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	094010	A. BUILDING _____ B. WING _____	3/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE NURSING AND REHAB	2394 MIDLAND RD BAY CITY, MI 48706

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F0000 SS=	INITIAL COMMENTS Carriage House Nursing and Rehab was surveyed for a Combined Standard/Abbreviated Survey exiting on 03/22/2023. Event ID: SQH111 Intake Numbers: MI00133975, MI00134446, MI00134456, Census: 90 Carriage House Nursing and Rehab was not in substantial compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities. The statement of deficiencies was reviewed through the Informal Dispute Resolution (IDR) process and the findings are as follows: Level G, F697 was deleted. Level G, F692 was amended to Level D; F692.	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F0550	Element 1 Resident # 61 has been educated on resident□s rights pertaining to voting for future elections per her wishes. Element 2 Residents residing in the facility who have been assessed and wish to vote in future elections have been notified of the voting rights policy. Element 3 The activities and Social Service staff have been educated by the Administrator on the voting rights policy on 4/5/2023, or during the next scheduled shift. The Activity Director will complete an activity assessment to include	4/12/2023

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

Electronically Signed | 04/12/2023

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	must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that one resident (Resident #61) was provided with the opportunity to vote, resulting in, the facility not arranging transportation for Resident #61 to vote at their local precinct in the Michigan Midterm Election after she expressed a desire to do so. Findings Include: During Resident Council on 3/16/2023 at 1:30 PM, attendees were asked if they were able to exercise their right to vote in November 2022. Resident #61 reported she expressed her desire to vote when staff approached her but was not allowed to as she is a registered		residents choice to vote per MDS guidelines to maintain compliance. The DON/Administrator reviewed and approved the Voting rights policy on 4/12/2023. Element 4 A audit will be completed and log updated monthly of those residents assessed and wish to vote by the Activities Director ongoing. The Activities Director will submit findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	

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voter in a different county.

On 3/16/2023 at approximately 3:45 PM, a review was completed of Resident #61's medical records and it revealed the resident was admitted to the facility on 4/13/2022 with diagnoses that included: Morbid Obesity, Hypertension, Hypothyroidism and Heart Failure. The resident is cognitively intact and able to make her own decisions. Further review of Resident #61's medical record showed the following:

Activities Notes:

4/25/2022 at 7:45 AM: " ... She is a registered voter, votes at the polls, and is Christian. She shared she enjoys going to bingo, reading, cooking and spending time with her family and friends. Staff will continue to provide resident with a monthly activity calendar, encourage her to engage in activities, and provide her with activity supplies upon request."

1/23/2023 at 10:23 AM: " ...She is a registered voter, votes at the polls ..."

On 3/17/2023 at 3:00 PM, Resident #61 stated activities staff came around in November 2022 and inquired if she wanted to vote in the upcoming election and she responded, "yes." About a week prior she approached Activity Aide "G" and asked about her voting and obtaining an absentee ballot. Activity Aide "G" followed up and

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	found it was pas the deadline to request an absentee ballot and Resident #61 would be required vote at her designated precinct. Resident #61 stated transportation was never secured to take her vote and was aware that other residents were provided with the opportunity to vote but she was not. On 3/17/2023 at 3:05 PM, an interview was conducted with Activity Aide "G" regarding her involvement with assessing residents want to vote. Activity Aide "G" explained the previous Activities Director asked a few weeks before the election if residents at the facility voted and they informed the Director that the residents were offered the opportunity to vote but the majority of the residents utilized absentee ballots. The activities aides were then instructed to ask all residents if they wanted to vote and bring the list back to the Director. Activity Aide "G" stated she completed the list and about 3-4 residents (on the unit she completed the audit on) expressed their want to vote and she provided the information to the Activities Director. About a week before the election Activity Aide "G" was informed by the Activities Director that it was too late to request absentee ballots and residents would have to vote at their precinct in their municipality. Activity Aide "G" reported if was upsetting to inform residents of this information but Resident #61 was still interested in voting. Aide "G" reported it was up to the Activities Director to secure transportation for the residents to vote at			

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	their designated precinct. On 3/22/23 at 8:25 AM, an interview was conducted with Activities Director "D" who began his tenure at the facility in February 2023. Director "D" stated he searched his office for any documentation related to residents voting and only found the absentee registration forms, but no other documentation was located. He reported he is aware their department is responsible for ensuring residents are afforded the opportunity to vote and beginning that process timely to guarantee residents are not missed. On 3/23/2023 at 10:00 AM, a review was completed of the facility policy entitled, "Voting Rights," revised 1/2022. The policy stated, "Residents are encouraged to exercise their right to vote in local, state and national elections. The facility will help residents expressing a desire to exercise their right to vote achieve that right ..."			
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified	F0578	Element 1 Resident #65 has been evaluated for competency by two physicians on 4/5/2023. Element 2 Residents residing in the facility have had an audit of advanced directives done by the social worker by 4/11/2023 evaluating for timely assessment of competency. Element 3 The licensed nursing staff and social worker	4/12/2023

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	in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to timely assess and formulate advance directives for one resident (Resident #65), resulting in Resident #65 being severely cognitively impaired with no established responsible party or guardian. Findings include:		were educated on advanced directives policy and completion of the resident□s competency in a timely manner by 4/12/2023 or during the next scheduled shift by the DON/designee. New Admissions advanced directives will be reviewed as part of the morning clinical meeting process with the Interdisciplinary team to maintain compliance. The DON/Administrator reviewed and approved the advanced directives policy on 4/5/2023. Element 4 A weekly audit of new admissions will be completed to ensure compliance. The Director of Nursing will submit findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	

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	Resident #65: During initial tour on 3/15/2023, Resident #65 was observed in her room, she did not appear to be in any distress but was not able to answer any questions from this writer. On 03/16/23 at 1:40 PM, a review was completed of Resident #65's medical records and it revealed the resident was admitted to the facility on 11/28/2022 with diagnoses that included: Hypertensive Chronic Kidney Disease, Peripheral Vascular Disease, Diabetes and Dementia. Upon admission Resident #65 was administered a cognitive assessment and scored a "0" which indicated severe cognitive impairment. Further review was completed of Resident #65's medical records and it revealed the following: Care Conference 11/30/2022 -"Spoke with (daughter #1) via phone ... (daughter #1) stated that daughter (#2) is the POA, but lives in Oregon. Will have (daughter #2) fax POA (Power of Attorney) paperwork ..." Social Work Progress Notes: 12/6/2022 09:19: "Admission assessment, resident is not alert and oriented. BIMS could not be completed. Dementia without diagnosis on file ...Possible DPOA (Durable Power of Attorney), family to fax when they find it."			

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02/27/2023 11:26: "SW contacted (Resident #65's daughter) regarding DPOA and code status. She is contacting her siblings for paperwork and to discuss DNR with them ..."

3/15/2023 09:54: "SW contacted (Resident #65's daughter), she stated her sister ...in Oregon has that paperwork, Jaime will contact her and have her call the facility."

There was no other documentation located in Resident #65's record regarding timely initiation of a capacity evaluation or guardianship application as the family had failed to provide the DPOA paperwork as requested. Resident #65 had been without care and custody at the facility since November 2022 with no other avenues explored to ensure continuum of care.

On 03/17/23 at 09:20 AM, an interview was conducted with Social Worker "B" regarding Resident #65's capacity to make informed decisions for herself. Social Worker "B" explained when the initial cognitive assessment was completed it showed severe impairments and after a second evaluation was completed it was the same outcome. Social Worker "B" reported the resident is not able to make informed decision for herself. The DPOA paperwork was requested from the family upon Resident #65's admission, and they just recently received it. Social Worker "B" was queried if a capacity evaluation has been completed and she

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	stated it was recently provided to the DON (Director of Nursing) for completion. A discussion was held with Social Worker "B" regarding the importance of not delaying pursing appropriate care/custody of any because of family delay in providing needed documentation. Social Worker "B" expressed understanding and stated they are working on new processes for advance directives. On 03/17/23 at 10:56 AM, Resident #65 was observed in self-propelling in the hallways with a cup of juice in her hand. This writer attempted to speak to the resident, but she did not acknowledge this writer and she mumbled inaudible words and sounds. On 3/23/23 at 11:00 AM, a review was completed of the facility policy entitled, "Advance Directive," reviewed 3/2021. The policy stated, " ...Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives ... Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives ... If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives...The resident will be given the option to accept or decline the			

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	assistance, and care will not be contingent on either decision ..."			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §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 and record review, the facility failed to ensure appropriate interventions were enacted and supervision was provided to prevent a fall for one resident (Resident #28) of eight residents reviewed for falls, resulting in Resident #28 falling when staff transferred the resident with 1-person assistance when 2-person assistance was required. Findings Include: Resident #28: On 3/15/23 at 1:16 PM, during a tour of the facility Resident #28 said she fell in the facility during a 1-person transfer. She said the staff usually used 2 people to transfer her. She said her left leg knee surgical incision opened. She said she went to the hospital and then returned and believes this is why her stay at the facility has taken so long.	F0689	Element 1 Resident #28 no longer resides in the center. Element 2 Residents residing in the facility have had their transfer status reviewed with care plan / Kardex updated by the DON/ designee by 4/5/2023 as needed. Element 3 The licensed nursing staff have been educated on fall risk managing policy by 4/12/2023 or during the next scheduled shift by the DON/designee. Residents incident reports will be reviewed as part of the clinical meeting process with the Interdisciplinary team to maintain compliance. The DON/ Administrator reviewed and approved the fall risk managing policy on 4/5/2023. Element 4 Fall incident reports will be audited weekly by the nurse managers for a total of 5 Incident reports to ensure compliance. The Director of Nursing will submit findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	4/12/2023

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A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #28 was admitted to the facility on 1/12/2023 with diagnoses: post surgical care following joint replacement/left knee, pain left knee, disruption of wound left knee 1/31/2023, debridement of left knee wound 1/31/2023, infection left knee 1/31/2023, hypertension, unsteadiness on feet, and depression. The MDS assessment dated 1/19/2023 revealed Resident #28 had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 14/15 and needed two-person assistance with transfers, ambulation, dressing, toileting, and hygiene.

A review of the Care Plans for Resident #28 revealed the following:

"I am at risk for falls related to decreased mobility, self-transferring and depression ..." Date initiated 1/12/2023 and revised 1/18/2023 with 5 Interventions: "Have commonly used articles within easy reach; Maintain bed in low position; observe for signs and symptoms of medication side effects and report to physician as needed; Reinforce the need to call for assistance," all dated 1/12/2023 and "Try to anticipate my needs before I try to self-transfer," dated 1/18/2023. There was no mention of providing assistance with transfers, toileting or ambulation.

"I have an ADL (activities of daily living) self-

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	care performance deficit related to left knee arthroplasty. I have generalized weakness, impaired mobility and impaired cognition. I am partial weight bearing to the left lower extremity," date initiated 1/12/2023, and revised 1/23/2023 with Interventions: "Toilet use: I require limited assistance by 2 staff for toileting," date initiated 1/12/2023; "Transfer: I require limited assistance by 2 staff to move between surfaces," date initiated 1/12/2023; "Ambulation: I require set up assistance by 1 staff to walk," date initiated 2/1/2023: this was updated from the 1/19/2023 MDS that indicated 2-person assistance was needed with ambulation. A record review of the progress notes identified the following: 1/12/2023 at 2:40 PM, a Physician/Practitioner Progress Note, " ... significant past medical history of vertigo (dizziness) and frequent falls admitted ... after undergoing a left knee arthroplasty with repair ... on 1/9/2023. She was unable to return to her assisted living as she was requiring more therapy ... generalized weakness ... " 1/12/2023 at 2:45 PM, a Nursing/Clinical note, "Resident arrived to facility via EMT's (Emergency medical technician's) from (hospital) related to a total left knee replacement ... was assisted to bed via help of EMT's and staff ... she has some bruising. She has 35 staples in left knee area. Staples are			

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	intact and some drainage noted. She is toe touch at this time. No other open areas no edema noted ..." 1/16/2023 at 9:37 AM, a Physician/Practitioner Progress Note, " ... Review of Systems ... Positive dizziness ... moving all extremities with generalized weakness ... Barrier to Discharge: Frequent falls. Partial weightbearing ... Current Functional Status/Progression to Goals: Bed mobility max; transfers dependent; mod ambulation; dependent ADL's ... Chronic right lower extremity weakness and numbness post lumbar laminectomy many years ago ..." 1/18/2023 at 3:09 AM, a Nursing/Clinical note, "Resident was transferring with CNA (Certified Nursing Assistant) & when she went to sit down missed the edge of the chair. She slid on to her butt & was lowered to the floor. She did not hit head. She did c/o (complain of) pain in her left knee. Dressing was saturated with blood ... She was requested to be taken to ER for an X-ray of knee ... She did not want to get up off of the floor until EMS arrived. They assisted her with CNA & nurse to be lifted to cart with a blanket under her ..." 1/18/2023 at 5:52 AM, " ... she arrived back via EMS at 0445. She was assisted to bed by two EMS & nurse ... 2 Island dressings in place with small amount of blood at bottom of incision. Left knee does now have some swelling & bruising ..."			

