was moaning during repositioning and during the removal of the saturated sacral wound dressing.	F 697	F697: Pain Management F697 1. R26 still resides at the facility. Resident received a new order on 9/27/24 to administer Morphine Sulfate 30 minutes prior to wound care. 2. All residents who require wound care have the potential to be affected. The DON/designee to complete an audit of all those who have orders for wound care. These residents will be cross-referenced with the active pain medication orders and recommendations from the wound care team to ensure they have all appropriate plans of care in place. 3. Root cause identified that the facility failed to develop a plan of care with measurable goals and interventions to prevent (to the extent possible) or manage the resident□s pain prior to wound care being provided. SDC/designee will re-educate nursing staff to look for signs of pain during wound care be provided for those who are unable to verbalize their pain level 4. The Director of Nursing / designee will audit residents identified with orders for wound care weekly x 4 weeks until 100% consecutively and then monthly x 2 months until facility reaches 100% success with the timing of pain medications. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will	

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F 697	Continued From page 64 9/25/24 at 8:17 AM - During an interview after the wound care observation, the Surveyor asked E26 (LPN) if she administered any medications to R26 this morning. E26 replied no. Review of the September 2024 eMAR revealed that R26 was last medicated with Tylenol for pain on 9/24/24 at 9:00 PM. 9/25/24 at 8:45 AM - The Surveyor observed E26 administer two Tylenol tablets to R26 for pain. The facility failed to administer pain medication prior to R26's wound care on 9/25/24. 10/2/24 at 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 697	be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		11/18/24

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F 732	Continued From page 65 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation and staff interviews, it was determined that the facility failed to post the required federal staffing information in a conspicuous area that was readily accessible to residents and visitors. Findings include: 1. 10/2/24 9:27 AM - An observation in the facility's main lobby revealed a state agency staffing worksheet encased in an acrylic sign holder. The sign holder was placed on top of the small round table at the lobby's corner near facility entrance door. The staffing worksheet had information of the facility's average daily census, care hours per resident and staffing ratios by daily shift with a date range from 9/22/24 through	F 732	F732: Posted Nurse Staffing Information F732 1. No residents were identified. 2. All residents have the potential to be affected. 3. Route cause analysis determined that the facility failed to post the required nursing staffing data sheet which includes but not limited to the current date, name of facility, number of RN, LPN and CNA scheduled per shift. This document will be displayed in a prominent for visitors and staff to view. The administrator has educated the staff scheduler, HR department as they are the back up and DON. 4. Administrator /designee will audit the	

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F 732	Continued From page 66 9/28/24. There was a lack of federal staffing posting in the lobby with the daily (10/2/24) census, correct date and licensed RNs/LPNs and CNA worked hours per shift. 10/2/24 9:28 AM - During interview, E29 (HR Director) stated that the staffing worksheet displayed in the lobby was the facility's staff posting. 2. 10/2/24 - Observations of the four units: Arcadia, New Castle, Heritage and Dover from 9:36 AM - 9:43 AM revealed that the staffing sheets did not contain the facility name, daily census and the total worked hours per shift for each discipline, Registered Nurse (RN), Licensed Practical Nurse (LPN) and Certified Nursing Assistants (CNA). 10/2/24 9:51 AM - Findings were discussed with E1 (NHA). E1 confirmed that the nursing staffing postings in the lobby and in the four units did not meet the federal staffing requirements. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 732	staffing posting X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then X 1 month until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. 5. Date of completion: 11/18/24	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		11/18/24

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F 757	Continued From page 67 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R116) out of two residents reviewed for hospitalizations, the facility failed to monitor and hold R116's blood pressure medication based on physician ordered parameters. Findings include: 1a. R116's clinical record revealed: 8/20/24 - R116 was admitted to the facility with diagnosis of high blood pressure among other medical conditions. 8/22/24 - A physician's order stated, "Norvasc oral tablet 5 MG ... Give 1 tablet by mouth one time a day ... hold if sbp (systolic blood pressure) less than 110." Review of R116's eMARs and nurse's notes for August 2024 and September 2024 lacked evidence that R116's blood pressures were taken prior to administration of her daily blood pressure	F 757	F757: Drug Regimen is free from unnecessary drugs 1. R116 no longer resides in the facility. Unable to correct 2. All residents on blood pressure medication withhold parameters have the potential to be affected. An audit of the last 24 hours of BP medication with parameters was conducted to verify appropriate documentation of BP and administration. Any issues will be brought to the provider for further discussion. 3. DON/designee will educate licensed nurses on blood pressure orders with parameters, obtaining and documentation of the blood pressure and holding medication based on blood pressure readings. Root cause determined to be lack of knowledge on entering BP and holding medication. 4. DON/designee will audit the 5 residents with blood pressure medications withhold	

