

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER Parkway Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1190 Vfw Parkway Boston, MA 02132	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>41019</p> <p>Based on record review, policy review and interview, the facility failed to inform two Residents (#19 and #49), out of a total sample of 26 residents, of their right to be informed of the use of psychotropic medications.</p> <p>Findings include:</p> <p>Review of the facility policy titled Psychotropic Medication Treatment in Long Term Care Centers, dated January 2021, indicated the following:</p> <p>-Prior to administering psychotropic medication listed on the schedule created under subsection (b), a facility shall obtain the informed written consent of the resident, resident's health care proxy or the resident's guardian. Informed written consent shall be obtained on a form approved by the department, which shall include, at a minimum, the following information: (i) the purpose for administering the listed psychotropic drug; (ii) the prescribed dosage; and (iii) any known effect of side effect of the psychotropic medication. The written consent form shall be kept in the resident's medical record.</p> <p>1. Resident #19 was admitted to the facility in February, 2023 with diagnoses including dementia and unspecified psychosis.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 2/14/24, indicated that Resident #19 scored a 2 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS further indicated that Resident #19 was taking an antipsychotic medication.</p> <p>Review of Resident #19's current psychotropic medication care plan indicated the following:</p> <p>- I am taking Seroquel, Trazodone (medications used to treat bipolar and depression) r/t [sic] Psychosis. I am at risk for side effects of this medication</p> <p>- My psychotropic medication consent can be found in my medical records under consent (initiated 6/1/23).</p> <p>Review of the medical record indicated that Resident #19 requires a health care proxy to make his/her medical decisions.</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration Record (MAR), for the month of March 2024, indicated that Resident #19 received Seroquel and Trazadone as ordered.</p> <p>Review of Resident #19's medical record failed to indicate that any consents for psychotropic medication administration had been completed.</p> <p>During an interview on 3/27/24 at 7:57 A.M., Nurse (#5) said that she could not find the consent for the Resident's medications in the chart.</p> <p>During an interview on 3/28/24 at 7:44 A.M., the Social Worker said that Resident #19's family never came in to sign the consents and she was not sure how to get them to come in to sign the consents. The Social Worker said that she hasn't mailed the forms in the past, but would consider mailing them. The Social Worker said that the facility doesn't have a process to handle unresponsive healthcare proxy's.</p> <p>During an interview on 3/28/24 at 7:52 A.M., the Assistant Director of Nursing said that if a psychotropic consent is not signed, then the doctor needs to be made aware and that it should be documented.</p> <p>45343</p> <p>2. Resident #49 was admitted to the facility in November, 2021 with diagnoses including Alzheimer's Disease, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 2/14/24, indicated Resident #49 had severe cognitive impairment. The MDS further indicated that Resident #49 was taking an antipsychotic medication.</p> <p>Review of Resident #49's current physician orders, indicated the following:</p> <p>-An order dated 1/12/24 for Seroquel Tablet 25 MG (Quetiapine Fumarate), Give 12.5 mg by mouth one time a day for psychosis.</p> <p>-An order dated 10/17/23 for Seroquel Oral tablet (Quetiapine Fumarate), Give 37.5 mg by mouth at bedtime for psychosis.</p> <p>Review of Resident #49's March Medication Administration Record (MAR), indicated Resident #49 was administered Seroquel daily from 3/1/24 to 3/27/24.</p> <p>Review of Resident #49's medical record failed to indicate that a psychotropic consent was obtained for Seroquel.</p> <p>During an interview on 3/28/24 at 7:12 A.M., Nurse (#3) said psychotropic medication consents are obtained on admission, with a new order, and then yearly.</p> <p>During an interview on 3/28/24 at 7:29 A.M., the Corporate Nurse said she was unable to locate a psychotropic consent form for Resident #49 and it should have been obtained with a new order and annually.