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1/18/2023 at 3:59 PM, a Nursing/Clinical note, "Post fall day 1: Resident with complaints of pain to knee this morning ..."

A record review of the Incident and Accident reports for Resident #28 revealed the following:

"Witnessed Fall,: date 1/18/2023 at 2:05 AM: "Nursing Description: Resident (#28) was transferring with CNA & when she went to sit down missed the edge of the chair. She slid on to her (buttocks) & was lowered to the floor ... Resident Description: CNA transferring me & I missed the chair ... She did c/o (complain of) pain in her left knee. Dressing was saturated with blood. Immediate Intervention: It was changed. She requested to be taken to ER for an x-ray of knee .... Therapy services in place, transfer PA x 2, staff education ... Predisposing Physiological Factors: Gait Imbalance ... 2-person transfer education completed with staff ..."

A review of the post fall nursing checklist dated 1/18/2023 at 2:08 AM for Resident #28 provided, "2-person transfer still, only one CNA was assisting."

On 3/15/23 at 1:40 pm, interviewed the Director of Nursing/DON and Unit Manager related to the fall and wound on left knee. DON provided a fall Incident and Accident Report. It identified that Resident #28 fell on

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	1/18/23. The resident had been complaining of discomfort to area prior to fall, would pick at knee dressing, confused/not normal for resident, reviewed wound care notes with pictures. The resident had increased pain in the left knee after the fall the surgical incision the opened. The DON said staff were reeducated related to transferring the resident with one assist when she needed 2 assist. A review of the facility policy titled, "Falls and Fall Risk, Managing," date revised March 2018 and reviewed 12/22 revealed, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling ... The staff, with input of the IDT (interdisciplinary team) will implement a resident-centered fall prevention plan ..."			
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §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	F0692	Element 1 Residents # 60 and #65 have had their weights obtained and nutritional assessments have been completed by the registered Dietitian on 3/29/2023 for resident #60 and 4/4/2023 for resident #65. Element 2 An audit of residents residing in the center who have had a significant weight loss/ gain have been assessed by the Registered Dietitian/designee with appropriate interventions updated on care plans by the IDT team as needed by 4/7/2023. Element 3	4/7/2023

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	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 observation, interview, and record review the facility failed to implement and operationalize policies and procedures for comprehensive and interdisciplinary nutritional monitoring, assessment, and documentation of nutritional status for two residents (Resident #60 and Resident #65) of two residents reviewed, resulting in a lack of ongoing monitoring per professional standards of practice, a lack of implementation of meaningful interventions to prevent loss and/or maintenance of weight, and reevaluation and documentation of the appropriateness of interventions. Resident #65 experienced a 12% weight loss in 30 days and Resident #60 experienced a 18.25 % weight loss over three months with the likelihood for malnutrition, decreased quality of life, and increased mortality. Findings include: Resident #60: On 3/16/23 at 10:37 AM, an interview was completed with Resident #60 in their room. The Resident was in bed, positioned on their back. The Resident was thin with a gaunt appearance. A bedside table was present near the Resident's bed, but no food/snacks were observed. An interview was completed at this time. When		The licensed nursing staff and registered Dietitian have been educated on weights policy by 4/7/2023 or during the next scheduled shift by the DON/designee. Weights will be monitored as part of the morning clinical meeting with the Interdisciplinary team to maintain compliance. The DON/Administrator updated, reviewed and approved the weight policy on 4/5/2023. Element 4 During the morning clinical meeting weights will be reviewed by the interdisciplinary team. At the weekly nutrition at risk meeting, residents□ weights will be reviewed with the IDT team for weight loss/gains with appropriate interventions and care plans updated as needed. The Registered Dietitian will submit its findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	

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	asked about mobility and assistance needed from facility staff, Resident #60 revealed they require staff assistance to get out of bed. When queried if they needed assistance with eating and if they eat in the dining room, Resident #60 indicated they eat independently after the staff bring and set up their tray. Resident #60 further revealed they eat in their room. A chair was not present in the room. When queried where in their room they eat, Resident #60 indicated they eat in their bed. When asked how often they get out of bed, Resident #60 stated, "The staff don't want to help me get out of bed." When queried regarding meals and food served by the facility, Resident #60 did not provide positive or negative feedback. Record review revealed Resident #60 was admitted to the facility on 12/21/22 for and readmitted on 1/30/23 with diagnoses which included uterine and cervical cancer, nephrostomy (surgically created opening through the back to the to the kidneys to allow for the drainage of urine), Right Lower Extremity (RLE) Deep Vein Thrombosis (DVT- blood clot), vesicovaginal fistula (abnormal opening between the bladder and vagina), and severe protein-calorie malnutrition. Review of the Minimum Data Set (MDS) assessment dated 12/28/22 revealed the Resident was cognitively intact and required limited to extensive assistance to complete Activities of Daily Living (ADL) with the exception of supervision with eating. The MDS further indicated the weighed 103 pounds (lbs) and did not have any weight loss. Review of Resident #60's care plans revealed a care plan entitled, "I have a nutritional problem R/T (Related To) Stage 4 cancer, recent			

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	chemotherapy and pain. Protein calorie malnutrition aeb (as evidenced by) BMI (Body mass index underweight at 16.1 and variable intake from poor appetite. 2/6/23 Improved appetite - Significant weight loss 17%" (Initiated: 12/21/22; Revised: 2/8/23). The care plan goal was, "I will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date (Initiated: 12/21/22)" and included the interventions: - "Diet as ordered: Regular" (Initiated and Revised: 12/26/22) - "Explain and reinforce to me the importance of maintaining the diet ordered. Encourage me to comply. Explain consequences of refusal, obesity/malnutrition risk factors" (Initiated: 12/21/22) - "Honor preferences as able. See tray card for preferences -Hot cocoa offered all meals. -PB & J sandwich with lunch prn (as needed) - Nutritional Juice offered. -HS Snack offered" (Initiated: 12/26/22; Revised: 2/8/23) - "Monitor for s/sx (signs/symptoms) malnutrition such as weight loss, poor appetite, muscle weakness, muscle loss/cachexia. Report to nursing/MD/RD (Registered Dietician) as needed" (Initiated: 12/26/22) - "RD to evaluate and make diet change recommendations PRN (as needed)" (Initiated: 12/21/22; Revised: 12/26/22) - "Supplements as ordered: ProStat BID (twice a day)" (Initiated and Revised: 1/18/23)			

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Review of Resident #60's documented weights in the Electronic Medical Record (EMR) revealed the Resident experienced an 18.25% weight loss from 12/21/22 to 3/10/23. A detailed review of all the Resident's documented weights included the following:

- 12/21/22 at 5:19 PM: 103.0 lbs

- 2/8/23 at 8:09 AM: 85.4 lbs

- 2/9/23 at 8:48 PM: 85.0 lbs

- 3/10/23 at 10:35 AM: 84.2 lbs

Census documentation in Resident #60's EMR revealed the Resident was transferred to the hospital and readmitted twice since their admission on 12/21/22. Dates included:

- Transferred on 1/7/23 and readmitted on 1/12/23

- Transferred on 1/23/23 and readmitted on 1/30/23

The Resident was not weighed upon their readmission to the facility on 1/12/23 nor on 1/30/23.

Review of Resident #60's EMR revealed a "Nutritional Evaluation ..." assessment dated 12/27/22. The evaluation detailed, "General Information ... Admission assessment ... Most Recent Weight: 103 (lbs) Date: 12/21/22 ... Usual Body Weight (UBW) ... 120 (lbs) ... Diet Orders ... Regular ... Any Skin Issues: Yes ... Fistula ... Are there any dental/oral issues affecting eating ...

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	edentulous on top; has teeth on bottom ...b Laboratory Values ... Hospital Values ... Alb (Albumin - protein level which can be indicative of malnutrition) ... Patient's Weight Status: Stable ... Estimated Nutritional Needs ... Calorie Needs: 1405-1873 (per day) ... Protein needs: 47-66 gms (grams) ... Are there any Nutrition Problems? Yes ... Inadequate protein-energy intake ... Altered nutrition related laboratory values ... Underweight ... Are there Nutrition interventions? Yes ... Vitamins and mineral supplements ... Liberalize diet ... Other: See POC (Plan of Care) ... Does the patient require Nutrition Education? No ... Admission Assessment: Resident is a 53-year-old ... admitted for rehabilitation after hospitalization for B/L (bilateral) LE (Lower Extremity) weakness d/t Stage 4 malignant cancer of the cervix s/p (status post) chemotherapy and radiation. Resident is eating ~50% meals ... appetite is "fair", declines supplements like Ensure or Boost/shakes. Agrees to try the Nutritional Juice drink. Has missing teeth on top but can chew Regular diet without trouble. Denies trouble swallowing food. Some difficulty with pills. Advised to try medications in applesauce and/or pudding. Discussed alternatives to menu offered, adequate protein, and supplements. Resident is able to eat independently and make own food selections ... underweight with a BMI of 16.1 although weight is stable x 7 months. Goal is weight gain, see POC. Will monitor PO (oral) intake, weight and labs ..." Review of Progress Note documentation in Resident #60's EMR revealed the following: - 1/18/23 at 9:06 AM: "Nutrition ... Resident has returned after a short hospital stay for sepsis. Has a sacral ulcer (pressure ulcer- wound caused by			

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	pressure) and continues with the rectal/vaginal fistulas ... eating well and snacking on PB & J sandwich at HS and PB (Peanut Butter) crackers between meals. Taking fluids well. Educated on adequate protein intake for healing ... agrees to Protein supplement; ProStat. Will start BID to provide 200 calories/30 gms protein daily." - 2/1/23 at 2:30 PM: "Physician/Practitioner Progress Note ... Physiatry (physical medicine and rehabilitation) consult for rehabilitation management ... Positive weight loss ..." - 2/6/23 at 3:30 PM: "Nutrition ... Resident has been eating ~75% meals since re-admission from short hospital stay. Continues a General diet; receives additional protein every meal (see care plan) and ProStat BID (Twice a Day) to assist in healing. Awaiting weight." - 2/8/23 at 8:17 AM: "Nutrition ... Resident weighed yesterday by therapy. Weight of 85.4# obtained. This is a loss of 17.6# or 17% which is significant. Much of the loss was during hospital stay as expected. Currently she is eating better and really trying to eat as much as she can. Diet preferences honored and updated. Discussed weight with resident and IDT." - 2/8/23 at 12:50 PM: "Nutrition ... Resident agrees to continue on the ProStat BID and will try taking it with soda. Dr. Pepper currently in the (unit) nourishment refrigerator." No other progress note documentation related to weight loss was noted in Resident #60's EMR. Review of Resident #60's Health Care Provider orders pertaining to diet and nutrition in the EMR			

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revealed the following:

- "Regular diet - Regular texture, Thin consistency" (Ordered: 12/22/22; Discontinued due to hospitalization: 1/10/23; Ordered (Active): 1/30/23)

- "Protein liquid two times a day for wound healing 30 mLs (milliliters): ProStat ..." (Ordered: 1/18/23; Discontinued due to hospitalization: 1/25/23; Ordered (Active): 2/2/23)

- "Multiple Vitamin Tablet Give 1 tablet by mouth one time a day for supplement" (Ordered: 12/21/22; Discontinued due to hospitalization: 1/10/23; Re-ordered: 1/12/23; Discontinued due to hospitalization: 1/25/23; Ordered (Active): 1/30/23)

- "Daily Weight - Call for weight gain greater than 3 lbs for 2 consecutive nights everyday shift for 3 Days" (Ordered: 1/13/23)

No orders for laboratory testing were noted in the EMR.

