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	085033	A. BUILDING _____ B. WING _____	C 09/25/2023

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PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 70 9/8/23 at 12:30 PM.	F 679	the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 684 SS=H	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of facility and other documentation as indicated, it was determined that for nine (R172, R143, R165, R182, R121, R132, R509, R513, and R26) out of thirteen residents reviewed for quality of care, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plans. For R172, the facility caused harm by the failure to ensure that R172 received adequate care to prevent a rehospitalization which included emergency procedures to save R172's life. While a resident at the facility, R172 failed to receive a facility arranged outpatient surgical foot doctor appointment after a 5/19/22 hospital discharge. Additionally, R172 did not receive a 5/24/22 dose	F 684	F684- Quality of Care A. 1. R172 no longer reside at the facility 2. R143 no longer reside at the facility 3. R165 no longer reside at the facility 4. R182 no longer reside at the facility 5. R121 Continues to reside at the facility. R121 continues to experience chronic loose stools due to IBS, colitis and lactose intolerance. R121 refuses lactated milk or Lactaid tablets and refused an appointment with gastroenterologist. Attending physician has been made aware and ordered anti-diarrhea medication and skin barrier cream. An intervention for turning and repositioning has been implemented with all interventions care planned.	11/30/23

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F 684	Continued From page 71 of a medication to stimulate/increase his red blood cell count. On 5/27/22, R172 was readmitted to the hospital emergency room as a Trauma Code, requiring several lifesaving emergency procedures as a result of his left foot wound bleeding and his critically low blood levels. For R143 the facility failed to ensure that R143 received competent nursing care to address R143's constipation when R143 did not have a bowel movement for six (6) consecutive days, 8/1/23 thru 8/7/23. For R165, the facility caused harm to a dialysis resident who missed treatment on 7/19/23. The facility failed to notify the physician, failed to monitor R165 for fluid overload, failed to obtain, monitor, and document complete vital signs. R165 was admitted to the hospital on 7/20/23 with diagnoses including, but were not limited to, unresponsiveness, hyperkalemia and fluid overload. For R182, the facility caused harm by the failure to initiate and monitor fluid intake when the practitioner ordered a 1,500 ml fluid restriction on 7/14/23 and failed to obtain a BMP lab. R182 was sent to the Emergency Department (ED) on 7/20/23 for a change of condition, admitted to the medical ICU, after hospital lab results revealed the sodium level was 105, a critical level. Additionally for R182, the facility caused harm by the failure to monitor and initiate a bowel protocol regimen, which resulted in R182 being diagnosed with a fecal impaction of the rectum on 7/20/23 after being emergently hospitalized for an unrelated change of condition. For R121 the facility caused harm by the failure to ensure R121 received treatment for continued loose stools/diarrhea and as a result of this failure R121 has developed a red and excoriated buttocks and scrotum area. For R132, the facility failed to ensure R132's abdominal binder and thigh high stockings were	F 684	6. R132 no longer resides at the facility. 7. R513 no longer resides at the facility 8. R509 no longer resides at the facility. 9. R26 continues to reside at the facility. Licensed nursing staff that did not document/perform wound treatments care provided will be counseled. R26 surgical wound was re-evaluated and care was changed to wound vac and is being completed as ordered and care planned. B. 1. All residents receiving medication(s) with parameters and ordered for follow-up consult appointments outside of the facility have the potential to be affected by this practice. DON/designee will audit all residents who have orders with parameters to ensure that the parameters are written to identify when to administer the medication. All residents who have been ordered a follow-up appointment outside the facility have the potential to be affected by this practice. Residents with orders and consultation reports for follow-up appointments will be audited by DON/designee to ensure attendance. Residents identified as missing appointments will have them rescheduled and followed by DON/designee to ensure attendance. Cross Reference 773 Lab Services 2. All residents have the potential to be affected by this practice. DON/designee will review all residents bowel movements for the last 3 days. Any resident identified as not having a BM within the last 3 days will have the bowel protocol initiated. 3. All residents who are receiving dialysis	

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F 684	Continued From page 72 applied on him as ordered by the physician and care planned to treat his orthostatic or postural hypotension (low blood pressure caused by postural changes). In addition, the facility failed to ensure a system was in place to monitor R132's actual total volume fluid intake to maintain the 1.5 L (liter)/day fluid restriction. For R513, the facility failed to administer the prescribed elavil, an antidepressant medication, for two occurrences on 8/7/23 and 8/9/23. For R509, the facility failed to ensure that the weekly skin assessments were completed by the nursing staff during R509's scheduled shower days. In addition, the facility failed to ensure that R509's consumption of the Ensure supplement drink was monitored and recorded, and for R26, the facility failed to provide surgical wound care as ordered by the physician. Findings include: 1. Cross refer to F656 and F710. Review of R172's clinical record revealed: 5/10/22 - R172 was admitted to the facility with multiple diagnosis including a recent left foot surgical toe removal, anemia, a bone infection, rehabilitation and a need for personal care. 5/11/22 - A physician's order was written for daily dressing changes to R172's left foot. 5/11/22 - R172 was sent to the hospital when his left foot wound began to bleed heavily. The hospital admitted R172 for foot wound care and the monitoring of R172's Hemoglobin (Hgb-levels of red blood cells). 5/19/22 - R172 was readmitted to the facility upon hospital discharge. The hospital discharge	F 684	services have the potential to be affected by this practice. The NHA will audit all residents receiving dialysis services transportation arrangements to ensure the arrangements have been made with an indefinite end date. The provider will be notified of missed dialysis sessions for further directions by the licensed nurse. Residents receiving dialysis services will have orders entered by the UM to alert licensed nurses to assess for fluid overload. 4. All residents who are on a fluid restriction have the potential to be affected by this practice. The dietitian will audit orders for fluid restrictions for fluid intake to ensure the residents are meeting their needs. The provider will be notified by the dietitian of those residents identified as not meeting their fluid needs for further directions. 5. All residents experiencing loose stools have the potential to be affected by this practice. DON/designee will perform a 1 week look back on all residents□ bowel movement documentation to identify those with loose stools. Any identified will have a body audit completed by the licensed nurse to identify if resident is experiencing sacrum excoriation. Those identified with loose stool and excoriation will have the provider notified for further recommendations by the DON. 6. All residents with orders for abdominal binder and ted stockings have the potential to be affected by this practice. The DON/designee will identify residents with orders to have abdominal binder, ted stockings, or other adaptive devices	

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F 684	Continued From page 73 records documented that R172 received one unit of blood during his hospital stay and that his Hgb was stable at 8. According to the Mayo Clinic, a normal Hgb range for a male is 13.2 to 16.6 grams per deciliter (g/dcl.) Additionally, R172 was to have a follow up visit to his surgical foot care doctor in the week after his hospital discharge. 5/22/22 - A physician's order was written by E6 to obtain a Complete Blood Count (CBC) laboratory test. The laboratory test would test for R172's Hgb level. 5/24/22 - A physician's order was written for Epoetin, inject 1 ml one time a day every week for anemia, hold for Hgb less than 10. A review of the prescribing information for Epoetin from the maker of the drug, Janssen Products, documents that the medication should be given when a Hgb level is less than 10 g/dL. 5/27/22 - Record review revealed R172 was found unconscious in his room with an extensive amount of blood surrounding him and R172 was sent to the hospital by ambulance. R172 was received as Trauma Code in the hospital emergency room with a critically low Hgb, and his blood pressure and blood oxygen level were both unmeasurable. R172 needed to have emergency procedures to support and to maintain his life, including the placement of an emergency airway tube for his breathing, advanced heart life support after R172's heart stopped beating, a surgically placed Intravenous (IV) access to receive blood transfusions, emergency surgery to his left foot to stop wound bleeding and further treatment in the hospital intensive care unit after R172's emergency care was provided.	F 684	will be place on the EHR Kardex and for supplemental documentation added to orders to have licensed nurses document application. 7. All residents receiving medications have the potential to be affected by this practice. The DON/designee will perform a 14-day look-back audit to all residents receiving medications to identify any missed administration. The provider will be made aware of missed administration for further directions by the DON. 8. All residents have the potential to be affected by this practice of not having a weekly skin assessment completed. Wound NP performed a skin sweep completed 9/10/23 and 9/18/23. Any residents noted with skin issues had new/updated orders for treatments and were care planned appropriately. The DON/designee will review all residents to identify any missed weekly skin assessments, those identified residents will have a skin assessment completed. All residents who are ordered Ensure have the potential to be affected by this practice. DON/designee will review all Ensure orders and have supplemental documentation added to alert the licensed nurses to document consumption %. 9. All residents receiving wound care have the potential to be affected by this practice. The DON/designee will audit TARs of residents receiving treatments to identify residents with missing treatment documentation and will have provider notified for further	

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F 684	Continued From page 74 8/16/23 - A review of R172's Electronic Medical Rrecord (EMR) documentation from 5/11/22-5/27/22 revealed the following: - R172 did not receive an injection of Epoetin on 5/24/22. - R172 was not provided with a surgical foot care appointment after his 5/19/22 hospital discharge, which was to have been scheduled by the facility. - R172's daily dressing changes were not documented in EMR by nursing staff. 8/29/23 - A review of the facility's Nursing Policies and Procedures-Wound Care-General Wound Care/Dressing Changes, effective 11/1/19 revealed the following: Policy: "A licensed nurse will provide wound care/dressing changes(s) as ordered by a physician. Procedure: ... 9. Document in Progress Notes any unusual findings and follow-up interventions ...". 8/29/23 10:15 AM - During an interview, E12 (LPN) stated that for the Epoetin order written to hold for Hgb less than 10, that she would have questioned/clarified the order with the provider because she knows that the medication should be given for a Hgb level below 10. 8/29/23 10:30 AM - During an interview, P1 (Surgical Orthopedics office staff) confirmed that R172 did not have a follow up surgical foot care appointment during the week 5/20/22 - 5/27/22. 8/30/23 11:00 AM - During an interview, E18 (Nurse Practitioner) stated that the instructions for the medication order Epoetin 1 ml injection one time for anemia, hold for Hgb less than 10, should have read to hold the medication for a Hgb greater than 10 and that R172 should have	F 684	instructions. C. 1. Root cause analysis completed results identified that the nurse failed to transcribe orders correctly, medical provider failed to accurately review order prior to signing. An order recap report which includes order summary and directions for administration will be ran and all new orders will be reviewed daily on 11-7 shift and at the clinical meeting to identify any inaccuracies, those identified will be brought to the provider's attention for further directions. A daily review of all consult order recommendations will be reviewed by the unit manager/supervisors to ensure accuracy and completion of order. The Medical Director will submit a memo to all providers educating them on reviewing each order for appropriate components (I.e; parameters, stop date, start date, route, dosage, frequency, etc) prior to signing the order. DON/designee will educate license nursing staff on transcribing orders, to ensure that the orders are read back to the provider to ensure accuracy and the parameters for medication(s). Root cause analysis completed results identified that there were no identified personnel identified as responsible to arrange for residents requiring follow-up appointments outside the facility . Upon admission to the facility, the UM/supervisor will review discharge orders to determine if any follow up appointments are required. The UM/supervisor will complete an appointment request form detailing the	

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F 684	Continued From page 75 received the medication. Upon seeing the Epoetin order written incorrectly in the EMR, E18 stated that the order must have been written incorrectly in the Emr by the nurse at the time that the order was given. R172 experienced harm from the facility not giving the medication Epoetin on 5/24/22, and the lack of the facility scheduling his surgical foot doctor follow up appointment the week of 5/20/22-5/27/22, after his 5/19/22 hospital discharge. 2. Review of R143's record revealed: 7/31/23 - R143 was admitted to the facility with multiple diagnoses including lung cancer and pneumonia. 7/31/23 - A physician's order was written for polyethylene glycol oral powder 17 GM, give 1 scoop by mouth one time a day for constipation. 7/31/23 - A physician's order was written for Fleet enema as needed for constipation, use only if the bisacodyl suppository is ineffective. 8/1/23 - A physician's order was written for bisacodyl suppository 10 mg, insert 1 suppository rectally every 24 hours as needed for constipation. 8/2/23 - R143's entry MDS assessment revealed a BIMS score of 5, which indicated severe mental impairment. 8/27/23 - A review of the facility policy: Medical Facilities of America Nursing Polices and Procedures for Constipation, revised 11/1/19,	F 684	appointment information (provider, location, phone, approximate date if applicable, reason for appointment, etc). This appointment request form will then be given to the unit clerk for scheduling of the appointment. The unit clerk will utilize the bottom of the form to indicate the date the appointment was scheduled for, transportation information and place the appointment sheet in the unit appointment binder under the date of the appointment. The unit clerk will also enter the appointment details in the EHR system until the resident's calendar. The UM/supervisor will review consultation sheets each day to determine if any follow up appointments are needed. The UM/supervisor will complete an appointment request form detailing the appointment information (provider, location, phone, approximate date if applicable, reason for appointment, etc). This appointment request form will then be given to the unit clerk for scheduling of the appointment. The unit clerk will utilize the bottom of the form to indicate the date the appointment was scheduled for, transportation information and place the appointment sheet in the unit appointment binder under the date of the appointment. The unit clerk will also enter the appointment details in the EHR system until the resident's calendar. The SDS will educate the UM, supervisors and unit clerks on the follow up appointment process. 2. Root cause analysis results identified failure of nurse to initiate bowel protocol	

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F 684	Continued From page 76 revealed the following: "Policy: Patient's will be monitored for regular bowel movements as evidenced by a bowel movement every three days or as determined by individual assessment, medical condition or functional status. Procedure: 1. Nurse will routinely review to determine patients in need of intervention to facilitate bowel movement. 3. Initiate any or all of the following interventions and document in the clinical record ... d. Stool Softeners, suppositories, laxatives and/or enemas as ordered by the physician". 8/28/23 - Review of the facility Documentation Survey Report revealed that R143 did not have a bowel movement from 8/1/23 at 11:19 PM until 8/7/23 at 11:22 PM. The review also revealed that R143 did not receive a bisacodyl suppository or a Fleet enema when R143 did not have a bowel movement after three (3) days from his last bowel movement on 8/1/23 at 11:19 PM. Additionally, R143 did not receive his daily scheduled doses of constipation medication polyethylene glycol oral powder 17 GM for the days 7/4/23 thru 7/8/23. 8/29/23 12:00 PM - During an interview, E56 (LPN) stated that the Electronic Medical Record (EMR) alerts a nurse when a resident has not had a bowel movement for nine (9) shifts/or for three (3) days. E56 confirmed that R143 had not had a bowel movement documented from 8/1/22 at 11:19 PM until 8/7/23 at 11:22 PM and that constipation relieving medications had not been started for R143. E56 stated that a resident's constipation status is not part of a nursing shift to shift report. 8/29/23 12:45 PM - During an interview, E57	F 684	per policy and failure to provide accurate shift to shift report regarding resident status. When starting their shift, the licensed nurse will review the PCC for pertinent information including but not limited to the clinical dashboard (which includes census data, BM list). If a resident is listed on the BM alert list, the 7 to 3 nurse will initiate the bowel protocol per provider direction. This will be documented in the EHR when initiated and effectiveness of bowel protocol. The 7 to 3 nurse will pass on during report if the bowel protocol was ineffective and the 3 to 11 nurse will initiate the next step and document it in the EHR. The 3 to 11 nurse will pass on during shift report if the bowel protocol was ineffective and the 11 to 7 nurse will initiate the 3rd step in the bowel protocol and document it in the EHR. If the resident did not have any effective results for the bowel protocol the licensed nurse will notify the provider for further direction. The UM/supervisors will pull a house wide BM alert list and follow up with licensed nurse to ensure the bowel protocol was started during their shift accordingly. The Staff Developer will educate licensed nurses on the constipation protocol and on how to locate clinical alerts within the EHR system, the steps within the bowel protocol and passing the progression of the bowel protocol along in shift to shift report. 3. Root cause analysis completed; results identified that there was a stop date transportation for resident receiving dialysis services and the transportation form was not completed to continue	

