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

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: October 17, 2023

STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES		COMPLE-TION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted at this facility from October 12, 2023 through October 17, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records, facility documentation and other resources as indicated. The facility census on the first day of the survey was 166. The survey sample size was 19 residents.			
3201	**Regulations for Skilled and Intermediate Care Facilities**			
3201.1.0	**Scope**			
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed 10/17/23: F580, F658, F684, F711, F760 and F842.	Please see POC on Aspen Epoc		12/8/23

Provider's Signature OfRochester Title Administrator Date 11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD 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 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from October12, 2023 through October 17, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records, facility documentation and other resources as indicated. The facility census on the first day of the survey was 166. The survey sample size was 19 residents. Abbreviations/definitions used in this report are as follows: Anticoagulant - medicines that increase the time it takes for blood to clot. They are commonly called blood thinners; Antiplatelet- medicines that reduce the ability of platelets to stick together (called platelet aggregation) and inhibit the formation of blood clots; BIMS -Brief Interview for Mental Status - assessment of the resident's mental status. The total possible BIMS score ranges from 0 to 15 with 15 being the best. Bell - curve onset with peak 4 -12 hours - from the time you give the insulin , the onset is the amount of time after injection it takes to have any significant effect on blood glucose. Peak time is the time period after injection will have the greatest impact at lowering blood glucose levels; Cardiovascular - heart and blood vessels; CNA - Certified Nurse Aide; CNO - Chief Nursing Officer; Contracture- a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult; cyanotic- bluish skin color due to decreased	F 000		

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

Electronically Signed | 11/09/2023

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

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F 000	Continued From page 1 amounts of oxygen in the blood; DO- Doctor of Osteopathy; DON - Director of Nursing; Dysphasia - a language disorder that affects the ability to produce and understand spoken language; eMAR (Electronic Medication Administration Record) - electronic documentation of medications administered to a patient; EMR (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format; Gastrostomy tube - surgically placed tube used to give direct access to the resident's stomach for supplemental feeding, hydration and medications; glucagon- an emergency medicine used to treat severe hypoglycemia (low blood sugar) in diabetes; hyponatremia- low sodium levels in the blood; iatrogenic- a medical injury or disorder caused in the process of medical treatment; LPN - Licensed Practical Nurse; MAR - Medication Administration Record; MD - Medical Doctor; Melatonin - sleep aid; Milligrams - mg; Milliliter (ml) - unit of volume; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; NP - Nurse Practitioner; PEG (Percutaneous Endoscopic Gastromstomy) tube - a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate; Respiratory Failure - lungs cannot release enough oxygen into the blood;	F 000		

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F 000	Continued From page 2 RN - Registered Nurse; spastic quadriplegic- condition that affects all four limbs, in which the person has lost control of his entire body but does display stiff, jerky movements stemming from increased muscle tone; RT- Respiratory Therapist; SMA - superior mesenteric artery; Spleen - a fist-size organ found in the upper left side of the abdomen, next to the stomach and behind the left ribs; SW - Social Worker; tachypneic- rapid, shallow breathing; Tracheostomy- small surgical opening that is made through the front of the neck into the windpipe or trachea that allows air in and for secretions to be removed; Ventilator - machine that acts as a bellows to move air in and out of your lungs.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		12/8/23

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F 580	Continued From page 3 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of nineteen residents reviewed for Quality of Care, the facility failed to ensure the provider was consulted for a significant change. R1 had an elevated heart rate, ranging from 120 to 154 beats per minute,	F 580	a. At time of survey provider had already been made aware of significant change. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this	