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	085028	A. BUILDING _____ B. WING _____	C 10/02/2024

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F 757	Continued From page 68 medication for: -four out of nine opportunities from 8/23/24 through 8/31/24; and -three out of five opportunities from 9/1/24 through 9/5/24. 1b. R116's clinical record revealed: 8/20/24 - R116 was admitted to the facility with diagnosis of high blood pressure among other medical conditions. 8/22/24 - A physician's order stated, "Norvasc oral tablet 5 MG ... Give 1 tablet by mouth one time a day ... hold if sbp (systolic blood pressure) less than 110." Review of the September 2024 EMARs and nurse's notes revealed that R116 was administered her blood pressure medication on the following days despite the parameters: -blood pressure 98/51 on 9/8/24; -blood pressure 109/76 on 9/11/24; and -blood pressure 107/69 on 9/12/24. 9/30/24 at approximately 3:30 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON). No further information was provided to the Surveyor.	F 757	parameters to ensure documentation and administration appropriate/completed weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then X 1 month until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. 5. Date of completion: 11/18/24	
F 760 SS=G	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 interview and review of clinical record	F 760	F760: Resident is Free of Significant	11/18/24

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F 760	Continued From page 69 and other documentation as indicated, it was determined that for one (R116) out of two residents sampled for hospitalization, the facility failed to ensure that R116 was free from a significant medication error. R116 was prescribed and administered Metformin and Ibuprofen at 8:00 AM every day from 9/10/24 through 9/15/24 despite two pharmacy warnings. In the setting of poor oral intake and the facility initiating hypodermoclysis during this timeframe, R116's creatinine increased from 0.8 baseline to 4.2 and BUN increased from 23 to 87 prior to being sent emergently to the hospital, requiring treatment with intravenous fluids and the discontinuation of the Ibuprofen. R116 was harmed. Findings include: R116's clinical record revealed: 8/20/24 - The hospital records included a Nephrology consultation, dated 8/20/24 at 10:20 AM, that stated, "... Acute kidney injury-due to intravascular volume depletion... creatinine has already improved from 2.5 to 1.7... continue hydration with normal saline... baseline... creatinine 0.9... on 6/5/24...". 8/20/24 - R116 was admitted to the facility with diagnoses that included, but were not limited to, acute kidney injury. 8/21/24 at 11:28 AM - R116's lab results revealed: -Creatinine = 0.8 (normal range 0.5-1.5) -BUN = 23 (normal range 10-26) -Calcium = 10.4 (normal range 8.5-10.5). 8/22/24 - A progress note by E4 (MD) documented, "... Diagnoses, Assessment and Plan... Acute kidney injury. Follow-up labs	F 760	Med Errors 1. R116 no longer resides in the facility. Unable to correct 2. All residents have the potential to be affected. The Director of Nursing/designee will audit all resident□s orders for possible drug interactions. Any interactions will be reviewed with the provider to determine if any further actions are needed. 3. Root cause determined to be the failure of nursing staff to alert provider of possible drug interaction prior to confirming new medication orders and communication between providers regarding new medication orders. The DON or staff development coordinator will educate the licensed nurses on the medication alerts within Point Click Care and notify the provider to make them aware of the alert and obtain guidance. The DON and/or ADON will educate nurse managers on reviewing alerts, the alert report and verifying provider notification of alerts was completed. 4. The Director of Nursing or administrative nurse will audit medication errors and drug interactions weekly x4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success in management of medication errors. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	

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F 760	Continued From page 70 reviewed and BUN/creatinine are at baseline at this time and continue to monitor clinically and encourage p.o. (oral) intake and maintain hydration...". 8/22/24 at 5:10 PM - A nutrition note documented, "... Resident received IVF (intravenous fluids) while in the hospital... admitted to the hospital with generalized weakness and an episode of hypotension. Resident also experienced AKI (acute kidney injury), acute metabolic encephalopathy, UTI (urinary tract infection), hypoglycemia (low blood sugar) and hyponatremia (low sodium) which per hospital records were affecting her mental status and PO intake. These issues have resolved and resident is now alert with improved energy levels and improved PO intake per resident's [family member] report...". 9/6/24 at 12:23 PM (Late Entry) - A Physical Medicine and Rehabilitation Follow Up Note by C6 (NP) documented, "... Chief Complaint: Weakness... PMHx (past medical history) reviewed... seen this am while working in the PT (physical therapy) gym. She reports lower back right-sided non-radiating muscle pain... A&P (Assessment and Plan)... Ibuprofen 600 mg q (every) 6 PRN (as needed) for muscle pain." 9/6/24 at 4:09 PM - An Order Note automatically populated and stated, "The order you have entered Ibuprofen Oral Tablet 600 MG... Give 1 tablet by mouth every 6 hours as needed for low back muscle pain Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction. The System has identified a possible drug interaction with the following orders: Metformin HCl Oral Tablet 1000 MG. Give 1 tablet	F 760		