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F 684	Continued From page 77 (LPN) stated that a constipation alert should had been present in the EMR when a resident has not had a BM for 3 days. E57 confirmed that constipation relieving medications had not been administered to R143 when he had not a bowel movement for three days. E57 stated that a resident's constipation status is not part of a nursing shift to shift report. 3. 11/1/19 - The facility's policy titled, "Fluid management/fluid restrictions included ...The nursing staff will monitor, and access residents placed on fluid restrictions." 11/1/19 - The facility's policy titled, "Transportation and Appointments included ...A licensed nurse will ensure that transportation to medically related appointments and will be responsible for coordinating those transports as appropriate." Review of R165' clinical records revealed: 3/2/23 - R165 was admitted to the facility with diagnosis including but not limited to end stage renal disease requiring dialysis (cleansing of the blood by artificial means when kidneys have failed) three times a week, hypokalemia (low potassium level in the blood), and type 2 diabetes mellitus. R165's admission records documented that R165 was scheduled for pickup from the facility between 6:25 AM - 6:55 AM and "a chair time" (time resident is expected to start hemodialysis treatment) on Monday, Wednesday, and Friday at 7:10 AM. 3/2/23- R165's care plan documented, "R165 is at	F 684	transportation. Upon admission to the facility, the UM/supervisor will review discharge orders to determine if any follow up appointments are required. The UM/supervisor will complete an appointment request form detailing the appointment information (provider, location, phone, approximate date if applicable, reason for appointment, if it is a one-time appointment or continuous (dialysis), etc). This appointment request form will then be given to the unit clerk for scheduling of the appointment. The unit clerk will utilize the bottom of the form to indicate the date the appointment was scheduled for, transportation information, verify it has no stop date for continuous (dialysis) appointments and place the appointment sheet in the unit appointment binder under the date of the appointment. The unit clerk will also enter the appointment details in the EHR system until the resident's calendar. The UM/supervisor will review consultation sheets each day to determine if any follow up appointments are needed. The UM/supervisor will complete an appointment request form detailing the appointment information (provider, location, phone, approximate date if applicable, reason for appointment, etc). This appointment request form will then be given to the unit clerk for scheduling of the appointment. The unit clerk will utilize the bottom of the form to indicate the date the appointment was scheduled for, transportation information and place the appointment sheet in the unit appointment binder under the date of the appointment.	

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F 684	Continued From page 78 increased risk due to requiring dialysis for end stage kidney disease." Interventions included dialysis every Monday, Wednesday, and Friday, and 1200 ml fluid restriction (480 ml with nursing, and 720 ml with dietary) every 24 hours. 7/19/23 - R165's medical record documented, "Patient was not picked up for dialysis this am ...transportation company stated that patient only had trips scheduled until 7/17/23. Dialysis center stated they would be unable to see patient today but would see tomorrow (7/20/23) at 11:45 AM. Transportation scheduled for pick up at 10:45 AM ...." The facility lacked evidence that R165 was monitored for fluid overload including assessment of lung sounds, weight, and a complete set of vital signs. The facility also lacked evidence that the physician was notified of the missed dialysis treatment. 7/20/23 - The facility lacked evidence that R165's vital signs were obtained prior to dialysis. 7/20/23 10:50 AM - R165's medical record documented, "Patient left facility for dialysis via stretcher ...communication binder and lunch sent with patient. " 7/20/23 12:13 AM - A nursing note documented, " ...Received call from dialysis... was notified patient was unresponsive upon arrival ... patient was sent to the Emergency Room." 7/20/23 - R165 was admitted to the intensive care unit with diagnosis including but not limited to ... critical hyperkalemia (high potassium in the blood) of 8.7 (normal is 3.5-5.2) and received	F 684	The unit clerk will also enter the appointment details in the EHR system until the resident's calendar. The unit clerk will complete the appropriate transportation form and submit it to the appropriate agency to continue with transportation. The SDS will educate the UM, supervisors and unit clerks on the follow up appointment process. Root cause analysis conducted results identified knowledge deficit on assessment for fluid overload for residents who missed dialysis services. If a resident misses dialysis, the licensed nurse will complete a fluid overload assessment including vital signs, lung sounds and assessing for edema. This assessment will be completed every shift until the resident has their next dialysis appointment. The provider will be notified of any missed dialysis appointments for further direction. DON/designee will educate licensed nurses that when a resident has missed a dialysis session a fluid overload assessment will be completed, and the provider is to be notified for further instructions. An order will be obtained by UM/Supervisor to alert licensed nursing staff to assess for fluid overload for residents receiving dialysis services when dialysis appointments are missed. 4. Root cause analysis completed results identified some knowledge deficit by the licensed nursing staff on ensuring a resident on fluid restriction meet the ordered needs. Dietician will provide Food Service Director a list of residents	

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F 684	Continued From page 79 continued renal replacement therapy (CRRT- 24 hours dialysis therapy for acute kidney injury and fluid overload.) R165 remained in the hospital from 7/20-8/15/23 (26 days). Review of R165's fluid intake records revealed: 5/1/23 - 5/31/23 - No evidence of fluid intake documentation. 6/1/23 - 6/30/23 - No evidence of fluid intake documentation. 7/12/23 = 2240 ml. 7/13/23 = 2500 ml. 7/17/23 = 1440 ml. 7/18/23 = 1440 ml. 8/28/23 1:01 PM - During an interview with E34 (LPN) on the 11-7 shift of 7/20/23 stated he could not remember what R165's status was prior to going to dialysis, "I take care of a lot of dialysis patients." 8/28/23 1:21 PM - During an interview with E32 (dialysis center RN) stated, "The resident arrived here almost out of it. He was breathing but that was about it. His blood pressure 88/34, pulse 78 and respirations 12. I did not feel that he was stable enough to be dialyzed here, so we called 911 and sent him to the ER." E32 further stated, "It is the responsibility of the nursing home to arrange and follow up with transportation for the residents who live there." 9/1/23 10:30 AM - During interview with R37 (LPN) stated that the facility has the responsibility to arrange transportation for the residents. R37 further stated, "I am on all of the units, so I don't what is followed up on or not." 4. The facility's policy and procedure entitled	F 684	on fluid restrictions and the amount that is assigned to each resident. The food service director will take that amount and ensure it is entered correctly in the dietary system so an accurate fluid amount can be provided on meal trays. Fluid intake is recorded every shift by provider order and POC documentation. A fluid intake report was developed by informatics nurse to allow for a review of residents□ fluid intake. This report will be pulled to ensure the resident is receiving the appropriate amount of fluid intake by the dietitian. Any decrease in intake will be reported to the provider for further information. The DON/designee will educate the nursing staff on order of intake and fluid intake report. 5. Root cause analysis results identified failure of nurse to initiate bowel protocol per policy and failure to provide accurate shift to shift report regarding resident status. When starting their shift, the licensed nurse will review the PCC for pertinent information including but not limited to the clinical dashboard (which includes census data, BM list). If a resident is listed on the BM alert list, the 7 to 3 nurse will initiate the bowel protocol per provider direction. This will be documented in the EHR when initiated and effectiveness of bowel protocol. The 7 to 3 nurse will pass on during report if the bowel protocol was ineffective and the 3 to 11 nurse will initiate the next step and document it in the EHR. The 3 to 11 nurse will pass on during shift report if the bowel protocol was ineffective and the 11 to 7 nurse will initiate the 3rd step in the bowel	

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F 684	Continued From page 80 Fluid Management/Fluid Restriction, effective date 11/1/19, stated, "The nursing staff will assess and monitor adherence to fluid management for patients placed on fluid restrictions. Procedure: Fluid Restrictions... 3. Determine amount of fluids with each meal, before bed time and with medication administration using guidelines in table... and consideration of patient preferences... 4. Monitor for signs of dehydration:... c. Abnormal serum sodium... levels... 5. Notify Physician and Responsible Party as indicated if non-adherence to fluid restriction status noted... 7. Document adherence/non-adherence to fluid restriction status, any signs of dehydration, any unusual findings and follow-up intervention including notification of physician/responsible party in the Progress Note. Document fluid intake." R182's clinical record revealed: 7/3/23 - R182 was admitted to the facility with diagnoses including, but were not limited to, rhabdomyolysis, hypo-osmolality and hyponatremia, urine retention with placement of an indwelling foley catheter on 7/1/23, mild cognitive impairment, chronic kidney disease and history of urinary tract infections. 7/3/23 at 8:09 AM - The Initial Physician Certification for Extended Care Services documented the following under the Malnutrition Review: "Monitor oral intake/meal tolerance, supplement as indicated- recent hospitalization...". 7/5/23 at 3:27 PM - Lab results revealed that R182's Sodium level was 133 (normal laboratory range 135 - 145).	F 684	protocol and document it in the EHR. If the resident did not have any effective results for the bowel protocol the licensed nurse will notify the provider for further direction. The UM/supervisors will pull a house wide BM alert list and follow up with licensed nurse to ensure the bowel protocol was started during their shift accordingly. The Staff Developer will educate licensed nurses on the constipation protocol and on how to locate clinical alerts within the EHR system, the steps within the bowel protocol and passing the progression of the bowel protocol along in shift to shift report. 6. Root cause analysis completed, and the results identified deficient practice by the licensed nurses by not validating the application of abdominal binder, ted stockings or other adaptive equipment. Orders for application of abdominal binders, ted stocking or other adaptive equipment will be entered on both the TAR for nursing validation and on the POC for CNA application/documentation. If an abdominal binder, ted stockings or other adaptive equipment is unavailable, the licensed nurse will notify their supervisor. The supervisor will obtain the abdominal binder, ted stockings or other adaptive equipment and provide it to the nurse. If the supervisor is unable to locate the device, the DON will be notified. DON/SDS will educate the nursing staff on the application of abdominal binder, ted stockings, or other adaptive equipment, and that it is the responsibility of the licensed nurses to ensure their	

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F 684	Continued From page 81 7/6/23 - R182's care plan for a nutritional problem or potential nutritional problem documented the following interventions: - administer medications as ordered; - encourage to eat; - RD (Registered Dietician) consult as needed; - record meal % (percentage) intake; - review dietary preferences with the resident as needed; - supplements as ordered; - therapeutic diet as ordered; and - weights as ordered. 7/6/23 - A physician progress note, by E17 (NP), documented that the plan for "Acute hyponatremia mild, NA (Sodium) 133 on 7/5/23, was 131 on 6/30/23, monitor." 7/6/23 at 9:21 AM - A nutrition assessment documented that there were no issues with R182's eating function; feeding ability was independent with tray set up; no edema, 7/5/23 Sodium lab was 133 (low), diet order was NAS (no added salt) diet, regular texture, thin liquids; at risk for malnutrition with interventions: weekly weights x 4 weeks, monitor PO intake and labs. 7/12/23 - Lab results revealed that R182's sodium level was 124 (low level). 7/12/23 at 11:11 AM - A physician progress note by E17 (NP) documented that R182 was seen and examined. Also noted that "Labs from 7/12/23 reviewed and noted with a hyponatremia at 124. trace edema noted to BLE (bilateral lower extremities)... Plan: Acute Hyponatremia Na (sodium) noted to be 124 on 7/12/23, was 133 on 7/5/23, was 131 on 6/30/23, will add Salt tablet 1	F 684	application. In addition, both nurses and CNA□s will be educated on the Kardex and where to locate any adaptive equipment for the resident. 7. Root cause analysis completed resulted knowledge deficit by licensed nursing staff in missed medication administration, ordering of medication to ensure timely delivery, location of over-the-counter medication, use of back up medication, and notification of provider of medication not available. The process for missing medications is that the licensed nurses will administer medication per provider order by reviewing EMAR and removing medication from medication cart. If medication is not available in the medication cart, the licensed nurse will review the OTC (over the counter list) and the Omnicell list to determine if the medication is available in either location. If the medication is available, the licensed nurse will pull the medication and administer it. If the medication is not available in either the OTC or Omnicell, the licensed nurse will contact the pharmacy to inquire where the medication is in the delivery process and when it will arrive. The licensed nurse will then notify the provider of the medication being unavailable and obtain further direction. The UM/Supervisors will pull the medication administration audit twice during the shift to ensure medications were given as ordered. Any medication not given as ordered will be evaluated to ensure the missing medication process was followed. DON/UM/Supervisors will educate the licensed nursing staff on	

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F 684	Continued From page 82 gm BID (twice a day), will repeat BMP on Monday and weekly on Mondays...". 7/12/23 at 12:05 PM - A Physician order by E17 (NP) stated to give R182 sodium tablet orally two times a day for a diagnosis of hyponatremia. R182's July 2023 eMAR revealed that she did not receive the ordered salt tablet on 7/12/23 evening scheduled dose and two doses on 7/13/23. 7/14/23 - A progress note by E17 (NP) documented that R182 was seen and examined and the plan for "acute hyponatremia Na (sodium) noted to be 124 on 7/12/23... added salt tablet ...(twice a day), awaiting supply from pharmacy, discussed with staff, will add fluid restriction 1500 ml/day, will repeat BMP (lab) on Monday and weekly on Mondays." 7/14/23 at 1:33 PM - A physician order by E17 (NP) stated to place R182 on a fluid restriction 1500 ml per day. 7/16/23 at 12:10 PM - A physician order by E17 (NP) stated to obtain a BMP lab every Sunday on night shift. 7/16/23 at 10:45 PM - The July 2023 eTAR revealed that a nurse signed off that the BMP lab was done. R182's clinical record lacked evidence of the 7/16/23 BMP lab, despite it being signed off as completed, and lacked evidence that the ordered fluid restriction of 1500 ml per day was initiated and being monitored. R182's July 2023 CNA Documentation Survey	F 684	medication administration and documentation on the administration of medications. 8. Root cause analysis completed and resulted that there was no supplemental documentation entered onto the EHR for consumption % of supplements by the dietitian. When an order is entered for supplement, the order will be entered into PCC under order type supplement. A prompt will be entered for the nurse to document how much of the supplement was taken by the resident. This amount/percentage will be documented on the MAR by the nurse. DON/designee will educate dietitian on ensuring that supplemental documentation is entered onto the order for consumption % documentation. Root cause analysis completed and resulted knowledge deficit of licensed nursing staff on scheduling of skin assessment. When a resident is admitted, the weekly skin check will be entered in the system as an order for the specific date/shift based on their room/bed number. This will be displayed on the TAR as needing to be completed on the appropriate day/shift. Under assessments, the weekly skin check will also be scheduled to trigger on the date/shift assigned to that resident. The nurse will complete the skin assessment under the assessment tab and sign off on the TAR indicating the skin check was completed. The UM/Supervisor will review UDA due/in progress/completed daily to verify the assigned skin checks were completed. The DON/SDS will educate	