A task entitled, "Was bedtime snack offered and accepted." The options for documentation included: "Yes ... 2 attempts and resident refused ... No ..." was noted in Resident #60's EMR. Review of Resident #60's documentation for the task from 2/20/23 to 3/20/23 detailed "No" was documented seven of the 28 days on 2/20/23, 2/21/23, 2/27/23, 3/1/23, 3/12/23, 3/13/23, and 3/15/23 indicating a bedtime snack was not offered and/or provided for 25% of the dates reviewed. The task documentation did not specify if the Resident actually ate and/or the percentage consumed the snack on the dates

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	when it was offered and accepted. Review of food intake documentation from 2/20/23 to 3/20/23 (30 day look back longest timeframe available for review in EMR) revealed documentation indicating the Resident's meal intake varied between 0 to 100% of their meals (intake documented as 0 ,25, 75 or 100 %). On 3/21/23 at 10:42 AM, Resident #60 was observed in their room, lying in bed. Upon entering the Resident's room, a pervasive, foul odor was immediately perceptible. The Resident's arms were visible and very thin, with a fragile appearance. When queried if they receive snacks before they go to bed, Resident #60 revealed they can ask for a snack if they want one. An interview was conducted with Registered Dietician (RD) "V" on 3/21/23 at 11:43 AM. When queried regarding Resident #60's weight loss, RD "V" indicated they were aware. When asked what Resident #60's goal weight was, in relationship to the initial assessment specifying Usual Body Weight (UBW) was 130 lbs. and being underweight (103 lbs.) at that time with a goal to gain weight, RD "V" revealed there was no specific weight goal. When queried regarding the contradictory goals between the nutritional assessment of gaining weight and the care plan of maintaining a stable weight, RD "V" was unable to provide an explanation. Resident #60's documented weights were reviewed with RD "V" at this time. When asked, RD "V" confirmed the Resident had significant weight loss. RD "V" was asked if a nutritional assessment is completed when a Resident is readmitted and stated, "No, only quarterly. I would just have a note." The			

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	Nutrition progress notes were reviewed with RD "V" at this time. When queried regarding identification of Resident #60's weight loss, RD "V" declared they had identified the Resident's weight loss occurred in the hospital as they wrote in their progress note dated 2/8/23. When asked how they knew the weight loss occurred in the hospital, when the Resident had not been weighed since 12/21/22 at the facility, RD "V" stated, "I said most (of the weight loss in progress note)." RD "V" was asked again how they knew the Resident did not lose weight in the facility and responded, "(Resident #60) refuses everything." RD "V" was asked where it was documented that Resident #60 "refuses everything" and stated, "Well it's not." When queried if they reviewed hospital documentation of the Resident's weight and nutritional status when they were readmitted, RD "V" revealed they did not recall but would have documented if they had. Any hospital documentation pertaining to Resident #60's weight and/or nutritional status was requested from RD "V" at this time. When queried regarding the facility policy/procedure regarding weight monitoring, RD "V" revealed all residents should be weighed upon admission and regularly as ordered by the physician. RD "V" was asked how Resident #60's weights were monitored and assessed when the Resident was not weighed at specific time intervals, and replied, "Well it is regular." When asked why the Resident was not weighed at the facility during the month of January 2023, RD "V" did not respond. When queried if Residents should be weighed when they are readmitted, RD "V" acknowledged they should be. When asked why Resident #60 was not weighted following their readmission on			

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	1/12/23 and 1/30/23, RD "V" declared that nursing staff is responsible to obtain weights. When queried regarding the facility procedure in place to ensure weights are obtained, RD "V" indicated they send a list of residents who need to be weighed to nursing staff. RD "V" was asked what interventions were implemented on 2/8/23 due to the identified 17% weight loss and stated, "I encourage (Resident #60)." RD "V" was then asked when the ProStat supplement was added. After reviewing Resident #60's EMR, RD "V" revealed they added the supplement in February. When asked why the original order indicated the supplement was started in January, RD "V" then confirmed it was started in January. When asked how much added nutrition Resident #60 received from the ProStat supplement, RD "V" replied, "15 grams protein and 200 calories." When asked about the order indicated the supplement was ordered for wound healing, RD "V" revealed the Resident had a pressure ulcer (wound caused by pressure) which was now healed. When asked what intervention was implemented following the identified significant weight loss, RD "V" revealed the Resident did not like beverages with thick consistency and a nutritional juice was provided with meal trays. When asked when the nutritional juice was implemented, RD "V" revealed they were unsure how to find the information. Resident #60's Nutritional care plan history was reviewed with RD "V" at this time. The care plan history detailed the following: - "Honor preferences as able. See tray card for preferences -Hot cocoa offered all meals. -PB&J sandwich with lunch prn Resident does not like supplements" (Revised: 12/26/22 by RD "V")			

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	- "Honor preferences as able. See tray card for preferences -Hot cocoa offered all meals. -PB&J sandwich with lunch prn - Nutritional Juice offered." (Revised: 12/27/22 by RD "V") - "Honor preferences as able. See tray card for preferences -Hot cocoa offered all meals. -PB&J sandwich with lunch prn - Nutritional Juice offered. -HS Snack offered" (Revised: 2/8/23 by RD "V") When queried if the nutritional juice was added on 12/27/22, RD "V" confirmed it was. When queried how they monitored if the Resident drank the nutritional juice, RD "V" revealed it is not documented. When asked if all Residents are offered snacks at bedtime, unless medically contraindicated, RD "V" revealed all Residents should be offered bedtime snacks. When queried if they reviewed food intake, including bedtime snacks, as part of the nutritional assessment data, RD "V" indicated they did. RD "V" was then asked if they were able to determine if the Resident ate the snack when accepted, RD "V" stated, "No." When asked how they knew the Resident was receiving adequate nutrition and calorie/protein intake, RD "V" revealed the Resident should receive adequate caloric intake from the meals to maintain current weight. When asked if the goal was to maintain or gain weight, RD "V" did not respond. When queried regarding their Admission assessment detailing Resident #60's albumin level was low at the hospital upon admission, RD "V" revealed they would anticipate the laboratory result to be decreased due to the Resident's diagnosis. When asked if the laboratory value had been redrawn since their admission to the facility, RD "V" stated, "No." When queried if they had discussed			

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	and/or recommended any additional laboratory tests to monitor the Resident's nutritional status with the Health Care Provider, RD "V" revealed they had not. When queried if the Resident's weight loss was discussed with the Health Care Provider, RD "V" did not provide a response. When asked if other interventions were considered such as medications, laboratory testing, additional weight monitoring, other supplements, activity/pain level, fortification of foods, etc., RD "V" revealed no other interventions were attempted. Why asked why they were not, an explanation was not provided. When queried regarding the Resident's last weight being obtained 10 days prior, on 3/10/23, with additional weight loss from weight on 2/9/23, and why the Resident had not been weighed again, RD "V" did not provide an explanation. At 3:22 PM on 3/21/23, an interview was completed with Unit Manager Registered Nurse (RN) "H". When queried regarding Resident #60's gaunt appearance and nutritional status monitoring, RN "H" indicated the Resident has had a difficult time with their health. When asked about nutritional assessment and needs, RN "H" revealed nutritional status is primarily assessed and evaluated by RD "V". When queried regarding the facility policy/procedure related to weight monitoring, RN "H" stated, "(RD "V") puts out a list and then says something in the morning meeting." Resident #60's weights and weight loss were reviewed with RN "H". When queried regarding interventions, RN "H" indicated interventions were on the care plan. On 3/22/23 at 9:05 AM, an interview was completed with Certified Nursing Assistant (CNA)			

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"P" and CNA "Q". When queried regarding Resident #60's intake, both CNA "P" and CNA "Q" indicated the Resident's intake varies. When asked, the CNA staff verified they document the percentage of food Residents eat for their meals. When asked how they determine what percentage to document, the staff indicated it is an estimate and they do not specifically document if a resident consumes a specific food and/or supplement.

Resident #65:

During initial tour on 3/15/2023, Resident #65 was observed in her room, she did not appear to be in any distress but was not able to answer any questions from this writer.

On 03/16/23 at 1:40 PM, a review was completed of Resident #65's medical records and it revealed the resident was admitted to the facility on 11/28/2022 with diagnoses that included: Hypertensive Chronic Kidney Disease, Peripheral Vascular Disease, Diabetes and Dementia. Upon admission Resident #65 was administered a cognitive assessment and scored a "0" which indicated severe cognitive impairment. Further review was completed of Resident #65's medical records and it revealed the following:

Weight Summary:

11/28/2022: 89.9 lbs(pounds)

11/30/2022: 88.4 lbs

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	12/1/2022: 90.2 lbs 12/20/2022: 95.2 lbs 1/1/2023: 94.8 lbs 2/8/2023: 92.4 lbs 3/1/2023: 88.0 lbs 3/19/2023: 81.4 lbs Care Plan: Focus: "I have nutritional problem or potential nutritional problem R/T (related to) sub-optimal nutritional intake; generally eating 50% most meals. Needs assistance and cueing d/t (due to) dementia. Underweight with BMI (Body Mass Index) of 17.6 3/2/2023 Weight loss, significant 5% x 30 days." Interventions: "2/20/23 Pureed diet ...3/2/23 Extra Margarine/Gravy on appropriate hot foods. Staff to assist and encourage with intake ...Explain and reinforce to me the importance of maintaining the diet ordered. Encourage me to comply. Explain consequences of refusal, obesity/malnutrition risk factors			

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...Monitor weights routinely ..."

It can be noted the resident is not cognitively intact and staff explaining "consequences of refusal," is not an effective care plan intervention. Resident #65 triggered for 5% weight loss on 3/1/2023 and a reweigh was not completed until 19 days later and she had lost 6.8 pounds without meaningful interventions in place.

On 03/17/23 at 10:56 AM, Resident #65 was observed in self-propelling in the hallways with a cup of juice in her hand. This writer attempted to speak to the resident, but she did not acknowledge this writer and she mumbled inaudible words and sounds.

On 03/17/23 at 12:07 PM, a interview was conducted with Registered Dietitian "V" regarding Resident #65's weight loss and current interventions in place to maintain her weight. Dietitian "V" stated the resident admitted to the facility in November with a weight of 89 pounds and she did gain some weight but gradually her weight began to decline. Dietitian "V" reported the resident is underweight and they added med pass, twice a day, chocolate milk and mighty shake upon her waking. Dietitian "V" stated Resident #65 sleeps through breakfast and many times they will hold her meal tray.

Dietitian "V" continued she did have a significant weight loss of 5% that was attributed to downgraded diet and fall with

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fracture. Dietitian "V" was asked if after her weight on 3/1/2023 that triggered her for significant weight loss were there any interventions added to stimulate her appetite and were reweighs ordered to verify this was a weight loss. Dietitian "V" reported she is not on weekly weights and was going to ask for a reweigh on Monday (3/20/2023) nor has an appetite stimulate or other interventions discussed.

A review was completed with Dietitian "V" of Resident #65's FAR (Food Acceptance Record) for the last 30 days and it showed the resident ate 0% of her breakfast 21 times over the last 30 days. Dietitian "V" was asked if Resident #65 not eating breakfast was on her nutrition care plan and she stated it was not. Dietitian "V" was asked if the resident was ordered a magic cup and she reported she was not, but she would add it.

Further review was completed of Resident #65's medical record and it showed the following:

Nighttime Snacks:

-Over the last 30 days Resident #65 was provided with a snack prior to bed 9 times of the 30 opportunities.

Registered Dietitian Progress Notes:

3/20/2023 at 10:16 AM: "Re-weigh obtained 3/19 at 81.2# which is down another 6.8#.

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Eleven pounds or 12% weight loss in 30 days ...Called resident's daughter ... (Daughter) stated that she is unsure about a feeding tube but would like to contact her sister first ... feels that her mom would not want a feeding tube nor tolerate it ..."

Resident #65 was already at risk on admission and there were minimal meaningful interventions to attempt to maintain her weight. Resident #65 triggered 5% weight loss on 3/1/2023 and her current interventions were not reassessed to ensure her nutritional needs were being met nor was she on reweigh to verify the weight loss. When she was finally reweighed, 18 days later, it was found she lost another 6.8 pounds and a discussion was held with her family regarding a feeding tube.

On 3/21/23 at 8:30 AM, an interview was held with Unit Manager "F" regarding Resident #65's weight loss. Manager "F" reported the resident is typically sleep during breakfast but once she awakes staff will assist with feeing her. Manager "F" stated she knew the resident had weight loss but was unaware of the significant weight loss over the course of the last month and the absence of meaningful interventions. Manager "F" expressed understanding of the concern of this writer.