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46339</p> <p>Based on observations, record review and interviews, the facility failed to provide professional standards of practice for two Resident (#53 and #97), out of a total sample of 26 residents. Specifically:</p> <ol style="list-style-type: none"> For Resident #53 the facility failed to offload heels as ordered. For Resident #97 the facility failed to ensure the Resident wore Prevalon boots while in bed as ordered. <p>Findings Include:</p> <ol style="list-style-type: none"> Resident #53 was admitted to the facility in August, 2021 with diagnoses including quadriplegia, muscle spasm and pressure induced deep tissue damage of left heel. <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 2/28/24, indicated that Resident #53 had intact short term and long-term memory. The MDS further indicated the Resident was at risk for pressure ulcers and had an unhealed deep tissue pressure injury.</p> <p>Review of Resident #53's current physician orders indicated the following:</p> <p>-Offload bilateral heels every shift related to functional quadriplegia.</p> <p>On 3/26/24 at 8:18 A.M., the surveyor observed Resident #53 lying in bed with his/her heels directly placed on the mattress.</p> <p>On 3/26/27 at 1:00 P.M., the surveyor observed Resident #53 lying in bed with his/her heels directly placed on the mattress.</p> <p>On 3/27/24 at 7:14 A.M., the surveyor observed Resident #53 lying in bed with his/her heels directly placed on the mattress.</p> <p>On 3/28/24 at 6:58 A.M., the surveyor observed Resident #53 lying in bed with his/her heels directly placed on the mattress.</p> <p>Review of Resident #53's care plan failed to indicate that the Resident refused to have his/her heels floated while in bed.</p> <p>During an observation and interview on 3/28/24 at 9:28 A.M., the surveyor and Nurse (#5) observed Resident #53 lying in bed with his/her heels on the mattress. Nurse #5 said the Resident's heels should be offloaded at all times while in bed per the physician orders.</p> <ol style="list-style-type: none"> Resident #97 was admitted to the facility in October 2023 with diagnoses including cerebral vascular disease, anoxic brain damage and muscle weakness. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the most recent Minimum Data Set (MDS) assessment, dated 2/22/24, indicated Resident #97 scored a five out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS further indicated that Resident #97 was at a high risk for developing pressure ulcers and required total dependence for all activities of daily living.</p> <p>Review of Resident #97's current physician orders indicated the following order:</p> <p>-Prevalon boots on both feet every shift remove for skin checks every shift.</p> <p>On 3/26/24 at 8:07 A.M., the surveyor observed Resident #97 lying in bed and he/she was not wearing Prevalon boots on his/her feet as ordered.</p> <p>On 3/26/24 at 12:15 P.M., the surveyor observed Resident #97 lying in bed and he/she was not wearing Prevalon boots on his/her feet as ordered.</p> <p>On 3/27/24 at 7:07 A.M., the surveyor observed Resident #97 lying in bed and he/she was not wearing Prevalon boots on his/her feet as ordered.</p> <p>On 3/28/24 at 6:50 A.M., the surveyor observed Resident #97 lying in bed and he/she was not wearing Prevalon boots on his/her feet as ordered.</p> <p>Review of Resident #97's care plan failed to indicate that the Resident refused to wear Prevalon boots.</p> <p>During an interview on 3/28/24 at 9:23 A.M., Certified Nursing Assistant (CNA) #2 said she takes care of Resident #97, and that she was not aware that Resident #97 was supposed to wear Prevalon boots.</p> <p>During an interview on 3/28/24 at 9:28 A.M., Nurse (#5) said Resident #97 did not have Prevalon boots and that he/she should have them according to the physician's orders.</p> <p>During an interview on 3/28/24 at 12:53 P.M., the Director of Nursing said that physician orders should be followed as ordered.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>41105</p> <p>Based on observation and interviews the facility failed to provide an ongoing program of meaningful and person-centered group activities designed to meet the interests of, and support the physical, mental and psychosocial well-being for residents on two out of three resident care units.