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F 684	Continued From page 83 Report revealed that 19 out of 51 meal opportunities documented over 17 days in the facility were blank. The CNA Kardex was not updated to reflect R182's 1,500 ml per day fluid restriction. 7/20/23 at 7:45 AM - A progress note by E74 (Physician) documented " ...F/u (follow-up) family concern of weakness ... She is seen per daughter's request due to a change in patient condition. Daughter states, she visits her mother on a daily basis and she thinks the patient is not at her usual baseline and has asked for a physician to see her. Patient is seen lying in bed before breakfast. Daughter states she gets frequent UTI. Patient has a foley that is draining yellow urine, no odor, her vital signs are stable. All these explained to the patient's daughter, but she insisted to have U/A, C&S done. UA, C&S ordered not yet on chart .... Patient has no complaints. Her appetite is good ... A&Ox1 (alert and oriented x 1 name) ... no BLE edema ... trace edema ...PLAN: change in mental status: Await UA, C&S next lab day, also await repeat of BMP, order on chart to get, will write stat. Hyponatremia: Continue Sodium... tablet... two times a day...". 7/20/23 - A physician order documented "BMP STAT for hyponatremia." 7/20/23 at 11:01 AM - A nurse's note documented that "Pt's (patient's) daughter concerned about her mother's health condition, request patient sent to ... ER (emergency room) for further evaluation. Patient evaluated by E17 (NP), pt denies pain, no signs of distress. Patient left facility 10:55 AM via ambulance. Pt vs (vital signs) Temp (temperature) 97.2 Resp	F 684	licensed nurses on ensuring that there is an order placed in the EMR to alert licensed nursing staff to the skin assessment assignment and the assessment for weekly skin check is scheduled for the appropriate day/shift. 9. Root cause analysis completed and resulted in licensed nursing staff failed to complete wound care as there was confusion about if the floor nurse or the wound care nurse would be completing the wound care. The wound care nurse will complete the treatments on pressure wounds Monday through Friday. The floor nurses will be responsible for completing all other treatments Monday through Friday and completing all wound treatments on the weekend. DON/designee will educate the licensed nursing staff on the breakdown of wound care treatments responsibilities. UM/Supervisor will be monitoring the administration audit report at least twice per shift to verify treatments have been completed and documented at such. D. 1. DON/designee will audit residents receiving medication(s) with parameters transcription accuracy weekly x 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. DON/designee will audit all new orders and consultation reports of visit for residents needing follow-up consulting appointments outside the facility for attendance weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months. All audits will be submitted to the QAA	

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F 684	Continued From page 84 (respirations) 18 HR (heart rate) 88 BP (blood pressure) 143/77 SPO2 (pulse ox) 95% room air." 7/20/23 at 11:52 AM - The hospital lab result revealed that R182's sodium was 105, a critical result. (normal hospital range 136-146) 7/20/22 at 3:22 PM - The hospital's History & Physical documented, "...Patient's daughter visits her every day and states that over the last 2 days patient has had increased leg swelling that she reported to the staff...Per daughter there was no administration of diuretics. Today patient became more confused acutely. She was having visual hallucinations which is new for her. She was unable to clearly communicate at times which is also knew for her...Daughter not aware of patient having prior issues with her serum sodium level... Assessment/Plan: Hyponatremia - Patient has presentation with what appears to be subacute severe life-threatening hyponatremia contributing to acute onset metabolic encephalopathy manifest with slowing of thoughts, disorganized thoughts, and hallucinations... She needs admission to the ICU due to her hyponatremia...Metabolic encephalopathy - secondary to severe hyponatremia...Patient remains critically ill requiring ICU level of care due to life-threatening hyponatremia with metabolic encephalopathy. High risk for further decompensation or death from this...". 7/20/23 at 3:46 PM - The hospital's ED Physician Record documented, "...On July 15, the daughter states they took the foley catheter out. Daughter was upset, and on July 16, they, at her request, put the catheter back in. There was a false passage apparently, it was not draining anything. They reinserted, and on July 17, seem to be	F 684	committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 2. DON/designee will audit clinical alerts for residents not having bowel movements in 3 days for initiation of bowel protocol weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 3. DON/designee will audit all residents receiving dialysis services transportation arrangements weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. DON/designee will audit all residents for missed dialysis sessions for documentation of fluid overload assessments and provider notification weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100% then monthly X 4 months until 100%. All audits	

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F 684	Continued From page 85 draining urine. however the urine volume is way down. Her oral intake of food... way down. For the last 3 days, daughter reports a decreased mental status. When she eats, she has food rolling down her front, which is unusual for her. Is just not as responsive. has a chronic cough intermittently but perhaps coughing more. Has a chronic runny nose. Not seemingly short of breath as per the daughter. She does not report any headache chest pain or abdominal pain. Daughter noted the abdomen was very hard yesterday, seems to have softened up today... spoke with...medical ICU...already spoken with nephrology...They changed the order to sodium levels every 4 hours. He had placed the order for the 3% saline, at 10 mls per hour. I did the urine lites, and urine Osmo as an add-on...". 8/3/23 at 3:28 PM - The Hospital Discharge Summary documented, "Diagnoses Treated This Hospitalization. 1. Metabolic encephalopathy; 2. Hyponatremia; 3. UTI due to Enterococcus... 9. Fecal impaction in rectum... presented to the emergency department on 7/20/23 with altered mental status from her skilled nursing facility. She was found to have hyponatremia with a sodium of 105, attributed to possible SIADH as well as E faecalis and Hafnia UTI. She was initially on hypertonic saline and now remains on salt tablets with gradual improvement in her sodium, now within normal limits on the day of discharge...". 8/28/23 at 10:57 AM - During an interview, E3 (Interim DON) confirmed that the 7/16/23 ordered BMP lab was never done. 8/29/23 at 11:07 AM - During an interview, E17 (NP) confirmed R182's sodium level upon arrival at the hospital on 7/20/23 was 105, a critical level.	F 684	will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 4. DON/designee will audit all residents on fluid restriction, fluid intake to ensure fluid load compliance weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. Results will be brought to the QAPI committee for review and further recommendations. 5. DON/designee will audit residents experiencing loose stools to ensure follow-up skin treatment as warranted weekly X 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 6. DON/designee will audit 5 resident observations with for abdominal binder, ted stockings, or other adaptive equipment for application weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4	

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F 684	Continued From page 86 E17 stated she has never seen a sodium level that low before. E17 confirmed that her physician orders for a BMP lab to monitor R182's sodium on 7/16/23 and the initiation of a fluid restriction were not taken off and followed despite discussing the plan with nursing staff in person and the orders entered into electronic health record. E17 also stated that R182's foley catheter was not to be removed as she discontinued her previous order after discussing with R182's family member on a possible voiding trial here at the facility. 8/31/23 at 12:10 PM - Findings were reviewed with E1 (NHA) and E3 (Interim DON). 5. The facility's policy and procedure for Constipation Prevention, effective date 11/1/19, stated, "Policy: Patient's will be monitored for regular bowel movements as evidenced by a bowel movement every three days or as determined by individual assessment, medical condition or functional status. Procedure: 1. Nurse will routinely review to determine patients in need of intervention to facilitate bowel movement. 2. Assess the patient for the following systems of constipation, such as: a. Smearing of feces. b. Loss of appetite. c. General malaise. d. Drowsiness. e. Elevation of temperature. f. Abnormal vitals signs. g. Frequent bouts of diarrhea. h. Abdominal distention. i. Nausea and/or vomiting. j. Malodorous breath. 3. Initiate any or all of the following interventions and document in the clinical record: a. Prune juice followed by a glass of warm water, or other food preparation assessed by dietary to enhance bowel evacuation. b. Increase activity or exercise as tolerated by patient (short distance ambulation or range of	F 684	months. 7. DON/designee will audit 10 residents□ MARs for administration of medication documentation weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 8. DON/designee will audit 10 residents with supplement orders for consumption % documentation weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. DON/designee will audit 10 residents for weekly skin assessment completion weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100% then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 9. DON/designee will audit 10 residents□ TAR for treatment completion documentation weekly X 4 weeks until	

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F 684	Continued From page 87 motion). c. High fiber foods with adequate fluids. d. Stool Softeners, suppositories, laxatives, and/or enemas as ordered by the physician. 4. Document bowel movements in the clinical record. 5. Contact physician for any needed orders. 6. Assessment of constipation or the history of constipation will be documented upon admission. 7. The plan for prevention of constipation will be documented on the comprehensive care plan." R182's clinical record revealed: 7/3/23 at 7:51 PM - The nursing admission note documented that R182 had a history of constipation, was alert and oriented x 1/2, and required a sit to stand mechanical lift with transfers. 7/3/23 at 10:39 PM - The facility's Admission Nursing Collection Tool documented that R182 was continent of bowel and was at risk for constipation with interventions to implement the bowel protocol when indicated, observe for signs and symptoms of constipation or extended abdomen that may indicate constipation and track and record bowel movements. The above interventions were captured on R182's at risk for constipation care plan. 7/3/23 at 11:19 PM - A physician's order documented to give two tablets of Senna 8.6 mg one time a day for constipation. R182's July 2023 eMAR revealed that the resident received the Senna medication on a daily basis.	F 684	100% then every 2 weeks X 1 month until 100% then monthly X 4 month until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 684	Continued From page 88 Review of the CNAs Kardex for R182 care needs stated to track and record her bowel movements. 7/4/23 - R182 was care planned for at risk for constipation with interventions that included: implement bowel protocol when indicated; observe for signs and symptoms of constipation or extended abdomen that may indicate constipation; and track and record bowel movements. 7/9/23 - The admission MDS assessment documented that R182 required extensive assistance of one staff member for toileting, was always incontinent of bowel, no bowel toileting program in use and no constipation present. R182's CNA Documentation Survey Report revealed that from 7/3/23 through 7/20/23 in the facility, R182 was documented as having a 5 incontinent bowel movements: - 7/4/23 two medium formed BMs; - 7/7/23 medium formed BM; - 7/9/232 medium formed BM; - 7/10/23 medium formed BM; and - 7/16/23 small putty-like BM. Despite having a facility policy and procedure for prevention of constipation, there was no evidence in the clinical record that R182's BMs were being monitored by nursing staff, no initiation of the bowel protocol regimen and no notification to a physician when R182 had no bowel movements from 7/11/23 through 7/16/23, for approximately six days. 7/20/23 at 11:01 AM - A nurse's note documented that R182 was emergently sent to the ER (emergency room) per her family member's	F 684		

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F 684	Continued From page 89 request for a change of condition. 7/20/23 - The hospital diagnostic test revealed that R182 had a finding of a rectal fecal impaction. 8/2/23 at 9:51 - A hospital Consult Note documented that R182's "...Constipation resolved with a bowel regimen...". 8/31/23 at 12:10 PM - During a combined interview with E3 (Interim DON) and E4 (RN/UM), E3 stated that she hasn't seen the facility's bowel policy and procedure. E3 and E4 both stated that in mid-August 2023, they initiated an alert monitoring system for residents' bowel movements which are discussed during the daily morning meeting. Nursing staff are then informed when a resident does not have a bowel movement over nine (9) consecutive shifts to initiate the bowel protocol and document it's effectiveness. E4 stated that she was planning to educate staff about the new process, but the LTC survey started, which it has been put on hold. 8/31/23 at 12:10 PM - Finding was reviewed with E1 (NHA) and E3 (Interim DON). 6. R182's clinical record revealed: 7/3/23 at 3:30 PM - R182 was admitted to the facility. 7/4/23 - R182 was evaluated by P10 (Wound Care NP) and noted with the following skin integrity issues: - Wound #1: left medial malleoulus; - Wound #2: right shin; and - Wound #3: left forearm.	F 684		

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F 684	Continued From page 90 7/4/23 - R182's physician orders for wound treatments were: - Left forearm: clean site with wound cleanser, apply Xeroform gauze to wound base, top with ABD pad then wrap with cling daily every evening shift. - Left medial malleoulus: clean with wound cleanser, apply Xeroform gauze to wound base and cover with a bordered gauze dressing daily every evening shift. - Right shin: clean with wound cleanser, apply Xeroform gauze to wound base, top with ABD pad and wrap with cling daily every evening shift. 7/12/23 - R182 was care planned for wounds with interventions that included, but was not limited to, treatment per eTAR. R182's eTAR revealed that treatments to her left malleoulus, right shin and left forearm were not done for 3 out of 15 days in the facility, specifically on 7/6/23, 7/15/23 and 7/16/23. 8/31/23 at 4:30 PM - Findings were reviewed with E1 (NHA) and E3 (Interim DON). No further information was provided to the Surveyor. The facility failed to ensure that R182's wounds treatments were consistently done. 7. The facility's Pharmacy policy and procedure for Ordering and Receiving Non-Controlled Medications, last revised on 8/2020, stated, "Medications and related products are received from the pharmacy on a timely basis ...". R182's clinical record revealed:	F 684		

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F 684	Continued From page 91 7/3/23 - R182 was ordered PreserVision AREDS, an over-the-counter medication, twice a day for a supplement. R182's July 2023 eMAR revealed that she was not administered 11 doses out of 32 scheduled opportunities. R182's nurse's notes documented the following reasons why she was not administered a physician ordered medication: -7/4/23 at 12:35 AM - "awaiting pharmacy delivery. NP aware." -7/5/23 at 5:30 PM - "med (medication) unavail. (unavailable) Awaiting pharm (pharmacy) arrival." -7/6/23 at 12:40 PM - "awaiting pharmacy delivery. NP aware." -7/7/23 at 10:34 AM - "awaiting pharmacy delivery. NP aware." -7/9/23 at 12:47 PM - "on order, rp (representative) aware." -7/12/23 at 8:19 AM - There was nothing documented. -7/16/23 at 9:30 AM - "not available." -7/17/23 at 11:14 AM - "medication not available, NP is aware, no new orders." -7/18/23 at 9:19 AM - "medication not available, NP aware. No new orders." -7/19/23 at 8:32 AM - "not available." -7/19/23 at 5:29 PM - "not available." 8/31/23 at 12:10 PM - During a combined interview, finding was reviewed with E3 (Interim DON) and E4 (UM/RN). The facility failed to ensure R182 received physician ordered medications consistently according to her plan of care.	F 684		

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F 684	Continued From page 92 8. Review of R121 clinical record revealed: 3/11/23 - A discharge summary documented R121 was hospitalized for stage III metastatic melanoma...and IBD. R121 came to the hospital for nausea, vomiting and diarrhea over the last four months. In the emergency room (ER) R121 was found to be hypotensive (low blood pressure), anemic, hypokalemic and with acute kidney injury. These diagnoses were thought to be secondary to the diarrhea from the ulcerative colitis. R121 was admitted for the management of symptoms. After admission GI was consulted and a colonoscopy result was consistent with ulcerative colitis. Patient was placed on oral prednisone 40 mg daily to control his symptoms. 3/12/23 - R121 was admitted to the facility for rehab after a hospital stay due to ulcerative colitis. 3/17/23 - The discharge MDS documented R121 was always continent of bowels. 3/17/23 - The resident was discharged to home. 5/18/23 - R121 was admitted back to the facility after a hospital stay with a history of colitis melanoma cancer. 5/18/23 - A care plan last revised on 7/10/23 included a risk for constipation related to medication use and lack of exercise. The care plan for nutrition mentioned a diagnosis of IBS. The care plan lacked evidence of the chronic loose stools/diarrhea that R121 was experiencing frequently. 5/19/23 - A History and Physical documented	F 684		