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F 580	Continued From page 4 intermittently for five days and consistently for sixteen hours prior to R1's 7/1/23 hospitalization with no interventions or notification of the provider. Findings include: [Facility] Healthcare Policy Title: Alert Charting - POLICY: it is the policy of [facility] Healthcare to utilize alert charting for residents experiencing changes in condition that warrant heightened observation as determined through nursing judgment. PROCEDURE: ... report changes in resident condition to the physician and the responsible party. 1. Review of R1's clinical record revealed: The American Heart Association states the normal resting adult human heart rate is 60-100 bpm. Tachycardia is a high heart rate, defined as above 100 bpm. 1/20/15 - R1 was admitted to the facility with diagnoses including but not limited to: chronic respiratory failure with the need for mechanical ventilation (machine to assist breathing). R1's heart rate was documented in the EMR on the following dates and times: 6/25/23 8:31 PM - 121 bpm (beats per minute) 6/26/23 2:12 AM - 113 bpm. 6/26/23 2:13 AM - 113 bpm 6/26/23 3:12 AM - 113 bpm 6/26/23 8:35 AM - 116 bpm 6/26/23 4:56 PM - E30 (NP) documented in a Follow Up Progress Note" ...Pulse 116 bpm (6/26/2023 8:35 AM) ...patient seen lying in bed, awake, non-verbal appears comfortable	F 580	deficient practice by taking the corrective actions outlined below in Section C. c. Root cause analysis was done and found that proper communication between our respiratory and nursing department when there was a significant change in condition did not take place. Staff Developer will educate licensed nurses and respiratory therapists on identification and provider reporting process of any significant health changes. d. The DON or designee will audit 10 residents for elevated heart rate and notification of provider if present. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 580	Continued From page 5 ...Afebrile ...Cardiac exam reveals RRR (regular rate and rhythm).." The Progress Note does not describe R1's intermittent elevated heart rate, which had been occurring for over 24 hours, and did not address this issue despite the documentation that R1's heart rate was 116. R1's heart rate was documented in the EMR on the following dates and times: 6/26/23 8:37 PM - 110 bpm 6/27/23 2:16 AM - 109 bpm 6/28/23 1:55 AM - 112 bpm 6/28/23 8:12 PM - 106 bpm 6/29/23 2:25 AM - 110 bpm 6/29/23 2:34 PM - 103 bpm 6/30/23 2:41 AM - 119 bpm 6/30/23 8:14 PM - 120 bpm 7/1/23 2:46 AM - E15 (Corporate Consultant) initiated an Alert Charting "for tachycardia" documentation for R1 in the EMR. R1's heart rate was documented in the EMR on the following dates and times: 7/1/23 2:48 AM - 137 bpm 7/1/23 2:57 AM - 135 bpm 7/1/23 3:33 AM - 128 bpm 7/1/23 7:50 AM - 122 bpm 7/1/23 12:38 PM - 154 bpm 7/1/23 - R1 was transferred to the hospital for an elevated heart rate. 7/1/23 11:05 AM - E29 (RN) notified R1's family of her transfer to the hospital.	F 580		

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F 580	Continued From page 6 7/1/23 11:49 AM - E13 (Emergency Department MD) documented in the ED Physician Record under History of Present Illness ..."52 year old female with past medical history of quadriplegia, CP (cerebral palsy), ventilator dependence, G-tube dependence, epilepsy presents today from [facility] due to tachycardia in the 150s and respiratory distress. The report given to the medics is that the patient's tachycardia has been ongoing for the last week ...At presentation, she (R1) was tachycardic into the 140's and tachypneic (rapid, shallow breathing) to 24. Adequate O2 (oxygen) saturations." 7/1/23 4:08 PM - E31 (Paramedic candidate) documented in the Prehospital Care Report ..." Staff on scene advised that the patient has had a HR (heart rate) of around 150 bpm for the past week. This morning they noticed the patient in respiratory distress with flushed skin and initiated 911 ... 7/20/23 1:23 PM - R1's Discharge Summary from the hospital stated that R1 was hospitalized with acute on chronic respiratory failure for a total of nineteen days. 10/10/23 11:35 AM - During a telephone interview, E24 (RT) stated that it is her practice to inform the nursing care provider when her assigned residents have abnormal vital signs such as heart rate, pulse oximetry (oxygen saturation) or respiratory rate. She confirmed that though she did not remember the specifics, she was confident that she spoke with R1's nurse provider on the nightshifts of 6/28/23, 6/30/23 and 7/1/23 regarding R1's elevated heart rate.	F 580		

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F 580	Continued From page 7 10/16/23 8:45 PM - During a telephone interview, E28 stated she remembered this incident (R1's transfer to the hospital on 7/1/23) "vividly". R1 had been having tachycardia (elevated heart rate) for "about a week or two ...The nurses were passing it on at shift report. She (R1) is usually smiling and follows me as I walk around her room with her eyes. I talk to her the whole time. That day, she was drenched and sweaty and she was not tracking me with her eyes. I told the supervisor that she was very different and needed to go to the hospital." 10/17/23 3:12 PM- Findings were reviewed during the Exit conference with E1 (NHA), E2 (DON), E5 (CNO), E15 (Corporate consultant) and E16 (Corporate nurse).	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that R3's care was implemented in accordance with professional standards of practice as evidence by a nurse prepared R3's medications and were administered by another nurse. Findings include: Nursing Rights of Medication Administration - "Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that	F 658	a. The resident received the right medication, at the right time, the right dose and the right route. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. Root cause analysis was done and	12/8/23