Review of facility policy/procedure entitled, "Weight Policy," (Reviewed 11/2022)

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	revealed, "Purpose: Weight changes have significant nutritional implications ... Procedures: 1. Admission height and weight are to be obtained by nursing staff and recorded in ... chart ... 2. Nursing staff weighs and records resident weights each month by the 10th of the month. Weekly weights are obtained on those residents within the first 4 weeks of admission and those residents deemed appropriate per the assessment of the dietitian, dietary manager, physician or as determined by IDT. 3. If the monthly or weekly weight shows more than a 5 # gain or loss, the resident is re-weighed within 24 hours. 4. Weights and re-weigh results with dates obtained are recorded and initialed by nursing staff in resident chart. 5. The weights are then evaluated by the RD for significant weight changes. Weight variance will be evaluated for significance ... 6. Significant, unplanned weight changes are reviewed by the IDT. The physician and family members are notified as necessary ..."			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F0695	Element 1 Residents # 86 had her oxygen tubing replaced and appropriately labeled and Oxygen orders validated for proper flow rate by the Unit Managers on 3/22/2023. Resident # 192 no longer resides in the center. Element 2 Residents residing in the center with oxygen orders were validated for proper flow rates and that oxygen tubing was appropriately labeled and stored correctly by the	4/12/2023

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Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for care and maintenance of respiratory therapy equipment for two residents (Resident #86 and Resident #192) of three residents reviewed, resulting in a lack of monitoring of oxygen therapy, incorrect oxygen administration rates, undated/labeled oxygen tubing, and the potential for alteration in respiratory status and infection.

Findings include:

Resident #86:

On 3/15/23 at 12:00 PM, Resident #86 was observed in their room. The Resident was in bed and their call light was not in reach. A portable oxygen tank with attached tubing was present in the holder on the back of the Resident's wheelchair. The tubing on the portable tank was undated.

Record review revealed Resident #86 was admitted to the facility on 2/24/23 with diagnoses which included depression, repeated falls, vertebra fracture, Congestive Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated 3/3/23 revealed the Resident was moderately cognitively impaired and required limited to extensive assistance to complete Activities of Daily Living (ADL) with the exception of supervision for eating. The MDS also revealed the Resident received oxygen therapy.

Review of Resident #86's Health Care Provider

DON/Designee on 4/5/2023.

Element 3
Nursing staff were educated on the oxygen administration policy by 4/12/2023 or during the next scheduled shift by the DON/designee. The management team will validate proper flow rates and ensure that oxygen tubing is appropriately labeled and is stored correctly randomly upon completing their weekly caring partner rounds. The DON/ Administrator reviewed and approved the Oxygen administration policy on 4/5/2023.

Element 4
A weekly audit of at least 10 residents that use oxygen will be completed for being appropriately labeled and oxygen flowing at the correct ordered rate. The Director of Nursing will submit findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.

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	Orders revealed the following orders: - "Oxygen at 2 Liters/minute via nasal cannula every shift continuous every shift" (Ordered: 2/24/23) - "Oxygen Tubing - Change Weekly every night shift every Mon" (Ordered: 2/24/23; Start Date: 2/27/23) - "Oxygen - clean O2 concentrator filter weekly every night shift every Mon" (Ordered: 2/24/23; Start Date: 2/27/23) Review of Resident #86's care plans revealed a care plan entitled, "I have altered respiratory status/difficulty breathing COPD Oxygen dependent" (Initiated: 2/24/23; Revised: 2/27/23). The care plan included the intervention, "Oxygen Settings: O2 (oxygen) via nasal cannula@ 2L (Liters) per minute" (Initiated and Revised: 2/27/23) On 3/21/23 at 9:49 AM, Resident #84 was observed in their room sitting in a wheelchair. Resident #84 had a nasal cannula in place for oxygen administration at a rate of 2.5 liters/minute connected to the concentrator in the room. The nasal cannula was positioned on the Resident's cheek and not in their nose. A portable oxygen tank with attached tubing was present in the holder on the back of the Resident's wheelchair. The tubing on the portable tank was undated. At 9:52 AM, Unit Manager Registered Nurse (RN) "H" was observed in the hallway outside of Resident #86's room. An interview and observation of Resident #86 was conducted with			

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	RN "H" at this time. RN "H" repositioned the nasal cannula tubing, so the flow of oxygen therapy was directed into the Resident's nose. When queried regarding the oxygen flow rate, RN "H" indicated the rate is supposed to be set at 2 liters/minute and adjusted the rate. When queried regarding the undated tubing attached to the portable tank, RN "H" confirmed the tubing was undated. RN "H" removed and disposed of the tubing at this time. When queried regarding the facility policy/procedure related to oxygen administration and tubing, RN "H" revealed the tubing should have been labeled and should be administered at the ordered rate. No further explanation was provided. Resident #192: On 3/16/23 at 9:08 AM, Resident #192 was observed in sitting in their wheelchair in their room. The Resident was visibly short of breath with accessory muscle use observed. When asked if they were okay, Resident #192 stated they felt like they could not breath. Resident #192 had oxygen therapy in place at 3 liters/minute. Resident #192 was queried what rate they normally received oxygen therapy and replied, "Normally at 2 liters." An interview was conducted with Certified Nursing Assistant (CNA) "Y" on 3/16/23 at 9:13 AM. When queried if Resident #192's vital signs had been obtained this shift, CNA "Y" replied, "Yeah." CNA "Y" was asked if the Resident had complained of shortness of breath when they were in the room and stated, "(Resident #192) did just a bit ago." When asked if they had informed the nurse, CNA "Y" stated, "No, I just turned (Resident #192's) oxygen up a little bit."			

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CNA "Y" was asked to have the nurse come to the Resident room.

An interview was completed with Unit Manager Registered Nurse (RN) "H" on 3/16/23 at 9:16 AM. When queried if CNA staff are supposed to titrate oxygen therapy administration rates, RN "H" stated, "No." When queried regarding observation and interview with CNA "Y", RN "H" verbalized they would complete staff education.

Record review revealed Resident #192 was admitted to the facility on 3/13/23 with diagnoses which included COPD, CHF, and renal failure with dialysis dependence. Review of the MDS assessment dated 3/20/23 revealed the Resident was cognitively intact but did not include the level of assistance required to complete ADL due to not occurring and/or only occurring once or twice. The MDS did not indicate the Resident was receiving oxygen therapy.

Review of Resident #192's care plans included a care plan entitled, "I use Oxygen Therapy r/t (related to) CHF" (Initiated and Revised: 3/20/23). The care plan included the interventions:

- "Give medications as ordered by physician. Monitor/document side effects and effectiveness" (Initiated: 3/20/23)

- "Monitor for s/sx (signs/symptoms) of respiratory distress and report to MD PRN (as needed): Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain,

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Accessory muscle usage, Skin color" (Initiated: 3/20/23)

- "Oxygen at 2L(liters)/NC (Nasal Cannula) to keep O2 (oxygen) sats (saturation) above 90%" (Initiated: 3/20/23)

Another care plan entitled, "Has COPD" (Initiated and Revised: 3/14/23) was present in Resident #192's EMR. This care plan included the interventions:

- "Droplet Precautions in Place when Nebulizer in use and 1 hour after. Wear PPE (Personal Protective Equipment) during Treatment and 1 hour after. Keep Door CLOSED during Treatment and 1 hour after" (Initiated: 3/16/23)

- "Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance" (Initiated: 3/14/23)

- "Oxygen Settings: O2 via 2L to keep O2 sat above 88%" (Initiated and Revised: 3/14/23)

On 3/21/23 at 9:42 AM, Resident #192 was observed sitting in their room in a wheelchair. The Resident was receiving oxygen therapy via nasal cannula at 3 liters/minute from the oxygen concentrator in the room. A portable oxygen tank was present on the back of the Resident's wheelchair with oxygen tubing attached. The oxygen tubing attached to the portable tank was not contained and hanging downward with the part of the tubing which is inserted in the nose touching the wheel.

An interview was completed with RN "H" on 3/21/23 at 4:24 PM. When queried what rate

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	Resident #192 was supposed to receive oxygen at, RN "H" stated, "Should be at two." When queried why it was it at 3 liters, RN "H" replied, "I don't know." Review of facility policy/procedure entitled, "Oxygen Administration and Storage" (Revised 3/23) detailed, "The purpose of this procedure is to provide guidelines for safe oxygen administration and storage ... 1. Verify that there is a physician's order ... 3. Monitor portable O2 tanks frequently to ensure tank is not nearing empty... Assessment: 1. While the resident is receiving oxygen therapy, assess as needed for any sign of respiratory distress and check SPO2 saturation levels as needed or as ordered. 2. Report saturation levels <88% to physician or as physician ordered. 3. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered per physician order. 4. Securely anchor and date the oxygen tubing. 5. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated and continues at the prescribed liter flow. 7. Periodically re-check liter flow settings on portable tanks and room concentrators ..."			
F0697 SS= G	Pain Management §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. This REQUIREMENT is not met as evidenced by:	F0697	F 697 Pain Element 1 Resident # 60 has had a pain assessment completed by DON on 4/6/2023 with orders and care plan updated as appropriate. Element 2 Residents residing in the center have had pain assessment completed by a licensed nurse by 4/5/2023 with new orders obtained as needed. Care plans have been updated	4/7/2023

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	Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures to ensure comprehensive pain management for one resident (Resident #60) of two residents reviewed for pain management, resulting in a lack of consistent pain assessment per professional standards of practice, implementation of non-pharmacological interventions, reassessment and evaluation of pain management regiment, uncontrolled pain, and resident's verbalization of feelings of discontentment. Findings include: Resident #60: On 3/16/23 at 10:37 AM, Resident #60 was observed in their room. From the hallway, an uncovered urine drainage bag was visible hanging from the side of the bed. Upon entering the room, Resident #60 was noted to be lying in bed, positioned on their back with a second uncovered, urine drainage bag hanging off the side of the bed not facing the room door. The room was dark and completely bereft of noise. The shades were drawn, and the room lights were off. An interview was completed at this time. When queried regarding the urinary drainage bags, Resident #60 revealed they had bilateral "nephrostomy tubes." With further inquiry, Resident #60 revealed they had cancer. When asked about mobility and assistance needed from facility staff, Resident #60 revealed they are unable to get out of bed without staff assistance. With further inquiry regarding staff assistance and how often they are positioned and get out of bed, Resident #60 stated, "The staff		with new orders as needed. Element 3 The licensed nurses have been educated on the pain management policy by 4/7/2023 or during the next scheduled shift by the DON/designee. Resident pain management will be reviewed as part of the morning clinical meeting and concerns will be addressed at that time to maintain compliance. The DON/ Administrator reviewed and approved the pain management policy on 4/5/2023. Element 4 An audit of at least 10 residents receiving pain medication will be completed by the Unit Manager/designee weekly for pain management compliance. The Director of Nursing will submit findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	

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	don't want to help me get out of bed." When asked to elaborate, Resident #60 revealed the staff are kind but do not want to help them get out of bed. Resident #60 became emotionally distressed with tears observed in their eyes. When asked if they have pain, Resident #60 replied, "Yes." When queried what their current level of pain was, on a scale of zero to 10 with ten being the worst, Resident #60 indicated their pain was tolerable if they did not move. When asked what level of pain was tolerable to them, the Resident revealed a three out of 10. The Resident revealed they had a fistula from their rectum to their vagina (abnormal connection between the rectum and vagina where stool will exit the body from the vagina) which caused constant pain in their peri area. When queried regarding pharmacological and non-pharmacological pain management interventions implemented by staff, Resident #60 signified they were unaware of any non-pharmacological pain interventions. When asked if they receive medications to help with their pain, Resident #60 revealed they have to ask for pain medications when their pain is really bad. When queried if nursing staff assess/ask their pain level, Resident #60 indicated revealed most nurses do not ask. When queried if the pain medication is effective when they do receive it, Resident #60 reiterated their pain was tolerable when they did not move. Record review revealed Resident #60 was admitted to the facility on 12/21/22 for and readmitted on 1/30/23 with diagnoses which included uterine and cervical cancer, nephrostomy (surgically created opening through the back to the to the kidneys to allow for the drainage of urine), Right Lower Extremity (RLE) Deep Vein Thrombosis (DVT- blood clot),			

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neuropathy (nerve pain), and vesicovaginal fistula (abnormal opening between the bladder and vagina). Review of the Minimum Data Set (MDS) assessment dated 12/28/22 revealed the Resident was cognitively intact and required limited to extensive assistance to complete Activities of Daily Living (ADLs) with the exception of supervision with eating. The MDS further indicated the Resident experienced frequent pain which limited their day-to-day activities.