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F 684	Continued From page 93 R121's stage III metastatic melanoma...inflammatory bowel disease and colitis. June 2023 - R121's CNA Documentation Survey Report revealed that the frequency of loose stools on the following dates: 6/4/23 -1, 6/10/23- 1, 6/11/23 - 2, 6/12/23 - 1, 6/15/23 - 1, 6/18/23 - 2, 6/19/23 - 2, 6/22/23 - 3, 6/23/23 - 1, 6/25/23 - 3, 6/26/23 - 2, 6/27/23 - 1, 6/29/23 - 1, 6/30/23 - 4. A total of 25 episodes of loose stools in the month of June. 6/14/23 1:00 AM - A physician progress note documented acute diarrhea, patient reported having multiple loose stools, none reported by staff, likely due to IBS and history of colitis, abdomen benign and laxatives, we will add Imodium 2 mg every 4 when necessary. 6/14/23 - A physician's order for an antidiarrheal drug loperamide HCl capsule 2 mg give one capsule by mouth every 4 hours as needed for diarrhea after each loose stool up 16 mg in 24 hours. The MAR documented R121 received one dose of loperamide in June. 6/21/23 - R121 admitted to hospice. 6/28/23 - The significant change MDS assessment documented the resident was always incontinent of bowel. Also, it was inaccurately documented "no" to ulcerative colitis, Crohn's, Inflammatory Bowel Disease. July 2023 - R121's CNA Documentation Survey	F 684		

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F 684	Continued From page 94 Report revealed that the frequency of loose stools on the following dates: 7/1/23 - 1, 7/3/23 - 1, 7/4/23 - 2, 7/5/23 - 1, 7/6/23 - 1, 7/7/23 - 3, 7/8/23 - 1, 7/10/23 - 2, 7/11/23 - 3, 7/12/23 - 1, 7/13/23 - 4, 7/14/23 - 9, 7/15/23 - 3, 7/17/23 - 1, 7/18/23 - 2, 7/19/23 - 1, 7/20/23 - 5, 7/21/23 - 5, 7/22/23 - 4, 7/23/23 - 4, 7/24/23 - 6, 7/25/23 - 3, 7/26/23 - 3, 7/27/23 - 6, 7/28/23 - 7, 7/29/23 - 3, 7/30/23 - 4, 7/31/23 - 2. A total of 88 episodes of loose stools in the month of July. The MAR documented R121 received two doses of loperamide in July. 7/15/23 - A skilled daily note documented R121 had diarrhea and it was reported to the physician. 7/15/23 11:55 AM - A physician order for loperamide HCl capsule 2 mg give 1 capsule by mouth every 4 hours as needed for diarrhea after each loose stool max 16 mg in 24 hours. R121 was having multiple loose stools. 8/3/23 - Hospice (H4) notes obtained from hospice documented that R121 was having multiple bowel movements possibly sitting in for longer periods of time. The Sacrum in reddened and non-blanchable. August 2023 - R121's CNA Documentation Survey Report revealed that the frequency of loose stools on the following dates: 8/1/23 - 4, 8/2/23 - 3, 8/3/24 - 3, 8/5/23 - 5, 8/6/23 - 7, 8/7/23 - 6, 8/8/23 - 9, 8/9/23 - 1, 8/10/23 - 4, 8/11/23 - 6, 8/12/23 - 7, 8/13/23 - 3, 8/14/23 - 7, 8/15/23 - 4, 8/16/23 - 3, 8/17/23 - 6, 8/18/23 - 2, 8/20/23 - 3, 8/21/23 - 3, 8/22/23 - 6, 8/23/23 - 2, 8/24/23 - 5, 8/25/23 - 2, 8/26/23 - 4, 8/27/23 - 3, 8/28/23 - 3, 8/29/23 - 4	F 684		

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F 684	Continued From page 95 A total of 115 episodes of loose stools in the month of August. R121 received two doses of loperamide in August. Skilled Nursing Assessments by a nurse 8/8/23, 8/11/23, 8/30/23, 8/31/23 lacked indication that R121 was having loose stools. 8/11/23 - H4 notes obtained from hospice documented that R121 reported increased frequency of bowel movements. 8/17/23 11:51 AM - During an interview R121 revealed that he has diarrhea, and it just squirts out. "It is uncomfortable, and it smells." An observation by the surveyor did reveal a foul smell. 8/23/23 1:16 PM - During an interview E47 (CNA) revealed that R121 had been changed twice so far today and the stool was loose and gooey. Also, it was stated "this is normal for R121 we know it is coming after the meal and he will need changing." 8/23/23 approximately 1:30 PM - During an interview, the patients nurse, E92 (RN) revealed she had no knowledge of R121 ever having diarrhea/loose stools. A review of the progress notes and MAR lacked evidence of E92 documenting after E47 informed E92 that R121 was having loose stools. 8/25/23 approximately 1:30 PM - An observation of care being provided to R121, the stool was brown very thin consistency. R121's buttocks and scrotum were red and excoriated.	F 684		

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F 684	Continued From page 96 8/25/23 1:45 PM - During an interview with E8 (LPN) confirmed awareness to R121's history of colitis and loose stools. E8 further revealed that E17 wants R121 to only have the antidiarrheal if more than two loose stools a day. This surveyor asked if E8 was aware that R121 had 56 episodes of loose stools in the last 30 days. E8 was unaware and additionally, E8 was unaware that R121 had a red and excoriated buttock. 8/25/23 2:29 PM - A progress note documented that R121 had one loose stool this shift antidiarrheal was administered. A new order for zinc oxide to the bottom every shift and as needed. 8/25/23 2:10 PM - During an interview E17 (NP), revealed that "[R121] has not complained of loose stools or abdominal pain when I have assessed." E17 further revealed that a person would have to have three loose stools a day to be considered a diagnosis of diarrhea. Additionally, E17 stated that R121 would need to have three episodes of diarrhea/loose stools to receive the antidiarrheal drug. 8/28/23 1:21 PM - During an interview with R121, a complaint of three episodes of loose stools so far today. It was further revealed by R121 that the facility was out of the cream to apply to the buttocks. The Surveyor was given permission to look around the room and in the drawers. There was no evidence of the prescribed cream in the room. 8/28/23 1:37 PM - During an interview with E76 (CNA) it was confirmed that R121 had a loose stool three times so far today and R121 was	F 684		

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F 684	Continued From page 97	F 684		

changed. It was further revealed that the cream for R121's buttock was empty and E76 looked in the two places where she would normally look and there was not any available. E76 had not notified the nurse but was going to follow up.

8/28/23 - A discussion with E1 (NHA) and E2 (Corporate Nurse) was conducted by the surveyor concerning R121's lack of care and services being offered. R121 has diarrhea/loose stools very frequently and now he has an excoriated buttock. It was agreed that R121 as a patient on hospice with a terminal diagnosis should receive what is needed to make him comfortable. E1 and E2 would follow up on R121 status right away.

8/29/23 12:31 PM - An SBAR documented the sacrum and buttocks area excoriated and reddened and the hospice nurse was called to get recommendations on treatment.

8/28/23 2:11 PM - A skilled daily note documented "Gastrointestinal symptoms none observed."

The following Skilled Nursing Assessments by a nurse on 9/1/23, 9/2/23 and 9/5/23, indicated that there were no concerns for R121. There was no mention of R121 having loose stools. Despite that on the following dates there were loose stools; 9/1/23 6 times, 9/2/23 6 times and 9/5/23 6 times.

9/6/23 1:47 PM - As a result of an interview with E17, an order was written for a daily routine dose of loperamide.

For R121 the facility caused harm by the failure to ensure R121 received treatment for continued loose stools/diarrhea and because of this failure

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F 684	Continued From page 98 R121 developed a red, excoriated buttocks and scrotum. 9. Cross Refer F657, Example # 9 a & b Review of R132's clinical records revealed: 5/17/23 - R132 was admitted to the facility. 5/23/23 - R132's admission MDS assessment revealed that R132 was cognitively intact. 6/21/23 - R132 was readmitted to the facility with diagnoses including but not limited to orthostatic hypotension or low blood pressure caused by a change in position. 6/21/23 - R132 had a physician's order for total fluid restriction - 1,500 ml with nursing TV Total Volume) of 360 mLs/24 hours (160 mLs day shift, 100 mLs afternoon and 100 mLs night shift). For dietary TV of 1,140 mLs/day inclusive of 420 mLs breakfast, 360 mLs lunch and 360 mLs dinner. 6/28/23 - R132 had a care plan initiated related to risk for cardiac complications ...hypotension with interventions including but not limited to abdominal binder as ordered as tolerated by patient. 6/28/23 - A careplan was initiated for R132's risk for complications secondary to diuretic (medicines that help reduce the amount of water/excess fluid in the body) use due to diagnosis of CHF with interventions including but not limited to observing for signs and symptoms of fluid imbalance including dehydration or fluid overload	F 684		

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F 684	Continued From page 99 a. 7/6/23 - R132 had a physician's order to apply abdominal binder before getting out of bed for orthostatic hypotension. 7/6/23 - R132 had a physician's order to apply thigh high compression stockings every morning and remove at bedtime for orthostatic hypotension. 8/2/23 - R132 had a physician's order to apply abdominal binder before getting out of bed every shift for orthostatic hypotension. 8/2/23 - R132 had a physician's order to apply thigh high compression stockings every morning and remove at bedtime for orthostatic hypotension daily and remove per schedule. R132 was noted out of bed with no abdominal binder and thigh high stockings in use on the following dates and times during the four random observations on: -8/16/23 at 1:00 PM -8/17/21 at 11:10 AM -8/21/23 at 11:27 AM -8/22/23 at 2:00 PM 8/23/23 8:30 AM - Review of R132's July 2023 TAR (Treatment Administration Record) revealed that the facility lacked evidence that the nursing staff signed off and applied the abdominal binder and thigh high compression stockings on R132. 8/23/23 8:45 AM - Review of R132's August 2023 TAR to date revealed that the facility lacked evidence that the nursing staff signed off and applied the thigh high compression stockings on R132 consistently for six occurrences on the following dates: 8/6/23, 8/7/23, 8/8/23, 8/12/23,	F 684		

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F 684	Continued From page 100 8/21/23, 8/22/23. In addition, the same review also revealed a lack of evidence that the nursing staff signed off and applied R132's abdominal binder for two occurrences on 8/6/23 and 8/22/23. 8/23/23 10:00 AM - An observation of R132 out of bed and seated in his wheelchair in his room revealed no abdominal binder and no thigh high stockings were in use. When interviewed, R132 stated that, "They (nursing staff) told me that I will start using the abdominal binder and the compression stockings but up until now they have not given it for me to wear yet. I don't know if they have them available or not. I have never seen them. All I have been wearing are these socks and booty." 8/23/23 10:31 AM - In an interview, E39 (CNA) stated that she was the assigned CNA for R132 but she was not familiar with the resident as it was her first time assigned to care for him. E39 added that she was not told during nursing report if resident (R132) had to have an abdominal binder and thigh high stockings on. 8/23/23 11:38 AM - During an interview, E40 (RN) stated that she was not familiar with the resident and the order for abdominal binder and thigh high stockings. 8/23/23 11:41 AM - In a follow up interview, E40 told surveyor that she checked R132's records and confirmed the physician's orders for abdominal binder and thigh high stockings. E40 further stated that she checked R132's drawers, "nothing could be found". 8/24/23 11:47 AM - Findings were discussed with E3 (DON) and E4 (RN UM). E3 confirmed that	F 684		

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F 684	Continued From page 101 R132 did not have the abdominal binder and thigh high stockings. In addition, E3 stated that the facility will order the supplies and make available for R132. b. 6/22/23 - A facility Nutrition Assessment completed by E38 (RD) revealed that R132 was on the following diet order: -Heart Healthy Diet -Regular Texture -Thin Liquids - Fluid Restriction: 1500 ml Fluid Restriction -360 mLs TV (total volume) Nursing (160 mLs (milliliters) morning, 100 mLs afternoon and 100 mLs evening) -1,140 mls TV Dietary (430 mLs breakfast, 360 mLs lunch and 360 mLs dinner 8/16/23 - R132's quarterly MDS assessment revealed that R132 was cognitively intact and was receiving diuretics. 8/25/23 10:00 AM - Review of R132's June and July 2023 medication and treatment records lacked evidence that R132's actual total volume of fluid intake was monitored for nursing. 8/25/23 10:02 AM - Review of R132's August 1-28, 2023 MAR lacked evidence that R132's actual total volume of fluid intake was monitored for nursing. 8/25/23 10:05 AM - Review of R132's CNA flowsheets from July 30, 2023 through August 28, 2023 revealed the following dietary (excluding nursing) total volume or amount that R132 had drank/day in (mLs): 7/30/23 - 720 mLs 7/31/23 - 1,040 mLs	F 684		

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F 684	Continued From page 102 8/1/23 - 1,020 mLs 8/2/23 - 1,950 mLs 8/3/23 - 720 mLs 8/4/23 - 720 mLs 8/5/23 - 1,950 mLs 8/6/23 - 400 mLs 8/7/23 - 1,950 mLs 8/8/23 - 720 mLs 8/9/23 - 720 mLs 8/10/23 - 600 mLs 8/11/23 - 720 mLs 8/12/23 - 900 mLs 8/13/23 - 481 mLs 8/14/23 - 1,950 mLs 8/15/23 - 840 mLs 8/16/23 - 840 mLs 8/17/23 - 555 mLs 8/18/23 - 840 mLs 8/19/23 - 1,950 mLs 8/20/23 - 240 mLs 8/21/23 - 1,950 mLs 8/22/23 - 530 mLs 8/23/23 - 720 mLs 8/24/23 - 1,950 mLs 8/25/23 - 1,040 mLs 8/26/23 - 1,300 mLs 8/27/23 - 840 mLs In 8 out of 30 occurrences, R132 exceeded the 1,140 mLs dietary Total Volume allowed for his fluid restriction order. In 22 out of 30 occurrences, R132 did not meet the 1,140 mLs dietary Total Volume allowed for his fluid restriction order. 8/25/23 11:30 AM - During an interview, E4 (RN UM) stated that R132 had congestive heart failure and resident (R132) was on 1.5 L (liters)/day fluid restriction. E4 furthermore stated, "... The CNAs	F 684		

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F 684	Continued From page 103 documented the actual dietary fluid intakes in the CNA flowsheets and the nurses were aware of R132's 1,500 mls fluid restriction order and how much nursing is supposed to give." 8/25/23 12:19 PM - In an interview, E38 (RD) confirmed and stated, "...There's no nursing documentation to record resident's (R132's) Nursing actual total volume of intake/day...Usually for my dietary assessments, I get the information from the fluid intake documented in the CNA flowsheets. For nursing, the nurses will only give the total volume allowed based on the fluid restriction order. The facility failed to ensure that a system was in place to monitor and ensure R132's total volume fluid restriction order of 1,500 mls/day was followed for nursing and dietary. 9/8/23 9:30 AM - Findings were discussed with E1 (NHA), E2 (RDC) and E3 (DON). 10. Review of R513's clinical records revealed: 8/5/23 - R513 was admitted to the facility with a diagnosis of major depressive disorder. 8/5/23 - R513 had a physician's order for amitriptyline HCL (Elavil) 75 mg (milligrams) at bedtime for depression. 8/7/23 - R513 had a care plan developed for potential nutritional problem related to ...depression with interventions to include administering medications as ordered. 8/7/23 7:43 PM - A nurse progress note documented "amitriptyline ...awaiting pharmacy	F 684		