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F 658	Continued From page 8 the medication is correctly prescribed and dispensed before administration. It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or "five Rs' of medication administration ...The traditional rights in the traditional sequence include: 'right patient', 'right drug', 'right route', right time', and 'right dose'." A basic premise of this standard is the nurse who performs the 'five rights' check will be the same nurse who is responsible to administer the medication to the patient. The consistency of one person initiating and completing the task of a patient's medication administration is a tenet of professional nurses in an effort to reduce medication administration errors. National Library of Medicine, Angela Hanson & Lisa M. Haddad, last updated September 5, 2022. 5/20/22 - R3 was admitted to the facility with a gastrostomy tube. 5/20/22 - E6 (MD) ordered melatonin tablet 3 mg, give two tablets via gastrostomy tube at bedtime for sleep and ascorbic acid tablet 250 mg give one tablet via gastrostomy tube two times a day for supplement. 5/20/23 - E30 (NP) ordered clonazepam (anti-anxiety medicine) oral tablet 0.5 mg, give 0.5 mg via gastrostomy tube at bedtime for anxiety. 7/21/23 Approximately 10:00 PM - Documentation on R3's MAR for 7/21/23 reflected that E46 (LPN) signed out R3's nighttime medications (clonazepam, ascorbic acid and melatonin).	F 658	found that nurse that signed off on the medication administration was not the nurse that administered the medication. Staff Developer will educate licensed nurses on the five rights of medication administration. d. The DON or designee will audit 5 medication passes. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 658	Continued From page 9 10/12/23 3:51 PM - During an interview, E3 (ADON) stated that E46 (LPN) crushed and prepped the evening medications for R3 on 7/21/23 but asked E47 (LPN) to administer the medications to R3 via her gastrostomy tube "but then E46 (LPN) signed out the meds (medications)". 10/13/23 9:45 AM - During an interview, E12 (Unit manager RN) stated that "the nurse who crushes the meds must give the med (medications). It all has to match the person who crushes the medicine, gives the medicine and signs out the medicine." 10/13/23 10:24 AM - During an interview, E48 (LPN) stated that for med (medication) pass, "the nurse who crushes med (medication) should be the person who gives the med". 10/13/23 2:10 PM - During a telephone interview, E46 confirmed that her sign out initials on the MAR. E46 stated that she handed E47 (LPN) the crushed medications and that he went into R3's room and E 47 administered the medicines via R3's gastrostomy tube. E46 stated that R3 receives "all her oral meds (medications) via the PEG (percutaneous gastrostomy tube)". 10/17/23 3:12 PM - Findings were reviewed during the Exit conference with E1 (NHA), E2 (DON), E5 (CNO), E15 (Corporate consultant) and E16 (Corporate nurse).	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		12/8/23

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F 684	Continued From page 10 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R2) out of nineteen residents reviewed for Quality of Care. R2 was transported to an outpatient medical center at which he did not have an appointment and then waited greater than five hours for a return ride back to the facility missing lunch and medications. Findings include: Review of R2's clinical record revealed: 5/18/18 - R2 was admitted to the facility with diagnoses that included but not limited to stroke, dementia and diabetes. 8/22/23 - R2's quarterly MDS Assessment documented a BIMS indicating moderate cognitive impairment. Based on review of records and interviews the following time line was established: 8/31/23 approximately 10:00 AM - R2 was dropped off at an outpatient medical center in the lobby by a transportation company. 8/31/23 11:22 AM - C1 (Outpatient practice nurse manager) called E2 (DON) to find out when transport was coming for R2.	F 684	a. Resident returned safely from being transported to outpatient medical center. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. Root cause analysis was done and found that proper communication between the transport company and our facility staff did not take place. Staff Developer will educate front desk staff, unit clerks and nurse managers on importance of verifying with transport what resident they are scheduled to pick up, where they are going and cross referencing our appointment calendar to verify accuracy. d. The DON or designee will audit 3 resident transports to ensure that transport company verifies who they are picking up, where they are being taken and that the appointment a valid appointment on our appointment calendar. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits	

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F 684	Continued From page 11 8/31/23 12:16 PM - E32 (RN) documented in the MAR, that R2 missed his dose of clonidine "for HTN (high blood pressure) patient out at doctor appointment". 8/31/23 12:30 PM - Lunch was served at the facility. 8/31/23 12:30 PM - C1 placed second call to E2's (DON) office number. 8/31/23 1:36 PM - C1 placed third call to E2's office number and then called the facility main number. 8/31/23 2:15 PM - R2 was picked up by an Uber that was sent by the facility. C1 stated that her staff helped R2 into the car and put his wheelchair into the trunk of the car. 10/11/23 11:16 AM - During an interview, E5 (CNO) stated that the facility does not have a policy for transporting a resident to an outpatient appointment. He confirmed that there was no policy delineating that a certain BIMs score requires an attendant to accompany the resident. E5 stated that the unit manager makes the decision if the resident can go to their outpatient appointment alone (if family is not able to meet them at the appointment). 10/12/23 8:30 AM - During a telephone interview, C1 (outpatient practice nurse manager) stated that, "he (R2) was dropped off in the downstairs lobby by transport. He did not have an attendant with him. He somehow self-propelled himself to the elevator and ended up on the second floor and in our office. Then our front desk staff called	F 684	will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 684	Continued From page 12 [facility] to find out why he was here since he is not our patient and did not have a scheduled appointment here or in the building." C1 reported that the front desk staff had call all the practices in the building to find out if R2 had an appointment with any of the other practices. C1 stated that she was informed about R2 on 8/31/23 at 11:22 AM and that he had been waiting since 10:00 AM for transport back to the facility. C1 then called E2 (DON) to find out when transport was coming for R2. C1 stated that E2 told her, "transport was called and there was not much more that she (E2) could do". C1 reported placing a second call to E2's office number on 8/31/23 at 12:30 PM but there was no answer and availability to leave a voicemail. C1 reported placing a third call on 8/31/23 at 1:36 PM to E2's office number but again there was no answer or availability to leave a voicemail. C1 then called the facility Main number and was transferred to E2's voicemail, where she left a message. During this time, C1 reported that her front desk staff was calling the Main number "pretty much every 30 minutes to find out when transport would arrive." Her front desk staff tried to call his emergency contacts but R2 reported that the first contact (FM1) had recently passed away. The staff called the second emergency contact's (FM2) number but FM2 did not pick up or return the call. "R2 only had a sheet of paper with him; the facesheet. So we were able to find out that he was a diabetic so we gave him some juice and crackers. We had no idea if he needed medications or insulin." 10/12/23 11:10 AM - During an interview, R2	F 684		