Review of Resident #60's care plans revealed a care plan entitled, "I have pain r/t (related to) cervical cancer" (Initiated: 12/21/22; Revised: 12/26/22). The care plan included the interventions:

- "Adjust times of ADL and treatment activities so that they occur after analgesia benefits have been achieved" (Initiated: 12/21/22)

- "Administer pain medication per physician orders" (Initiated: 12/22/22)

- "Encourage/Assist resident to a position of comfort, utilize pillow and appropriate positioning devices" (Initiated: 12/21/22)

- "Implement nondrug therapies to assist with pain and monitor for effectiveness. Encourage to try different pain-relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, cold application, muscle stimulation, ultra-sound" (Initiated: 12/21/22; Revised: 1/19/23)

- "Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective" (Initiated: 12/21/22)

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- "Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc." (Initiated: 12/21/22)

Another care plan entitled, "I am at risk for pain r/t fistula and cervical cancer" (Initiated: 12/21/22; Revised: 12/26/22) was present in Resident #60's Electronic Medical Record (EMR). The interventions included:

- "Administer pain medications as ordered" (Initiated: 12/21/22)

- "Avoid pressure to areas of pain" (Initiated: 12/21/22)

- "Encourage/Assist resident to a position of comfort, utilize pillow and appropriate positioning devices" (Initiated: 12/21/22)

- "Implement nondrug therapies to assist with pain and monitor for effectiveness. Encourage to try different pain-relieving methods i.e. positioning, progressive relaxation, bathing, cold application, muscle stimulation, ultra-sound" (Initiated: 12/21/22)

- "Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective" (Initiated: 12/21/22)

- "Report G.I. distress secondary to analgesia such as nausea, constipation, diarrhea" (Initiated: 12/21/22)

- "Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying,

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thrashing, change in breathing, etc." (Initiated: 12/21/22)

On 3/17/23 at 3:10 PM, Resident #60 was observed in their room. The Resident was in bed, positioned on their back in bed with their eyes closed. The room was dark with the shades drawn, the room lights off, and devoid of noise. Upon knocking and saying their name, Resident #60 opened their eyes. When asked how they were doing, Resident #60 indicated they were in pain and wanted to rest.

An interview was conducted with Physical Therapy Assistant (PTA) "T" on 3/17/23 at 3:14 PM. When queried if they worked with Resident #60, PTA "T" revealed the Resident was on their caseload. PTA "T" then stated, "(Resident #60) didn't want to get up today (for therapy) because it is so painful." When asked if the Resident has complained of severe pain before, PTA "T" revealed they had and that the Resident frequently experiences severe pain which prohibits movement. When asked if the facility nursing staff were aware of the Resident's pain, PTA "T" responded that they inform the Resident's assigned nurse when they complain of pain. When queried if they coordinate and communicate planned therapy times with Resident #60's assigned nurse for pain management and medication, PTA "T" revealed they do their best.

Review of Resident #60's Health Care Provider (HCP) orders revealed the following active orders related to pain management:

- "Oxycodone-Acetaminophen (Perocet - narcotic pain medication) Oral Tablet 10-325 mg

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	(milligrams) ... Give 1 tablet by mouth every 6 hours as needed for pain a 7 to 10 on pain scale" (Start Date: 1/18/23). The medication was reordered starting 1/31/23 following the Resident's readmission to the facility. - "Lidocaine HCl External Gel 2% (topical, over the counter, numbing medication used for local pain relief). Apply to back topically every 24 hours as needed for pain" (Start Date: 1/30/23) - "Methocarbamol (Robaxin- medication used to treat muscle spasms) Oral Tablet 500 mg ... Give 1 tablet by mouth every 6 hours as needed for muscle spasm" (Start Date: 12/21/22). The medication was reordered following the Resident's readmission to the facility on 1/30/23. - "Gabapentin Capsule 100 mg (medication used to treat nerve pain). Give 1 capsule by mouth every 8 hours for neuropathy" (Start Date: 12/26/22). The medication was reordered following the Resident's readmission to the facility on 1/30/23. - "Acetaminophen (Tylenol) Tablet 325 mg; Give 2 tablet by mouth every 4 hours as needed for general discomfort" (Start Date: 1/12/23). The medication was reordered following the Resident's readmission to the facility on 1/30/23. - "Document Post Pain level as needed for Post Pain medication" (Start Date: 1/30/23) - "Pain Score every shift for Pain" (Start Date: 1/30/23) Review of Resident #60's discontinued HCP ordered revealed the following:			

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- "Ice Pack to vaginal area as needed for swelling and pain every 20 minutes as needed" (Start Date: 12/22/20; Discontinued: 1/10/23)

On 3/21/23 at 10:42 AM, Resident #60 was observed in their room. The Resident was laying in bed, positioned on their back. The room was dark and quiet with no TV or radio. The shades were drawn, and the room lights were off. Resident #60 was asked how they were and replied, "Feel awful." When asked if they were having pain, Resident #60 replied, "Yes, so much pain in my tail bone." When asked to rate their pain, on a scale of zero to 10, Resident #60 replied, "Seven." Resident #60 was then asked if they had informed the staff of their pain and they specified they had. When queried if they had received any medication for pain, Resident #60 did not reply. When asked if staff provided any non-pharmacologic interventions such as warm or cold therapy, the Resident shook their head to indicate no. Resident #60 was queried if the nursing staff ask them their pain level and revealed not all nurses ask them about their pain. When asked if they do not want to get out of bed because of the pain, Resident #60 confirmed and reiterated their pain is tolerable when they do not move.

An interview was completed with Licensed Practical Nurse (LPN) "R" on 3/21/23 at 10:29 AM. When queried, LPN "R" revealed they were Resident #60's assigned nurse. When asked about Resident #60's pain, LPN "R" revealed the Resident frequently had pain related to their cancer diagnosis. When queried regarding the Resident's current pain level, LPN "R" did not provide a response.

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At 1:10 PM on 3/21/23, Resident #60 was observed in their room. The Resident was in bed, positioned on their back. When asked if they were still having pain, Resident #60 revealed they were but did not provide a numeric rating when asked.

An interview was conducted with Occupational Therapy Staff "U" on 3/21/23 at 3:16 PM. When asked about Resident #60, Staff "U" indicated they were working with the Resident for "Upper Extremity ADLs." When queried if Resident #60 complained of pain when they were working with them, Staff "U" revealed the Resident's pain was related to their cancer diagnosis but did not elaborate further.

On 3/22/23 at 8:55 AM, Resident #60 was observed in their room. The Resident was laying in bed, positioned on their back. The room was dark with the lights off, blinds closed, and no stimulation When queried if they were having pain, Resident #60 responded they were but did not provide a numeric pain rating.

An interview was completed with LPN "O" on 3/22/23 at 9:00 AM. When queried regarding Resident #60's pain, LPN "O" revealed the Resident has constant pain related to cancer. LPN "O" further revealed the Resident had constant bowel drainage from their fistula which is very irritating and uncomfortable for them. With additional inquiry regarding Resident #60, LPN "O" indicated the Resident was cognitively intact and able to verbalize their needs to staff. When queried regarding the frequency in which they ask about and assess Resident #60's pain, LPN "O" stated, "(Resident #60) will just tell you."

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	When asked to clarify, LPN "O" disclosed that Resident #60 is able to inform staff of their needs, so they do not routinely ask them about their pain level. When queried regarding non-pharmacologic pain management interventions for Resident #60, LPN "O" stated, "Position." LPN "O" continued, "A lot of times we offer reposition and (Resident #60) will say that's not going to help me." When queried if other non-pharmacologic pain management interventions had been attempted and/or implemented, LPN "O" indicated they were unaware of any other interventions. LPN "O" was then asked if Resident's current pain management medications, LPN "O" reviewed the Resident's EMR and stated, "Gets scheduled gabapentin. Everything else is PRN (as needed)." On 3/22/23 at 9:05 AM, an interview was completed with Certified Nursing Assistant (CNA) "P" and CNA "Q". When asked, both CNA "P" and CNA "Q" revealed Resident #60 rarely gets out of bed due to pain. When queried if they assist the Resident to reposition in bed, CNA "P" replied, "No, (Resident #60) doesn't like it (being repositioned)." When asked why, CNA "P" revealed moving increased their pain. When queried if Resident had any other non-pharmacologic interventions for pain management such as warm or cold therapy, CNA "Q" stated, "We haven't tried that." CNA "P" indicated the Resident used to have an intervention for ice packs but did not anymore. CNA "Q" then stated, "(Resident #60) says it really hurts when we clean them up." When asked to clarify, both CNA staff revealed anytime incontinence and/or peri care was provided, Resident #60 experienced a lot of pain. With further inquiry, both CNA staff specified that			

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stool constantly drains from the Resident's vagina due to the fistula and causes them a great deal of pain and irritation in that area. When queried regarding products used during hygiene care, CNA "Q" revealed they utilize "washcloths" because Resident #60 told them the premoisten wipes cause burning pain. When asked if the washcloths were soft, both CNA "Q" and CNA "P" revealed they were not. When asked if the washcloths also caused Resident #60 discomfort, both CNA staff revealed it is painful for the Resident. When asked if the facility had attempted to use any other and/or different products/wipes during care, both CNAs revealed they were unaware of any other products being available and/or attempted.

Review of Resident #60's "Pain Level Summary" documentation in the EMR revealed the Resident experienced pain on a daily basis ranging from zero to 10 on a numeric pain scale. Resident #60's average highest documented pain score from 3/1/23 to 3/21/23 was seven out of 10. Review further revealed inconsistent documentation of pain levels at the same date/time including, but not limited to, the following:

- 3/20/23 at 8:31 AM: Pain Level 0

- 3/20/23 at 8:32 AM: Pain Level 7

- 3/21/23 at 7:49 AM: Pain Level 3

- 3/21/23 at 7:49 AM: Pain Level 7

- 3/2/23 at 8:14 PM: Pain Level 7

- 3/2/23 at 8:14 PM: Pain Level 0

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- 12/28/22 at 9:18 AM: Pain Level 4

- 12/28/22 at 9:18 AM: Pain Level 10

Documentation of elevated pain levels did not consistently include documentation of reassessment.

Review of Resident #60's Health Care Provider progress note documentation in the EMR included documentation indicating the Resident's pain was controlled and/or better controlled. Both HealthCare provider and Nursing progress note documentation were reviewed and no documentation was noted which identified and addressed Resident #60's ongoing elevated pain levels, pain reassessment, implementation of non-pharmacologic interventions, and/or comprehensive reevaluation of pain management plan.

An interview was conducted with Nurse Manager Registered Nurse (RN) "H" on 3/22/23 at 9:23 AM. When queried regarding non-pharmacologic interventions for Resident #60's pain, RN "E" stated, "We used to do ice but (Resident #60) doesn't ask for it anymore." When queried why an ice pack was not an active intervention on the Resident's care plan, RN "H" did not provide an explanation. RN "H" was then asked about repositioning, observations of the Resident being in bed on their back with the room dark, and if the facility had attempted a recliner or other furniture and stated, "The pain increased with sitting up." When queried if other interventions had been attempted and if the Resident's pain medication had been timed and adjusted to ensure optimal effectiveness during movement,

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	RN "H" did not provide a response. When asked if Resident #60 did not get out of bed related to their pain, RN "H" detailed they were aware that the Resident did not want to move due to pain. RN "H" revealed Hospice and/or palliative care were discussed with Resident #60, but they were not ready for that care transition. When queried regarding Resident #60's diagnoses and pain levels, RN "H" confirmed Resident #60's medical conditions and diagnoses would cause a significant pain. When asked why other non-pharmacological pain management interventions had not been attempted, RN "H" was unable to provide an explanation. When queried regarding nursing assessment of Resident #60's pain, RN "H" replied, "If you ask them, they will usually say it (pain level) but they don't always say it." RN "H" revealed Resident #60 would very rarely verbalize their pain level and/or complain unless asked by staff. RN "H" was queried regarding Resident #60's pain medications and the frequency in which they received them. Resident #60's Medication Administration Record (MAR) was reviewed with RN "H" at this time. RN "H" revealed the only scheduled pain medication Resident #60 was receiving was gabapentin (Neurontin) for nerve pain. When asked if the type of pain Resident #60 was experiencing from their cancer and fistula was nerve pain, RN "H" responded that Resident #60's pain would be related to skin and organs. When asked if gabapentin was effective in treating that type of pain, RN "H" revealed it was not. RN "H" detailed Resident #60 also had an order for Percocet as needed and stated, "(Resident #60) doesn't ask for it (Percocet) even as often as they can get it." RN "H" was queried regarding the effectiveness of Percocet being			