</p> <p>Findings include:</p> <p>During the Resident Group meeting on 3/27/24 at 11:00 A.M., 8 of 8 residents reported the following:</p> <ul style="list-style-type: none"> -There have been no group activities at the facility for months and that they wished there would be activities again so that they would have something to do during the day. -The facility used to have activities such as Bingo, music and arts and crafts but they are no longer offered, despite what is scheduled on the activity calendar. -Two girls volunteer one hour a day, a few days a week at the facility, but that they do not run activities. <p>Review of the activity calendar indicated that on 3/28/23 the following activities were scheduled for the morning:</p> <ul style="list-style-type: none"> -9:30 A.M.: Gentle exercise. -10:00 A.M.: Bible study. <p>On 3/28/24 at 9:43 A.M., a surveyor observed the Gardner 1 unit day room. There were 4 residents seated in the dining room. One staff member was in the room sitting with one of the residents. The other residents were not being engaged. The scheduled gentle exercise and Bible study did not take place. The following was observed:</p> <ul style="list-style-type: none"> -The Social Worker was in the dining room until 10:00 A.M. sitting next to one resident attempting to get him/her to color. -Another Resident was sitting in his/her wheelchair with his/her head slumped. -One Resident was sitting with a wordsearch in front of him/her, but not engaging with it. <p>On 3/28/24 from 9:25 A.M., until 9:56 A.M., the surveyor observed the Gardner 2 unit day room. There were 8 residents seated in the unit dining room. The TV was on a financial news station however none of the residents were interacting or watching the television. The surveyor continued to make the following observations:</p> <ul style="list-style-type: none"> -At 9:56 A.M., the Nursing Home Administrator (NHA) and a Volunteer came to the unit day room. <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-From 9:56 A.M., to 9:58 A.M., the Volunteer stood in front of the room stretching, however no residents were engaged while the NHA placed sheets of coloring paper in front of the residents.</p> <p>-At 9:58 A.M., the Volunteer said okay are you guys ready to color and stopped stretching.</p> <p>-At 10:00 A.M., when Bible Study was scheduled to begin the Volunteer sat down at a table with a resident. She failed to interact with the resident began coloring her own sheet of paper.</p> <p>During an observation and interview on 3/28/24 at 10:03 A.M., the surveyor observed the Volunteer seated at a table coloring a picture of a tulip on the Gardner 2 unit. The Volunteer said that she comes to the facility a few days a week to get volunteer hours for school. The Volunteer said that she is not provided with the facility's activity calendar and does not run activities according to the facility's calendar. She said I mix things up. The surveyor inquired if the Volunteer planned to run the 10:00 A.M., scheduled Bible Study and she said she was going to do it at 1:00 P.M., that day.</p> <p>On 3/28/24 between 9:30 A.M., and 10:30 A.M., there were no activities being run in the facilities Main Day room.</p> <p>The facility's Activities Assistants were not present in the facility during survey and unable to be interviewed.</p> <p>During an interview on 3/28/24 at 10:01 A.M., the Corporate Nurse said that the facility does not have an activities director and the position has been open since December. The Corporate Nurse said that the facility has two volunteers that come in a few times a week and other staff have been filling in as they can. The Corporate Nurse said that they try to provide one activity in the morning and one in the evening to keep the residents engaged.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>41105</p> <p>Based on observations, record review, policy review and interviews, the facility failed to ensure for one Resident (#3), who required dialysis, that they receive such services consistent with professional standards of practice, out of a total sample of 26 residents. Specifically, for Resident #3 the facility failed to ensure nursing maintained visible and accessible emergency equipment supplies at the bedside.</p> <p>Findings include:</p> <p>The facility policy titled End Stage Renal Disease, Care of Resident With, dated January 1, 2020, indicated:</p> <ul style="list-style-type: none"> -Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. -Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. -Education and training of staff includes, specifically: <ul style="list-style-type: none"> d. How to recognize and intervene in medical emergencies such as hemorrhages and septic infections. <p>Resident #3 was admitted to the facility in September, 2018 and has diagnoses that include End Stage Renal Disease and Chronic Kidney Disease- stage 5.