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F 684	Continued From page 13 stated that he remembered going out to this appointment but he did not know "I even had an appointment". He stated that he was not upset or distressed about the incident. "They took good care of me there." R2 was able to state his name and that he lived at "[facility]". 10/12/23 11:25 AM - During an interview, E35 (Unit clerk) explained the process for setting up transportation to an outpatient appointment for a resident. E35 stated that the clerk gets an appointment sheet or a script from the doctor or unit manager. The clerk then makes the appointment. After confirming the payor source, the clerk then books the transport. "The transport company depends on the payor source a lot of the time." If the resident was confused, the clerk calls the family/ representative person to see if they are able to meet the resident at the appointment. If not, she lets the unit manager know and they organize if the resident will be accompanied. Regarding the incident with R2, E35 (Unit clerk) stated that E34 (front desk clerk) called her on the morning of 8/31/23 and stated that transport was her to pick up R2. "The building did not know that he had an appointment or who it was with. The aide then rushed to get R2 ready to go out. When R2 rolled passed her (E35) on his way to the lobby, E35 asked him 'why didn't you tell me that you had an appointment?" to which R2 replied 'I didn't know that I had an appointment'." E35 stated that after receiving multiple calls from the outpatient office that R2 was at, the facility booked an Uber to transport R2 back to the facility. "I had to find a large vehicle so that the wheelchair could fit."	F 684		

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F 684	Continued From page 14 10/12/23 2:05 PM - During an interview with E36 (SW) and E37 (SW), "We don't handle transport. But we do update emergency contacts. We know about his brother's death but it is a bit of a dilemma as the sister in law (FM2) does not want to be his representative person and his other brother lives in New York." When asked about transporting cognitively impaired persons, the response was "Anyone with a BIMS of 11 or less is considered cognitively impaired." 10/13/23 9:55 AM - During an interview, E32 (RN) stated that R2 did not return on her shift (7 AM to 3:30 PM). E32 stated that R2 missed "both his hydralazine and clonidine doses during my shift." 10/13/23 12:10 PM - During a telephone interview, E33 (LPN) confirmed that R2 returned to the facility "sometime between 3:30 PM and dinner, which is around 5 PM". E33 stated that R2 "brushed it off" with regards to being out of the facility all day when he did not have an appointment. 10/15/23 1:30 PM - During telephone interview, E34 (front desk clerk) confirmed the transportation company worker did show her a screen shot on his cell phone with R2's name and the location of R2's appointment. E34 also stated that the outpatient practice where R2 was called the building "about every 30 minutes for hours" requesting that the facility "come pick him up". "I believe it was a communication issue on the facility's part." 10/17/23 3:12 PM- Findings were reviewed during the Exit conference with E1 (NHA), E2 (DON), E5 (CNO), E15 (Corporate consultant) and E16	F 684		

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F 684	Continued From page 15 (Corporate nurse).	F 684		
F 711 SS=J	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R5 and R19) out of four residents reviewed for physician visits, the facility failed to ensure that the physician reviewed R5's total program of care including medications.R5's Eliquis (anticoagulant-medication that works to prevent clotting of blood) was not re-started following R5's outpatient procedure on 3/21/23. The facility's failure to ensure the physician/providers had a process to track residents on anticoagulants placed R5 in immediate jeopardy (IJ) of a serious adverse outcome. R5 had chronic atrial fibrillation, which placed him at risk for developing clots; R5 has been prescribed eliquis since 11/3/20 in order to prevent the development of clots. Due to this	F 711	Past noncompliance: no plan of correction required.	

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F 711	Continued From page 16 failure, R5, whose anticoagulant (Eliquis) had been discontinued pre-operatively beginning 3/6/23 did not receive his Eliquis (anticoagulation) from 3/21/23 through 4/17/23. On 4/17/23, R5 was sent to the hospital with complaints of abdominal pain and nausea and was found to have significant blood clots impacting several organ systems. R5 was placed on comfort care and died the following day on 4/18/23. The immediate jeopardy is being cited as past non compliance with an abatement date of 4/19/23. For R19, the facility failed to ensure the provider was reviewing and responding to R19's clinical lab work. Findings include: Eliquis (apixiban) Drug Package Insert...Black Box Warning: "WARNING: (A) PREMATURE DISCONTINUATION OF ELIQUIS INCREASES THE RISK OF THROMBOTIC EVENTS... 2.3 Temporary Interruption for Surgery and Other Interventions- ELIQUIS should be discontinued at least 48 hours prior to elective surgery or invasive procedures with a moderate or high risk of unacceptable or clinically significant bleeding. Eliquis should be discontinued at least 24 hours prior to elective surgery or invasive procedures with a low risk of bleeding or where the bleeding would be non-critical in location and easily controlled. Bridging anticoagulation during the 24-48 hours after stopping Eliquis and prior to the intervention is not generally required. Eliquis should be restarted after the surgical or other procedures as soon as adequate hemostasis has been established...5.2 Bleeding-... The pharmacodynamic effect of Eliquis can be expected to persist for at least 24 hours after the last dose, i.e. for about two drug half-lives..." Bristol Myers Squibb revised September 2021.	F 711		