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	scheduled as needed when they stated Resident #60 will not always say they have pain unless they are asked. RN "H" verbalized understanding. When asked how often facility nursing staff should assess Resident #60's pain, RN "H" replied, every shift. When asked if the staff were supposed to ask the Resident their pain level, per facility policy/procedure, RN "H" confirmed they were. When queried why both Resident #60 and staff verbalized lack of pain assessment, RN "H" did not provide an explanation. RN "H" was then asked if Resident #60's pain was controlled and if their pain management program was effective when documented pain levels in their EMR indicated the Resident experienced pain at an average level of seven out of 10 daily, RN "H" confirmed it was not. RN "H" was then asked if Resident #60 was receiving a long-acting pain medication and replied, "No." When asked if a long-acting pain medication had been attempted, RN "H" replied, "Not tried." When queried if the facility had attempted scheduled, rather than PRN, pain medications to assist with pain control and improve quality of life, RN "H" revealed the facility had not attempted scheduled pain medication. When asked if Resident #60 did not move or get out of bed due to pain, RN "H" verbalized confirmation. RN "H" then stated "(Resident #60) definitely had more pain since came back" from having their nephrostomy tubes replaced. When asked why the facility had not assessed and revised the Resident's pain management program, RN "H" was unable to provide an explanation but indicated they were going to call the Resident's health care provider. At 9:33 AM on 3/22/23, an interview was completed with RN "H" and the Director of Nursing (DON). RN "H" revealed they spoke to			

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	Resident #60's health care provider and the Resident's Percocet was going to be scheduled twice a day as well as available as needed for break through pain. When queried regarding Resident #60's pain including lack of assessment and comprehensive pain management, lack of movement due to pain, and decreased quality of life, the DON did not provide further explanation. Review of facility policy/procedure entitled, "Pain Assessment and Management" (Reviewed: 1/22) revealed, Purpose: The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines 1. The pain management program is based on a facility-wide commitment to resident comfort. 2. "Pain management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Effectively recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. 4. It is important to recognize cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain ... 6. Assess the resident's pain and consequences of pain at least each shift for acute pain or			

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	significant changes in levels of chronic pain and at least weekly in stable chronic pain ... Recognizing Pain ... 2. Possible Behavioral Signs of Pain ... d. Behavior such as resisting care, irritability, depression, decreased participation ... e. Limitations in his or her level of activity due to the presence of pain; f. Guarding, rubbing or favoring a particular part of the body; g. Difficulty eating or loss of appetite ... i. Evidence of depression, anxiety, fear or hopelessness ... 4. Ask the resident if he/she is experiencing pain. Be aware that the resident may avoid the term "pain" ... 5. Review the medication administration record to determine how often the individual requests and receives pain medication, and to what extent the administered medications relieve the resident's pain ... Defining Goals and Appropriate Interventions: 1. The pain management interventions shall be consistent with the resident's goals for treatment ... 2. Pain management interventions shall reflect the sources, type and severity of pain ... Implementing Pain Management Strategies: 1. Non-pharmacological Interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: a. Environmental - adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.; b. Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; c. Exercise - range of motion exercises to prevent muscle stiffness and contractures; and d. Cognitive or Behavioral - relaxation, music, diversions, activities, etc. 2. Pharmacological interventions (i.e., analgesics) may be prescribed to manage pain ... 4. The physician and staff will establish a treatment			

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	regimen based on consideration of the following: a. The resident's medical condition; b. Current medication regimen; c. Nature, severity and cause of the pain; d. Course of the illness; and e. Treatment goals. 5. Strategies that may be employed when establishing the medication regimen include ... b. Administering medications around the clock rather than PRN; c. Combining long-acting medications with PRNs for breakthrough pain; d. Combining several analgesics or analgesics with other drug classes; and e. Reducing or preventing anticipated adverse consequences of medications (e.g., bowel regimen to preventing constipation related to opioid analgesics). 6. Implement the medication regimen as ordered, carefully documenting the results of the interventions. Monitoring and Modifying Approaches: 1. Re-assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. 2. Monitor the following factors to determine if the resident's pain is being adequately controlled: a. The resident's response to interventions and level of comfort over time ... 3. Monitor the resident by performing a basic assessment with enough detail and, as needed, with standardized assessment tools (e.g., approved pain scales, etc.) and relevant criteria for measuring pain management (e.g., target signs and symptoms). 4. If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated ... Documentation 1. Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in			

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	accordance with the pain management program ..."			
F0698 SS= D	Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to operationalize policies and procedures to ensure that assessment and coordination of care for in-facility peritoneal dialysis (process by which toxins are removed through the body placing and removing dialysate fluid through a surgically inserted tube in the abdomen) treatments for one resident (Resident #196) of one resident reviewed, resulting in a lack of assessment, monitoring, and documentation of vital signs, weights, and the potential for further decline in kidney function and overall health. Findings include: Resident #196: On 3/16/23 at 10:04 AM, an interview was conducted with Resident #196 in their room. Peritoneal dialysis equipment was observed in the Resident's room. When queried regarding the equipment, Resident #196 revealed they receive peritoneal dialysis every night in the facility. When asked if the dialysis was completed by facility nursing staff, Resident #196 revealed an	F0698	Element 1 Resident #196 no longer resides in the center. Element 2 An audit of other residents receiving dialysis has been completed by the Unit managers 4/5/2023 to assure vitals and weights are being obtained per physician orders. Element 3 The licensed nursing staff and Registered Dietitian have been educated on weights policy and dialysis policy by 4/12/2023 or during the next scheduled shift by the DON/designee. Weights and Vitals will be reviewed in the morning clinical meeting by the IDT team to maintain compliance. The DON/Administrator updated and approved the weight policy on 4/5/2023. Element 4 During the morning clinical meeting weights and vitals for dialysis resident will be reviewed by the IDT team for compliance. At the weekly nutrition at risk meeting, residents□ weights will be reviewed with the IDT team for weight loss/gains with appropriate interventions and care plans updated as needed. The Registered Dietitian will submit its findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	4/12/2023

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	external dialysis company comes to the facility to connect and disconnect the treatment. Review of Resident #196's Electronic Medical Record (EMR) revealed the Resident was admitted to the facility on 3/9/23 with diagnoses which included diabetes mellitus, heart disease, and end stage kidney disease with dialysis dependence. Review of the Minimum Data Set (MDS) assessment dated 3/16/23 revealed the Resident was cognitively intact, required supervision to limited assistance to perform Activities of Daily Living (ADL), and was dependent on renal dialysis. Review of Resident #196's care plans revealed a care plan entitled, "I need peritoneal dialysis. It is provided nightly by (external dialysis provider)" (Initiated and Revised: 3/10/23). The care plan included the interventions: - "Labs as ordered by MD and report as necessary" (Initiated: 3/10/23) - "Monitor/document and report to physician signs/symptoms of renal insufficiency, changes in level of consciousness, change in skin turgor, change in vital signs or heart/lung sounds, access site infection" (Initiated: 3/10/23) - "My peritoneal dressing will be changed by (external dialysis provider)" (Initiated: 3/10/23) Review of Resident #196's health care provider orders revealed the order, "Peritoneal Dialysis nightly to be provided by (external company) every shift ..." (Ordered: 3/10/23). There was no order related to obtaining and/or monitoring the Resident's weight.			

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Review of Resident #196's progress note documentation in the EMR included the following:

- 3/10/23 at 7:03 PM: "Peritoneal Dialysis Progress Note-Connection ...Weight: None taken ... Staff/patient education provided ...Daily weights"

- 3/11/23 at 8:02 AM: "Dialysis Progress Note-Disconnection ... Fluid volume out: 2800 ...Staff/patient education provided: Daily weight ..."

- 3/15/23 at 8:54 AM: "Peritoneal Dialysis Progress Note-Disconnection ... Fluid volume out: 3300ml ... Staff/patient education provided: asked for new weight today ..."

- 3/16/23 at 6:18 AM: "Peritoneal Dialysis Progress Note-Disconnection ...Fluid volume out: 3000 ... Staff/patient education provided: daily weights ..."

- 3/16/23 at 7:19 PM: "Peritoneal Dialysis Progress Note-Connection ... Weight: none taken ... Staff/patient education provided: daily weights ..."

- 3/17/23 at 6:17 AM: "Peritoneal Dialysis Progress Note-Disconnection ... Fluid volume out: 2900 ..."

- 3/17/23 at 8:06 PM: "Peritoneal Dialysis Progress Note-Connection ... Vitals (and blood glucose level if the patient has diabetes): 142/78 (blood pressure), 70 (pulse), 20 (respirations), 97.3 (temperature), Weight: none taken today ...

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Staff/patient education provided: daily weight ..."

Note: No Blood Glucose Level included in note

- 3/18/23 at 6:06 AM: "Peritoneal Dialysis Progress Note-Disconnection ... Staff/patient education provided: daily weights ..."

Review of Resident #196's "Weight Summary" documentation in the EMR indicated the Resident was only weighed on 3/10/23. The documentation included:

- 3/10/23 at 1:02 PM: 244.0 pounds (lbs), Standing

- 3/10/23 at 1:06 PM: 239.4 lbs, Wheelchair

Review of Resident #196's Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include any additional weight documentation.

An interview was conducted with Certified Nursing Assistant (CNA) "P" and CNA "Q" on 3/21/23 at 10:55 AM. When queried regarding the peritoneal dialysis equipment in Resident #196's room, both CNA's revealed the equipment stays in the room for the dialysis staff. When asked how often Resident #196 is supposed to be weighed, CNA "P" and CNA "Q" revealed they were not aware of having a task in place to weigh the Resident.

On 3/21/23 at 11:06 AM, an interview was completed with Resident #196 in their room. When queried regarding their peritoneal dialysis, Resident #196 revealed they were completing the treatment at home prior to coming to the facility.

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	When queried regarding monitoring their weight related to dialysis, Resident #196 stated, "I weigh myself at home before dialysis." When asked if they are weighed before dialysis at the facility, Resident #196 stated, "No, not here." When asked why, Resident #196 indicated the dialysis staff said they spoke to the facility staff about getting their weights but the facility staff are busy. An interview was completed with Registered Dietician (RD) "V" on 3/21/23 at 11:34 AM. When queried regarding weight and nutritional monitoring and assessment for Residents receiving dialysis, RD "V" stated, "Gotta follow the policy for where you're at for how often weigh (residents)." RD "V" was then asked if Resident #196 had an order for weight monitoring in the EMR. RD "V" reviewed the EMR and stated, "I do not see a weight order." When asked if there should be an order to monitor the Resident's weight, RD "V" indicated there should be. RD "V" stated, "I don't know why not. I thought it was automatic." When asked what they meant, RD "V" revealed they thought an order for weight monitoring was automatically entered in the EMR when a resident was admitted. With further inquiry, RD "V" stated, "I don't know. I don't put that in." When asked if they monitor Resident weights, RD "V" indicated they did. RD "V" was then asked to review Resident #196's documented weights. When queried regarding the weights documented, including variation in the two weights on the same day, RD "V" stated, "I can't explain that." When asked if they were aware Resident #196 was receiving peritoneal dialysis, RD "V" revealed they were. When queried regarding nutritional and weight monitoring and assessment, RD "V"			

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	stated, "(Resident #196) should have weights for sure. For peritoneal (dialysis), we are supposed to be weighing them." No further explanation was provided. An interview and review of Resident #196's EMR was completed with Unit Manager Registered Nurse (RN) "H" on 3/21/23 at 3:50 PM. When queried regarding Resident #196's peritoneal dialysis, RN "H" specified the treatment is completed nightly by an external dialysis provider who comes to the facility. RN "H" was queried regarding communication between the dialysis provider and the facility including written documentation such as an information binder and stated, "They don't have a folder because they chart in our charts." When queried how often Residents who are receiving dialysis daily should be weighed, RN "H" replied. "Daily." RN "H" was asked to review Resident #196's healthcare provider orders in the EMR. After reviewing the orders, RN "H" stated, "No daily weights." When queried why there was no order to obtain the Resident's weight, RN "H" confirmed but did not provide an explanation. RN "H" revealed they would put in an order for weights. When queried if vital signs should be obtained prior to and/or after dialysis, RN "H" indicated vital signs should be obtained before and after the treatment. Resident #196's documentation was reviewed with RN "H" at this time. When asked if the vital signs documented in the notes and vital sign section were pre or post dialysis treatment, RN "H" stated, "Those are all pre (dialysis) vitals." When asked about the completion of post dialysis vitals, RN "H" stated, "I would think it's important." When queried why post dialysis vitals were not obtained and documented, RN "H" did not			