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F 760	Continued From page 71	F 760		

by mouth two times a day for DM. Severity: Moderate. Interaction: Coadministration of Metformin and Ibuprofen Oral Tablet 600 MG may increase the risk of acute renal failure...". This warning was acknowledged by E54 (LPN).

9/9/24 - A progress note documented by E4 (MD) documented, "... Medication List:... Ibuprofen Oral Tablet 400 MG, Give 1 tablet by mouth one time a day for (sic) pain... ACTIVE, 9/10/2024... Chief Complaint/Nature of Presenting Problem: Acute metabolic encephalopathy, diabetes type 2, hypertension... Patient this a.m. resting comfortably and appears (sic) no acute distress. Patient also with a history of acute kidney injury and I will repeat Chem-7 this week. P.o. intake has been stable and patient agrees to continued rehab services secondary to debility... Diagnosis, Assessment and Plan... Acute metabolic encephalopathy. Clinically patient has been stable and again reinforced safety and use of call bell and patient for rehab services secondary to debility... Diabetes mellitus type 2 with neurological manifestations. Patient continues with diabetic diet and metformin 1000 mg twice a day and sugars have been managed... continue to monitor... Acute kidney injury. Patient for follow-up Chem-7 this week... Measures... I have utilized all available immediate resources to obtain, update, or review the patient's current medications (including all prescriptions, over-the-counter products...".

9/9/24 at 12:41 PM (Late Entry) - A progress note by C6 (NP) documented, "... seen for today... PMHx (Past Medical History) reviewed... seen this am while sitting in the therapy gym. She tells me that she has been comfortable and has not had any knee pain all weekend. She did tell me

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F 760	Continued From page 72 that she took Ibuprofen this morning. We will continue to monitor her knee pain to see if we need to make adjustments...". 9/10/24 at 12:22 AM - An Order Note automatically populated and stated, "The order you have entered Ibuprofen Oral Tablet 400 MG... Give 1 tablet by mouth one time a day for (sic) pain Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction. The System has identified a possible drug interaction with the following orders: Metformin HCl Oral Tablet 1000 MG. Give 1 tablet by mouth two times a day for DM. Severity: Moderate. Interaction: Coadministration of Metformin and Ibuprofen Oral Tablet 400 MG may increase the risk of acute renal failure...". This warning was acknowledged by E55 (RN). 9/11/24 at 12:42 PM (Late Entry) - A progress note by C6 (NP) documented, "... Chief Complaint: Weakness... seen for today... did well today while in PT (physical therapy) and speech group... no changes to plan." 9/11/24 - R116's lab results received at 5:36 PM revealed: -Creatinine = 1.1, up from 0.8 on 8/21/24; -BUN = 49, up from 23 on 8/21/24. The BUN doubled; and -Calcium = 11.7, up from 10.4 on 8/21/24. 9/12/24 - A progress note by E4 (MD) documented under the "... Medication List: ... Ibuprofen Oral Tablet 400, Give 1 tablet by mouth one time a day for pain... ACTIVE, 9/10/2024... Chief Complaint/Nature of Presenting Problem: Acute metabolic encephalopathy, hypercalcemia, diabetes type 1, hypertension, acute kidney	F 760		

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F 760	Continued From page 73 injury... Patient with follow-up laboratory studies and I note that she has an elevated calcium of 11.7 and this is new as previous laboratories demonstrated a normal calcium level. My immediate concern is that patient with volume depletion and I will initiate hypodermoclysis D5W... for 2 L (liters) and repeat a Chem-7 (labs) in the a.m. Patient this a.m. resting comfortably and appears in no acute distress and I reinforced with the resident the importance of maintaining hydration. If elevated calcium persists will consider further workup especially in the setting of metastatic breast disease... Labs... BUN 49, creatinine 1.1, calcium 11.7... Diagnosis, Assessment and Plan... Hypercalcemia. Most recent calcium with normal limits and concerns for current elevation due to volume depletion and will initiate D5W (sugar in water fluid)... for 2 L and will repeat a calcium level in the a.m. If remains elevated and/or increases and/or changes in mentation may need to send to the emergency room for further treatment... Acute kidney injury. I do note slight increase in the BUN and creatinine from most previous and again encourage fluids and will initiate hypodermoclysis and repeat a Chem-7 in the a.m... Acute metabolic encephalopathy. Patient currently appears at her baseline and I again reinforced safety and use of call bell and encourage p.o. intake to maintain hydration... Measures... I have utilized all available immediate resources to obtain, update, or review the patient's current medications (including all prescriptions, over-the-counter products...". 9/12/24 on 3-11 PM shift - R116 started to receive fluids by hypodermoclysis. 9/13/24 at 5:45 AM (LATE ENTRY) - A note by C6	F 760		