</p> <p>Review of the most recent comprehensive Minimum Data Set (MDS) assessment, dated 1/17/24, indicated that on the Brief Interview for Mental Status exam Resident #3 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated that Resident #3 had no behaviors.</p> <p>Review of the current dialysis care plan included the following intervention:</p> <ul style="list-style-type: none"> -Please keep my emergency supplies at my bed side, start date 11/20/23. <p>On 3/27/24 at 7:58 A.M., Resident #3 was observed in bed. There were no emergency supplies observed at the bedside or in the room. Resident #3 said that he/she did not know if there were any available.</p> <p>During an observation and interview on 3/28/24 at 10:26 A.M., Nurse (#6) and the surveyor observed Resident #3's bedside and room however there were no emergency supplies present or available. Nurse #6 said that there was supposed to be an emergency kit at Resident #3's bedside that included items needed in the event that Resident #3 was bleeding from the fistula (a connection between an artery and vein surgically created in residents who require dialysis). Nurse #6 said that bleeding from the fistula site would be a dangerous emergency.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/28/24 at 10:32 A.M., the facility's Corporate Nurse (#1) said that there was supposed to be an emergency supply kit at the bedside of all residents who require dialysis treatment.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>46339</p> <p>Based on observations, record reviews, policy review, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5 percent. One out of two nurses observed made five errors in 28 opportunities on one of three units resulting in a medication error rate of 17.86%. These errors impacted two Residents (#99 and #8), out of 4 residents observed.</p> <p>Findings include:</p> <p>Review of the facility policy titled Medication Administration- General Guidelines, undated, indicated the following:</p> <p>-Medications are administered in accordance with written orders of the prescriber.</p> <p>-Five rights- right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration. When the medication is selected, when the dose is removed from the container and finally just after the dose is prepared and the medication is put away.</p> <p>1. During a medication pass on 3/27/24 at 8:04 A.M., the surveyor observed Nurse (#4) prepare the morning medications for Resident #99. The medications included the following:</p> <p>-Atorvastatin 20 mg (milligram) one tablet</p> <p>-Mirtazapine 15 mg one table</p> <p>-Tamsulosin 0.4 mg one capsule</p> <p>-Amlodipine 10 mg one tablet</p> <p>-Senna 8.6 mg one tablet</p> <p>-Multivitamin with mineral one tablet.</p> <p>-Chlorhexidine gluconate 0.12 % 15 ml (milliliter)</p> <p>Nurse #4 then brought the medications into Resident #99's room and was ready to administer. The surveyor asked Nurse #4 to not administer the medications and return to the medication cart to review the medications that had been prepared.</p> <p>Review of the current physician order indicated the following medications were scheduled as follows:</p> <p>-Atorvastatin 20 mg (milligram) one tablet by mouth at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Mirtazapine 15 mg one table by mouth at bedtime</p> <p>-Tamsulosin 0.4 mg one capsule by mouth at bedtime</p> <p>-Polyethylene glycol powder give 17 grams by mouth one time a day for constipation dissolve 17 grams in any four or eight ounces of beverage at 9:00 A.M.</p> <p>During an interview on 3/27/24 at 8:10 A.M., Nurse #4 said if the surveyor did not stop her from administering the medication, she would have administered the wrong medications, at the wrong time. Nurse #4 said she is supposed to do the five rights when preparing and administering medications. She further said she did not administer the polyethylene glycol during morning medication pass as the Resident prefers to have the medication with his/her meals. Nurse #4 said the order did not indicate this and said it was an omission at the time of administration.