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F 711	Continued From page 17 Review of R5's clinical record revealed: 9/13/13 - R5 was admitted to the facility with diagnoses including but not limited to stroke, heart failure and atrial fibrillation. 10/22/20 - E6 (MD) ordered, "Eliquis (anticoagulant) tablet 5 mg (milligram) Give 1 tablet by mouth two times a day for Afib (atrial fibrillation)." 12/2022 - Pre-operative paperwork was received by the facility from an ENT (Ear, Nose and Throat) Surgeon regarding R5's upcoming surgical procedure scheduled for 3/21/23. An instruction sheet provided to the patient from an ENT surgery center stated, "...Unless otherwise directed, we must ask you to avoid any of these medications for at least two weeks prior to surgery. If any of these medications have been prescribed for you by your family doctor, please notify them of your pending surgery." A list of medications included with the paperwork and eliquis was circled. 3/2/23 - E6 (MD) gave a verbal order to E13 (RN) to discontinue Eliquis,"give 1 tablet... two times a day for afib until 03/06/23 23:59." 3/6/23 was 15 days prior to R5's surgical date of 3/21/23. 3/6/23 8:00 PM - R5's Medication Administration Record (MAR) documented R5's last dose of Eliquis. 3/21/23 - An operative report documented, R5 underwent an outpatient surgical procedure with the a right ear. R5 tolerated the procedure well and returned to the facility.	F 711		

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F 711	Continued From page 18 3/21/23 3:40 PM - R5's Discharge Instructions from the procedure documented no changes to R5's medications including Eliquis, specifically the term "unchanged" was used with regards to R5's Eliquis on this document. 3/21/23 5:32 PM - A nursing progress note documented that R5 returned to the facility without incident. 3/30/23 1:00 AM - E7's (NP) progress note documented, "...History of Present Illness:..Pt with decline in functions, constantly c/o (complaint of) dizziness... Chart, labs, meds reviewed... Plan:...Dizziness - Possibly dt (due to) meds. Meds reconciled and made changes today...A-fib- cont (continue) eliquis, sotalol...". 4/17/23 - A nursing progress note documented "Resident requested to be sent out to the hospital for abdominal pain and nausea. (E7) was made aware and approved." 4/17/23 11:48 AM - An Emergency Department physician record documented R5 had "atrial fibrillation on Eliquis presenting from a nursing facility with altered mental status and green stool. He is not following commands...tender when he pushes abdomen and nods yes when asked if he is tender." A CT scan (imaging test that takes detailed pictures of the inside of the body) was performed and the results determined, R5 had an "occlusion of the SMA with signs of ischemia (an inadequate blood supply to a body organ), complete occlusion of the common illiac artery, left external iliac artery, and left femoral artery and a new infarct of the kidney and spleen" (a blood clot in the intestines, three arteries that bring blood to the legs, and blood clots in the	F 711		

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F 711	Continued From page 19 arteries that bring blood to the kidneys and spleen). 4/17/23 - A hospital History and Physical report documented "He has not been taking his Eliquis...seen by vascular surgery team" and underwent an exam of blood vessels by taking an x-ray and a surgical procedure to remove blood clots from an artery or vein. Following the procedure R5's heart rate was in the 140's (normal range is 60-100 beats per minute), rapid breathing greater than 20 breaths per minute (normal range is 12-20 breaths per minute), and a lack of oxygen in the tissues to sustain bodily functions. R5 was admitted to the ICU (intensive care unit). 4/18/23 - A Discharge Summary documented, R5 in collaboration with family members "have elected to proceed with comfort measures (care that helps or soothes a person who is dying)...they declined hospice and would like to stay in the unit during his dying process." 4/18/23 - Review of Certificate of Death established R5 was pronounced deceased at 3:53 PM. Documented cause of death: "Mesenteric ischemia, Superior Mesenteric Artery Occlusion" (inadequate blood flow to the small intestine), and "Atrial Fibrillation" (an irregular, often rapid heart rate that commonly causes poor blood flow). 10/13/23 10:30 AM - An interview was conducted with E1 (NHA), E2 (DON), E5 (RN,CNO), E11 (COO) regarding the events leading up to R5's death. E1, E2, and E5 confirmed that on 3/21/23 when R5 returned from his outpatient procedure that Eliquis was not re-started and they stated	F 711		