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	provide further explanation. Review of facility provided policy/procedure entitled, "Policy: Performing Dialysis in the SNF Procedure" (Effective 9/2022) did not include any information pertaining to vital sign and/or weight monitoring. Review of "Nursing Facility Peritoneal Dialysis Agreement" (Effective Date: 9/7/22) detailed, " ... Duties and Responsibilities ... 3. Nursing Facility is responsible for ... d. Monitoring the patients before, during, and after dialysis treatments for complications possibly related to dialysis ..."			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%, when 5 medication errors were observed from a total of 27 opportunities, for 5 residents (Resident # 41, Resident #62, Resident #75, Resident #80 and Resident #242) of 7 residents observed for medication administration, resulting in an error rate of 18.51%. Findings Include: Medication Administration:	F0759	Element 1 Residents # 41,62,75,80, and 242 have had a chart review completed by the DON to ensure there were no negative effects related to the breech in practice by 4/12/2023. Element 2 A nurse manager (or provider) has reviewed the current status of resident□s vital signs and blood glucose trends to identify any movement from baseline. This was completed by 4/11/2023. Element 3 The licensed nurses have been educated on the Administering of Medications Policy by 4/12/2023 or during the next scheduled shift by the DON/designee. The consultant Pharmacist will conduct monthly random Medication administration audits of nurses to maintain compliance. The DON/ Administrator reviewed and approved the administering medication policy on 4/5/2023.	4/12/2023

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	On 3/17/2023 at 9:40 AM, Medication administration was observed with Nurse "I" for Resident # 62. The resident received two injections of insulin. The orders revealed the following: "Insulin Detemir Solution Inject 20 units subcutaneously two times a day for diabetes," Start date 4/21/2022. "Insulin Aspart Solution 100 units/ml, Inject 4 units subcutaneously before meals for diabetes, hold if accucheck below 100," start date 4/27/2022. The Medication Administration Record (MAR) indicated the Insulin Detemir was to be given at 8:00 AM and 8:00 PM and the Insulin Aspart was to be given at 8:00 AM, 12:00 PM and 5:00 PM. Nurse "I" was asked about the Insulin being given after breakfast, as the resident had already eaten and stated, "We try to give it before meals." Resident #62: A record review of the Care Plan for Resident #62 revealed, "I have Diabetes Mellitus," date initiated and revised 9/7/2021, with Interventions: "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness," date initiated 9/7/2021.		Element 4 An audit of medication pass will be completed by the DON/designee at least 4 times per week. The Director of Nursing will submit findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	

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	On 3/17/2023 at approximately 11:40 AM, medication administration was observed with Nurse "W" for Resident #80, the resident received an injection of 10 units of insulin for a blood glucose of 366. Resident #80 was asked what she had eaten that day and she said she was on her way to lunch, but she listed a variety of foods she had eaten for breakfast and during facility activity functions. The resident stated, "I had my insulin lat this morning; It was after breakfast. The insulin order was identified as follows: Insulin Lispro Junior Kwikpen subcutaneous Solution Pen-injector 100 units/ml (Insulin Lispro) Inject as per sliding scale: ... subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus ... start date 2/15/2023. Resident #80: The MAR for Resident #80 indicated the Insulin Lispro per sliding scale was to be given at 7:30 AM, 11:30 AM, 4:30 PM and 8:00 PM. A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #80 indicated the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 15/15. A review of the Care Plan for Resident #80 provided, "I have Diabetes Mellitus, type II," date initiated and revised 3/15/2023 with			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interventions: 'Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness," date initiated and revised 3/15/2023. Resident #242: A medication pass observation for Resident #242 was completed with Licensed Practical Nurse (LPN) "X" on 3/17/23 at 8:04 AM. LPN "X" was observed removing the following medications from the medication cart for administration to the Resident: - Iron Supplement 325 milligram (mg); one tablet - Midodrine HCL (medication used to treat hypotension- low blood pressure) 10 mg; one tablet - Potassium Chloride (supplement) 10 milliequivalent (mEq); two tablets - Metformin (medication used to treat diabetes mellitus) 1000 mg; one tablet - Effient (anti-platelet medication) 10 mg; one tablet - Zoloft (antidepressant medication) 5 mg; one tablet - Bumex (diuretic medication)1 mg; one tablet LPN "X" rapidly removed the medications from the original containers, marked the medications off with a "Y" in the Electronic Medication Record (EMAR) to indicate they were being			

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	administered, and placed them in a medication cup. LPN "X" then returned the medication containers to the medication cart. LPN "X" proceeded to lock the cart and pick up the medication cup containing the medication to take to Resident #242's room for administration. Observation revealed there were only seven pills in the medication cup. Prior to entering Resident #242's room to administer the medications, LPN "X" was asked to stop and count the number of pills (medications) in the medication cup. LPN "X" counted the pills in the medication cup and stated there were "seven." When queried how many medications (pills) Resident #242 was supposed to receive and how many medications they marked off on the EMAR, LPN "Y" indicated seven medications. LPN "Y" was asked to verify the EMAR. After review, LPN "Y" revealed the Resident should have "eight" pills. LPN "Y" revealed they were unaware a medication was missing. A visual review and comparison of Resident #242's medications revealed the medication not contained in the medication cup was Resident #242's Bumex 1 mg tablet. LPN "X" placed the Bumex 1 mg tablet in the medication cup for administration. LPN "Y" was queried regarding the reason the medication not being in the cup and documented as being administered on the EMAR prior to this Surveyor stopping them but did not provide an explanation. Resident #41: On 3/17/23 at 8:23 AM, a medication observation for Resident #41 was completed with LPN "X". LPN "X" removed an eye drop medication contained in a box from the medication cart and indicated that was the only medication Resident #41 had due at this time.			

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	The medication removed from the medication cart was Prednisone 1% (steroid) Ophthalmic (eye) drops and "Opened 2/15/23" was written on the container. LPN "X" marked "Y" for administration on the EMAR, placed the container in a plastic cup, and proceeded to walk into the Resident's room to administer the medication. Prior to administration, LPN "X" was stopped. When asked how long Prednisone 1% eye drops are able to be used for after opened, LPN "X" stated, "I don't know." LPN "X" was asked if there is a facility policy/procedure pertaining to shelf life and efficiency after opening and indicated they did not know. LPN "X" then Googled the medication and identified it was good for "28 days" after opening. When asked, LPN "X" revealed the medication was past 28 days since being opened. LPN "X" further revealed the medication would need to be reordered from the pharmacy as there was not any more available. When asked why they were going to administer an expired medication to Resident #41, LPN "X" did not provide an explanation. Following this medication pass observation, LPN "X" was asked if they had any Resident's receiving intravenous (IV) medications. LPN "X" revealed Resident #75 had an IV medication due later in the day and observation of the medication was scheduled. This Surveyor requested to observe all steps of IV medication administration including all preparation and spiking of the IV tubing. LPN "X" verbalized understanding. Resident #75: A planned intravenous (IV) medication pass observation for Resident #75 was completed with			

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	LPN "X" on 3/17/23 at 1:00 PM. LPN "X" presented a prepared and spiked bag of Unasyn (IV antibiotic) 1.5 gram (gm)/100 milliliter (mL) with the tubing attached. When queried regarding the IV bag being spiked and tubing connected, LPN "X" indicated they had prepared the medication but did not provide further explanation. LPN "X" entered Resident #75's room to administer the IV medication. LPN "X" adjusted the Resident's clothing to access their right upper chest wall central line. LPN "X" wiped the hub of the lumen with an alcohol pad and flushed the line with 10 mL of normal saline without checking for blood return. LPN "X" then disconnected the flush and dropped the lumen where it was observed touching the Resident's clothing. LPN "X" proceeded to program the IV pump and feed the tubing through the pump. LPN "X" then wiped the central line lumen with an alcohol pad and attached the IV tubing three seconds later. Observation of the IV pump revealed it was programmed for Unasyn 1.5 gm/50mL at a rate of 100 mL per hour. The volume to be infused was set at 50 mL. LPN "X" was asked what the medication infusion rate was supposed to be and indicated 100 mL per hour after reviewing the information on the IV medication bag. When asked why the pump settings did not reflect the medication being administered, LPN "X" revealed the medication was not an option in the pump. LPN "X" was then asked what the medication volume to be infused was. After reviewing the information on the medication bag, LPN "X" indicated it was 100 mL. When asked why the pump volume to be infused was set at 50 mL when the volume of the medication was 100 mL, LPN "X" adjusted the pump settings but did not provide an explanation for the incorrect rate.			

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Review of LPN "X's" nursing competency documentation revealed a form entitled "RN-LPN Orientation Checklist." The form revealed LPN "X" was hired on 3/11/22 and the checklist was completed 4/19/22. The section on the checklist entitled, "Medication Pass/Documentation/Emergency Boxes" were blank indicating the checkoff for competency was not completed.

An interview was completed with the Director of Nursing (DON) on 3/21/22 at 11:00 AM. When queried regarding LPN "X's" competency checklist section for medication administration being blank, the DON indicated they had missed that when they reviewed it. When asked, the DON indicated they would look to see there was additional documentation pertaining to medication administration competency in LPN "X" file. A document entitled "Medication Pass Observation" dated 5/12/22 was provided by the facility. Review of the provided document revealed it was an observation of LPN "X" passing oral medications but did not address competency for any other routes of administration.

A review of the facility policy titled, "Administering Medications," revised April 2019 and reviewed 1/2023 revealed, "Medications are administered in a safe and timely manner, and as prescribed ... 4. Medications are administered in accordance with prescriber orders, including any required time frame ... 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 11. The following information is

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	checked/verified for each resident prior to administering medications ... 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container ..."			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to label and store medications and discard expired medications in accordance with acceptable pharmaceutical standards of practice for two	F0761	Element 1 Manor North Medication cart was inspected by the DON on 4/5/2023 and any items not labeled, expired or stored properly were discarded at once. Manor North Treatment cart was inspected by the DON on 4/5/2023 and any items not labeled, expired or stored properly were discarded at once. West South medication cart was inspected by the DON on 4/5/2023 and any items not labeled, expired or stored properly were discarded at once. Element 2 Medication rooms, treatment carts and medication carts were inspected by the DON on 4/4 &5/2023 for any items not labeled, expired or stored improperly, any concerns identified were corrected at once. Element 3 The licensed nurses have been educated on the Medication Storage/ labeling policy by 4/12/2023 or during the next scheduled shift by the DON/designee. The DON will have monthly medication administration in-services to review procedures with return demonstration to maintain compliance. The DON/ Administrator reviewed and approved the medication storage/labeling policy on 4/5/2023. Element 4	4/12/2023

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	medication carts: Manor North and West South, and one treatment cart: Manor North, resulting in the potential for incorrect administration of medications, unauthorized access to medications, lack of therapeutic benefits to promote healing for residents and adverse effects. Findings Include: On 3/17/23 at 10:05 AM, during an observation of medication administration on the Dementia unit, Insulin vials were observed not dated when opened. The plastic container holding the insulin vial was dated when opened, but not the insulin vial itself. Eye drop bottles were also observed with no resident name or date when opened. On 3/22/23 11:25 AM, during a review of the West South medication cart with Nurse "W" a bottle of Prostat liquid supplement was observed to have expired on 12/17/2022. The Prostat was dated as opened on 2/24/2023 and had a dried sticky substance on it, as if it had been poured. The Nurse said it should not be in the medication cart because it was expired. A tour of the Manor North Medication cart was completed on 3/17/23 at 8:43 AM with Licensed Practical Nurse (LPN) "X". The following was observed in the medication cart: The top drawer of the medication cart was noted to be divided into sections. One of the sections		An audit of the Medication/ treatment carts will be completed 3 times per week for proper storage/ labeling and no expired items by the Unit Manager/designee. The Director of Nursing will submit findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	

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	contained multiple insulin pens for various residents. The pens were intermingled and not contained in bags and/or separated by who they belonged to. - 30 fluid ounce (oz) Pro-Stat; Opened and undated - A specimen cup containing an unidentified clear colored liquid with "NR" written on the top was noted in the drawer with medications. - Prevantics antiseptic chlorhexidine gluconate 3.15 % and isopropyl alcohol 70% swab; Quantity 100; Expired 3/1/23 - Ultatrak Complete Glucometer test strips; Open and undated - Ultratrak Glucose Low Testing Solution; Expired 5/8/22 - Ultratrak Glucose Low Testing Solution; Expired 4/29/22 - Allergy Relief Tablets; Quantity 100; Expired: 3/23 - Airduo inhaler for Resident #11; Open and undated - Calcium acetate 667 mg tablets labeled for administration to Resident # 53; Quantity 270; Label specified, "Discard by 12/23/22." - Prednisone 1% ophthalmic solution labeled for administration to Resident #41; Opened 2/15/23			