</p> <p>2. During a medication pass on 3/27/24 at 8:16 A.M., the surveyor observed Nurse #4 prepare and administer the following medication to Resident #8 without checking Resident #8's blood pressure.</p> <p>-Metoprolol tartrate 25 milligram one tablet by mouth.</p> <p>Review of the medication package indicated the following:</p> <p>-Metoprolol tartrate 25 milligram give one tablet by mouth daily hold systolic blood pressure less than 100 and heart rate less than 60.</p> <p>During an interview on 3/27/24 at 11:26 A.M., Nurse #4 said she should have checked Resident #8's blood pressure before administering the medication as the directions for parameters were on the medication packaging. Nurse #4 further reviewed the physician order and said whoever received the order did not schedule the blood pressure parameters correctly and so it wasn't being done.</p> <p>During an interview on 3/27/24 at 1:58 P.M., the Director of Nursing said the nurses are to follow the five rights of medication administration, medications should be given as ordered and if the resident had a preference the order should reflect that. He also said medications that require parameters should be checked.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44095</p> <p>Based on observations, interviews and policy review, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws.</p> <p>Specifically, the facility failed to ensure medications were labeled and stored according with manufacture's guidelines on one of three sampled medication carts.</p> <p>Findings include:</p> <p>Review of the facility policy, Storage of Medications, undated, indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal</p> <p>-Expiration Dating (Beyond-use dating)</p> <p>C. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency.</p> <p>c. Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is:</p> <ol style="list-style-type: none"> 1. In a multi-dose injectable vial 2. An ophthalmic medication <p>D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.</p> <p>1.) The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating.</p> <p>G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Parkway Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1190 Vfw Parkway Boston, MA 02132	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/24 at 4:31 P.M., the surveyor observed the following on the Gardner 2 High side medication cart:</p> <ul style="list-style-type: none"> - one bottle of timolol eye drops, opened and undated - one insulin glargine pen, opened and undated - two bottles of latanoprost eye drops, opened and undated - two vials of glargine insulin, opened and undated and - two bottles of liquid protein opened and undated, review of the manufacturer's guidelines indicated good for 3 months once opened. <p>During an interview on 3/26/24 at 4:39 P.M., Nurse #1 said that eye drops, insulins, and liquid protein should be dated when opened.</p> <p>During an interview on 3/26/24 at 4:48 P.M., the Director of Nursing said eye drops, insulins, and liquid protein should be dated when opened.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>41019</p> <p>Based on observation, record review, and interview, the facility failed to serve what was listed on the menu, or provide a substitution, for a breakfast meal.</p> <p>Findings include:</p> <p>On 3/28/24 at 8:01 A.M., the cook was observed plating from the serving line and was serving mixed fruit and a muffin.</p> <p>Review of the menu for the week indicated that the a 4oz yogurt should have been served in addition to the fruit and muffin.</p> <p>During an interview on 3/28/24 at 8:03 A.M., the cook said that they had run out of yogurt and he did not make a substitution.</p> <p>During an interview on 3/28/24 at 8:07 A.M., the Food Service Director said that he was not made aware that the staff had run out of yogurt, but he would have expected them to tell him so he could make a substitution. The Food Service Director said that when a substitution is made he has to get approval from the dietitian and then will plan to make a substitution.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095</p> <p>Based on observations, record review and interviews, the facility failed to follow a therapeutic diet, as prescribed by the attending physician, for one Resident (#15) out of a total sample of 26 residents.</p> <p>Specifically, for Resident #15 the facility failed to ensure the kitchen provided a fluid restriction as ordered by the physician.