STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075383	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seabury	200 Seabury Drive Bloomfield, CT 06002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #28) reviewed for advanced directives, the facility failed to have a signed advanced directive available in either the paper or electronic clinical record. The findings include: Resident #28's diagnoses included congestive heart failure and chronic kidney disease. The admission Minimum Data Set assessment dated [DATE] identified Resident #28 was severely cognitively impaired and required moderate assistance for bed mobility and transfers. The Resident Care Plan dated 2/11/24 identified that Resident #28 was a Do Not Resuscitate (DNR) and a Do Not Hospitalize (DNH). Review of the monthly physician's orders for January, February, and March 2024 failed to identify a current or discontinued order for a DNR or DNH. In an interview and clinical record review with the DNS and ADNS on 3/20/24 at 9:21 AM, Resident #28's clinical record failed to reflect a completed and signed advanced directive form and failed to demonstrate a physician's order for an advanced directive. The DNS and ADNS indicated that the facility policy required an advance directive to be signed on admission and have a subsequent physician's order in the clinical record. Neither the DNS nor ADNS could explain why the clinical record failed to contain the required advance directive documentation. Interview with RN #2 on 3/20/24 at 11:28 AM indicated that if a resident was found unresponsive, she would check in the electronic or paper clinical record for a code status however, she was unable to find a physician's order or consent for Resident #28. RN #2 indicated that there was a banner in the electronic clinical record which identified Resident #28 was a DNR/DNH but was unable to identify where or how the information had been placed there without the corresponding order or consent. RN #2 indicated that Resident #28's code status should have been obtained when s/he was admitted to the facility. Review of the Advanced Directive policy dated 2022 directed, in part, that upon admission, should the resident have an advanced directive, copies will be made and placed in the chart as well as communicated to the staff.

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50095 Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #14) reviewed for edema, the facility failed to notify the provider of a significant change in the resident's weight. The findings include: Resident #14's diagnoses included heart failure, anemia, and atrial fibrillation (irregular heartbeat). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was moderately cognitively impaired, required substantial/maximal assistance of staff to transfer, and required substantial/maximal assistance of staff to propel the wheelchair. The Resident Care Plan dated 11/5/23 identified that Resident #14 had heart failure and was at risk of having too much fluid in his/her circulatory system. Interventions included notifying the medical staff if the resident had any signs or symptoms of heart failure and updating the medical staff of any significant changes in the resident's condition. A physician's order dated 1/21/24 directed to weigh Resident #14 each morning before breakfast and to notify the provider if the resident gained more than 2-3 pounds in 24 hours or more than 5 pounds in a week. Review of Resident #14's documented weights from 1/21/24 through 3/20/24 identified the following weight changes in a 24-hour period: A 5.8-pound increase from 1/29/24 to 1/30/24. A 4.0-pound increase from 2/3/24 to 2/4/24. A 15.5-pound increase from 2/8/24 to 2/9/24. A 6.4-pound increase from 2/19/24 to 2/20/24. Review of Resident #14's documented weights from 1/21/24 through 3/20/24 identified the following weight changes in a week: An 8.2-pound increase from 1/29/24 through 2/4/24. A 11.2-pound increase from 2/3/24 through 2/9/24. A 16.1-pound increase from 2/8/24 through 2/14/24. A 22.8-pound increase from 2/27/24 through 3/6/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and review of Resident #14's clinical record with the Assistant Director of Nursing (ADON) on 3/20/24 at 9:06 AM, the ADON failed to identify documentation that any provider had been notified of Resident #14's weight increases per the physician ordered parameters. Although provider notification is expected to be documented in the nursing progress notes, via text message on the supervisor's cell phone, or with an entry on a physician notification log, when the documentation was reviewed, the ADON failed to reflect notification to the provider. During an interview with PA #1 on 3/20/24 at 10:45 AM, it was reported that facility staff inconsistently communicate weight changes as instructed by the physician's order. PA #1 further explained that she frequently discovered uncommunicated weight changes while reviewing resident records. Review of the Change of Condition policy dated 2/2022, directed, in part, to consult with the resident's physician when there is a need to alter the resident's treatment, such as an exacerbation of a chronic condition.