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F 684	Continued From page 104 delivery." 8/9/23 7:51 PM - A nurse progress note documented "amitriptyline ...awaiting pharmacy delivery." 8/11/23 - R513's admission MDS assessment revealed that R513 was cognitively intact and was receiving antidepressant medication for depression. 8/17/23 1:50 PM - In an interview, R513 told surveyor that her "Elavil" medication did not arrive until 5 days after she was admitted to the facility on 8/5/23. R513 added, "I am afraid that staff will be borrowing medications from residents in the other wing." 8/29/23 11:29 AM - Review of R513's August 2023 to date MAR revealed that for two occurrences on 8/7/23 and 8/9/23 at bedtime, the facility lacked evidence that nursing staff signed off and administered the medication amitriptyline HCL 75 mg to R513. 8/29/23 11:30 PM - Review of R513's nurse progress notes revealed the following documentation: -8/7/23 7:43 PM - "amitriptyline ...awaiting pharmacy delivery." -8/9/23 7:51 PM - "amitriptyline ...awaiting pharmacy delivery." 8/29/23 12:07 PM - During an interview, E17 (NP) confirmed that that she saw the resident (R513) the Monday after admission (8/7/23) and stated that resident told the NP about her missing amitriptyline dose "last night" (8/6/23). E17 confirmed the discussion between herself and the	F 684		

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F 684	Continued From page 105 resident and stated "No one from the facility called me or notified me about the medication not being available and were awaiting from pharmacy at that time". 9/8/23 9:30 AM - Findings were discussed with E1 (NHA), E2 (RDC) and E3 (DON). 11. Cross Refer F657, Example # 9 Review of R509's clinical records revealed: The facility's policy and procedure, titled, "Skin Assessments", dated 11/1/19, documented, "Skin assessments will be completed for all patients ...Procedure: ...#3. The weekly skin assessment will be completed ...#4 Care plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs." 8/10/23 - R509 was admitted to the facility with diagnoses including malnutrition (lack of sufficient nutrients in the body) and unstageable pressure ulcer (a full thickness tissue loss where the depth of the wound or bed sore is completely obscured by eschar or black color dead tissues in the wound dead) of the sacrum (large triangular bone at base of spine). 8/11/23 - R509 was care planned for pressure ulcer risk related to decreased mobility and chronic sacral wound with interventions including assessing for skin breakdown and skin assessment as indicated. 8/14/23 - R509 was care planned for actual and potential nutritional problem with interventions including provision of supplement (8/18/23).	F 684		

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F 684	Continued From page 106 8/15/23 - R509 was care planned for chronic unstageable pressure ulcer to the sacrum and was at risk for worsening wounds related to chronic health conditions. R509's interventions included referral to wound physician, skin assessments and wound reviews as indicated. 8/16/23 - R509's admission MDS assessment revealed that R509's cognition was moderately impaired and in addition, R509 had an unstageable pressure ulcer over a bony prominence. 8/16/23 10:42 AM - A social worker note by E25 (SW) documented, "Patient makes her daily decisions ...". a. 8/20/23 - R509 was care planned for possible osteomyelitis (infection and inflammation of the bone) to the sacrum with interventions including medication as ordered ... and observing signs and symptoms of worsening osteomyelitis and treatments as ordered, change and observe wound and continue with antibiotic treatment as prescribed. 9/21/23 9:00 AM - Review of R509's weekly Skin Observation Tool from August 11, 2023 through September 20, 2023 revealed: 8/14/23 - ..." Sacrum Pressure Ulcer - Resident (R509) has sacral wounds ...". 9/6/23 - ..."Sacrum Pressure Ulcer - Treatment in progress". 9/21/23 9:30 AM - In an interview, E90 (RNC) confirmed that the facility utilizes the Skin Observation Tool for the nursing staff to complete during weekly skin checks done on assigned	F 684		

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F 684	Continued From page 107 shower days. E90 further confirmed that R509 only had two assessment records completed on 8/14/23 and 9/6/23. 9/21/23 1:30 PM - Review of R509's CNA care tasks revealed that R509's showers were scheduled every Wednesday and Saturday during the 3-11/evening shift. 9/21/23 3:00 PM - In an interview, E9 (LPN) stated that residents have their skin checks done once a week during shower days and the licensed nurse documents the findings by completing the Skin Observation Tool in the EHR (Electronic Health Record). E9 further confirmed that for the resident (R509), the nursing staff only completed the Skin Observation Tools dated 8/14/23 and 9/6/23. The facility failed to ensure that the weekly skin assessments were completed by the nursing staff during R509's assigned shower days. 9/25/23 8:45 AM - Findings were discussed with E1 (NHA). b. 8/16/23 - R509's admission MDS assessment revealed that R509's nutrition status revealed that she held food in the mouth or cheeks and had no known weight loss or gain during the review period. 8/18/23 2:04 PM - A dietary note documented by E91 (RD) documented, "Resident's spouse (FM3) requesting resident receives Ensure ...Spoke with resident who states she drinks ensure QD (daily) at home with lunch- likes chocolate flavored. Will add QD to provide 8 oz 220 kcal (kilocalorie), 9 gm (gram) protein".	F 684		

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F 684	Continued From page 108 8/24/23 3:15 PM - A dietary note documented by E38 (RD) documented, "Spoke with resident's husband due to concerns about poor po (by mouth) intake ...Ensure will be increased to TID (three times a day) to provide additional nutrition support for resident ...". 8/24/23 - R509 had a physician's order for 8 oz (ounce) Ensure (chocolate flavored supplement drink) every day with breakfast, lunch and dinner and to record the amount % (percentage) consumed. 9/6/23 1:08 PM - A dietary note further documented that R509 was evaluated for significant weight loss related to poor intake and was a high risk related to the pressure ulcer. 9/7/23 11:35 AM - A dietary note documented, " ...Will continue to monitor and adjust POC (Plan of Care) as needed. 9/21/23 12:00 PM - Review of R509's August 25 - 31, 2023 MAR (Medication Administration Record) revealed a lack of evidence that R509's amount of ensure consumed was monitored and recorded. 9/21/23 12:15 PM - Review of R509's September 1 - 11, 2023 MAR revealed a lack of evidence that R509's amount of Ensure consumed was monitored and recorded. 9/21/23 3:10 PM - During an interview, E9 (LPN) confirmed that R509's amount of ensure supplement consumed was not monitored and documented in the MAR from 8/25/23 through 9/6/23.	F 684		

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F 684	Continued From page 109 The facility failed to ensure that R509's consumption of the Ensure supplement drink was monitored and recorded. 9/25/23 8:45 AM - Findings were discussed with E1 (NHA). 12. Review of R26's clinical record revealed: 6/29/23 - R26 was admitted to the facility with a diagnosis of a right forefoot amputation, a right foot infection, bipolar disorder, and vascular dementia. A facility policy and procedure titled "General Wound Care Dressing Changes" policy # 3201 dated 11/1/19 documented... 1. Provide treatments as ordered... 2. Remove and reapply dressings as ordered... 3. Licensed nurses will follow recognized standards of practice regarding dressing changes. 7/4/23 12:09 PM- A physician's order written for R26 documented... 1. Right foot surgical incision clean with wound cleaner... 2. Apply Calcium Alginate to base and top with gauze, ABD (Extra Thick Dry Dressing Pad)... 3. Then wrap with cling daily every evening shift. 7/28/23 10:12 PM - A physician's order written for R26 documented...1. Right foot surgical incision clean with mild soap and water dry completely... 2. Apply Calcium Alginate to base and top with gauze and ABD pad... 3. The wrap with cling daily every evening shift. 8/31/23 11:23 - Review of R26's TAR (Treatment Administration Record) for 7/6/23, 7/12/23,	F 684		

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F 684	Continued From page 110 7/13/23 and 7/17/23 and 8/6/23 lacked evidence that R26's dressing had been changed as ordered by the physician. Additionally further review of R26's progress notes for 7/6/23, 7/12/23, 713/23, 7/17/23 and 8/6/23 lacked evidence R26's dressing had been changed. The facility failed to provide surgical wound care as ordered by the physician. Findings were reviewed with E1(NHA), E2 (RCD) and E3 (DON) during the annual survey exit on 9/8/25 with additional of review of findings on 9/25/23.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for three (R173, R174 and R410) out of three residents reviewed for accidents the facility failed to ensure the resident's environment was free from accident hazards and/or adequate supervision was provided to prevent accidents. F173, had a fall from bed while reaching for a urinal left out of reach resulting in harm, subsequently sustaining two broken areas in the spine. For R174, the facility failed to provide adequate supervision and assistance with	F 689	F689- Free of Accident Hazards/Sup/Devices A. 1. R173, R174, R410 no longer residents at the facility B. 1. All residents have the potential to be affected by this process. The regional clinical nurse will audit the last 14 days of falls and complete a thorough root cause analysis on the fall and ensure the appropriate interventions were put into place. Depending on the outcome of	11/30/23

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F 689	Continued From page 111 toileting resulting in harm when the resident fell and sustained a broken hip. For R410, the facility failed to assess resident falls and implement measures to prevent falls. Findings included: 11/1/19 - The facility's fall policy titled, "Falls Management Program included - A licensed nurse will intervene, assess ...investigate, record surroundings the fall, complete post fall assessment ...the interdisciplinary team will analyze and trend ...and present findings to the Quality Assurance Committee." 1. Review of R173's clinical record revealed: 4/11/22 - R173 was admitted to the facility with a diagnosis including, but not limited to dementia; lymphedema (a condition that results in swelling of the leg or arm); and adult failure to thrive. 4/11/22 - R173 was care planned for alteration in musculoskeletal status with interventions including but not limited to: monitoring for risk of falls, educating the resident, family/caregivers on safety measures to reduce risk of falls (9/18/22), bed in low position (4/12/22); educate resident on calling for help prior to reaching for nightstand (2/6/23); and educate resident on use of reacher and calling for help (2/2/23). 4/12/23 - The annual MDS assessment documented a BIMS (Brief Interview for Mental Status) score of 12 indicating moderately impaired cognition; bed mobility showed extensive assist for self-performance and one person physical assist for support; transfer showed limited assistance for self-performance and one person physical assist for support; eating with supervision for self-performance and	F 689	review interventions may be changed or added. 2. All residents have the potential to be affected. The DON will review the last 14 days of progress notes to ensure no falls have occurred, that were not investigated, and had no appropriate interventions put into place. Any identified will be investigated and have appropriate interventions put into place. C. 1. Root cause analysis completed and identified an opportunity for improvement on developing a root cause for accidents. The corporate clinical nurse will provide root cause analysis training for IDT members utilizing Stratis Health Root Cause Analysis Toolkit for Long Term Care (Root Cause Analysis Toolkit for Long-Term Care - Stratis Health) This RCA process will be utilized to complete investigations/problems within the facility. 2. Root cause analysis completed and identified that staff failed to report a resident fall appropriately and the IDT team failed to address fall listed in progress note(s). The Director of nursing/SDS will educate all staff on falls (what constitutes a fall- any unintentional change in plane) the need to report the fall immediately to the nursing supervisor. The licensed nurses will be educated on completion of post fall assessment(s) and need to place immediate intervention. The corporate clinical nurse will educate the IDT team on pulling progress notes for the previous 24 to 72 hours to review notes for any notations of falls. Any identified will be	

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F 689	Continued From page 112 one-person physical assist for support; and toilet use with extensive assistance for self-performance and one person physical assist for support. 5/25/23 at 4:15 PM - A nurse's note documented that E60 (RN) was notified that R173 was found on the floor by the nurse E59 (LPN) assigned to the resident. Upon getting to the room R173 was lying on the floor on the left side of the bed and on the left side. Blood was noted on the floor from an injury to the left side of the forehead. The bed was in low position. According to the note, R173 reported trying to reach for a urinal when the fall occurred. The E6 (MD) was made aware, and an order was given for the resident to be sent to the hospital for evaluation. 5/25/23 - Per the facility's investigative reporting written statement from E54 (CNA), the incident occurred at about 4:10 PM on 5/25/23. E54 went to answer R173's light after shift change. Upon the E54's arrival, the resident was sitting on the chair and asked to be put back in bed. During the process E54 noticed R173 had a bowel movement and told the resident a diaper was needed so R173 could be changed. E54 went to get a diaper and had left the bed in low position. E54 realized there were no wipes, upon returning to the room. E54 reportedly left for less than 1 minute and upon return saw R173 on the floor. When asked what R173 was doing before ending up on the floor, the resident said, 'trying to reach urinal'. The witness statement further documented that R173 never asked for the urinal before E54 left for the wipes, and the urinal was not close to the resident because E54 cleared off the area in order to change R173 before setting him back up when done.	F 689	addressed immediately and the staff member who documented it without following post fall protocol will be re-educated. D. DON/designee will audit all falls to ensure that they were investigated thoroughly, and appropriate interventions are developed, in place and care planned, weekly X 4 weeks until 100%, every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. DON/designee will audit 10 resident progress notes to verify no fall notation exists without post fall investigation weekly x 4 weeks until 100%, every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 689	Continued From page 113 5/25/23 (initial vital signs taken at 5:16 PM) - Emergency Room notes revealed R173 "was here after falling out of bed this afternoon. Apparently struck head. Unknown if there was loss of consciousness but nothing reported. [R173] was at baseline confused. The examination showed a 4 - centimeter stellate (resembling a star) laceration over the left forehead with avulsion (layers of skin are removed). C-collar (cervical (neck) collar) in place, no chest wall tenderness, no abdominal tenderness, alert and moving all 4 extremities". "Impression: fall, forehead laceration, C1 and C2 (cervical vertebra 1 and cervical vertebra 2 [neck area]) fractures" (on CT scan and MRI of the cervical spine). "Will be placed in a Miami J collar, anticipate further CT scans to evaluate for any other injury given baseline dementia and difficult historian". 9/6/23 at 11:50 AM - Per interview with E54, while performing rounds, R173's call light was on. When E54 answered the light, R173 requested to be move to a chair. E54 left the room to get wipes and a diaper because there were no supplies in the room. E54 went to the supply cart, which also did not have supplies, then walked a short distance farther down the hall to the supply closet. Upon return to the room, the resident was found lying on the floor. According to E54, R173 reported trying to get the urinal. E54 stated the urinal was not close by the resident because E54 had made the space to change R173. E54 then called another CNA to call the nurse came and examined the resident. E54 noticed the resident's head had been hit and was bleeding in the left forehead area. Per E54, R173 was lying in bed when left alone and had been given the	F 689		

