STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365094	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King David Post Acute Nursing & Rehabilitation LLC	27100 Cedar Rd Beachwood, OH 44122

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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on observation, interview, record review, and policy review the facility failed to ensure Resident #764's call light was within reach and Resident #666's bed was of a comfortable length. This affected two of three residents reviewed for accommodation of needs, Residents #764 and #666. The facility census was 318. Findings include: 1. Review of the medical record for Resident #764 revealed an admitted [DATE] with diagnoses including difficulty walking, muscle weakness and diabetes mellitus. Resident #764 was discharged from the facility on 05/03/24. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #764 had intact cognition, was dependent on staff for chair to bed transfer, and ambulation was not attempted due to medical condition or safety concerns during the assessment period. Observation and interview on 05/01/24 at 11:36 A.M. of Resident #764 revealed her call light was attached the handrail of her bed and the cord was wrapped around the handrail multiple times. Resident #764 was in her wheelchair across the room, approximately six to eight feet away. Resident #764 stated if she had an emergency or needed someone she would not be able to call because her call light was attached on her bed. Resident #764 was e very soft spoken. Interview on 05/01/24 at 11:37 A.M. with Registered Nurse (RN) #952 verified Resident #764's call light was on the handrail of the bed and not within reach of the resident. Review of the facility policy titled, Call Lights, last reviewed by the facility on January 2024, revealed staff should ensure the call light was within the resident's reach while in bed or in a chair. 47568 2. Review of medical record revealed Resident #666 was admitted to the facility on [DATE] with medical diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type two diabetes mellitus with diabetic neuropathy, diabetic neuropathic arthropathy, and diabetic peripheral angiopathy without gangrene. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 04/26/24 revealed Resident #666 had an amputation of left toes and a right below the knee amputation. Interventions included to change positions frequently. Further review of care plan revealed Resident #666 had the potential for impairment to skin integrity. Interview on 04/29/24 at 1:46 P.M. with Resident #666 revealed he felt the bed the facility provided him with was not long enough as his left foot touched the bottom of the bed which caused pain to shoot up and down his leg. Observations on 04/29/24 at 1:46 P.M., 04/30/24 at 9:45 A.M. and 05/06/24 at 10:28 A.M. revealed Resident #666's left foot was pressed against the foot board at the bottom of the bed. Observation and interview on 05/06/24 at 10:35 A.M. with Licensed Practical Nurse (LPN) #1043 confirmed Resident #666 was pulled all the way up in the bed, and his left foot was resting on the foot board. LPN #1043 stated she would put in a work order to see if she could get him a bed that better fit him. This deficiency represents non-compliance investigated under Complaint Number OH00152850.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 47568 Based on medical record review, interviews, and facility policy review, the facility failed to ensure advanced directives were accurate and consistently recorded in the record. This affected one (Resident #43) of 42 residents whose records were reviewed for advanced directives. The census was 318. Findings include: Review the medical record for Resident #43 revealed an admitted [DATE]. Diagnoses includes spondylosis of the lumbar spine, weakness, diabetes, muscle abscess, peripheral vascular disease, and bacteremia. Review of Resident #43's Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required partial assistance by at least one staff member for activities of daily living including toileting, dressing, showers, and transfers. Review of Resident #43's physician orders dated [DATE] to [DATE] revealed there was not an order in the resident's chart reflecting the resident's wish to be a full code and to have all life sustaining measures implemented including Cardiopulmonary Resuscitation (CPR). Interview on [DATE] at 11:25 A.M. with Licensed Practical Nurse (LPN) #1272 and LPN #1356 confirmed there was not physician order in place for Resident #43's code status and they were unable to identify if the resident wanted all life sustaining measures implemented or not. Interview on [DATE] at 11:28 A.M. with Resident #43 revealed no one at the facility ever spoke with her regarding her code status and her wishes. Resident #43 stated she would like to be a full code and have all life sustaining measures implemented. Review of the undated facility policy titled Advanced Medical Directives under the category titled Procedure under number two stated As a routine part of resident care, the Social Worker will, at reasonable intervals, ascertain whether initial choice and decisions expressed by the resident at the time of admission continues to reflect his/her wishes. When this is not the case the Social Worker will document the changes in the resident's wishes.