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 sampled residents (Resident #7) reviewed for pressure ulcers, the facility failed to ensure a weekly skin check was conducted by a licensed staff member and for 1 of 5 sampled residents, (Resident #48) reviewed for unnecessary medications, the facility failed to follow physician orders regarding pain medications. The findings include: 1. Resident #7 had a diagnosis of cerebral infarction with paralysis, hypertension, and congestive heart failure. Review of the physician orders dated 8/14/23 directed Resident #7 to have skin assessments performed weekly on Mondays. The Minimum Data Set assessment dated [DATE] identified Resident #7 was without cognitive impairment, was dependent on staff for transfers and personal hygiene, and required maximal assistance from staff for bathing, and toileting. Resident #7's Resident Care Plan dated 1/26/24 identified Resident #7 was at risk for pressure ulcers/injury related to the use of a splint (medical device) to the left upper extremity, skin integrity was to be monitored, and to thoroughly wash and dry the hand/arm prior to splint application daily. Additionally, splint removal was to occur daily for a thorough skin check and staff was to notify the physician for any signs of skin breakdown. Observation of Resident #7 on 3/15/24 at 12:11 PM identified him/her with a small red area noted to his/her left thumb. Resident #7 indicated the area was caused by a blue splint indicating a splint which was lying next to him/her. Resident #7 stated that s/he had informed staff the area had become red within the last week. Review of Resident #7's 14-day weekly skin assessment dated [DATE] and signed by LPN #1 identified intact skin. Observation and interview on 3/18/24 at 10:15 AM with Resident #7 identified that the left thumb area was red, uncovered and that no treatment had been administered. Additionally, Resident #7 indicated that s/he had been given a shower this morning. Review of the nursing progress notes from 3/15/24 through 3/19/24 failed to identify any alteration in Resident #7's skin. In an interview with LPN #1 on 3/19/24 at 12:38 PM LPN #1 identified that although she had signed for Resident #7's weekly skin review on 3/18/24, the NA (Nurse Aid) had conducted the skin check on 3/18/24. LPN #1 indicated that she usually performed resident skin assessments, however, she had been too busy with other tasks on 3/18/24 and relied on the NA report of Resident #7's intact skin condition for her observation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Wound Care Nurse (RN#5) on 3/20/24 at 10:51 AM, identified that licensed staff members were to perform weekly skin checks and that skin checks were to be conducted on the resident's shower day. Additionally, RN #5 indicated that it was not an acceptable practice for a NA's to perform weekly skin checks. The facility Skin Assessment policy states that a full body audit, or head to toe skin assessment would be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter. 2. Resident #48's diagnoses included dementia, mood disorder, and muscle weakness. A physician's order dated 6/27/23 directed to administer Acetaminophen (Tylenol) 650 mg four times a day as needed. A physician's order dated 6/28/23 directed to administer Tramadol 50 mg every 8 hours as needed for severe back pain if not responsive to Tylenol. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #48 was moderately cognitively impaired and was totally dependent on staff for toileting, bathing, and upper/lower body dressing, and required partial/moderate assistance with walking. The MDS further identified that Resident #48 was not on a scheduled pain medication regimen and had not received any as needed (PRN) pain medication in the last 5 days. The Resident Care Plan updated 10/6/23 identified the potential for pain related to immobility. Interventions included to administer an opioid as ordered, attempt to gradually decrease frequency of use as able, and to complete a pain assessment each shift. Review of the Electronic Medication Administration Record (EMAR) indicated that Resident #48 had received Tramadol (an opioid medication) on 11/10/23, 11/11/23, 11/29/23, 12/7/23, 12/20/23, 12/21/23, 12/22/23, 12/23/23, 12/25/23, 12/26/23, 12/27/23, 1/2/24, 1/5/24, 1/11/24, 1/12/24, 1/13/24, 1/20/24, 1/22/24, 1/26/24, 1/27/24, 1/28/24, 2/3/24, 2/4/24, 2/14/24, 2/18/24, 2/22/24, 2/23/24, 2/26/24, 2/28/24, 2/29/24, 3/4/24, 3/5/24, 3/13/24, 3/17/24, and 3/18/24 (35 times in approximately 4 months) without first receiving