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F 711	Continued From page 20 that no medication reconciliation was done as the procedure was performed as a same-day procedure. They confirmed that R5 had been taking the medication since 2020 for A-fib. 10/13/23 1:45 PM - During an interview with E6 (MD), this Surveyor asked E6 "why was R5's Eliquis not re-started upon his return to the facility from his procedure?" E6 replied "It should have been." E6 also confirmed that she had given a verbal order to E13 (RN) to discontinue the medication on 3/2/23 and also confirmed that it should have been an order to hold and resume upon return. 10/16/23 11:55 AM - During an interview, E7 (NP) confirmed that she had seen R5 on 3/30/23. E7 stated, "I have been seeing this resident for five years, I discontinued his psychiatric medicines because he was fatigued and dizzy. I thought this was secondary to his psych. medications." When asked about her note regarding Eliquis and if she had reviewed the meds, E7 replied that she didn't know Eliquis had been discontinued. E7 stated she had reviewed R5's medicine list in "Gerimed", the electronic application that E6 (MD) has her NPs document in and the Eliquis was still listed there. When E7 was asked if "Gerimed" communicates in real time with Point Click Care (the electronic application used by the facility to order and document in a resident's record within the facility) to update medicines, E7 stated' "No, I have to update the meds. This application (Gerimed) doesn't automatically update; updates are done manually." When asked if she had looked at the discharge summary, E7 replied "If I looked at it, I would have signed it." 10/16/23 12:17 AM - During an interview, E7	F 711		

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F 711	Continued From page 21 confirmed that the discharge summary for the 3/21/23 procedure in R5's clinical record was not signed and she had not looked at it. 10/17/23 - Review of all documentation of the corrective action plan that was abated on 4/19/23 included: - Timely reporting to State Agency; - An immediate QAPI plan of action initiated; - Education of all nursing staff, including providers; - A house sweep with a 90 day lookback of all residents taking blood thinners; - A 30 day lookback of care plans of those residents taking blood thinners, then monthly audits conducted through October 23; - A 30 day lookback at all consults for outpatient procedures; - System changes initiated for all residents returning from outpatient procedures. The nurse will notify the unit manager, who will take it to the provider. If clarification is needed, the provider will contact the outside entity. For R5, the facility failed to resume an anticoagulant medication used to treat atrial fibrillation and prevent blood clots upon return from a same day outpatient procedure, causing an adverse outcome and ultimately death.	F 711		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of	F 760	Past noncompliance: no plan of	

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F 760	Continued From page 22 other facility documentation, it was determined that for one (R4) out of four residents reviewed for medication errors, the facility failed to ensure R4 received the correct dose of NPH (Neutral Protamine Hagedorn) insulin on 9/7/23. The facility's failure placed R4 at risk for a serious adverse outcome, hypoglycemia and diabetic coma. An IJ was identified and due to the facility's corrective measures following the incident on 9/7/23 at approximately 5:00 PM this is being cited as past non-compliance with an abatement date of 9/8/23. Findings include: A facility policy "Blood Glucose Monitoring" last revised 11/12/21, reviewed 1/20/23 documented, "It is the policy of Cadia Healthcare to provide safe blood glucose monitoring ... verify the resident's order... obtain blood sample, check results...document results in Medical record and administer" Review of R4's clinical record revealed: 3/24/23 - R4's most recent admission to the facility included diagnoses of but not limited to stroke, tracheostomy and diabetes. 8/2/23 - A physician order written by E6 (MD) documented, "NPH Insulin 100 UNIT/ml (means there are 100 units of insulin in each millimeter of insulin). Inject 15 units subcutaneously two times a day for diabetes, at breakfast and dinner". 9/7/23 - A facility investigation documented, at approximately 5:00 PM, R4 was inadvertently administered 100 units of NPH insulin by E4 (LPN) instead of the prescribed 15 units. E4 immediately self-reported the error and R4 was given glucagon (an emergency medicine used to	F 760	correction required.	

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F 760	Continued From page 23 treat severe hypoglycemia [low blood sugars] in diabetes) and orange juice via peg tube. 911 was called and EMS transported R4 to the hospital. 9/7/23 5:54 PM - An ED Physician Record documented, R4 arrived..."from the facility for evaluation of incorrect medication administration...blood glucose initially 324 in the emergency department... anticipate patient will require admission for observation. Discussed case with pharmacy who reports that NPH has a bell-curve (a graph after administration and can cause effects up to 24 hours afterwards".) onset with peak onset 4 hrs - 12 hours 9/7/23 6:28 PM - E18 (ED MD) documented in the ED Teaching Physician Record..." (R4) presents after an overdose administration of her insulin...Patient was given 100 units of NPH just prior to the arrival at 4:55 PM. She was given glucagon as well as orange juice via her PEG tube immediately afterwards...Iatrogenic (a medical injury caused in the process of medical treatment) insulin overdose...". 9/8/23 6:58 AM - E20 (MD) documented on a hospital Admission History & Physical..."accidental insulin overdose... initial blood glucose 290 on BMP (basic metabolic panel) now trended down to 80 most recently... lactate 3.7... She was started on D5LR (a solution that is a source of water, glucose, and electrolytes) in the ED and rate has been increased to 200 ml (milliliters)/ hr...Assessment/Plan: Accidental overdose of insulin: monitor blood glucose every 2 hours x 4, then switch to 4 hours...Diabetes - holding diabetic medications due to an accidental insulin overdose...".	F 760		