</p> <p>Findings include:</p> <p>Review of the facility policy titled Fluid Restriction, dated 12/21/22, indicated fluid restrictions are ordered, in writing, by physicians in the individual's medical record. Both the Dietary Department and Nursing Department are assigned specific amounts of fluids they may provide the individual daily.</p> <p>-Purpose:</p> <p>To standardize and communicate nutrition care approaches and processes throughout the organization.</p> <p>-Procedure:</p> <ol style="list-style-type: none"> 1. Nursing personnel are responsibility for informing Dietary of residents placed on fluid restrictions, specifying the cc level permitted. 2. Nursing must determine specific cc levels of fluids to be provide by dietary and specific levels provide by Nursing. <ol style="list-style-type: none"> a. Fluid distribution (Dietary vs. Nursing) must be indicated on the diet cards (i.e., 1000 cc fluid restriction/ 500 cc Food Service and 500 cc Nursing). <p>Review of the facility policy titled Therapeutic Diet Orders, dated 6/15/20, indicated to assure that residents receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment, plan of care, in accordance with his/her goals and preferences.</p> <ol style="list-style-type: none"> 1. Therapeutic diets will be based on the individual needs of the resident and must be prescribed by the attending physician or his delegate of a registered or licensed dietitian to the extent allowed by State law. 5. All therapeutic diet orders will be documented in the resident's medical record and communicated to dietary. <p>Resident #15 was admitted to the facility in October 2023 with diagnoses including hyponatremia, orthostatic hypotension, and polydipsia.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/11/24, indicated Resident #15 resident required supervision or touching assistance and did not have behaviors.</p> <p>Review of the plan of care related to dehydration risk, dated 10/27/23, indicated:</p> <ul style="list-style-type: none"> - Dehydration risk: fluid restriction 1 liter. - Provide, serve diet as ordered. Monitor intake and record every meal. <p>Review of the [NAME]-Nutrition Assessment Comprehensive assessment, dated 1/24/24, indicated:</p> <ul style="list-style-type: none"> - Resident #15 presents at nutritional risk due to excessive fluid intake r/t food and nutrition-related knowledge deficit concerning appropriate fluid intake as evidenced by diagnosis hypo/hyponatremia and 1 liter fluid restriction. - Diet: Regular diet Regular Texture Thin Liquids, 1 liter fluid restriction decreased 1/15/24. <p>Review of the physician's order, dated 3/19/24, indicated:</p> <ul style="list-style-type: none"> -1 liter fluid restriction 120 milliliters (ml) (4 ounces/oz) with Breakfast 120 ml (4 oz) with Lunch 120 ml (4 oz) with Dinner Kitchen = 360 ml daily <p>Nursing to provide an additional 640 ml through the whole day, every shift for syndrome of inappropriate antidiuretic hormone secretion (SIADH).</p> <p>On 3/26/24 at 8:29 A.M., the surveyor observed Resident #15 eating his/her breakfast. There was 4 oz orange juice, 4 oz milk, and 8 oz of coffee on the tray. Review of the diet slip failed to include the physician's ordered fluid restriction. The diet slip indicated 4 oz of orange juice and 4 oz of milk, there was 8 oz of fluid provided from the kitchen.</p> <p>On 3/26/24 at 12:19 P.M., the surveyor observed two 4 oz glasses of water next to his/her lunch tray. There was a 4 oz glass of apple juice and an 8 oz mug of black coffee. Review of the diet slip failed to include the physician's ordered fluid restriction. The diet slip indicated 4 oz of fruit juice and 4 oz of milk, there was 8 oz of fluid provided from the kitchen.</p> <p>On 3/26/24 at 12:35 P.M., the surveyor observed Resident #15 finish his/her lunch tray. The 4 fluid items (600 oz) were consumed on the finished tray.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/24 at 4:57 P.M., the surveyor observed Resident #15's dinner tray. The tray included 4 oz milk and 4 oz juice. Review of the diet slip failed to include the physician's ordered fluid restriction. The diet slip indicated 4 oz of fruit juice and 4 oz of milk, there was 8 oz of fluid provided from the kitchen.</p> <p>On 3/27/24 at 8:11 A.M., the surveyor observed Resident #15's breakfast tray. The tray included 4 oz milk, 4 oz orange juice, and 8 oz mug of coffee. Review of the diet slip failed to include the physician's ordered fluid restriction. The diet slip indicated 4 oz of orange juice and 4 oz of milk, there was 8 oz of fluid provided from the kitchen.