Tylenol. Additionally, Resident #48 had received the Tramadol predominantly for reasons other than the physician prescribed reason, severe back pain. A nurse's note dated 11/29/23 at 1:13 AM identified Tramadol was given for left neck/arm pain per Resident #48's request, and that the resident had refused Tylenol first. Interview with RN #3 on 3/20/24 at 12:42 PM identified that the physician orders indicate to administer Tylenol 650 mg four times a day as needed, and to administer Tramadol when Tylenol was not effective for severe back pain. Additionally, RN #3 identified that there was no indication when to use the Tylenol order, however, stated this would be given for pain or fever. RN #3 indicated that she gave Tramadol for reasons other than back pain and without giving Tylenol first because Resident #48 would indicate that s/he wanted Tramadol instead of Tylenol. Subsequent to surveyor inquiry, RN #3 contacted PA #1 on 3/20/24 at 12:56 PM and received a verbal order to change Tramadol to be administered for severe pain (not solely for severe back pain) if the pain was not responsive to Tylenol. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with PA #1 on 3/21/24 at 10:11 AM identified that Tramadol was directed to be given to Resident #48 after administering and making the determination that Tylenol was ineffective. Tramadol had been prescribed this way due to the possible sedating side effect of Tramadol. PA #1 indicated she would have expected nurses to notify her both when the Tylenol was ineffective in relieving Resident #48's pain, and when Resident #48 refused Tylenol and requested Tramadol be given first. PA #1 indicated if she had been notified, she would have counseled Resident #48 on the side effects of Tramadol and would have reassessed Resident #48 for pain, possibly directing changes to Resident #48's pain medication regimen. Review of the PRN Medications policy directed, in part, that orders for medications to be given on an as needed basis shall have clear instructions about how and when to administer them. Additionally, when administering a PRN medication, legally authorized staff are to verify the physician's order for the medication, document the reason voiced by the resident and/or assessment findings that show the resident needs the medication, and verify the reason is for the prescribed indication for the medication. 50177

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #14) reviewed for edema, the facility failed to follow the provider's order for daily weights, and for 1 of 2 sampled residents (Resident #18) reviewed for skin conditions the facility failed to ensure a treatment order was correctly transcribed to the kardex and that post-surgical wound treatments were performed. The findings include: 1. Resident #14's diagnoses included heart failure, anemia, and atrial fibrillation (irregular heartbeat). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was moderately cognitively impaired, required substantial/maximal assistance of staff to transfer, and required substantial/maximal assistance of staff to propel the wheelchair. The Resident Care Plan dated 11/5/23 identified that Resident #14 had heart failure and was at risk of having too much fluid in his/her circulatory system. Interventions included notifying the medical staff if the resident had any signs or symptoms of heart failure and updating the medical staff of any significant changes in the resident's condition. A physician's order dated 1/21/24 directed to weigh Resident #14 each morning before breakfast and to notify the provider if the resident gains more than 2-3 pounds in 24 hours or more than 5 pounds in a week. Review of Resident #14's weight and vital sign clinical records from 1/21/24 to 3/20/24 identified 59 opportunities for Resident #14 to be weighed and that documentation of Resident #14's weight occurred 35 times since the physician order commenced on 1/21/24 (24 opportunities of missed resident weights). During an interview with RN #2 (the resident's nurse) on 3/20/24 at 8:53 AM, she indicated that all weight measurements and refusals should be documented in the clinical record and identified several missing entries as well as a lack of documentation that Resident #14 had refused to be weighed. Review of the paper log of monthly weights with RN #2 failed to reflect the missing weight documentation. RN #2 stated according to the facility practice, the nursing assistants (NAs) were responsible to obtain Resident #14's weight and that the licensed nurses were responsible to oversee and ensure that NA were weighing and documenting each weight. RN #2 was unable to explain the missing entries, indicated that Resident #14 was dependent on staff to be weighed, and that subsequent to surveyor inquiry, she would obtain Resident #14's weight. Interview with the ADON on 3/20/24 at 9:06 AM, identified that Resident #14 had a physician's order to be weighed prior to breakfast. The ADON was unable to identify why staff were not following the physician directed order's. Additionally, the ADON was unable to locate any documentation related to the 24 missing weights. Review of the Weight Monitoring policy (2/2022), directed, in part, to monitor a resident's weight daily, if clinically indicated, and to document the weight at the time it was obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #18's diagnoses included bipolar disorder, delusional disorder, hypothyroidism, and skin lesion. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 was cognitively intact and required set-up or clean up assistance with eating and oral hygiene, supervision or touching assistance with upper body dressing, and personal hygiene, and had open lesions. The Resident Care Plan dated 3/15/24 identified Resident #18 had impaired skin integrity and was at risk for pressure ulcers and skin injuries. Interventions included keeping the area clean and dry, monitor for pain and discomfort, monitor for signs and symptoms of infections, and minimize skin exposure to moisture. Observation of Resident #18 on 3/18/24 at 11:59 AM identified a clean, dry, and intact dressing to the left forearm that lacked a dressing date (indicating when the treatment was last performed). Review of the physician's order dated 2/26/24 directed facility staff to cleanse the left dorsal (backside) of the wrist with normal saline, pat dry, apply Telfa (non-stick pad), wrap with kerlix gauze daily and as needed. The physician's order on the first electronic record screen was noted to have been discontinued on 2/26/24 but when the original order was fully opened in the electronic record, the discontinue date was noted to have been 3/7/24. The nursing note dated 2/27/24 at 11:11 AM identified Resident #18 was to continue with the current treatment orders of the left dorsal wrist area. Review of the Medication Administration Record (MAR) where treatments were documented and signed as completed, and nursing progress notes from 2/27/24 until 3/6/24 failed to show wound care treatments had been completed for Resident #18. Interview with the DNS on 3/20/24 at 10:26 AM identified that there was a gap in wound care treatments being completed because no wound care orders were in place from 2/27/24 until 3/6/24. The DNS believed the reason were not completed was due to a glitch in the electronic health record. The DNS indicated that although the order was correctly transcribed, the system failed to bring the orders forward and facility staff failed to identify that treatment orders were missing. Subsequent to surveyor inquiry the DNS indicated she would call the electronic health record provider to identify the issue. Interview with MD #1 on 3/21/24 at 10:05 AM identified that there should have been wound care orders in place from 2/27/24 through 3/7/24 and wound treatments should have been performed during that timeframe. Review of the facility policy for physician orders last revised on 11/2023 identified all physician orders in the medical record must be accurate, timely and meet all requirements by state and federal regulations. 50095

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on observations, review of the clinical record, facility policy, and staff interviews for 1 of 3 residents, (Resident #7), reviewed for pressure ulcers, the facility failed to ensure that a weekly skin assessment was completed by a licensed staff member. The findings included: Resident #7's diagnosis included hypertension, congestive heart failure, and hemiplegia/ hemiparesis following a cerebral infarction affecting the left side. Review of the physician orders dated 8/14/23 directed Resident #7 to have weekly skin checks completed on Mondays during the day shift. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 was cognitively intact, was dependent on staff for transfers, required set up for eating, and personal hygiene, and required maximal assistance for bathing, and toileting. The Resident Care Plan dated 1/26/24 identified Resident #7 was at risk for pressure ulcers/injury related to the use of a splint (medical device) to left upper extremity, skin integrity was to be monitored, and skin was to be thoroughly washed and dried prior to daily splint application. The splint was to be removed daily for a thorough skin check and staff were to notify the physician of any signs of breakdown. Observation and interview with Resident #7 on 3/15/24 at 12:11 PM identified s/he had a small, red area noted to the left thumb. Resident #7 stated the area was from a blue splint (which was lying next to him/her.) Resident #7 indicated that s/he had previously informed staff of the area, and that the area had become red within the last week. Re-observation and re-interview with Resident #7 on 3/18/24 at 10:15 AM identified that the left