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F 760	Continued From page 24 9/15/23 6:44 PM - On R4's Hospital Discharge Summary, E21 (DO) documented..."Admitted for hypoglycemia...accidental overdose of insulin." 10/12/23 12:05 PM - A Surveyor observed insulin administration to a resident by E11 (LPN) prior to lunch being served, which revealed right resident, right medication, right dose, right route, right time. 10/13/23 10:30 AM - During an interview E1 (NHA), E5 (RN, CNO), and E10 (COO) all confirmed that R4 had been administered the wrong dose of insulin on 9/7/23 and the nurse immediately reported the error and R4 was sent to the hospital. E2 immediately educated E4 (LPN) with regards to the eight rights of medication administration, verifying orders and due to E4 being a new nurse she stated that when administering insulin to have another nurse double check the order with her. E2 stated she "went over the insulin competency" with E4 and had her return demonstrate the nine listed tasks. Based on this event, the facility initiated education for all staff nurses on 9/8/23, which included: insulin types, onset, peak and duration, eight rights of medication administration, selecting the correct syringe, and return demonstration of drawing up the medication and verifying the order. 10/13/23 1:25 PM - During an interview, E2 (DON) confirmed that by 9/8/23 that all nurses had completed the competencies/education regarding insulin. 10/17/23 1:45 PM - During an interview, E11 (LPN), E12 (RN), and E14 (RN) all confirmed they had completed the competencies/education	F 760		

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F 760	Continued From page 25 regarding insulin that the facility implemented in response to the medication error. The survey team reviewed and confirmed the corrective actions were completed on 9/8/23. 10/17/23 3:12 PM- Findings were reviewed during the Exit conference with E1 (NHA), E2 (DON), E5 (CNO), E15 (Corporate consultant) and E16 (Corporate nurse).	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		12/8/23

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F 842	Continued From page 26 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842		

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F 842	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R19 and R1) out of 19 residents reviewed the facility failed to ensure the provider accurately documented in the clinical record. Findings include: 1. Review of R19's clinical record revealed: 8/21/23 - R19 admitted to the facility with diagnoses including diabetes and hyponatremia (low blood sodium level). 8/22/23 4:29 PM - R19's lab work reviewed and flagged as abnormal with serum sodium result as 125 (normal serum sodium range 137-145). 9/1/23 1:00 AM - E8's Re-admission History & Physical documented, " ...History of Present Illness: ...chronic hyponatremia (low blood sodium level) with sodium level of 129 Labs 8/28/23 Na (sodium) 128 (L) [low] mmol (millimoles)/L (liter) ...PLAN: ...hyponatremia (low blood sodium)- sodium (sic) Today is 125. Discussed with dietician to reevaluate cardiac diet as appropriate. Trend labs ...". 9/1/23 6:32 PM - E8 reviewed R19's lab work with serum sodium level reported as 127 (normal range 137-145). This result was flagged as abnormal. 9/5/23 1 AM - E8's Follow up progress note documented, " ...History of Present Illness: ...chronic hyponatremia with sodium level of 129 ...Labs 8/28/23 Na 128 (L) mmol/L ...PLAN: ...hyponatremia - sodium (sic) Today is 125. Discussed with dietician to reevaluate cardiac diet	F 842	a. Plan of care was not affected for either resident due to inaccurate documentation. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. Root cause analysis was done and found that providers did not accurately document in clinical records. Medical Director will educate providers on importance of accurate documentation in the clinical record. d. The Medical Director will audit records for 3 patients for accuracy. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 842	Continued From page 28 as appropriate. Trend labs ...". The note did not reflect the most recent lab work in which the sodium was 127. 9/7/23 - E8 wrote an order for R19 to receive "Sodium chloride tablet 1 gm (gram)- give one tablet by mouth two times a day for electrolyte imbalance". 9/21/23 10:55 AM - E8's Follow up progress note documented," ...History of Present Illness: ...chronic hyponatremia with sodium level of 129 ...Labs 8/28/23 Na 128 (L) mmol/L ...PLAN: ...hyponatremia - sodium (sic) Today is 125. Discussed with dietician to reevaluate cardiac diet as appropriate. Trend labs ...". The sodium tablets that were ordered on 9/7/23 were not documented in the medication list of this progress note nor did the note reflect the most recent lab work in which the sodium was 127. 9/22/23 9:41 AM - E8 reviewed R19's lab work dated from 9/21/23 with serum sodium level reported as 131 (normal range 137-145). This result was flagged as abnormal. 10/4/23 9:12 AM - E8's Follow up progress note documented, " ...History of Present Illness: ...chronic hyponatremia with sodium level of 129 ...Labs 8/28/23 Na 128 (L) mmol/L ...PLAN: ...hyponatremia - sodium (sic) Today is 125. Discussed with dietician to reevaluate cardiac diet as appropriate. Trend labs ...". The sodium tablets that were ordered on 9/7/23 were not documented in the medication list of this progress note nor did the note reflect the most recent lab work in which the sodium was 131. 10/9/23 9:15 AM - E8's acute progress note	F 842		