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36307 Based on interview, record review, and policy review the facility failed to report an allegation of misappropriation to the state survey agency in a timely manner. This affected one resident (Resident #21) of three residents investigated for concerns related to abuse (Resident #21, Resident #110 and Resident #217) The facility census was 318. Findings include: Review of Resident #21's clinical record revealed she was admitted to the facility on [DATE] and had diagnoses including cognitive communication deficit and major depressive disorder. During interview on 04/30/24, Resident #21 revealed that both she and her niece had discovered unauthorized charges on her bank credit card. Resident #21 indicated she had not initiated the charges. Resident #21 confirmed that her niece had reported the suspicious charges to Unit Manager (UM) #1339. Resident #21 was alert, oriented and able to respond to interview questions appropriately. During interview on 05/07/24 at 2:30 P.M., UM #1339 verified that Resident #21's niece had reported an allegation of misappropriation due to unauthorized charges made on the resident's bank card. UM #1339 said the niece wanted to file a police report. UM #1339 immediately reported the allegation of misappropriation to the facility Executive Director (ED) and the Director of Nursing (DON). UM #1339 was unable to recall the exact date the allegation was reported. UM #1339 confirmed that a city Police Officer came to the facility to investigate. During interview on 05/07/24, the ED confirmed that she was told about the credit card charges. The ED described the charges as Lyft charges and indicated that the niece did not indicate that the charges occurred at the facility or that the facility was involved in any way. The ED indicated she tried to reach out to the niece but had not received a return phone call. The ED verified that she did not file an SRI (Self-Reported Incident) until 05/07/24. Review of the Self-Reported Incident submitted on 05/07/24 revealed that the allegation of misappropriation was reported to the ED on 04/23/24. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 2019, revealed the facility had a policy in place that residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Review of the document revealed the facility did not implement the policy in regard to the allegation of misappropriation. Allegations of misappropriation were to be reported to the relevant state agencies within 24 hours. In response to misappropriation allegations, the facility was to have evidence that all alleged violations were thoroughly investigated.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36307 Based on interview, record review, and policy review the facility failed to thoroughly investigate an allegation of misappropriation. This affected one resident (Resident #21) of three residents investigated for concerns related to abuse (Resident #21, Resident #110 and Resident #217) The facility census was 318. Findings include: Review of Resident #21's clinical record revealed she was admitted to the facility on [DATE] and had diagnoses including cognitive communication deficit and major depressive disorder. During interview on 04/30/24, Resident #21 revealed that both she and her niece had discovered unauthorized charges on Resident #21's bank credit card. Resident #21 indicated she had not initiated the charges. Resident #21 confirmed that her niece reported the suspicious charges to the Unit Manager (UM) #1339. Resident #21 was alert, oriented and able to respond to interview questions appropriately. During interview on 05/07/24 at 2:30 P.M., UM #1339 verified that Resident #21's niece had reported an allegation of misappropriation due to unauthorized charges made on the resident's bank card. UM #1339 said the niece wanted to file a police report. UM #1339 immediately reported the allegation of misappropriation to the facility Executive Director (ED) and the Director of Nursing (DON). UM #1339 was unable to recall the exact date the allegation was reported. UM #1339 confirmed that a city Police Officer came to the facility to investigate. During interview on 05/07/24, the ED confirmed that she was told about the credit card charges. The ED described the charges as Lyft charges and indicated that the niece did not indicate that the charges occurred at the facility or that the facility was involved in any way. The ED indicated she tried to reach out to the niece but had not received a return phone call. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Self-Reported Incident (SRI) submitted on 05/07/24 revealed that the allegation of misappropriation was reported to the ED on 04/23/24. The SRI indicated that their investigation was completed on 05/08/24. Review of the facility's investigation indicated that after their thorough investigation they felt that misappropriation did not occur. It was stated there was no proof that the alleged event occurred on campus and that Resident #21 ordered online and at different places frequently. The Lyft charges took place in San Francisco, California, according to the bank statement Resident #21's niece brought in. The resident and niece made a police report to help investigate which the facility indicated they would follow up on. The investigative findings indicated there were too many variables to suggest misappropriation occurred at the facility. Resident #21 was re-educated on the importance of locking all items up when not in use or resident out of the room. The facility provided Resident #21 with education on keeping bank account safe when ordering online. The facility also provided the resident with a lockbox. Further review of the facility investigation revealed that the facility did not conduct interviews with staff across all shifts, auxiliary staff who had access to the resident's room, or residents who resided near the resident to determine if other residents had similar concerns or if staff had knowledge of any misappropriation of residents' property. The facility did not provide a copy of the police report or evidence of further attempts to contact Resident #21's niece for additional information. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 2019, revealed the facility had a policy in place that residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Review of the document revealed the facility did not implement the policy in regard to the allegation of misappropriation. Allegations of misappropriation were to be reported to the relevant state agencies within 24 hours. In response to misappropriation allegations, the facility was to have evidence that all alleged violations were thoroughly investigated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure assessments were accurately completed. This affected four (Residents #77, #110, #217 and #281) of 42 residents reviewed for Minimum Data Set (MDS) 3.0 assessments. The facility census was 318. Findings include: 1. Review of the medical record for Resident #77 revealed an admitted [DATE] with diagnoses including dementia, anxiety and pain. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77 had clear speech, understood staff and was able to be understood by staff. Review of section C (assessment for cognition) under sections C0100, C0200, C0300, and C0400 revealed the questions were answered as not assessed which resulted in a dash for the cognitive score for Resident #77. The staff interview section for Resident #77 for cognition was also not assessed. Review of section D (assessment for mood) revealed interview with the resident was not performed and the questions were answered not assessed. The staff was not interviewed for Resident #77's mood. On section E (assessment for behaviors) the questions under section E0100 for the resident having hallucinations or delusions were dashed and the questions were not answered. On section J (assessment for health conditions including pain) revealed interview of the resident for pain in section J0200, J0300, J0410, J0510, J0520 and J0600 questions were not answered and indicated not assessed. The staff assessment for pain was not conducted. Interview on 05/06/24 at 12:41 P.M. with Registered Nurse (RN) #1141 verified the MDS assessment dated [DATE] for Resident #77 was not completed accurately. She stated the questions were answered not assessed or had dashes because other staff had not completed their assigned sections of the MDS assessment timely. 2. Review of the medical record for Resident #110 revealed an admitted [DATE] with diagnoses including dementia, diabetes and depression. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #110 had clear speech, usually understood staff and was usually able to be understood by staff. Review of section C under sections C0100, C0200, C0300, and C0400 revealed the questions were answered not assessed which resulted in a dash for the cognitive score for Resident #110. The staff interview section for Resident #110 for cognition was also not assessed. Review of section D revealed interview with the resident was not completed and the questions were answered not assessed. The staff was also not interviewed. On section E the questions were answered with dashes or not assessed. On section F (assessment for preferences for routine and activities) revealed interview of the resident was not performed nor the staff questioned as all questions were answered not assessed or had dashes. Interview on 05/06/24 at 12:41 P.M. with RN #1141 verified the MDS dated [DATE] for Resident #110 was not completed accurately. She stated the questions were answered not assessed or had dashes because other staff had not completed their assigned sections of the MDS assessment timely. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	3. Review of the medical record for Resident #217 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, hypertension and depression. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #217 had clear speech, usually understood staff and was usually able to be understood by staff. Review of section J revealed interview of the resident for pain should be conducted, however on questions J0300, J0410, J0510, J0520, J0530 and J0600 questions were not answered and stated not assessed or had dashes. The staff assessment for pain was not conducted. Interview on 05/06/24 at 12:41 P.M. with RN #1141 verified the MDS dated [DATE] for Resident #217 was not completed accurately. She stated the questions were answered not assessed or had dashes because other staff had not completed their assigned sections of the MDS assessment timely. 4. Review of the medical record for Resident #281 revealed an admitted [DATE] with diagnoses including Alzheimer's disease and diabetes mellitus. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #281 had clear speech, was sometimes understood by staff and sometimes was able to understand staff. Review of section C under sections C0100, C0200, C0300, and C0400 revealed the questions were answered not assessed which resulted in a dash for the cognitive score for Resident #281. The staff interview section for Resident #281 for cognition was also not assessed. Review of section D revealed interview with the resident was not performed and the questions were answered not assessed. The staff was also not interviewed for Resident #281's mood. Interview on 05/06/24 at 12:41 P.M. with Registered Nurse RN #1141 verified the MDS dated [DATE] for Resident #281 was not completed accurately. She stated the questions were answered not assessed or had dashes because other staff had not completed their assigned sections of the MDS assessment timely.