thumb area continued to be red area. The red area was noted to be open to air (uncovered) and Resident #7 indicated that s/he had a shower earlier in the morning. Review of the clinical record weekly skin audit identified that on 3/18/24 Resident #7 had a skin check performed by LPN #1, and that Resident #7's skin was noted to be intact. Interview and review of the weekly skin observation with LPN#1 on 3/19/24 at 12:38 PM identified that she usually performed Resident #7's skin check while the Nurse Aid (NA) provided care, but she was too busy giving out medications on 3/18/24. Further, LPN #1 indicated that she had relied on the NA to conduct the skin observation, the NA had identified and reported that Resident #7 had no skin impairment and that was why she had documented she had completed the observation on the Treatment Administration Record (TAR) and documented that Resident #7's skin was intact. Subsequent to surveyor inquiry Resident #7 was noted with a blister to the left thumb and was to be seen by the PA. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the PA note dated 3/19/24 at 1:47 PM identified that Resident #7 had been wearing a day splint for several months without issues and had a newer night splint for a left hand contracture. A small closed blister was noted on the left lateral thumb that appeared may have been rubbing on the splints that were worn. The PA indicated that the area was likely due to shearing against the splint, directed discontinued use of all splints until the area healed, and that Occupational Therapy evaluate splint use. Interview with the Wound Nurse (RN #5) on 3/20/24 at 10:51 AM identified that per the facility policy, a licensed staff member was to perform weekly skin checks and that skin checks were to occur on the resident's shower day. Additionally, RN #5 indicated that it was not acceptable for a NA to perform a weekly skin check. The facility policy for Pressure Injury Prevention and Management stated that licensed nurses would conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings would be documented in the medical record and the assessment for pressure injuries would be performed by a licensed nurse and documented on the wound tracker sheet.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on observations, review of the clinical record, facility policy, and interviews for 2 of 3 sampled residents (Resident #10 and #215) reviewed for respiratory issues, the facility failed to obtain a physician's order for oxygen administration. The findings include: 1. Resident #10's diagnosis included malignant neoplasm of the frontal lobe, atrial fibrillation (irregular heartbeat), and congestive heart failure. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #10 was severely cognitively impaired and was totally dependent on staff for toileting and personal hygiene. The Resident Care Plan dated 2/28/24 identified Resident #10 utilized oxygen with interventions that included regularly monitoring his/her oxygen saturation levels and application of oxygen via nasal cannula as needed. Review of the nursing note dated 3/7/24 at 7:21 AM identified that at 12:30 AM Resident #10 had a low oxygen saturation level on room air (without oxygen) ranging between 85 percent (%) to 87 %, oxygen was applied at 2 Liters (L), and Resident #10's oxygen saturation was rechecked and was 91 % on 2L of oxygen. A Physician Assistant progress note dated 3/7/24 at 3:36 PM identified Resident #10 was still requiring oxygen at 2L. Additionally, the PA progress note identified Resident #10's oxygen saturation levels decreased when the resident self-removed the tube providing the oxygen. Resident #10 was currently taking Moxifloxacin (an antibiotic) for bronchitis/possible pneumonia and was on scheduled nebulizers. The nursing note dated 3/8/24 at 7:06 AM identified Resident #10's oxygen saturation, at the beginning of the shift, was 84% on room air, oxygen at 2L was applied, and the oxygen saturation level was 91% on 2L of oxygen. The nursing note dated 3/8/24 at 4:07 PM identified Resident #10's oxygen saturation was 94% on oxygen via nasal tubing. Review of physician orders in effect on 3/7/24 and 3/8/24 failed to identify a physician order that oxygen was directed despite oxygen being applied on 3/7/24 at and 3/8/24. Interview with LPN #1 on 3/19/24 at 2:35 PM identified Resident #10 was on antibiotic therapy and receiving oxygen for a respiratory illness. Additionally, LPN #1 noted there should have been a physician order in the computer for oxygen, but she had failed to review the physician orders to ensure oxygen was ordered due to needing to tend to her assignment. Interview with the ADNS on 3/19/24 at 2:45 PM identified when oxygen was initiated the nurse on the shift should have obtained an order for oxygen. Additionally, the ADNS identified that if a resident had a low oxygen saturation level, the nurse would put the resident on oxygen and then notify and obtain a physician's order from a provider for oxygen administration. (continued on next page)