</p> <p>During an interview on 3/27/24 at 8:35 A.M., Certified Nurse Assistant (CNA) #1 said she was not aware Resident #15 was on a fluid restriction.</p> <p>During an interview on 3/27/24 at 9:15 A.M., Nurse (#2) said Resident #15 is on a fluid restriction, Nurse #2 said that therapeutic diets are reported to the kitchen on a diet slip, and fluid restrictions are provided by the kitchen.</p> <p>During an interview on 3/27/24 at 9:21 A.M., the Food Service Director (FSD) said he was not aware of any fluid restrictions in the facility. The FSD said he would be notified by nursing and put the fluid restriction on the diet slip. The surveyor and the FSD reviewed Resident #15's kitchen slip and there was no fluid restriction indicated.</p> <p>During an interview on 3/27/24 at 9:42 A.M., the Director of Nursing said the kitchen should be aware of the therapeutic diet and provide the fluid restriction on the tray ticket.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>44095</p> <p>Based on observations, record review and interview, the facility failed to ensure medical records were complete and accurately documented for two Residents (#40 and #97) out of a total of 26 sampled Residents. Specifically:</p> <ol style="list-style-type: none"> 1. For Resident #40 the facility failed to ensure nursing documented wound treatments as complete. 2. For Resident #97 the facility failed to ensure nursing accurately documented when Prevalon boots were applied in the Treatment Administration Record. <p>Findings include:</p> <p>Review of the facility policy titled Wound Care, undated, indicated:</p> <p>The following information should be recorded in the resident's medical record:</p> <ol style="list-style-type: none"> 1. The type of wound care given. 2. The date and time the wound care was given. 4. The name and title of the individual performing the wound care. 10. The signature and titled of the person recording the data. <p>1. Resident #40 was admitted to the facility in November 2016 with diagnoses including dementia and osteoarthritis.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/17/24, indicated Resident #40 had a stage 4 pressure ulcer and required application of dressings to the feet.</p> <p>Review of the plan of care related to actual skin break down, dated 10/24/23, indicated:</p> <p>- Please do all my treatments the way my physician's has ordered in the treatment administration record.</p> <p>Review of the physician's order, dated 3/11/24, indicated:</p> <p>-right heel wound wash with normal saline pat dry, apply calcium alginate followed by dressing, abdominal pad with cling daily, one time a day for wound.</p> <p>Review of the Treatment Administration Record (TAR), dated March 2024, indicated nursing failed to document the physician's order for wound dressing changes on 3/20/24, 3/21/24, 3/24/24, 3/25/24, and 3/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/24 at 10:17 A.M., the surveyor observed Resident #40 was in his/her bed, the dressing on his/her right foot was dated 3/25/24.</p> <p>On 3/27/24 at 8:25 A.M., the surveyor observed Resident #40 was in his/her bed, the dressing on his/her right foot was dated 3/26/24.</p> <p>During an interview on 3/27/24 at 9:14 A.M., Nurse (#2) said the treatment to the heel should have been documented on the treatment administration record but was not.</p> <p>During an interview on 3/27/24 at 9:43 A.M., the Director of Nursing said the treatment to the heel should have been documented on the treatment administration record but was not.</p> <p>46339</p> <p>2. Resident #97 was admitted to the facility in October 2023 with diagnoses including cerebral vascular disease, anoxic brain damage and muscle weakness.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 2/22/24, indicated Resident #97 scored a five out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS further indicated that Resident #97 was at a high risk for developing pressure ulcers and required total dependence for all activities of daily living.</p> <p>Review of Resident #97's current physician orders indicated the following order:</p> <p>-Prevalon boots on both feet every shift remove for skin checks every shift.</p> <p>Review of the Resident #97's Treatment Administration Record (TAR) indicated that the nurses had signed off on the TAR that the Resident was wearing the Prevalon on 3/26/24, 3/27/24 and 3/28/24.