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F 689	Continued From page 114 call bell. The Hoyer lift was used by E54, the other CNA and the nurse to pick up R173 from the floor. R173, who was not assessed for an individualized toileting plan, fell trying to use the bathroom independently resulting in a broken neck. 2. Review of R174's records revealed: 3/2/22 6:30 PM - R174 was admitted to the facility with diagnoses including but not limited to acute kidney failure, dementia, need for assistance with personal care, and urinary tract infection. 3/2/22 - R174's admission orders included - keflex capsule 500 mg every 12 hours for three more days for urinary tract infection, bladder scan (non-invasive method to measure the amount of urine in the bladder) every shift. Straight catharize (soft, thin tube used to remove urine from the bladder) for greater than or equal to 400 ml every shift. 3/2/22 - R174's nursing admission assessment documented, "Continent" (of bladder), bowel continence was not assessed, and fully dependent (on staff) for transfer 3/2/22 - R174's admission care plan documented, "At risk for falls due to ambulatory dysfunction with interventions to, "Encourage to transfer and change positions slowly, provide assist to transfer and ambulate as needed, and bed in low position." The surveyor was unable to locate a fall score in the clinical record. 3/6/22 4:30 PM - R174's clinical record documented, " ...Patient stated that she was	F 689		

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F 689	Continued From page 115 trying to go to the bathroom and slid to the floor." 3/7/22 - R174's care plan documented, "Offer and assist patient with toileting prior to the end of each shift, provide assist to transfer and ambulate as needed." There was no evidence that the facility assessed R174 for an individualized toileting program to prevent falls. 3/8/22 1:52 PM - R174's clinical record documented, "...Patient was transferring unassisted back and forth from bed to the wheelchair ...one time order obtained for trazodone (an anxiety medication) ...ambulated with rolling walker with therapy." 3/8/22 10:43 PM - R174's clinical records documented, "Resident is sitting at the nurses' station. New orders for Ativan (anti-anxiety medication) 0.25 mg tab every eight hours as needed for agitation, melatonin (sleep aide) 3 mg at bedtime. Psychiatry consult." 3/9/22 6:47 AM - R174's clinical record documented, " ...Was restless throughout the night, and trying to get out of bed multiple times. Brought up to the nurses' station for closer observation and monitoring." 3/10/22- R174's MDS documented, a BIMS of 2 indicating severe impairment , no bowel/bladder trial voiding diary, no prompted voiding, no toileting program, frequently incontinent of bladder, and occasionally incontinent of bowel. 3/11/22 1:33 PM - R174's nurses notes	F 689		

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F 689	Continued From page 116 documented, "....Out of bed to wheelchair. Yelling out frequently "nurse, help", banging on bedside the table." 3/12/22 11:50 PM - R174's clinical record documented, "Called to the room and observed resident sitting on the floor in the bathroom leaning against the wall. Resident complained of right leg pain. No obvious deformity noted to right leg. Resident was assisted back to bed, continued to complain of right leg pain. Received new order for STAT x-ray of right hip to rule out fracture." 3/13/22 3:47 AM - R174's clinical record documented, "There is a comminuted (broken bones fractured into more than three pieces) right hip fracture with moderate displacement (ends are not lined up straight.) Resident sent to the emergency room for evaluation." 8/22/23 1:30 PM - During a phone interview R174's son stated that the resident is, "Bed bound at another facility." 8/23/23 2:15 PM - Review of R174's clinical documentation failed to show evidence that a fall incident or investigation report was completed, or an interdisciplinary team review was done. Record review also failed to show evidence that the care plan interventions for ambulation were done. A care plan intervention for hipsters (undergarment worn to help reduce hip fractures from falls) was initiated on 3/12/22 but there was no evidence that this care was provided on R174's clinical records. On 3/16/23 a care plan was initiated for toileting before and after each shift and ambulate as needed. R174 was sent to the emergency room on 3/13/22.	F 689		

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F 689	Continued From page 117 The facility failed to ensure that R174 received adequate assessment, interventions, and assistance to prevent accidents. This resulted in a fall with a fracture. 3. Review of R410's records revealed: 8/7/23 3:23 PM - R410 was admitted to the facility with diagnoses including but not limited to cognitive communication deficit (difficulty with thinking and language use), urinary tract infection, fracture of the left hip bone. 8/7/23 - R410's nursing admission assessment documented a fall score of 12 (a scale used to evaluate the risk for falls -12 indicated a high fall risk.) The bowel and bladder documented "incontinent of bowel and bladder." R410's BIMS (Brief Interview for Mental Status) was 1, which indicated a severe cognitive deficit (difficulty with language and speech) and required assistance of one person with transfers. An evaluation for toileting or a voiding diary was not initiated or done. 8/7/23 - R410's care plan documented, "At risk for falls related to cognitive impairment with impulsive behaviors, impaired mobility, and history of falls with fractures. Interventions included but not limited to... low bed, resident wear glasses when out of bed, remind resident to use call light, to ask for assistance with activities of daily living, and wear nonskid socks." R410's care plan also documented, "Incontinent of bladder and bowels due to dementia." 8/8/23 9:41 AM - R410's clinical record documented, "Resident was walking in hallway,	F 689		

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F 689	Continued From page 118 holding on to side rail and placed herself on the floor in a sitting position. Resident educated on asking for assistance with transfers and placed at nurse station for safety. Staff will continue to monitor resident." The surveyor was unable to locate the incident report, investigation, and interventions for this fall. E2 (Regional Clinical Director) confirmed that the report, investigation and interventions were not done. 8/10/23 - R410's clinical record documented a new order for trazodone 25 mg (antianxiety medication) every eight hours as needed for agitation. 8/11/23 9:10 AM - R410's clinical record documented, "Resident fell in the room, hit her head, and sustained a laceration (4 cm x 2 cm) on her right elbow. Resident was sent to the emergency room for evaluation." R410' s fall score was on this assessment 12 (high risk.) R410 returned to the facility at 6 PM. The surveyor was unable to locate the interdisciplinary team fall review for this incident. 8/17/23 - R410's fall care plan was updated to include, "Scoop mattress placed on resident's bed to help identify bed boundaries due to resident's poor eyesight. Provide toileting hygiene with brief change." 8/23/23 5:15 PM - R410's clinical record documented, "Resident had fallen by the lounge .... resident was wheeled to the nursing station for close monitoring." R410's fall score was now 13 (high risk.) The surveyor was unable to locate the interdisciplinary team's fall review and interventions.	F 689		

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F 689	Continued From page 119 8/26/23 9:13 PM - R410's clinical records documented, "Patient restless and agitated .... will not sit still. Snacks given and diversional activities attempted with no success. Will medicate and evaluate for effectiveness." Review of R410's medication records for the use of PRN (as needed) trazodone 25 mg revealed that was given on 8/12, 8/19, 8/23/23 with effective results, and 8/26/23 with ineffective results. 9/5/23 11:30 AM - R410's clinical records documented, " ...Resident fell in her room ...no new orders ... brought up to the nurses station." 9/6/23 5:01 AM - R410's clinical records documented, "Still on one-on-one observation to prevent fall, all nursing care on going. Trazodone was given with Ineffective results. Remained in wheelchair for most of the night with increased agitation and trying to walk. Walking unsteady, unable to redirect ..." Review of R410's medication records for the use of PRN (as needed) Trazodone 25 mg revealed that was given on 9/2, 9/3, 9/4, 9/6, 9/9, 9/10, 9/11/23 with effective results, and 9/5/23 with ineffective results. R410 had a total of 4 falls from 8/7/23 to 9/5/23. The surveyor was unable to locate the interdisciplinary team's fall review and interventions to prevent falls. The facility failed to ensure that R410 was accurately assessed and appropriate interventions were implemented to prevent accidents.	F 689		

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F 689	Continued From page 120 9/8/23 at 12:30 - Findings were reviewed with E1 (Nursing Home Administrator), E2 (Regional Clinical Director), and E3 (Director of Nursing) at the exit conference.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		11/30/23

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F 690	Continued From page 121 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for two (R126 and R139) out of two residents reviewed for bowel and bladder management, the facility failed to ensure that appropriate assessments, treatments, and services were rendered to achieve normal bowel and bladder continence to the extent possible. Findings include: A review of the facility's policy titled "Assessment for Bowel and Urinary Toileting Program" dated 11/1/19 revealed that "licensed nurses will assess patients for unusual bowel patterns or urinary patterns, habits, and continence status. Assessments findings will determine selection of patients who may benefit from participating in a bowel or urinary retraining program." 1. Review of R126's clinical records revealed: 5/24/23 - R126 was admitted to the facility with diagnoses including but not limited to cerebrovascular disease (a group of conditions that affect blood flow and blood vessels in the brain), major depressive disorder, slurred speech, congenital malformation syndromes (developmental delay primarily involving the limbs.) 5/24/23 - R126's admission assessment documented, "Cognitively intact", (Cognitively Intact - able to make own decisions).	F 690	F690- Bowel/Bladder Incontinence, Catheter, UTI A. R126 and R139 continue to reside at the facility. DON/designee will initiate a 3-day voiding diary, once completed will be reviewed by nursing management team and a bladder assessment completed and interventions implemented based on results. B. All residents experiencing incontinence have the potential to be affected by this practice. DON/designee will review all resident's bladder continence/incontinence documentation, residents experiencing incontinence will have a 3-day voiding diary initiated. Completed voiding diaries will be reviewed by DON/UM/Supervisors and an individualized toileting program was developed if applicable. C. No policy changes are needed. Root cause analysis completed resulted the facility failed to complete the 3 day voiding diary on residents on admission, readmission or with identified changes in continent status. RDCS will educate MDS, UMs, Licensed nurses and CNAs on the bowel and bladder assessment that is completed on admission, readmission, quarterly and with significant changes. The 3 day voiding diary and evaluation upon completion, will be used to identify any patterns and initiation of an	

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F 690	Continued From page 122 5/24/23 - R126's care plan documented, "...Maximum assistance with personal hygiene and dressing, and minimum to moderate assistance for assist to turn and reposition in bed, and for transfers. Incontinent of bladder and bowel with interventions including but not limited to .... check and change briefs frequently as needed, provide toileting hygiene as needed." The facility lacked evidence that a bowel and bladder evaluation/toileting/voiding diary or evaluation was done to determine if R126 was a candidate for a toileting program. (Voiding Diary - a record of voiding (urinating) for 72 hours and/or three days done on admission or readmission or upon changes in continency status to assist with the development of a toileting program. Prompted void - technique of bladder training in which the patient is instructed to urinate according to a predetermined schedule; toileting program - fixed times for toileting assistance to help with urinary incontinence (National Institute of Health 2017.) 6/2/23 - R126's MDS documented, "Extensive assist of one person with bed mobility and transfers, and dressing, extensive assist of one person with toileting. Frequently incontinent of bowel, always incontinent of urine." The facility lacked evidence that a trial/prompted toileting diary or a toilet program was implemented. 8/16/23 1 PM - During an interview with R126 while he was lying in the bed, a strong smell of urine and feces was noted. R126 stated that he was, "Just cleaned up." 8/16/23 3:30 PM - R126 was observed lying in the bed. R126 stated, "The girl changed me."	F 690	individualized toileting program. D. DON/UM/Supervisors will audit residents with decline in continence weekly x 4 weeks until 100%, then every 2 weeks until 100% then monthly X 4 months until 100% to ensure voiding diary started and evaluated. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 690	Continued From page 123 8/17/23 8:30 AM - R126 was observed lying in the bed. He was alert and oriented, a strong odor of urine was smelled around his bed clothing and person. 8/17/23 11:20 AM - R126 was observed lying in bed, a strong urine odor continued to be present. 8/17/23 12:10 AM - R126's incontinence was confirmed with E4 (RN Unit Manager.) 8/22/23 9:45 AM - During an interview with E61 (Agency Certified Nursing Assistant), stated "I mostly work on this unit when I am here. He (R126) is always incontinent. I was never told that he goes to the toilet. I change him in the bed. Maybe two of the residents on this unit goes on the toilet. I mostly change them in bed." 8/22/23 11:30 - During an interview with E36 (Licensed Practical Nurse) stated, "There is no assessment or evaluation for bowel and bladder for residents. The CNAs take care of cleaning and changing them." A review of R126's bowel documentation from 7/22/23 to 8/22/23 revealed one episode of bowel continence, 25 episodes of incontinence, and six days without any bowel movements. R126 had three episodes of bladder continence, and 94 episodes of bladder incontinence during the same review period for a total of 119 episodes of incontinence. The facility was unable to provide documentation from 5/24 to 7/21/23. 8/22/23 11:38 AM - During an interview with E57 (RN, MDS Coordinator) regarding the residents' assessments for continence/incontinence and toileting programs for the MDS, E57 stated, "The	F 690		

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F 690	Continued From page 124	F 690		

nurses on the floors do the bowel and bladder evaluation. I look at the flow sheets, and the notes for information to do the MDS. This company does not do toileting/voiding diaries. The RAI manual (Resident Assessment Instrument that helps facility staff gather definitive information on a resident's strengths and needs which must be addressed in the individualized care plan) has many steps to do. We don't do them." The surveyor asked E57 about the process for a resident who was previously continent, and later became incontinent. E57 stated, "I would let the nurse know, and I would care plan them for incontinence if they continued to be incontinent."

The facility failed to ensure that R126 received appropriate assessments, treatments, and services were rendered to achieve normal bowel and bladder continence to the extent possible.

2. Review of R139's records revealed:

7/1/23 2:15 PM - R139 was admitted to the facility. The admission assessment documented, "continent of bowel and bladder." BIMs of 14-cognitively intact (7/12/23)

7/1/23 - R139's care plan documented, "...Resident was primarily continent of bladder, and incontinent of bowels, and needed extensive assist of one to two persons for transfers to toilet as needed."