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F 760	Continued From page 74 (NP) documented that R116 was seen today and resident was on... fluids for elevated calcium levels. R116's major rehabilitation goals: improve functional level and pain. Under Assessment and Plan section, C6 documented, "... Deconditioning/ gait instability: Secondary to Weakness, the patient is at high risk for functional impairment without therapy as needed, and adequate pain control... no changes to plan." 9/13/24 - A progress note by E4 (MD) documented under the "... Medication List... Ibuprofen Oral Tablet 400 MG, Give 1 tablet by mouth one time a day for pain... ACTIVE, 9/10/2024... Chief Complaint/Nature of Presenting Problem: Hypercalcemia, acute metabolic encephalopathy, acute kidney injury... past medical history of metastatic breast cancer... admitted to our facility for rehab services status post hospitalization for acute metabolic encephalopathy. Patient with follow-up labs and was found to have an elevated calcium of 11.7 and I initiated hypodermoclysis and patient appears to be tolerating at this time. I again reinforced the importance of hydration and proper nutrition with the resident (sic) staff working with the resident in this regard as well and if persist patient may need to be sent to the emergency room for further evaluation... Labs:... BUN 67, creatinine 1.7... Diagnosis, Assessment and Plan... Acute kidney injury - Most likely due to hypovolemia as discussed earlier and patient is continuing with hypoderclysis (sic) staff working to encourage p.o. intake to maintain hydration and patient for follow-up labs which are pending at this time. As I stated before if persist patient may need to go to the emergency room... Hypercalcemia. Slight improvement of the calcium level and continue with the	F 760		

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F 760	Continued From page 75 hypodermoclysis (sic) patient for follow-up (labs)... Acute metabolic encephalopathy. Patient hospitalized previously and resting comfortably this a.m. and I again reinforced the importance of nutrition and proper hydration... Measures... I have utilized all available immediate resources to obtain, update, or review the patient's current medications (including all prescriptions, over-the-counter products...". E4 documented that he reviewed R116's medications, but made no mention of the metformin and ibuprofen interaction having the potential to cause renal failure. 9/13/24 at 2:01 PM - R116's lab results revealed: -creatinine = 1.7, up from 1.1 on 9/11/24; -BUN = 67, up from 49 on 9/11/24; -Calcium = 11.5, down from 11.7 on 9/11/24. Despite initiating fluids by hypodermoclysis, both creatinine and BUN continued to elevate. Review of the nurse's notes and the CNA Documentation Survey Report during this timeframe lacked evidence that R116's oral intake was being encouraged and monitored by nursing staff. 9/14/24 at 9:30 AM (collected time) - R116's lab results revealed: -creatinine = 2.8, up from 1.7 on 9/13/24; -BUN = 76, up from 67 on 9/13/24; -calcium = 11.1, down from 11.5 on 9/13/24. R116's BUN and creatinine continued to elevate despite receiving fluids by hypodermoclysis. 9/14/24 at 3:45 PM - An Orders - Administration	F 760		

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F 760	Continued From page 76 Note documented that 2 liters of... fluids were administered subcutaneously for elevated calcium level were completed. 9/14/24 at 10:08 PM - A lab note documented, "Lab results received, Cr 2.8, BUN 76. Patient completed ordered Hypodermoclysis fluids today. Oncall NP [E56] notified and new orders given to repeat BMP in AM. Orders noted, patient and family aware. 9/15/24 at 6:26 AM - A nurse's note documented, "STAT order called in for blood draw this morning d/t (due to) abnormal lab results...". 9/15/24 at 11:09 AM - R116's lab results revealed: -creatinine = 4.2, up from 2.8 on 9/14/24; -BUN = 87, up from 76 on 9/14/24; -calcium = 11.0, down from 11.1 on 9/14/24. Despite the pharmacy's black box warnings, review of the September 2024 EMAR revealed that R116 was administered Ibuprofen medication daily from 9/10/24 through 9/15/24 at 8:00 AM, at the same time as Metformin medication. Six doses of Ibuprofen 600 mg were given to R116 from 9/10/24 to 9/15/24. Review of the September 2024 CNA Documentation Survey Report revealed R116's daily fluid intake during meals, including the Ensure drink, as: -9/10/24 = 770 mls; -9/11/24 = 770 mls; -9/12/24 = 720 mls; -9/13/24 = 577 mls; -9/14/24 = 837 mls; and -9/15/24 = 142 mls.	F 760		