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F 842	Continued From page 29 documented, " ...History of Present Illness: ...chronic hyponatremia with sodium level of 129 ...Labs 8/28/23 Na 128 (L) mmol/L ...PLAN: ...hyponatremia - sodium (sic) Today is 125. Discussed with dietician to reevaluate cardiac diet as appropriate. Trend labs ...". The sodium tablets that were ordered on 9/7/23 were not documented in the medication list of this progress note nor did the note reflect the most recent lab work in which the sodium was 131. 10/11/23 10:18 AM - E8's acute progress note documented, " ...History of Present Illness: ...chronic hyponatremia with sodium level of 129 ...Labs 8/28/23 Na 128 (L) mmol/L ...PLAN: ...hyponatremia- sodium (sic) Today is 125. Discussed with dietician to reevaluate cardiac diet as appropriate. Trend labs ...". The sodium tablets that were ordered on 9/7/23 were not documented in the medication list of this progress note nor did the note reflect the most recent lab work in which the sodium was 131. 10/11/23 7:37 PM - E8 reviewed R19's lab work dated from 10/10/23 with serum sodium level reported as 133 (normal range 137-145). This result was flagged as abnormal. 2. Review of R1's clinical record revealed: 1/20 2015 - R1 admitted to the facility with diagnoses including but not limited to: chronic respiratory failure with the need for mechanical ventilation (machine to assist breathing) through a tracheostomy (surgical opening in the windpipe that allows air to enter and secretions to be removed), and spastic quadriplegic (a condition that affects all four limbs in which the person has lost control of her entire body but does display	F 842		

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F 842	Continued From page 30 stiff, jerky movements stemming from increased muscle tone) cerebral palsy. a. 7/2/23 4:51 PM - E43's (Otolaryngology [ears, nose & throat] MD Hospital Consult note documented, " ... Shiley in place. CT ... the tracheostomy was exchanged for a Bivona flexible tracheostomy secured at 9 cm (centimeters) at the skin. There was immediate improvement ..." 7/23/23 1:35 AM - E9's (Pulmonary MD) Pulmonary consult follow up note documented, "...Patient has a size 6 Shiley XLT (extra long trach)..." [(R1)] just returned from the hospital. She now has a #6 Bivona trach. Remains on Assist control mode (ventilator setting) 24/7. ... Assessment/Plan: ... continue trach management ...". 7/30/23 11:01 PM - E9's Pulmonary consult follow up note documented, "... Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 8/8/23 7:05 AM - E9's Pulmonary consult follow up note documented, "...Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 8/13/23 10:42 PM - E9's Pulmonary consult follow up note documented, "Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 8/20/23 10:32 PM - E9's Pulmonary consult follow	F 842		

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F 842	Continued From page 31 up note documented, "...Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 8/27/23 8:57 AM - E9's Pulmonary consult follow up note documented, "...Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 9/3/23 10:30 PM - E9's Pulmonary consult follow up note documented, "Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 9/9/23 11:14 PM - E9's Pulmonary consult follow up note documented, "...Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 9/25/23 8:27 AM - E9's Pulmonary consult follow up note documented, "...Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 10/1/23 10:32 PM - E9's Pulmonary consult follow up note documented, "...Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6 flex tracheostomy at this time. 10/6/23 10:53 AM - E9's Pulmonary consult follow up note documented, "...Patient has a size 6 Shiley XLT..." R1 had a tracheostomy exchange on 7/19/23 while hospitalized and had a Bivona 6	F 842		

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F 842	Continued From page 32 flex tracheostomy at this time. The provider continued to document the incorrect type of tracheostomy. b. 6/16/23 - R1's quarterly Minimum Data Set (MDS) documented R1 as being severely cognitively impaired and never or rarely made decisions regarding tasks of daily life. R1 was unable to participate in a Basic Inventory of Mental Status (BIMS) evaluation due to her cognitive impairment. 7/1/23 11:49 AM - E17 (Emergency Department MD) documented in the ED Physician Record under History of Present Illness ..."52 year old female with past medical history of quadriplegia, CP (cerebral palsy), ventilator dependence, G-tube dependence, epilepsy presents today from [facility] due to tachycardia in the 150s and respiratory distress ... Assessment/ Plan: I did attempt to contact the family to discuss her care however the number included in her records is not in working order." 7/1/23 4:25 PM - E17 documented in ED progress note, " ...I was able to speak with staff at [facility] who was able to provide me with an alternative phone number to contact patient's family ...". R1 was non-verbal and severely cognitively impaired and relied on a Surrogate decision maker for all health care decisions. There was a 4.5 hour delay in care due to the facility's failure to undate R1's contact information 10/17/23 3:12 PM- Findings were reviewed during the Exit conference with E1 (NHA), E2 (DON), E5	F 842		

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F 842	Continued From page 33 (CNO), E15 (Corporate consultant) and E16 (Corporate nurse).	F 842		