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568 Based on interviews, record reviews, and facility policy review the facility failed to ensure care plans reflected resident wishes regarding code status. This affected two (Resident #43 and #28) of 42 residents whose care plans were reviewed. The facility census was 318. Findings include: 1. Review of the medical record for Resident #43 revealed an admitted [DATE]. Diagnoses included spondylosis of the lumbar spine, weakness, diabetes, muscle abscess, peripheral vascular disease, and bacteremia. Review of Resident #43's Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required partial assistance by at least one staff member for activities of daily living including toileting, dressing, showers, and transfers. Review of Resident #43's physician orders dated 04/07/24 to 05/01/24 revealed there was not an order in the resident's chart reflecting the resident's wish to be a full code and to have all life sustaining measures implemented. Review of Resident #43's care plan dated 04/07/24 revealed there was not a care plan in place related to the resident's wish to be a full code and to have all life sustaining measures implemented. Interview on 05/01/24 at 11:25 A.M. with Licensed Practical Nurse (LPN) #1272 and LPN #1356 confirmed there was not a care plan or physician order in place for Resident #43's code status and they were unable to identify if the resident wanted all life sustaining measures implemented or not. Interview on 05/01/24 at 11:28 A.M. with Resident #43 revealed no one at the facility ever spoke with her regarding her code status and her wishes. She stated she would like to be a full code and have all life sustaining measures implemented. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled Care Plans, Comprehensive Person-Centered, last revised March of 2022 revealed under the policy statement it stated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Under the section titled Policy Interpretation and Implementation number four each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to A. participate in the planning process, B. identify individuals or roles to be included, C. request meetings, D. request revisions to the plan of care, E. participate in establishing the expected goals and outcomes of care, F. participate in determining the type, amount, frequency and duration of care, G. receive the services and/or items included in the plan of care, and H. see the care plan and sign it after significant changes are made. Under section number seven the comprehensive, person-centered care plan, letter B. states the care plan should describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing including: 1. Services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights including the right to refuse treatment. 2. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE] and discharged from the facility on 04/30/24. Medical diagnoses for Resident #28 included unspecified protein-calorie malnutrition, atrial fibrillation, essential primary hypertension, chronic kidney disease stage four, anemia in chronic kidney disease and generalized anxiety disorder. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively impaired. Resident #28 was dependent for eating, toileting hygiene, shower/bathing, upper body and lower body dressing, and personal hygiene. Resident #28 was always incontinent of bowel and bladder. Review of physician orders for Resident #28 revealed an order for a Do Not Resuscitate Comfort Care (DNR-CC) dated 01/02/24. Review of document titled DNR Order Form revealed Resident #28 had a physician signed DNR-CC order on 12/27/23. Review of care plan dated 07/29/22 revealed Resident #28's code status was not reflected in the resident's care plan. Interview on 05/06/24 at 1:52 P.M. with the Director of Nursing (DON) confirmed Resident #28's code status was not included in Resident #28's care plan. The DON explained the facility did not include code statuses in care plans as they were unable to keep up with how often code statuses changed to ensure care plans were the most accurate. Review of facility policy titled Comprehensive Person-Centered Care Plans dated 03/22 revealed a comprehensive person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. Assessments of residents were ongoing and care plans were revised as information about the resident and the resident's conditions changed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568 Based on record review, interview, and policy review the facility failed to ensure medical records were accurate and complete. This affected four residents (#28, #43, #179 and #317) of 42 residents reviewed for accurate medical records. The facility census was 318. Findings include: 1. Review of medical record revealed Resident #28 was admitted to the facility on [DATE] and discharged from the facility on 04/30/24. Medical diagnoses for Resident #28 included unspecified protein-calorie malnutrition, atrial fibrillation, essential primary hypertension, chronic kidney disease stage four, anemia in chronic kidney disease and generalized anxiety disorder. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively impaired. Resident #28 was dependent for eating, toileting hygiene, shower/bathing, upper body and lower body dressing, and personal hygiene. Resident #28 was always incontinent of bowel and bladder. Review of the care plan dated 07/29/22 revealed Resident #28 had an unstageable wound to left heel, and skin tears to the right lower extremity. Interventions included to perform current treatment as ordered. Review of physician orders for Resident #28 revealed an order dated 11/23/23 for treatment to left heel, cleanse with normal saline, pat dry, apply Anasept gel, then apply calcium alginate, pad with abdominal pad and wrap with Kerlix daily. Review of Resident #28's Medication Administration Record (MAR) for February 2024 and March 2024 revealed the left heel wound care was not documented as completed for 02/16/24, 02/28/24, and 03/13/24. Review of physician orders for Resident #28 revealed an order dated 03/14/24 for treatment to left heel, cleanse with normal saline, pat dry, apply Anasept gel, apply Xeroform, and pad daily. Review of Resident #28's MAR for March 2024 and April 2024 revealed left heel wound care was not documented as completed for 03/30/24, 04/01/24, 04/08/24, 04/19/24, 04/22/24, 04/24/24, and 04/27/24. Interview on 05/08/24 at 10:45 A.M. with Assistant Director of Nursing (ADON) #1332 confirmed missing documentation for Resident #28's left heel dressing for 02/16/24, 02/28/24, 03/13/24, 03/30/24, 04/01/24, 04/08/24, 04/19/24, 04/22/24, 04/24/24, and 04/27/24. The facility was unable to provide additional documentation that showed Resident #28's left heel dressing was completed per physician order for 02/16/24, 02/28/24, 03/13/24, 03/30/24, 04/01/24, 04/08/24, 04/19/24, 04/22/24, 04/24/24, and 04/27/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365094	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King David Post Acute Nursing & Rehabilitation LLC	27100 Cedar Rd Beachwood, OH 44122

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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Charting and Documentation dated 07/17 revealed all services provided to the resident, were to be documented in the resident's medical record. Documentation in the medical record was to be objective, complete and accurate. Documentation of procedures and treatments was to include care specific details including: - The date and time the procedure or treatment was provided; - The name and title of the individual who provided the care; - The assessment data and or any unusual findings obtained during the procedure or treatment; - How the resident tolerated the procedure or treatment; - Whether the resident refused the procedure or treatment; - Notification of family, physician or other staff, if indicated; - The signature, the title of the individual documenting. 2. Review the medical record for Resident #43 revealed an admitted [DATE]. Diagnosis includes spondylosis of the lumbar spine, weakness, diabetes, muscle abscess, peripheral vascular disease, and bacteremia. Review of Resident #43's Medicare five-day MDS assessment dated [DATE] revealed the resident was cognitively intact and required partial assistance by at least one staff member for activities of daily living (ADLs) including toileting, dressing, showers, and transfers. Review of Resident #43's meal intakes from 04/09/24 to 05/06/24 revealed there was missing documentation on 04/09/24, 04/11/24,04/14/24, 04/17/24, 04/18/24, 04/19/24, 04/20/24, 04/21/24, 04/24/24, 04/26/24, 04/27/24, 04/28/24 and 05/06/24. Interview on 05/07/24 at 11:25 A.M. with Dietitian #1182 revealed facility nursing staff including nurses or State tested Nursing Assistants (STNAs) were to document all meal intakes in the electronic medical record and this was not completed often. Interview with the Director of Nursing (DON) and ADON on 05/08/24 at 1:47 P.M. verified the missing documentation related to meal intakes. 3. Review of the medical record for Resident #179 revealed an initial admitted [DATE] with re-entry on 05/04/24. Diagnoses included metabolic encephalopathy, reduced mobility, diabetes mellitus type II, kidney disease stage III, hypertension, kidney failure, and peripheral vascular disease. Review of Resident #179's Medicare five-day MDS assessment dated [DATE] revealed he had severely impaired cognition and required substantial assistance by staff for all ADLs. Review of Resident #179's meal intakes from 03/20/24 to 04/16/24 revealed there was missing documentation on 03/22/24, 04/06/24, 04/07/24, 04/11/24, 04/13/24, and 04/16/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365094	A. Building B. Wing	05/09/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/07/24 at 11:25 A.M. with Dietitian #1182 revealed facility nursing staff including nurses or STNAs were to document all meal intakes in the electronic medical record and this was not completed often. Interview with the DON and ADON on 05/08/24 at 1:47 P.M. verified the missing documentation related to meal intakes. 4. Review of Resident #317's medical record revealed an admitted [DATE]. Resident #317 was discharged to the hospital on 11/11/23 and did not return to the facility. Diagnoses includes cellulitis of left lower limb, reduced mobility, diabetes, severe obesity, kidney failure, and osteoarthritis of the hip. Review of Resident #317's progress notes from 11/10/24 to 11/11/24 revealed there was no documentation related to the resident going to the hospital on 11/11/24. There was no documentation related to the reason why, the condition of the resident or when the resident went to the hospital. Interview with the DON and ADON on 05/08/24 at 1:47 P.M. verified there was no documentation in the nurse progress notes of why or when Resident #317 went to the hospital. Review of the facility policy titled Charting and Documentation last revised July 2017, revealed under Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, was to be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.