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F 760	Continued From page 77 9/15/24 (Sunday) at 12:08 PM - A change of condition note documented, "Lab results received, Cr 4.2, BUN 87. Oncall NP... notified and gave new order to send patient to... ER for evaluation and treatment. Dx. Acute Kidney Failure... [F1, R116's family member] present and notified in person. Patient sent to... ER via 911 ambulance at 11:30 AM. 9/15/24 at 1:12 PM - The hospital ER record documented that R116's creatinine was 5.19, BUN of 86... calcium 11.2... continue with fluid resuscitation...". 9/18/24 at 3:12 PM - The hospital record documented that "... AKI (acute kidney injury) suspected due to decreased oral intake/dehydration. Also receiving ibuprofen at rehab facility. Nephrology is following. On IV fluids for prerenal AKI...". 10/1/24 at 11:25 AM - During an interview, C6 (NP) stated that she prescribed Ibuprofen prior to Physicial Therapy to help R116 do better in therapy. C6 stated that R116 wasn't taking the PRN dose due to her cognitive deficit, so C6 ordered the scheduled Ibuprofen dose prior to therapy. C6 requested a BMP lab to monitor R116's renal function after ordering Ibuprofen. C6 stated that there were other contributing factors that may have played a part in her renal injury/hospitalization: metastatic cancer and poor oral intake. C6 stated that she spoke to E50 (NP) when she was prescribing the Ibuprofen. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 760		

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F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R116) out of three residents reviewed for nutrition, the facility failed to order and provide an Ensure drink based on the admission nutrition assessment and resident preference. Findings include: R116's clinical record revealed: 8/20/24 - R116 was admitted to the facility. 8/22/24 at 5:10 PM - A nutrition note by E13 (Dietician) documented, "... Her oral intake varies between 26-100%, and she eats independently without any issues with chewing or swallowing. No supplements are currently ordered, and food preferences were obtained through a conversation with her [family member, F1]. [F1] reports that resident enjoys drinking Ensure and would like for her to receive one in between meals. Will recommend to add Ensure once daily...". 9/13/24 - A physician's order stated to give "Ensure two times a day for optimal PO (oral) intake...". 9/30/24 at 4:00 PM - During an interview, F1	F 807	F807: Drinks Available to Meet Needs/Preference/Hydration 1. R116 no longer resides at the facility. Unable to correct 2. All residents have the potential to be affected. FSD/designee completed an audit for all new admissions to obtain their needs and or preferences. 3. Root cause determined that the dietician did not follow proper procedure to verbalize new admissions nutritional needs and/or preferences. The dietitian will note the residents' dietary needs/preferences in their admission assessment. Those needs/preferences will be relayed to the dietary department for following. The NHA will educate the Dietitian to ensure that recommendations or preferences are discussed during clinical meetings to ensure needs are known. 4. DON /Designee to complete a 30 day look back on new admissions to ensure recommendation and preferences are being honored. Audits on nutritional assessment will be completed weekly x 4 weeks until 100% consecutively and then monthly x 2 months until facility reaches	11/18/24

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F 807	Continued From page 79 (R116's family member) stated that during the care conference on 8/26/24, the request for Ensure drink was brought up again. The facility failed to order the Ensure drink until 9/13/24, 22 days after E13's dietary recommendation. 10/2/24 at 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON, E46 (VPO) and a representative from the Ombudsman's Office.	F 807	100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed store, prepare,	F 812	F812: Food Procurement, Store/Prepare/Serve-Sanitary	11/18/24