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	075383	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seabury	200 Seabury Drive Bloomfield, CT 06002

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, an order was obtained on 3/19/24 at 3:33 PM from the PA that directed staff to apply 1 L of oxygen as needed (PRN) for an saturation level less than 89%. 2. Resident #215's diagnoses included heart failure, atrial fibrillation (irregular heartbeat), and dementia. The admission Minimum Data Set assessment dated [DATE] identified Resident #215 was severely cognitively impaired, required setup for personal hygiene, and supervision assistance for bed mobility and transfers. The MDS did not identify oxygen therapy was in use. Observation on 3/15/24 at 11:40 AM identified Resident #215 was in bed and an oxygen concentrator, turned to the off position, was at the bedside. Observation on 3/18/24 at 9:42 AM identified an oxygen concentrator at Resident #215's bedside with oxygen tubing labeled 3/17/24 from the 11:00 PM to 7:00 AM shift. The oxygen nasal cannula was on the resident and the concentrator was running at 2.0 Liters Per Minute (LPM). Review of the physician, APRN, and nursing progress notes from 2/16/24 through 3/18/24 failed to identify that Resident #215 had been ordered or was utilizing oxygen. Review of the physician orders in effect from 2/20/24 through 3/19/24 failed identify that Resident #215 had an order for oxygen use. Interview and observation with LPN #1 on 3/19/24 at 2:32 PM identified that if she had any residents on oxygen, the order would show up on the Medication Administration Record (MAR) and there would be a physician's order. LPN #1 indicated that if there was an emergency, staff would administer the oxygen first, and then call the provider and get an order before the end of the shift. If a resident appeared distressed or complained of shortness of breath or difficulty breathing, she indicated she would take vital signs and an oxygen saturation level, followed by notifying the provider of her assessment. Upon observation of Resident #215 with LPN #1, she said that she had not previously noticed the concentrator in the room and did not know the resident to ever have used oxygen. Further, LPN #1 identified she was unaware who had put the concentrator in the room as there was no order for oxygen therapy. Interview with LPN #2 on 3/19/24 at 2:42 PM identified that Resident #215 was complaining of shortness of breath earlier in the shift and checked an oxygen saturation level which was noted to be 97% on room air. LPN #2 reported Resident #215 was able to calm down and no new interventions were put into place. LPN #2 denied placing the oxygen concentrator in the room or putting the nasal cannula on the resident. LPN #2 was unable to identify how long the concentrator had been in the room but stated she had seen it at the beginning of the shift. Subsequent to surveyor inquiry, a physician's order dated 3/19/24 was obtained directing staff to apply 1.0 to 2.0 liters of oxygen via a nasal cannula for shortness of breath as needed. Review of the Oxygen Administration policy dated 1/2024 directed, in part, that oxygen was administered under orders of a physician. except in the case of an emergency. In such cases, oxygen was administered and orders for oxygen were obtained as soon as practicable when the situation was under control. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50249

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy, and interviews for the only sampled resident (Resident #28) reviewed for hospice, the facility administered hospice services without a physician's order. The findings include: Resident #28's was admitted on [DATE] with diagnoses that included congestive heart failure and chronic kidney disease. The admission Minimum Data Set assessment dated [DATE] identified Resident #28 was severely cognitively impaired and required moderate assistance for bed mobility and transfers. Additionally, the MDS identified that Resident #28 received hospice care. The Resident Care Plan dated 2/11/24 identified that Resident #28 was on hospice care. Interventions included performing a pain assessment every shift, administering comfort meds as ordered and assessing the response, and education on the progression of terminal illness and symptoms during the dying process. Review of the monthly physician's orders dated January, February, and March 2024 failed to identify an active or discontinued order for hospice services. A nurse's note dated 1/17/24 at 4:11 PM identified that Resident #28 was admitted for long term care on hospice. Review of the home hospice clinical note dated 1/17/24, written by the home hospice Licensed