7/12/23 - R139's MDS documented, resident received extensive assist of one person for toileting, and occasionally incontinent of bladder, always incontinent of bowel". R139 was not evaluated or placed on a trial bowel/bladder

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	085033	A. BUILDING _____ B. WING _____	C 09/25/2023

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PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F 690	Continued From page 125 program, scheduled toileting, or prompting. 8/16/23 12 PM - R139 was observed lying on his bed. During a brief interview R139 stated, "I rang the call bell so someone can come in and change me" A pair of soiled briefs were observed in the garbage bin in the bathroom. 8/16/23 3:40 PM - R139 was observed lying on his bed. A strong smell of urine was noted coming from the room. 8/17/23 8:30 AM - R139 was observed lying on his bed. A strong smell of urine was noted coming from the room. 8/18/23 10:49 AM - During an interview with R139 stated, "I only started using the diapers since I have been here. I did not wear them when I was at home." During an interview with a family member (with R139's permission) stated, "The only time he (R139) goes to the toilet is when we are here to take him." R139 stated "I go in the diaper, and they come in and change me. I would like to use the toilet, but I need someone to help me get there." A review of R139's bowel documentation from 7/23/23 to 8/22/23 (31 days) revealed one episode of bowel continence, seven episodes of incontinence, and 22 days without any documented bowel movements. R139's bladder documentation revealed 67 episodes of continence and seven episodes of incontinence. 8/22/23 11:38 AM - During an interview with E57 (RN, MDS Coordinator) regarding how the residents' are assessed for continence/incontinence for the MDS, E57 stated,	F 690		

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F 690	Continued From page 126 "The nurses on the floors do the bowel and bladder evaluation. I look at the flow sheets, and the notes for information to do the MDS. This company does not do toileting/voiding diaries. The RAI manual (Resident Assessment Instrument that helps facility staff gather definitive information on a resident's strengths and needs which must be addressed in the individualized care plan) has many steps to do. We don't do them." The surveyor asked E57 about the process for a resident who was previously continent, and later became incontinent. E57 stated, "I would let the nurse know, and I would care plan them for incontinence if they continued to be incontinent." The facility failed to ensure that R139 who was incontinent of bladder received appropriate assessment, treatment, and services to restore continence to the extent possible. Additionally, the facility failed to ensure that R139 who was incontinent of bowel received appropriate treatment and services to restore as much normal bowel function as possible. 9/8/23 at 12:30 - Findings were reviewed with E1 (Nursing Home Administrator), E2 (Regional Clinical Director), and E3 (Director of Nursing).	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		11/30/23

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F 692	Continued From page 127 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R49 and R75) out of four residents reviewed for nutrition, the facility failed to provide necessary services to maintain adequate nutrition. For R49, the facility failed to consistently provide a nutritious meal for R49 when scheduled to be out of the facility on a regular basis for dialysis. For R75, the facility failed to provide the necessary services to maintain good nutrition when he was not served his pre-packed lunch before he left for a doctor's appointment on 8/21/23. Findings include: 1. Review of R49's clinical record revealed: 3/28/23 - R49 was admitted to the facility with diabetes and kidney disease requiring dialysis. 8/14/23 3:00 PM - A progress note documented: "Dialysis staff (name) called and stated that they have a chair time available for M/W/F and (sic.) 6 am. Resident should be at dialysis at 0545 hrs. (5:45 AM)." Breakfast is not served to the	F 692	F692- Nutrition/Hydration Status Maintenance A. R49 Continues to reside at the facility. The dietary department has been notified of residents scheduled dialysis days and will provide a boxed meal prior to resident departure time, nursing staff will ensure that meal is given to the resident prior to pick up time. An order will be placed in the EMR to alert the nurse to validate that the resident received boxed meal. R75 continues to reside at the facility. Any future appointment times follow a new procedure to ensure boxed meals will be provided if scheduled during mealtimes. B. All residents that require dialysis services and appointments outside of the facility have the potential to be affected by this practice. DON/designee will audit residents requiring dialysis services and appointments outside of the facility, to ensure that dietary department is notified	

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F 692	Continued From page 128 residents on the Linden Unit until approximately 8:30 AM. 8/16/23 1:43 PM - During a random screening interview, R49 stated that she was not always provided with a bagged breakfast for dialysis. In addition, she stated that the facility does not always have a lunch tray ready for her when she returns from dialysis. She stated that most of the time the staff had to call the kitchen to get her a meal. Review of R49's dialysis communication sheets revealed that three (2 undated sheets and 8/17/23) out of eight days, R49 was not provided with a meal to consume while out of the building. 8/25/23 11:14 AM - During an interview, D1 (Dialysis Nurse Manager) confirmed that if R49's dialysis communication forms were checked that a meal was not provided, then that was correct information. D1 stated that they have some small snacks available at dialysis, but not enough, especially for a patient with diabetes. 2. Review of R75's clinical records revealed: 7/6/23 - R75 was admitted to the facility with diagnoses including dementia. 7/12/23 - R75's admission MDS assessment revealed that R75 was cognitively impaired and required supervision of one staff member assist with eating. R75 was holding food in mouth/cheek or residual food in mouth after meals. 7/10/23 - R75 had a care plan for an actual or potential nutritional problem related to dementia...with interventions including but not	F 692	of the residents□ need of boxed meals and an order placed in the EHR to alert nurse to validate that the meal is given to the resident prior to pick up time. C. No policy changes are needed. Root cause analysis completed result identified that there was not a procedure in place to ensure that a resident receives box meals for appointments outside of the facility. All residents who receive dialysis services and appointments out of the facility will have a dietary communication form filled out by Licensed nurse and an order to alert licensed nurses to ensure that the resident is provided with the boxed meal and will validate that the resident has the boxed meal prior to departure. DON/designee will educate dietary and nursing staff regarding the provision of boxed meals for residents that will be out of the facility during mealtimes. D. DON/designee will audit 5 residents who require a box meal for outside appointment weekly X 4 weeks until 100%, every 2 weeks X 1 month until 100%, monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 692	Continued From page 129 limited to: "encourage to eat...record meal % intake...therapeutic diet as ordered...". 8/18/23 1:27 PM - A nursing progress note documented that R75 was rescheduled for an endocrinologist appointment "for Monday (8/21/23) at 1:30 PM at (hospital)." 8/21/23 - Multiple observations of R75 seated on his rock and go chair from 10:30 AM through 1:00 PM revealed that the facility lacked evidence that the nursing staff offered a pre-arranged lunch for R75 nor offered him a bagged lunch before he left for a doctor's appointment at 1:00 PM. 12:40 PM - Transport service arrived, waiting for E44 (LPN) to complete R75's transfer papers. R75 was sleeping with eyes closed on his rock and go chair in front of the nurse station. 12:47 PM - Food truck for residents in Bethany Hall (long hall) arrived (with R75's food tray on it). Nursing staff started to pass food tray in resident's room. 12:56 PM - Transport service received completed transfer papers from E44. Two staff from transport service were observed calling R75's name, woke him up and assisted him to transfer from the rock and go chair to the stretcher. 1:00 PM - R75 was transported via stretcher by two transport staff for his doctor's appointment with out receiving his lunch. 8/21/23 1:51 PM - A nursing progress note documented, "Resident at endocrinologist appointment". 8/21/23 2:23 PM - A follow up nursing progress note documented, "Resident left for endocrinologist appointment via stretcher. Resident left out with paperwork".	F 692		

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F 692	Continued From page 130 8/21/23 3:30 PM - Review of R75's 7 AM -3 PM CNA Tasks on meal and fluid intakes revealed the following documentation: 12:11 PM - consumed and eaten 75%-100% of the meal, drank 240 mls fluid 12:14 PM - independent with eating, no setup or physical help from staff, occurring two times 1:22 PM - consumed and eaten 26%-50% of the meal drank 240 mls fluid 8/21/23 4:00 PM - During an interview, E45 (CNA) stated, "...He (R75) was already here when I got here for the 3-11 shift. I was told that he just came back from doctor's appointment. No, I do not know if he was able to eat his lunch. Nothing was passed on to me at report. When I came in, resident was already seated in front of the nurse's station, sleeping". 8/21/23 4:05 PM - In an interview, E46 (LPN) stated, "I did not know if resident had lunch when he returned from doctor's appointment. He was already here when we arrived". 8/21/23 4:10 PM - In an interview, E4 (RN UM) stated, "Once nursing staff is aware of a resident's outside consults and appointments, nursing usually calls and notifies the kitchen to request for an early lunch or early meal. Residents can also bring a bagged lunch with them too". 8/22/23 10:19 AM - In an interview, E48 (CNA) stated, "Resident (R75) was on my assignment and he left for doctor's appointment before the food truck with his food tray arrived. He returned on the 3-11 shift. I was not here when he came back. Usually when a resident leaves for an	F 692		

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F 692	Continued From page 131 appointment, the nursing staff would ask for an early lunch. He did not get an early lunch. To be honest, I did not know he was going out for a doctor's appointment until I saw the transport service assisting him to lay on the stretcher. There was no early meal tray delivered for the resident. By the time the food truck for his hall with his food tray on it arrived, the resident had already left the building. The resident was not back yet when I left my shift at 2:10 PM. I do not know if he was offered a late lunch when he returned from the appointment." When asked to explain her 8/21/23 7-3 documentation in the CNA tasks, E48 explained, "My documentation in the computer for his food and fluid intakes were for his breakfast and snack but no, I did not assist him with his early lunch tray." 8/22/23 11:30 AM - During an interview, E44 (LPN) stated, "Resident (R75) did not have an early lunch or brought a bagged lunch with him to his doctor's appointment yesterday. I asked the CNA if he ate that morning and his CNA said he ate a sandwich." The facility failed to ensure that R75 received the necessary services to maintain good nutrition when he missed his lunch prior to his doctor's appointment on 8/21/23. 9/8/23 9:30 AM - Findings were discussed with E1 (NHA), E2 (RDC) and E3 (DON). Findings were reviewed with E1, E2 and E3 on 9/8/23 beginning at 11:30 AM.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		11/30/23

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F 695	Continued From page 132 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review. it was determined that for one (R132) out of four sampled residents reviewed for respiratory care, the facility failed to ensure that R132 was provided respiratory care consistent with his physician order and comprehensive person-centered care plan. Findings include: Review of R132's clinical records revealed: 6/21/23 - R132 was readmitted in the facility with diagnoses including CHF (Congestive Heart Failure) and low blood pressure. 6/28/23 - R132 had a care plan initiated for respiratory complications secondary to COPD (Chronic Obstructive Pulmonary Disease) and supplemental O2 (oxygen) use with interventions including but not limited to administering oxygen as ordered. 7/21/23 - R132 had an active physician's order for oxygen therapy at 1 L (liter)/min (minute) via nasal cannula (a tube placed into nostrils to deliver oxygen) every shift for monitoring. 8/16/23 - R132's quarterly MDS assessment revealed that the resident was cognitively intact	F 695	F695- Respiratory/Tracheostomy Care and Suctioning A. R132 no longer resides at the facility B. All residents receiving Oxygen therapy have the potential to be affected by this practice. DON/designee will audit all residents receiving O2 to ensure that the flow rate coincides with the physician□s order. DON/UM/Supervisors will assess the resident to ensure that the rate of O2 meets the resident□s needs. Residents identified as needs not being met by current O2 order, provider will be notified for further directions. C. No policy changes are needed. Root cause analysis completed results identified nursing staff knowledge deficit in identifying the O2 needs and relaying the information to the provider for further directions. DON/UM/Supervisor will educate licensed nursing staff on ensuring that the actual O2 flow rate coincides with ordered flow rate, and communicating the residents O2 needs to the provider to obtain further directions if needed. License nurses will confirm ordered O2 flow rate and actual flow rate during medication passes.	

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F 695	Continued From page 133 and receiving oxygen therapy. Multiple random observations of R132 receiving oxygen therapy revealed the following: 8/16/23 1:11 PM - with O2 at 2 L/min - O2 concentrator 8/21/23 12:13 PM - with O2 at 2.5 L/min - O2 concentrator 8/22/23 9:20 AM -with O2 at 2 L/min - O2 concentrator 8/23/23 10:46 AM - with O2 at 4 L/min - O2 tank 8/23/23 10:46 AM - In an interview, E40 (RN) stated that R132's oxygen therapy order was at 1 L/min via nasal cannula. E40 further confirmed that the oxygen setting that R132 was receiving and observed by surveyor to be at 4 L/min was not the correct order. E40 told this surveyor that she was going back to R132's room to adjust the flow rate on the oxygen tank. 8/25/23 11:55 AM - During an interview, E17 (NP) stated that R132's oxygen therapy is based on her symptoms like shortness of breath. E17 also stated, " We have been adjusting the flow rate based on how far the resident (R132) can tolerate and what physical activities he got himself involved. We tried to taper or wean him off from oxygen but he still ranges between receiving O2 at 1-4 L/min via nasal cannula. I will clarify the physician's order for resident's (R132) oxygen therapy." 9/8/23 9:30 AM - Findings were discussed with E1 (NHA), E3 (RDC) and E3 (DON).	F 695	D. DON/UM/Supervisor will audit all residents who receive O2, actual flow rate and ordered flow rate coincides, weekly X 4 weeks until 100%, 5 every 2 weeks X 1 month until 100%, 5 monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 695	Continued From page 134 Findings were reviewed with E1, E2 and E3 on 9/8/23 beginning at 11:30 AM.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for two (R167 and R508) out of eight residents reviewed for pain management the facility failed to ensure the treatment and care for was in accordance with professional standards of practice related to pain management. For R167, pain was not managed resulting in the resident being sent to the emergency room for uncontrollable pain to the left hip causing harm to the resident. For R508, the facility failed to provide pain medication to a resident in pain in a timely manner. Additionally, R508 had a recommendation for adding another dose of morphine after being seen in a palliative care center and the facility failed to acknowledge and implement for a week. Findings include: A policy and procedure titled "Pain Management Assessments" dated 11/01/19 documented... ...Patient will be assessed for acute and chronic pain by a licensed nurse and a plan of care will be established...1. Assess all patients for pain a part of the admission nursing assessment...2. Initiate a pain assessment any time thereafter should a	F 697	F697- Pain Management A. R167 and R508 no longer reside at the facility. B. All residents who are on pain management and are receiving hospice care have the potential to be affected by this practice. DON/UM/Supervisor will audit residents receiving controlled pain medications to ensure that their pain is being managed and have a sufficient supply according to their usage. DON/UM/Supervisor will review hospice/palliative care recommendations timely to ensure any changes in pain medications are communicated to the provider for consideration. C. No policy changes are needed. Root cause analysis was completed results identified that the facility failed to obtain a prescription for a refill pain medication in a timely manner and failed to respond to hospice recommendations to increase a resident□s pain medication. DON/UM/Supervisor will audit resident□s	11/30/23

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F 697	Continued From page 135 patient experience pain that is unusual for the patient...3. Administration of pain medication and effectiveness will be documented...4. Non-pharmacological interventions will be documented with administration of PRN (as needed pain medication) ...5. If pain is not relieved, notify the physician. Any unusual findings and follow up interventions are to be documented on the progress note including notification of physician and responsible party...6. Care plan specific interventions will be developed based on pain assessment and individual patient needs. 1. Review of R167's clinical record revealed: 3/8/23 - R167 was admitted to the facility with a diagnosis of chronic pain and left hip infection. 3/8/23 - Review of R167'S care plan for "Pain" related to chronic pain revised 3/27/23 documented...1. The resident will report satisfaction with their pain medication regime through the review period...2. Administer medications as ordered...3. Notify physician as indicated...4. Request pain medication review from physician. 3/8/23 1:36 PM - A physician's order included: Pain assessment every shift. 3/8/23 1:36 PM - A physician's order included: administer non-pharmacological pain intervention as applicable. Use the key below to document non-pharmacological interventions used. 3/8/23 4:05 PM - A physician's order included: oxycodone oral capsule 5 mg (milligrams) give 5 mg by mouth every four hours PRN (as needed)	F 697	active narcotic countdown form twice weekly to ensure that residents have sufficient supply of medication to address their pain the provider will be notified of needed supply, if the provider does not response the facility□s medical director will be notified for further directions. UM/Supervisors will bring hospice recommendations to the clinical meeting for review to ensure that recommendations were given to providers for timely follow-up. Hospice Nurses will give recommendations to the assigned licensed nurse, that nurse will communicate any recommendations to the provider for follow-up. DON will educate UM/Supervisor to audit residents□ active narcotic countdown form and bringing hospice recommendations to clinical meetings to ensure provider notification and follow-up. D. DON/designee will audit 10 residents including those on hospice services narcotic countdown sheet for sufficient supply and hospice recommendations weekly X 4weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 697	Continued From page 136 for moderate pain of 4-6. 3/8/23 4:05 PM - A physician's order included: oxycodone oral capsule 5 mg. give 10 mg by mouth every four hours as needed for severe pain of 7-10. 3/11/23 6:18 PM - A nurse's progress note documented ... 1. R167 complained of hip pain ... 2. pharmacy had been notified that R167 was almost out of pain medication ... 3. E51 (LPN) had been told by the Pharmacy that R167 needed another prescription for pain medication ... 4. E51 left a message for the physician to call back ... 5. E51 had not received a call back from the physician. E51's medication administration note revealed Oxycodone 10 mg had been given to R167 for severe pain 8 out of 10. 3/12/23 12:04 AM - A progess note documented..."Give 10 mg by mouth every four hours as needed for severe pain scale of 7-10." 3/12/23 12:10 AM - R167 was administered Oxycodone 10 mg for pain. Further review of R167's controlled drug administration record revealed R167 had been given the last two Oxycodone 5 mg tablets at 12:10 AM. Further review of R167's clinical record revealed no PRN pain medication had been administered to R167 after the last dose had been given on 3/12/23 at 12:10 AM. 3/12/23 7:51 AM - A facility transfer form revealed R167 had uncontrolled pain of 9 out of 10 to the left hip. 3/12/23 12:50 PM - A late progress note	F 697		