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F 812	Continued From page 80 distribute, and serve food in accordance with professional standards for food service safety. Findings include: 9/19/24 8:45 AM - During the initial kitchen tour the following was observed: - The lack of hand drying towels at the handwashing sink. - A cooked pork roast left uncovered on a counter, with flying insects (gnats) observed in the kitchen. -Pork sausage patties in open unsecured plastic bag in walk in freezer. 9/23/24 approximately 10:00 AM - Observations revealed the following: -the walk-in freezer temperature was reading 27°F. -review of the walk-in freezer temperature logs for July revealed temperatures between -6°F and 35°F. 9/23/24 1:45 PM - During an interview, E7 (Director of Dietary Services), confirmed the findings. 9/23/24 12:30 PM - During the survey of the facility at approximately 12:30 PM, the first-floor nourishment refrigerator was observed to have spilled substances at the base of the refrigerator, the presence of unlabeled resident food items, and open juice container, without an open date. 9/23/24 12:30 PM - During an interview, E8 (Regional Director of Clinical Reimbursement) confirmed the findings.	F 812	1. No residents were identified. 2. All residents have the potential to be affected. 3. A daily check (Kitchen Inspection Checklist) list was created for dietary staff to utilize twice daily to inspect the food for appropriate covering of food, storing it appropriately and securely, recording of temperatures and having hand drying supplies at the handwashing sinks. The NHA will educate Dietary staff on properly covering food items while cooling, storing food items properly and securely in walk in freezer/refrigerator, recording accurate freezer/refrigerator temperatures and having the hand drying supplies at the handwashing sink for proper hygiene. 4. The Administrator and/or designee will round the kitchen with the Kitchen Inspection Checklist on a weekly basis for X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 1 month until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. 5. Date of completion: 11/18/24	

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F 812	Continued From page 81 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		11/18/24

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F 842	Continued From page 82 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (R6, R26 and R116) out of 46 sampled residents, the facility failed to clinical records are complete and accurately documented. Findings include:	F 842	F842: Resident Rights: Identifiable Information 1. A. R6 continues to reside at the facility. Medical Director will complete an	

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F 842	Continued From page 83 1. R26's clinical record revealed: 1/17/24 at 11:21 AM - A Medical Progress Note documented by E50 (NP) documented, "... Assessment and Plan... 1. Protein malnutrition- encourage PO intake (sic) monitor CMP. 2. Muscle weakness-PT/OT. 3. MDD-Mirtazapine 7.5mg GDR not appropriate at this time. 4. GERD- D/C (discontinue) Omeprazole 20mg to trial symptoms and need for medication. 5. HTN- Monitor BP Q shift Lasix 40mg Amlodipine 5mg. 6. Constipation monitor BM Miralax, Fleet enema, MOM, Senna, Biscodyl, Colace. 7. CAD- ASA 81mg. 8. Anemia- Iron 325mg monitor CBC. 9. Cellulitis BLE- continue wound care LLE add Santyl and gauze. 10. ABD distention check US ABD Pelvis. 11. MI - Ativan and Morphine continue on oxygen and hospice Nitro SL... Chart and medications reviewed...". The following 12 Medical Progress Notes documented by E50 repeated the same "Assessment and Plan". - 2/6/24 at 2:03 PM; - 2/28/24 at 10:05 PM; - 3/11/24 at 2:33 PM; - 3/20/24 at 1:34 PM; - 3/27/24 at 1:15 PM; - 4/15/24 at 10:58 PM; - 5/6/24 at 5:45 PM; - 6/11/24 at 1:03 PM; - 6/25/24 at 1:58 PM; - 7/8/24 at 10:14 PM:	F 842	assessment and provide an updated progress note. A Fall Risk Scoring tool will be completed. B. R116 no longer resides at the facility. Unable to correct 2. All residents have the potential to be affected. An audit was completed of current residents last provider progress note to ensure they accurately reflected the residents current orders. Any corrections were sent to the provide for revisions. An audit was completed of the last 24 hours of CNA documentation to verify completeness. Any missing documentation was corrected. An audit was completed of the last week of falls to ensure the Fall risk tool was completed and accurate. Any corrections were completed. 3. NHA and/or DON will educate providers on progress note accuracy. DON/designee will provide education to licensed nurses on assessment accuracy and completion. DON/designee will provide education to CNA on completion of required documentation. Nursing staff will be re-educated on monitoring of the completion of the POC documentation. Root cause analysis determine lack of knowledge of processes for accurate/complete documentation. 4A. MDS/designee will complete an audit of 5 residents written by E50 weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100%. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for	

