STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A438	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwestern Veterans Center	7060 Highland Drive Pittsburgh, PA 15206

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 41984 Based on review of facility documents and staff interview, it was determined that the facility failed to provide access to medical records to a resident or representative within a 24 hour period and/or to provide copies of medical records to the resident or representative within 48 hours for one of three residents (Resident R202). Findings include: Review of facility documents indicated that a request for a copy of medical records by a representative of Resident R202 was received on 11/21/23 and was never sent. During an interview on 5/8/24, at 1:15 p.m. Medical Records Employee E2 stated that she received the signed request from Resident R202's representative on 11/21/23, but did not send them, she misunderstood the regulation. 28 Pa. Code 201.29(a) Resident rights.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41984 Based on facility policy, clinical record review and interviews with staff, it was determined that the facility failed to revise the comprehensive care plan after a diet update for one of four residents (Resident R119). Findings include: A review of facility policy Support Plans/Comprehensive Care reviewed 4/19/24 , indicated it shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. A review of the clinical record indicated Resident R119 was admitted to the facility on [DATE], with diagnoses that included chronic atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), malaise and dry eye syndrome. A review of the Minimum Data Set (MDS-a mandated assessment of a resident's abilities and care needs) dated 2/12/24, indicated the diagnosis remained current. A review of resident physician's orders dated 4/9/24 indicated that Resident R119s tube feeding was discontinued. Review of Resident R 119's current careplan has tube feeding as being active. During an interview on 5/9/24, at 1:45 p.m. Registered Dietitian Employee E1 confirmed Resident 119's care plan was not revised to reflect the resident's current status. 28 Pa. Code: 211.11(d) Resident Care Plans 28 Pa. Code: 211.12(d)(1)(5) Nursing Services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49469 Based on observations and resident and staff interviews, it was it was determined that the facility failed to obtain physician's orders for five of seven residents (Resident R25, R88, R89, R90, and R94) failed to develop comprehensive care plans to meet resident care needs for three of five resident records (Residents R88, R89, and R90) and failed to complete a bed safety risk assessment for three of four resident (R88, R89, and R90). Findings Include: Review of facility policy Simple Dressing Change last reviewed 4/19/24, indicated to clean wound with normal saline or prescribed cleanser. Follow procedure for wound cleansing/irrigation. Review of facility policy Wound Care last reviewed 4/19/24, indicated the implementation of medication procedures according to physician orders and established facility guidelines to ensure the standards of resident care are delivered in wound therapy. Review of facility policy Bed Entrapment Zone Inspection last reviewed 4/19/24, indicated entrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed assist rails, mattress, or bed frame. Review of the facility policy Support Plans/Comprehensive Care last reviewed 4/19/24, indicated to ensure accurate, written, medical and comprehensive assessment of each resident medical and functional capacity upon admission, annually, and as required by change in a resident's condition. A review of the clinical record indicated that Resident R25 was readmitted to facility on 4/24/24, with diagnosis of dementia, depression, and functional quadriplegia (inability to move without spinal cord injury). A review of the Minimum Data Set (MDS-periodic assessment of care needs) date 2/22/24, indicated the diagnoses remain current. A review of physician order dated 5/7/24, indicated apply Medi honey and foam dressing to left buttock wound daily and as needed. Interview 5/8/24, at 9:07 a.m. Employee E4 confirmed the orders did not include direction for cleansing of the wound. A review of the clinical record indicated that Resident R94 was readmitted to facility on 4/13/24, with diagnosis of Alzheimer's disease (type of dementia), hypothyroidism (thyroid gland does not produce enough hormones affecting metabolism), and epilepsy (neurological disease-causing seizures). A review of physician order dated 4/22/24, indicated clean dry dressing to left ankle deep tissue injury daily and as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview 5/9/24, at 11:26 a.m. Employee E4 