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	- Levemir Flexpen Insulin; Open and undated. A sticker and/or Resident identification was not present on the insulin pen. Illegible writing was present on the cap of the pen but was unable to be read. - Lispro Insulin Pen, labeled for administration to Resident # 21. The cover of the pen was loose and partially off in the section of the medication drawer containing multiple resident's insulin pens. - Kwikpen Insulin Pen 100 unit/mL labeled for administration to Resident #53. The cover of the pen was loose and partially off in the section of the medication drawer containing multiple resident's insulin pens. - Insulin Aspart Flexpen 3 mL; Open and undated. An illegible, handwritten resident name was present on the cap of the cap of the insulin pen. - Insulin Aspart Flexpen 3 mL; Open and updated. A handwritten resident name was present on the cap of the cap of the insulin pen. - Insulin Aspart Flexpen 3 mL; Labeled for administration to Resident #13. The insulin pen was undated and labeled as refrigerate until opening. It was unable to determine if opened. On the left side of the bottom drawer of the medication cart, a bottle of Liquid Drug Disposal (liquid solution which dissolves medications for disposal) was observed sitting directly next to medications. LPN "X" was queried how long Pro-Stat is able to be used for after opened and revealed they did			

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	not know. When queried if medications with only a month and year expired on the first or last day of the month, LPN "X" replied, "First day." When queried what was in the specimen cup, LPN "X" revealed they did not know what is was or who it belonged to. When asked if glucometer test strips should be dated when opened, LPN "X" revealed glucometer testing is completed by night shift staff. LPN "X" was asked if the strips had to be used within a certain timeframe after opening but did not provide a response. When queried regarding the loose insulin pen caps and the potential for contamination, LPN "X" did not provide an explanation. An interview and observation of the above identified items in the Manor North medication cart was completed with Unit Manager Registered Nurse (RN) "H" on 3/17/23 at 9:00 AM. When asked about the medications identified above, RN "H" confirmed the medications were expired, unlabeled, and/or inappropriately labeled. When queried regarding the potential for contamination of the Insulin pens when the caps were loose and stored together, RN "H" verified the potential for ineffective infection control and contamination. When asked if the insulin pens were delivered by the pharmacy in bags for each Resident, RN "H" confirmed they were. When queried why the pens were not kept in the bag when they were placed in the drawer, RN "H" revealed the pharmacy sent multiple pens for each resident and the extra insulin pens were stored in the pharmacy bag in the refrigerator. On 3/22/23 from 9:00 AM to 9:15 AM, the Treatment Cart in the hall of the Manor North unit was observed unlocked. Multiple staff			

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	members and residents were observed moving past the Treatment Cart during this time frame. At 9:15 AM, RN "H" was shown the Treatment Cart. RN "H" verified the cart was unlocked but did not provide further explanation. When asked why the Treatment Cart was unlocked, RN "H" replied, "Not sure why the nurse left it unlocked." RN "H" was asked when the Treatment Cart was last used and replied, "Probably this morning." No further explanation was provided. A review of the facility policy titled, "Storage of Medications," dated Revised April 2019 and reviewed 1/23 provided, "The facility stores all drugs and biological's in a safe, secure, and orderly manner ... Drugs and biological's used in the facility are stored in locked compartments under proper temperature, light and humidity controls ... The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner ... Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy ... Discontinued, outdated, or deteriorated drugs or biological's are returned to the dispensing pharmacy or destroyed ... Antiseptics, disinfectants, and germicides used in any aspect of resident care have legible, distinctive labels that identify the contents and the directions for use, and are stored separately from regular medications ... Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's are locked when not in use ... Unlocked medication carts are not left unattended ... Resident medications are stored separately from each other to prevent the possibility of mixing medications between residents ..."			

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F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §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: This Citation Pertains to Intake Numbers MI00133975 and MI00134446. Based on observation, interview and record review, the facility failed to date opened food and dispose of outdated and expired food, ensure cleanliness of the kitchen floors and surfaces, ensure stacked dishes were dry, and obtain food temperatures in a sanitary manner, resulting in the potential for the spread of foodborne illness to all residents receiving meal service from a census of 90 residents. Kitchen:	F0812	Element 1 The Dietary Manager at time of walk through with surveyor corrected to the following items immediately upon seeing them, juice machine soiled filter was cleaned along with the dust remove from front of machine, the kitchen floor (including under the prep table) was swept and mopped, prep table was cleaned and sanitized, microwave was cleaned and sanitized, the 2 sink/prep sink was cleaned and sanitized. The gelatin, spaghetti, salt container, brown sugar, jars of garlic and cheese were discarded. The employee that didn□t complete the cleaning log the previous shift was re-educated at once for completing the cleaning duties on each shift. Element 2 Infection Control RN nurse reviewed the past 30 days of surveillance logs and identified no evidence of food born illness. Element 3 Dietary staff were educated on the Food Service Sanitization policy by 4/12/2023 or during the next scheduled shift by the Administrator/ CDM/designee. The Dietary Manager will complete a Kitchen Quick Rounds audit randomly of the food service department to maintain compliance. The DON/Administrator reviewed and approved the Nutrition Retention of food policy and the Food Service Sanitation policy on 4/5/2023. Element 4 The Dietary manager will complete a kitchen sanitation audit 5 times per week, the CDM/RD will complete a kitchen sanitation audit weekly. The RD/ Dietary Manager will submit findings to the QAPI committee monthly. The QAPI committee will determine	4/12/2023

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	On 3/15/23 at 9:20 AM , during a tour of the kitchen with Dietary Manager "J" the following were observed: The Juice machine had a dirty, soiled filter with caked on dust on the front of the machine. When the Dietary Manager was asked when the filter was last cleaned or changed, he said "Never." The floors in the kitchen were soiled with food pieces and dirt in all visible areas including under the prep tables. The prep tables were also soiled with pieces of food scattered about. The Dietary Manager was asked about cleaning schedules and upon review the 3/14/2023 12:00 Pm to 8:00 PM cleaning schedule was not initialed as completed. The Manager said, "They did not do it." A copy of the cleaning logs was requested at that time. The microwave was soiled with dried on food debris. The 2 sink/prep sink was soiled with dried on food debris on the food prep side and staff were observed using it soiled. The dry storage room had an opened gelatin bag with no date to identify when it was opened; the spaghetti was not dated when opened; the salt container was open to air and not closed; the brown sugar was opened and not dated; 2 jars of garlic were expired with one opened; two cheese containers were		the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not closed. The dishes (cups/plates) were observed stacked together wet on carts; the manager said they were supposed to be dry and ready for service. On 3/15/2023 at approximately 11:00 AM, the Administrator provided copies of the requested cleaning logs for the kitchen. The cleaning log that was not initialed as completed on 3/14/2023 at 12:00 PM to 8:00 PM was now filled in. This occurrence and the lack of cleanliness in the kitchen was reviewed with the Administrator. On 3/17/2023 at 12:07 PM, an observation of dietary staff obtaining food temperatures occurred. The Dietary Manager said the Cooks took the food temperatures and were trained online and with a hands on check off during a 7-day orientation; Cook "L" was observed during the process. She did not wear gloves or wash hands her hands. She used an alcohol wipes to wipe off thermometer, with her bare hands. Her hands were touching the alcohol wipe and rendered it contaminated. While temping the cooked cabbage, the thermometer fell into the cabbage and out of the bare hands of the cook. She retrieved it bare handed. A review of the facility policy titled, "Sanitization" dated revised October 2008; 2/23 provided, "The food service area shall be maintained in a clean and sanitary manner ...			

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	094010	A. BUILDING _____ B. WING _____	3/22/2023

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	All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish ... All utensils, counters, shelves and equipment shall be kept clean ... All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils ... Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment."			
F0849 SS= D	Hospice Services §483.70(o) Hospice services. §483.70(o)(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(o)(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 at least the following: (A) The services the	F0849	Element 1 Resident # 12 medical record has been updated to provide coordination of care with hospice group. Element 2 Residents residing in the center that are on hospices services have been audited to assure hospices monthly coordination of care schedules were available and medical records of hospice visits have been uploaded into the residents medical records by the IDT team by 4/5/2023. Element 3 The Interdisciplinary team has been educated on the Hospice Program Policy to include coordination of care with hospice by 4/12/2023 or during the next scheduled shift by the DON/designee. The Interdisciplinary team will meet monthly with the hospices groups to review coordination of care to maintain compliance. The DON/ Administrator reviewed and approved the hospice program policy on 4/5/2023. Element 4 Residents on hospice services will be audited	4/12/2023

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	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 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		weekly for coordination of care by the IDT team to ensure compliance. The Director of Nursing will submit findings to the QAPI committee monthly. The QAPI committee will determine the ongoing frequency of audits. The Administrator/ Director of Nursing are responsible for sustained compliance.	

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	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(o)(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 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			

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	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 furnishing care to LTC residents. §483.70(o)(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:			

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Based on observation, interview, and record review the facility failed to collaborate with hospices services for one resident (Resident #12), resulting in hospice and the facility failing to establish an effective communication and collaboration process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.

Resident #12:

During initial tour on 3/16/2023, Resident #12 was observed in the dining area resting in his Broda chair. He did not appear to be in distress but was not able to be interviewed.

On 3/16/2023 at approximately 4:00 PM, a review was completed of Resident #12's medical records and it revealed the resident was admitted to the facility on 9/30/2022 with diagnoses of Alzheimer's Disease, Dementia, Major Depressive Disorder, Anxiety Disorder and Chronic Kidney Disease. Resident #12 is severely cognitively impaired and required assistance with his daily cares and is a hospice patient since before his admission to the facility. Further review of Resident #12's records revealed the following:

Care Plan:

Focus: "I am on end of life comfort care with facility and ...Hospice."

Interventions: "Assist me to from activities of my choice. Assist me with activities as needed. I enjoy western movies. Provide me with activity supplies upon request ..."

Progress Notes:

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	Resident #12's progress notes were reviewed from December 2022 to March 2023 and there was no indication of when/if hospice visited the resident at the facility nor which disciplines that worked with him. Miscellaneous Items: Review was completed of Resident #12' scanned in documents and it was found there were two hospice documents scanned into his record. There was no other record of hospice being involved with the resident's care. - 1/19/23 -Comprehensive Assessment and Plan of Care update - 12/30/22- Comprehensive Assessment and Plan of Care update On 03/17/23 at 09:47 AM, an interview was conducted with Social Worker "B" regarding Resident #12 and his hospice team. Social Worker "B" most of their hospice companies are wonderful with sending their documentation timely and communicating with the facility. Social Worker "B" explained they are supposed to send over their documentation upon completion and the facility will upload them into the resident's chart for access. There is a concern with Resident #12's hospice company not sending their documentation for them to upload into the resident's chart timely. Social Worker "B" stated there should be a calendar on unit that indicates the residents schedule. Social Worker "B" was informed there were only two hospice documents scanned into Resident #12's record when he was admitted on hospice in 9/2022. A discussion was held it is unclear how the facility it is collaborating effectively for the care of Resident #12 when there seems to be a breakdown in communication and processes. Social Worker "B"			

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	expressed understanding of the concern. On 3/17/2023 at 10:30 AM, Nurse "I" was asked for the hospice book for Resident #12. Nurse "I" reported when hospice visits the a facility nurse sign their tablets that to affirm they were in the facility with the resident. She continued she was not sure how many times a week they come or which disciplines. Nurse "I" and this writer reviewed the hospice book and observed that hospice representatives sign the calendar upon their arrival to the facility. It is unknown what their hospice schedule is and when they are coming until they arrive. Furthermore, it is not known which hospice disciplines are involved in Resident #12's care. On 3/24/2023 at 2:00 PM, a review was completed of the facility policy entitled, "Hospice Program," reviewed 3/23. The policy stated, " ...In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including: Determining the appropriate hospice plan of care; Changing the level of services provided when it is deemed appropriate; Providing medical direction, nursing and clinical management of the terminal illness; Providing spiritual, bereavement and/or psychosocial counseling and social services as needed; and Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms ... Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day ... Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being ..."			

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	On 3/24/2023 at 1:30 PM, a review was completed of the Hospice Company that provided services for Resident #12, the contracted was secured on 2/24/2021. The contact stated, " ...Hospice shall promote open and frequent communication with facility and shall provide facility with sufficient information to ensure that the provision of Facility Services under this agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and care coordination ..."			