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F 842	Continued From page 84 - 8/7/24 at 8:18 PM; and - 9/9/24 at 11:18 AM: The following should be noted that were not accurately documented in R26's medical progress notes by E50: -R26 was not receiving PT and OT services as they were discontinued on 1/2/24. -From 12/1/23 through 10/2/24, R26 was not prescribed Mirtazapine 7.5mg. -Omeprazole 40mg tablet was discontinued on 1/8/24. -Lasix and Amlodipine medications were discontinued on 1/8/24. -Miralax medication was discontinued on 1/1/24. Senna and Colace were discontinued on 1/8/24. -Aspirin was discontinued on 1/8/24. -Iron was discontinued on 1/8/24. -Santyl treatment was discontinued on 1/1/24. -Ultrasound abdomen/pelvis for abdominal distention was completed on 12/30/23. -Ativan was discontinued on 1/14/24. Oxygen was discontinued on 7/8/24. It should also be noted that from 6/27/24 through 10/2/24, R26 was being treated for an ongoing sacral pressure ulcer, which was not addressed in R50's progress notes. The facility failed to ensure documentation on the 1/17/24 Medical Progress Note by E50 (NP) was accurate and not repeatedly copied on 12 subsequent Medical Progress Notes for R26 from 2/6/24 through 9/9/24. 2. R116's clinical record revealed: 9/30/24 at 4:00 PM - During an interview, F1 (R116's family member) stated that he arrived at	F 842	additional audits. 4B. The Director of Nursing/designee will audit 5 residents each shift for POC completion weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 4C. The Director of nursing or administrative nurse will audit falls weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months 5 Date of compliance: 11/18/24	

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F 842	Continued From page 85 the facility and found R116 incontinent laying on her bed. Review of the September 2024 CNA Documentation Survey Report revealed that care was not documented for R116 on 9/15/24 during 7 AM to 3 PM shift prior to R116 being sent to the emergency room at 11:30 AM. The facility failed to ensure R116's care was documented in the clinical record. 3. Review of R6's clinical record revealed the following: A facility policy titled "Fall Management Program" effective 1/29/24 documented, "...A fall is defined...unintentional change in elevation coming to rest on the ground or onto the next lower surface...Procedure...Prevention 1. A Fall Risk Scoring Tool will be completed...and as needed for change in condition...". 8/6/24 11:55 AM - A nurse progress note documented that R6 was noted on the floor on her knees, and her head was over the bath tub in her bathroom. 8/7/24 - A facility Fall Risk Scoring Tool for R6 with a score of 7 (low risk) was completed by E28 (LPN). 8/11/24 3:51 AM - The same Fall Risk Scoring Tool for R6 was struck out for the reason: "data entry error". 9/30/24 10:30 AM - In an interview, E2 (DON) stated that the Fall Risk Scoring Tool for [R6] completed by [E28] on 8/7/24 was not accurate.	F 842		

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F 842	Continued From page 86 E2 further confirmed that R6's Fall Risk Scoring Tool after the 8/6/24 fall incident was not updated and not corrected. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 842		
F 849 SS=E	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out	F 849		11/18/24

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F 849	Continued From page 87 at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical	F 849		

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F 849	Continued From page 88 supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the	F 849		

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F 849	Continued From page 89 resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff	F 849		

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	085028	A. BUILDING _____ B. WING _____	C 10/02/2024

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F 849	Continued From page 90 furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and other documentation as indicated, it was determined that for one (R26) out of one resident reviewed for hospice, the facility failed to ensure that R26 received hospice care and services as per the written agreement with the Hospice Provider. Specifically in reference to the deficiency cited at Severity Level 3, at F686, the facility failed to notify and collaborate with the Hospice Provider on developing and implementing a sacral pressure ulcer plan of care with interventions to meet the resident's needs. In addition, the facility failed to update the Hospice Provider that R26's eight medications were discontinued in January 2024; and ensure that current Hospice documentation was present and readily accessible in R26's facility clinical record. Findings include: Cross refer to F686, example 1, F656, F657, F697 8/9/23 - The General Inpatient and Respite Care Skilled Nursing Facility Agreement stated the following: " ... 3.3 Designation of an Interdisciplinary Group Member. Facility will designate a member of the	F 849	F849: Hospice Services F849 1. For R26, the Administrator/DON met with Hospice designee to discuss the areas discovered in the 2567. The DON (E2) will implement a communication process with hospice and have scheduled monthly meetings to ensure needs of the residents are met as requirements state. Upon discovery, all hospice notes were made available and binders updated. Hospice care plans were updated. List of hospice on-call and schedule of hospice aids readily available and updated in the binders. Care plans will be resident specific and updated with hospice RN. Wound care nurse for facility will collaborate with assigned hospice RN to update findings. 2. All residents on hospice care have the potential to be affected. 3. Staff development coordinator will educate Unit managers and nurses on reviewing the hospice binder for updated notes, reviewing the care-plan, and notifying hospice of any changes in meds and/or treatments. The assigned hospice	