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F 697	Continued From page 137 composed by E53 (RN) documented R167 requested to be sent to the hospital due to uncontrollable pain of 9/10 in R167's left hip. Additionally, E53 (RN) documented "the facility had not been able to reach the Pharmacy for medication." 9/5/23 9:00 AM - Review of R167's hospital note dated 3/12/23 documented... requesting pain management for hip pain. Additionally, R167 revealed to the provider in the emergency room, "the facility said they had no pain medication for R167." Further review of the hospital notes revealed, "Case management had confirmed Pike Creek Rehabilitation had no Oxycodone available to treat R167's pain. 9/5/23 12:53 PM - In a phone interview E51 (LPN) revealed R167 had been taking PRN Oxycodone 10 mg every four hours for pain. In addition, E51 stated, "R167 had been sent to the emergency room for unrelieved pain." The facility failed to send R167 a resident who had uncontrollable severe pain to the hospital for evaluation and treatment in a timely manner. Additionally, R167's pain level on 3/12/23 at 7:51 AM had been assessed and was 9 out of 10. Furthermore, R167 arrived at the hospital on 3/12/23 at 12:13 PM, and had not received pain medication since 12:04 AM on 3/12/23 at the Pike Creek Nursing and Rehabilitation Center. 2. Review of R508's clinical record revealed: 7/24/23 - A most recent admission to the facility with a history of cancer and chronic pain. a. 8/9/23 - A physician's order for oxycodone HCl	F 697		

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F 697	Continued From page 138 Oral Tablet 15 mg give 1 tablet by mouth every 4 hours as needed for pain. 8/10/23 - A physician's order for lidocaine external patch 5 % (lidocaine) apply to lower back topically one time a day for pain. 8/12/23 - A care plan for a risk of pain with interventions to administer medications as ordered, notify the doctor as indicated and observe for physical indicators of pain. 8/23/23 5:17 AM - An oxycodone HCl Oral Tablet 15 mg was administered. 8/23/23 10:08 AM - A routine lidocaine patch was applied to the lower back for pain. 8/23/23 11:35 AM - An observation of R508's call bell ringing. E86 (LPN) was nurse's station. 8/23/23 11:43 AM - An observation of R508's call bell ringing. E86 and E92 (RN) were at the nurse's station. 8/23/23 11:52 AM - An observation of R508's call bell ringing. 8/23/23 11:57 AM - An observation of R508's call bell ringing. E86 and E92 were sitting at the nurse's station. 8/23/23 12:05 PM - An observation of E93 (CNA) answering R508's call bell approximately 30 minutes later. 8/23/23 approximately 12:15 PM - An interview with E93 (CNA) revealed that R508 was ringing the call bell because R508 was in pain but E93	F 697		

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F 697	Continued From page 139 thought that the nurse was already aware R508 was in pain. E93 stated "I am going to tell her now." 8/23/23 Approximately 12:18 - An observation of E92 telling E40 (RN) that R508 was in pain. 8/23/23 2:32 PM - The MAR documented a pain medication for his knee was administered, three hours after R508 rang the call bell for pain medication. b. 8/15/23 - The MDS assessment documented that R508 had received a scheduled pain medication regimen, Received PRN pain medications or was offered and declined and did not receive non-medication intervention for pain. Pain presence in last 5 days was yes. Pain frequency was almost constantly. Over the past 5 days has pain made it hard for the resident to sleep at night. Over the past 5 days the pain did not limit your day-to-day activity NO. Pain intensity Numeric rating was a 10 on a 0-10 scale. 8/15/23 - A palliative care consult note documented that "Given [R508's] near-constant joint pain, I believe it is reasonable to increase his MS Contin (morphine) 30 mg from every 12 hours to TID and we will keep his PRN oxycodone as it is." 8/18/23 1:52 PM - A late entry progress note documented that R508 went for a palliative care appointment today. "Spoke to family who wants morphine sulfate ordered three times a day. The physician was notified and made aware. Also, passed on to this information to the oncoming nurse."	F 697		

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F 697	Continued From page 140 8/22/23 5:57 PM - During an interview with FM1, it was revealed that the facility "does not listen, it was promised to me last Thursday (8/17/23) someone would follow up on the morphine recommendation from the palliative care practitioner." The recommendation was to increase the morphine order from two times to three times a day. FM1 gave the document to the facility when returned from the appointment that day. FM1 stated "[E28 (MD)] was supposed to get it and on Thursday." FM1 stated "I approached [E4 (UM)] and asked where the paperwork from the palliative care practitioner was, [E4] did not know." It was further revealed "There has not been a medication change to date." A request was made by the surveyor to E1 (NHA) for R508's palliative care visit consult note, but it was never received. 8/23/23 4:00 PM - An order for MS Contin (morphine sulfate) oral tablet extended release 30 mg give 1 tablet by mouth every 8 hours for pain. The recommendation from the palliative care specialist to increase the morphine sulfate from every 12 hours to every 8 hours on 8/15/23 was never acted on until seven days later. 9/6/23 4:14 PM - During an interview E28, revealed he was not aware of the recommendation from the palliative care specialist until 8/22/23 when E25 (SW) inquired about the medication change. E28 further revealed that he had felt R508's pain was doing better and indicated that the resident was never in	F 697		

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F 697	Continued From page 141 unmanaged pain. 9/8/23 at 12:30 - Findings were reviewed with E1 (Nursing Home Administrator), E2 (Regional Clinical Director), and E3 (Director of Nursing).	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §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 record review, interview, and review of other facility documentation, it was determined that for one (R49) out of two residents reviewed for dialysis services, the facility failed to review a medication order conveyed by R49's dialysis communication form upon return to facility after dialysis. In addition, the facility failed to clarify the recommended order to ascertain whether the dosage/frequency of the medication and whether it was to be administered at the facility, or to be administered at dialysis. The facility also lacked evidence that six out of eight opportunities R49's post dialysis communication documentation sheets were reviewed by the facility for any pertinent information or recommendations. Findings include: Review of R49's clinical record revealed: 3/28/23 - R49 was admitted to the facility with kidney disease requiring dialysis.	F 698	F698- Dialysis A. R49 continues to reside at the facility. The order for the medication, Cinacalcet, was clarified to be given by the dialysis unit provider. B. All residents who receive dialysis services have the potential to be affected by this practice. DON/designee will audit 30 day of resident□s dialysis communication sheets to clarify any recommended medication(s) to include who will be administering the medication(s). C. No policy changes are needed. Root cause analysis completed results identified that the facility failed to review dialysis communication sheets for recommendations that needed to be clarified. The assigned licensed nurse will review dialysis communication form when resident returns and communicate recommendations to the provider. UM will	11/30/23

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F 698	Continued From page 142 8/10/23 - A facility dialysis communication form was returned to the facility with R49 after dialysis. The post dialysis portion of the form documented: "Pt (patient) has new prescription for cinacalcet 30 mg (milligrams) to take daily. 8/10/23 11:35 AM - A nursing progress note documented, "Resident returned from dialysis via stretcher at 1100. New order for cinacalcet. RP (responsible party) and NP (nurse practitioner) made aware." 8/14/23 9:31 AM - A nursing progress note documented: "Resident made this writer aware that per dialysis, she's to start on cinacalcet 30 mg PO daily due to hypercalcemia (per dialysis labs results). This information verified per dialysis communication paperwork on Thur 08/10. NP made aware. Order in place. RP made aware." 8/14/23 12:10 PM - A facility physician's order included: cinacalcet HCl (Hydrochloride) Oral Tablet 30 mg. give 1 tablet by mouth one time a day for hypercalcemia. This order was written by the facility four days after the communication came from dialysis. 8/15/23 4:29 PM - A nursing progress note documented cinacalcet HCl (Hydrochloride) tablet 30 mg one time a day for hypercalcemia (high calcium levels in the blood). 8/16/23 1:41 PM - During an interview, R49 stated to the Surveyor that she had a new medication ordered at dialysis last week. R49 stated that she inquired about the medication to a nurse on Monday (8/14/23) and that the nurse told her that the medication was not at the facility yet, and the order had not been written or sent to	F 698	review the dialysis communication sheets upon resident□s return to the center to ensure recommendations are communicated to the provider and will clarify any unclear recommendation to include who or when medications need to be administered. DON will educate the nursing management team to bring dialysis communication sheets to clinical meetings for review to ensure recommendations are followed up to include clarification of who will be administering medication. DON/UM/Supervisor will educate licensed nurses to review dialysis communication sheet upon residents return to the facility and communicate any recommendations to provider for further direction. D. DON/designee will audit residents□ dialysis communication sheets weekly X 4 weeks until 100%, every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 698	Continued From page 143 the pharmacy. R49 additionally stated that she thought that the name of the medication was "Sensipar" (a brand name of cinacalcet). R49 stated that she has high calcium levels and should be receiving the medication for that reason. 8/17/23 5:04 PM - A nursing progress note documented that the facility was "awaiting pharmacy delivery." 8/18/23 7:07 PM - A nursing progress note documented that R49's cinacalcet "awaiting delivery." 8/19/2023 9:44 PM - A nursing progress note documented: "Pharmacy contacted and stated that med is being process (sic.) by another pharmacy and per tech will contact them in the morning and request it to be forward to their pharmacy phone number provided for pharmacy where med is being process(ed) ..." 8/19/23 - Review of R49's dialysis order report revealed an order for cinacalcet 30 mg 1st, 2nd, and 3rd day tx (dialysis treatment). 8/19/23 8:52 PM - A nursing progress note documented: "med (cinacalcet medication) is not available will contact pharmacy for follow up." 8/20/23 5:35 PM - A nursing progress note documented: (cinacalcet) "pending delivery from pharmacy." 8/21/23 5:35 PM - A nursing order note included: "This order is outside of the recommended dose or frequency. cinacalcet HCL tablet 30 mg ...one time a day every other day for hypercalcemia pt	F 698		

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F 698	Continued From page 144 (patient) receives at dialysis on 1st, 2nd , and 3rd treatment days of the week. Profile only do not send medications." Review of R49's clinical record revealed that the provider order noted on R49's dialysis communication document was not clarified from 8/10/23 until 8/21/23. R49 was at risk to be administered the medication (cinacalcet) every day at the facility and additionally on the 1st, 2nd , and 3rd day of dialysis treatment three times a week which would be well over the recommended dosage. 8/25/23 11:14 AM - During an interview, D1 (Dialysis Nurse Manager) at R49's dialysis location confirmed that her (D1's) center was never contacted by the nursing facility to clarify the order for her Cinacalcet and the medication had not been started at the center until 8/19/23. Review of R49's dialysis communication documents (in R49's dialysis communication book) revealed that six out of eight documents lacked evidence dialysis dates, and that were reviewed by the facility for any pertinent information or recommendations. 8/25/23 approximately 2:45 PM - During an interview, E2 (RCD) and E3 (DON) confirmed the lack of clarification of R49's cinacalcet provider order and the risk for receiving outside the recommended dosage. E2 also confirmed the lack of evidence of review of post dialysis pertinent information and/or recommendations. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 698		

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F 710	Continued From page 145	F 710		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interviews and reviews of clinical records, the facility failed to ensure that for one (R172) out of seventy-six residents in the investigative sample that were reviewed for medical care supervised by a physician, the facility failed to ensure that one of R172's medication orders contained accurate medication administration instructions. Findings include: Cross refer to F684. Review of R172's clinical record revealed: 5/10/22 - R172 was admitted to the facility with multiple diagnoses including a recent (4/22) left foot surgical toe removal and anemia (reduced	F 710	F710- Resident□s Care Supervised by Physician A. R172 no longer resides at the facility. E-6 was educated on correctly transcription of Epoetin Orders B. All residents who are ordered medication with parameters have the potential to be affected by this practice. DON/designee will audit all residents who have orders with parameters to ensure that the parameters are written to identify when to hold the medication correctly according to parameters. Cross Refence F773 Lab services C. No policy changes are needed. Root cause analysis completed results	11/30/23

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F 710	Continued From page 146 ability of red blood cells to carry oxygen to organs, causing tiredness). 5/11/22-5/19/22 - R172 was hospitalized for foot wound care and for the monitoring of his anemia. 5/19/23 -R172 was readmitted to the facility. Review of the hospital discharge summary revealed that R172 received treatment for his chronic anemia while hospitalized, which included a transfusion (receiving blood products into a vein) of two (2) units of blood. R172's Hemoglobin (Hgb- protein in red blood cells to carry oxygen from lungs to the body) at the time of discharge was stable at 8. 5/22/22 - A physician's order was written by E6 for the facility to obtain a Complete Blood Count (CBC) laboratory test. The laboratory test would test for R172's Hgb level. 5/24/22 - A physician's order was written for Epoetin (a medication to treat anemia) inject 1 ml one time a day every week for anemia, hold for Hgb less than 10. 5/25/2022 12:30 - A review of a Nurse Practitioner/Physician Comprehensive progress note revealed ..."CBC Date - 05/23/2022 CBC Results ...H ... 9.8 ... Epogen 20000u Q weekly ...". 8/16/23 - A review of R172's EMR documentation from 5/11/22-5/27/22 revealed that the documentation for the results of the Complete Blood Count (CBC) lab test ordered on 5/22/22 were not present in the chart. Additionally, R172 did not receive an injection of Epoetin on 5/24/22, the nurse indicated the reason to not give the	F 710	identified that the nurse failed to transcribe orders correctly, medical provider failed to accurately review order prior to signing. The Medical Director will submit a memo to all providers outlining accurate parameters for medication] administration. DON/designee will educate license nursing staff on transcribing orders, to ensure that the orders are read back to the provider to ensure accuracy. An order recap report which includes order summary and directions for administration will be ran and all new orders will be reviewed daily on 11-7 shift by the licensed nurse and at the clinical meeting to identify any inaccuracies, those identified will be brought to the provider's attention for further directions. D. DON/designee will audit residents with new orders for medication parameter accuracy weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100% then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 710	Continued From page 147 medication was for a Hgb of 9.8. 8/30/23 11:00 AM - During an interview, E18 (Nurse Practitioner) stated that the instructions for the medication order Epoetin 1ml injection one time for anemia, to hold for Hgb less than 10, should have read to hold the medication for a Hgb greater than 10 and that R172 should have received the medication on 5/22/22. E18 confirmed that the Epoetin medication order was written incorrectly in the Electronic Medical Record (Emr) and that the reason was that the nurse who entered the order in the Emr wrote the order incorrectly. 8/30/23 2:00 PM - During an interview, E3 (DON) stated that the 5/22/22 laboratory test for R172 had not been completed as the documentation of the test could not be located. R172 was hospitalized on 5/27/22 when he was found unconscious in his room at the facility. R172's Hgb level at the time of his hospital admission on 5/27/22 was at 6, which was a critical level for Hgb. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 710		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 725		11/30/23