</p> <p>On 3/26/24 at 8:07 A.M., the surveyor observed Resident #97 lying in bed and he/she was not wearing Prevalon boots on his/her feet as ordered.</p> <p>On 3/26/24 at 12:15 P.M., the surveyor observed Resident #97 lying in bed and he/she was not wearing Prevalon boots on his/her feet as ordered.</p> <p>On 3/27/24 at 7:07 A.M., the surveyor observed Resident #97 lying in bed and he/she was not wearing Prevalon boots on his/her feet as ordered.</p> <p>On 3/28/24 at 6:50 A.M., the surveyor observed Resident #97 lying in bed and he/she was not wearing Prevalon boots on his/her feet as ordered.</p> <p>During an interview on 3/28/24 at 9:23 A.M., Certified Nursing Assistant (CNA) #2 said she takes care of Resident #97, and that she was not aware that Resident #97 was supposed to wear Prevalon boots.</p> <p>During an interview on 3/28/24 at 9:28 A.M., Nurse (#5) said that nurses should not sign off on the TAR that Resident #97 had the Prevalon boots on, if they were not on.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/28/24 at 12:53 P.M., the Director of Nursing said that Resident #97 does refuse to wear the Prevalon boots and that nurses should not be documenting that the boots were on when they were not.</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>46339</p> <p>Based on observations, policy review and interviews, the facility failed to ensure a gap in the bed was filled to prevent possible entrapment for one Resident (#97) out of a total sample of 26 residents.</p> <p>Findings include:</p> <p>Review of facility policy titled Side Rail Entrapment Risk, undated, indicated the following:</p> <ul style="list-style-type: none"> -Each resident will have a safe and comfortable bed environment that meets his/her assessed needs. -The space between the bed rail and the mattress and the headboard and the mattress should be filled either by an added firm inlay or a mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails. -Maintenance and monitoring of bed, mattress, and accessories such as resident/ caregiver assist items should be on going. -The entrapment assessment will use the standard form and measuring tool and assess recognized entrapment zones. -Resolution may include an alternate mattress, alternate type or style of rails, adding padding to space at the head or foot of the bed, or similar entrapment risk mitigation interventions. -Zone 7: space between the head or the foot is a potential for entrapment. <p>Resident #97 was admitted to the facility in October 2023 with diagnoses including cerebral vascular disease, anoxic brain damage and muscle weakness.</p> <p>Review of Resident #97's most recent Minimum Data Set (MDS) assessment, dated 2/22/24 indicated Resident #97 scored a five out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS further indicated that Resident #97 was totally dependent on staff for all activities of daily living.</p> <p>On 3/26/24 at 8:07 A.M., the surveyor observed Resident #97 lying in bed. There was a large gap between the mattress and the foot board and a foam bolster was observed on top of the bedside dresser.</p> <p>On 3/26/24 at 12:15 P.M., the surveyor observed Resident #97 lying in bed. There was a large gap between the mattress and the foot board and a foam bolster was observed on top of the bedside dresser</p> <p>On 3/27/24 at 7:07 A.M., the surveyor observed Resident #97 lying in bed. There was a large gap between the mattress and the foot board and a foam bolster was observed on top of the bedside dresser</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/28/24 at 6:50 A.M., the surveyor observed Resident #97 lying in bed. There was a large gap between the mattress and the foot board and a foam bolster was observed on top of the bedside dresser</p> <p>During an interview on 3/28/24 at 9:23 A.M., Certified Nursing Assistant (CNA) #2 said the foam bolster should be between the mattress and the foot board. She further proceeded to place the foam bolster in between the mattress and the foot board.</p> <p>During an interview on 3/28/24 at 9:28 A.M., Nurse (#5) said Resident #97's bed required the foam bolster between the mattress and the foot board. She said it is nurses' responsibility to ensure the gap is filled if the resident is lying in bed as gaps, are potential hazards.</p> <p>During an interview on 3/28/24 at 12:53 P.M., the Director of Nursing said that the gap in Resident #97's bed should be filled by the bolster as the bed was assessed for potential entrapment.</p>