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F 849	Continued From page 91 Facility's Interdisciplinary Group ("IDG Member") who is responsible to work with Hospice staff to coordinate care provided to the Hospice Patient. The IDG Member must have a clinical background, function within their state scope of practice act, and have the ability to assess the Hospice patient or have access to another person who has the skills and capabilities to asses the Hospice patient. The IDG Member is responsible for the following: 3.3.1 Collaborating with Hospice representatives and coordinating Facility staff participation in the care planning process for those Hospice Patients receiving Hospice Services. This includes establishing how communication will be documented between Hospice and Facility to ensure the needs of the patient are addressed and met 24 hours per day; 3.3.2 Communicating with Hospice representatives and other healthcare providers participating in the provision of care for patient's terminal illness, related conditions, and other conditions to ensure quality of care for the patient and family. 3.3.3 Ensuring that Facility communicates with the Hospice medical director, the patient's attending physician ... participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. 3.3.4 Obtaining the following information from the Hospice: a. The most recent Hospice Plan of Care for each Hospice Patient; b. Hospice election form; c. Physician certification or recertification of the terminal illness for each Hospice Patient; d. Names and contact information for the Hospice personnel involved in the care of each Hospice	F 849	RN will collaborate with the facilities wound care nurse and discuss any changes in skin condition. Staff nurses will be provided with the hospice aides schedules, assignments, and planned interventions. Root cause identified as hospice failure to keep facility binders updated, provide care as planned, failure to communicate with the facility. Facility failed to ensure hospice care was provided as planned and failed to communicate with hospice interdisciplinary team. Unit Managers and Wound Nurse will monitor and collaborate with hospice RNs/aides to ensure documents are up to date, open communication is effective, and care plans are updated. 4. The DON / designee will audit residents receiving hospice care weekly x4 weeks until 100% success with updated notes, Care Plan compliance, and monthly meetings. The results of the audits will be reviewed by the Quality Assurance and Assessment Committee (AA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	

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F 849	Continued From page 92 Patient; e. Instructions on how to access Hospice's 24 hour on call system; f. Hospice medication information specific to each Hospice Patient; g. Hospice physician and attending physician orders for each Hospice Patient; 3.3.5 Ensuring Facility staff provides orientation to Hospice staff concerning Facility policies and procedures, including patient rights, appropriate forms, and record keeping requirements. 3.4 Plan of Care. Hospice will collaborate with Facility on a coordinated Plan of Care developed jointly between Hospice and Facility. Each patient's written plan of care must include both the most recent Hospice Plan of Care and a description of the services furnished by Facility to attain or maintain the Hospice Patient's highest practicable physical, mental and psychological well-being ... Facility agrees to abide by patient care protocols for palliative medicine established by Hospice and to collaborate with the Hospice Interdisciplinary Group prior to any action relating to treatment ... 3.5 Medical Record ... Documentation of care and services provided by Hospice will be filed and maintained in the Facility medical record. Facility will provide Hospice with a copy of the medical record ... 3.12 Notification to Hospice. Facility will immediately notify Hospice if: 3.12.1 A significant change in a Hospice Patient's physical, mental, social, or emotional status occurs ...". R26's clinical record revealed: 8/14/23 (revised on 9/23/24) - R26 was care planned for hospice with the following	F 849		

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F 849	Continued From page 93 interventions: -hospice to provide bath or shower aid (dated 8/14/23); and -see hospice plan of care [name of hospice]. (dated 8/14/23, revised 9/7/23). The facility failed to review, revise and collaborate with the Hospice Provider on R26's care plan. It should be noted that R26 was not being bathed or showered by Hospice staff from January 2024 through October 2024. 9/24/24 - Observation of R26's hospice binder located in the nurse's station revealed the following: -the absence of who and how to contact members of the Hospice Care Team; -sign-in sheet of hospice staff starting from 2/1/24 through 9/10/24; -8/4/23 hospice election statement; -8/4/23 admission agreement; -8/4/23 plan for primary caregiving; -8/7/23 verbal certification by attending physician; -8/7/23 hospice certification period adjustment order; -8/4/23 to 11/1/23 Hospice Certification and Plan of Care; -12/20/23 Hospice IDG Comprehensive Assessment and Plan of Care Update Report; and -handwritten hospice staff notes from 8/7/23 through 8/27/24, which included 28 notes from the Chaplain, one from a Priest and three from C5, hospice RN. The facility failed to ensure that current Hospice documentation was present and readily accessible in R26's facility clinical record.	F 849		