Clinical Social Worker (LCSW) identified that Resident #28 was initially admitted to home hospice on 12/5/23 and had just transferred, on that day, from her apartment to the Skilled Nursing Facility. Interview and clinical record review with the DNS on 3/20/24 at 10:13 AM indicated that Resident #28 had transferred from independent living to long term care in January and had already been on hospice services prior to his/her admission. She identified that the resident did not have a new hospice order since being admitted to the facility and was unable to explain the lack of a physician order. Review of the Coordination of Hospice Services policy dated 2022 directed, in part, that the facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice. Review of the Physician Orders policy dated 11/2023 directed, in part, that at the time of admission, the facility must have physicians' orders for the resident's immediate care. All physicians' orders in the medical record must be accurate, timely and meet all requirements by state and federal regulations.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on review of the clinical record, facility policy, and interviews for 1 of 5 sampled residents, (Resident #18), reviewed for unnecessary medications, the facility failed to obtain lab services per the physician order. The findings include: Resident #18's diagnoses included bipolar disorder, hypertension, dementia, and hypothyroidism. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #18 required set-up or clean up assistance with eating and oral hygiene, and supervision or touching assistance with upper body dressing and personal hygiene. The physician orders dated 1/18/24 directed facility staff to obtain laboratory work which included a complete blood count, basic metabolic panel, thyroid stimulating hormone, and vitamin D12 levels. Review of the clinical record failed to identify Resident #18 had laboratory results available per the physician's order on 1/18/24. Interview with the DNS on 03/21/24 at 11:56 AM identified that the facility staff failed to have the physician directed laboratory work completed from the 1/18/24 order for Resident #18. The DNS further stated that the floor nurses are responsible to verify the laboratory orders and complete a requisition form for the laboratory provider. The DNS was unable to explain why the physician's order for laboratory work was not carried out. Review of the facility policy for laboratory services identified, in part, that the facility was responsible for the timeliness of laboratory services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50059 Based on observation in the Dietary Department, staff interview, and facility policy, the facility failed to ensure food items were labeled and dated, and failed to ensure an adequately clean water filter system for the steam receptacles. The findings include: During a tour of the Dietary Department on 3/15/24 at 10:38 AM with the Executive Chef the following was identified: a. A 40-gallon plastic bin containing loose sugar (approximately 1/4 full) failed to identify the date the sugar was poured into the bin and failed to identify the expiration date of the sugar. b. A 40-gallon plastic bin containing loose rice flour (approximately 1/3 full) failed to identify the date the rice flour was poured into the bin and failed to identify the expiration date of the rice flour. c. A 40-gallon plastic bin containing loose brown rice was (approximately 1/16 full) failed to identify the date the brown rice was poured into the bin and failed to identify the expiration date of the brown rice. d. A 40-gallon plastic bin of approximately 2 cups of loose flour failed to identify the date the flour was poured into the bin and failed to identify the expiration date of the flour. e. A water filter system that feeds a steam receptacle was noted to be soiled and streaked with green/white substances. This filter system was located above a food storage unit and empty food containers. Subsequent to surveyor's inquiry, the water filter system was cleaned. Interview with the Executive Chef on 3/15/24 at 10:38 AM noted that he was unable to explain the reason the bins of rice flour, flour, sugar, and brown rice were not dated when filled or why an expiration date was not identified. He explained that the evening staff conducted nightly inventory checks on all supplies before clocking out which ensured the kitchen was fully stocked and prepared for meal prep the following day. Additionally, the Executive Chef was unable to identify the substances that were noted to have streaked down the water filter system. The facility's Food Storage policy directed culinary managers to maintain adequate food and supplies for food service operations. Additionally, the policy stated that all items were to be appropriately labeled with the expiration or opening date as needed.