confirmed the orders did not include direction for cleansing of the wound. Review of the clinical record indicated Resident R89 was admitted to facility on 4/26/18, with the diagnosis of coronary artery disease (CAD- limits blood flow in arteries), hyperlipidemia (high fats in the blood), and depression. A review of the Minimum Data Set (MD -periodic assessment of care needs) date 3/29/24, indicated the diagnoses remain current. Observation 5/8/24, at 1:25 p.m. revealed Resident R89 had thick blue fall matts placed on both sides of bed, a silent bed alarm was also noted. Review of Resident R89's physician orders failed to include thick blue fall matts and silent bed alarm. Review of Resident R89's facility safety assessment, failed to include a bed safety risk assessment with the use of thick fall mats. Interview 5/8/24, at 1:41 p.m. Registered Nurse (RN) Employee E3 confirmed no orders were obtained for the thick blue fall mats or silent bed alarm alarms and confirmed the thick blue fall mats did not have a current care plan. Interview 5/10/24, at 9:29 a.m. the Director of Nursing (DON) confirmed the facility failed to complete a bed safety risk assessment for Resident R89. Review of the clinical record indicated Resident R88 was readmitted to facility on 7/15/22, with the diagnosis of heart failure, high blood pressure, and Alzheimer's disease (type of dementia), A review of the Minimum Data Set (MDS - periodic assessment of care needs) date 4/11/24, indicated the diagnoses remain current. Observation 5/9/24, at 10:07 a.m. revealed Resident R88 had thick blue fall matts placed on both sides of bed. Review of Resident R88's physician orders failed to include thick blue fall matt. Review of Resident R88's facility safety assessment, failed to include a bed safety risk assessment with the use of thick fall matts. Interview 5/9/24, at 10:39 a.m. RN Employee E14 confirmed no orders were obtained for the thick blue fall matts and confirmed the thick blue fall matts did not have a current care plan. Interview 5/10/24, at 9:29 a.m. the Director of Nursing (DON) confirmed the facility failed to complete a bed safety risk assessment for Resident R88. Review of the clinical record indicated Resident R90 was readmitted to facility on 5/7/24. with diagnosis of heart failure, dementia, and Parkinson's disease (affects the nervous system). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Minimum Data Set (MDS - periodic assessment of care needs) date 4/4/24, indicated the diagnoses remain current. Observation 5/9/24, at 10:45 a.m. revealed Resident R90 had thick blue fall matts placed on both sides of bed. Review of Resident R90's physician orders failed to include thick blue fall matt. Review of Resident R90's facility safety assessment, failed to include a bed safety risk assessment with the use of thick fall matts. Interview 5/9/24, at 10:07 a.m. RN Employee E3 confirmed no orders were obtained for the thick blue fall matts and confirmed the blue thick fall matts did not have a current care plan. Interview 5/10/24, at 9:29 a.m. the Director of Nursing (DON) confirmed the facility failed to complete a bed safety risk assessment for Resident R90. Interview 5/10/24, at 9:29 a.m. the Director of Nursing (DON) confirmed the facility failed to obtain physician's orders for five of seven residents (Resident R25, R88, R89, R90, and R94) failed to develop comprehensive care plans to meet resident care needs for three of five resident records (Residents R88, R89, and R90) and failed to complete a bed safety risk assessment for three of four resident (R88, R89, and R90). 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code: 211.10(c)(d) Resident care policies 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on observation, clinical record review and staff interview, it was determined that the facility failed to provide treatment and services to prevent further decrease in range of motion for two of four residents (Residents R2 and R25). Findings include: Review of Title 42 Code of Federal Regulations (CFR) S483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Interview with the Director of Nursing on 5/8/24, at 1:25 p.m. indicated the facility does not have a policy on assistive devices or palm guards (a splint for the hand). Review of the admission record indicated Resident R2 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS- a periodic assessment of care needs) dated 4/18/24, indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs), and hemiplegia (paralysis of one side of the body). Review of Resident R2's current physician orders on 5/6/24, indicated left palm guard, on at 6:00 a.m. and off at 8:00 p.m. Review of Resident R2's current care plan on 5/6/24, indicated resident will maintain current level of range of motion (ROM) through use of left hand/wrist splint. Check for skin break down daily. Observation 5/6/24, at 9:35 a.m. Resident R2 was in bed and did not have a left palm guard in place. It was noted on the bedside dresser. Interview on 5/6/24, at 9:40 a.m. Licensed Practical Nurse (LPN) Employee E9 confirmed Resident R2's left palm guard was not in place as ordered. Observation 5/7/24, at 9:38 a.m. Resident R2 was in bed and did not have left palm guard in place. Interview on 5/7/24, at 9:45 a.m. LPN Employee E9 confirmed Resident R2's left palm guard was not in place as ordered. Review of the admission record indicated Resident R25 was admitted to the facility on [DATE]. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R25's MDS dated [DATE], indicated the diagnoses of functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord), contracture of muscles, multiple sites (occurs when muscles, tendons, joints, or other tissues tighten or shorten causing a deformity), and dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life). Review of Resident R25's current physician orders on 5/8/24, indicated resident to wear bilateral (both sides) palm guards up to four hours with skin checks before and after wear in order to maintain skin integrity and reduce risk for contracture formation every shift - days, evenings, and nights. Review of Resident R25's current care plan on 5/8/24, indicated resident requires splint/brace assistance of bilateral palm guards daily. Check for skin break down daily. Observation on 5/8/24, at 9:30 a.m., and 1:00 p.m. Resident R25 was observed out of bed in Broda chair (specialty chair that tilts for positioning purposes) and did not have bilateral palm guards in place as ordered. Interview on 5/8/24, at 12:55 p.m. Registered Nurse (RN) Employee E10 indicated I guess they just communicate to know when the four hours starts or ends. Interview on 5/8/24, at 1:00 p.m. Nurse Aide (NA) Employee E11 indicated she thought the palm guards were to be worn only while resident was in bed and confirmed they were not in place as ordered. Interview on 5/8/24, at 1:25 p.m. the Director of Nursing indicated there was not a system to ensure the wear schedule of up to four hours for Resident R25 and that the facility failed to provide treatment and services to prevent further decrease in range of motion for two of four residents (Residents R2 and R25). 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.11(a) Resident care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.29(d) Resident Rights

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, incident reports and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of three residents (Resident R140) and resulted in a cat bite for two of three residents (Residents R14 and R119). Findings include: Review of the facility policy Incidents and Accidents dated 4/19/24, indicated the protocol is to provide guidance to assist with maintaining the Residents' safety and prevention of serious injury to the extent possible. Root Cause Analysis (RCA) is a method of problem solving used for identifying the root cause of faults or problems. It includes the process of learning from consequences wherein healthcare providers take a step back and gain knowledge from near misses, or adverse events to prevent recurrence. Review of the facility policy Wandering/Elopement assessment dated [DATE], indicated Elopement Risk Assessment will be completed on admission to the facility, quarterly, annually, and as needed with change in condition for episodes of wandering. Review of the facility policy Elopement Prevention Policy and Procedure dated 4/19/24, indicated ensure compliance that every resident is assessed for exit seeking and wandering behavior by the interdisciplinary team and that any unusual events will be reported to the Nursing Supervisor and Security. All staff will maintain a heightened awareness of their surroundings, the residents in the facility's care and environmental issues that might lead to a resident' s elopement. Review of the admission record indicated Resident R140 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/1/24, indicated the diagnoses of Non-Alzheimer's Dementia (a condition in which symptoms of Alzheimer's disease and Parkinson's disease are present at the same time), depression, and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). Section E indicated delusions (misconceptions or beliefs that are firmly held, contrary to reality). Review of the clinical record indicated Resident R140 had an Elopement Assessment completed on 5/17/23, that indicated he was not at risk for elopement. Quarterly Elopement Assessments were not completed in August 2023, November 2023, or February 2024. Interview on 5/8/24, at 1:00 p.m. the Director of Nursing confirmed the Elopement Assessments were not completed quarterly as required. Review of Resident R140's care plan dated 2/9/24, indicated resident is unable to make daily decisions without cues/supervision related to Autistic Disorder (a spectrum disorder that affects the nervous system common symptoms include difficulty with communication, social interaction, obsessive interests, and repetitive behaviors). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note dated 4/8/24, at 2:17 p.m. indicated the Interdisciplinary team met today to discuss recent behaviors/falls. Review of the facility provided Elopement/Wander Report and Investigation Check List dated 4/16/24, indicated that at 6:05 p.m. Resident R140 exited the front lobby door, unnoticed by Security. Review of Registered Nurse Supervisor Employee E19's progress note dated 4/16/24, at 6:00 p.m. indicated I was notified by the security officer of the following. Activity staff alerted security that Resident R140 was seen by activity staff walking out of the main entrance towards the administration parking lot. Per witness he had walked to the end of the road where there is a road bump. Review of Activity Assistant Employee E12's note dated 4/16/24, at 8:28 p.m. indicated I was in the lobby in the drawer of face masks and noticed Resident R140 walking/sprinting out the front door and I notified security. Review of Security Guard Employee E13's witness statement dated 4/16/24, indicated Resident has no wander guard (a bracelet that alerts staff when a resident attempts to leave an unauthorized area). At approximately 6:00 p.m. I opened the FIT Test (a process to fit N95 respirators securely without air gaps)/Mailroom door. As I was walking back to the security desk Resident R140 was quickly walking out the front door. Interview with Activity Assistant Employee E12 on 5/6/24, at 2:38 p.m. indicated I was getting a fit test done. I was in the drawer in front lobby looking for the mask to use, as I pulled the mask out of the drawer I turned and thought I saw somebody walk by, but they were so fast. I realized it was a resident. There was another resident and a family member outside on the patio, I thought he may have been with them and maybe he had to use the restroom. I reported it to Security. He's been very confused recently. After the bingo he tried to leave again, and the security guard was in the doorway. I've seen him down here walking aimlessly and ask him where he's going and he'd say oh, I think he forgot where he was going. Interview with Security Guard Employee E13 on 5/7/24, at 2:43 p.m. indicated I know Resident R140 very well. I was at the desk and an employee came up and asked if I had time to do a FIT test. I said, yes, go pick out a mask. I went the opposite direction to grab the papers from the FIT Room door and was out of sight of the front door. Out of the corner of my eye I saw Resident R140 four steps from the door and caught him going toward the seat he always sits in when he uses his cell phone, he didn't keep the same path and I thought the wander guard would alarm, but it didn't. I was not aware that he no longer had a wander guard device on. Interview on 5/8/24, at 11:30 a.m. Security Guard Employee E16 indicated we (security) keep track of the book with the resident photos. Interview with Institutional Fire and Safety Specialist Employee E17 on 5/8/24, at 8:30 a.m. indicated the front area of the facility that no residents are allowed out unless a staff member is with them. All staff know that a resident cannot go out without someone. Review of the facility provided Root Cause Analysis dated 4/17/24, indicated the first cause of elopement was security guard left desk unattended. The second cause of the elopement was staff inattentiveness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission record indicated Resident R14 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/11/24, indicated the diagnoses of diabetes mellitus (disease in which the body ' s ability to produce or respond to the hormone insulin is impaired), diabetic retinopathy (abnormal blood vessels in the retina) and osteoarthritis. Review of facility provided documents indicated on 10/4/23 at 1:15 p.m. that Resident R14 sustained two puncture wound to right index finger from feeding the cats outside. CRNP notified, bite treated and resident ordered tetanus booster. Review of the admission record indicated Resident R119 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/11/24, indicated the diagnoses of chronic atrial fibrillation (heart arrhythmia that causes the top chambers of your heart, the atria, to quiver and beat irregularly), malaise (general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify) and depression. Review of facility provided documents indicated on 4/27/24 at 5:00 p.m. Resident R119 sustained two cat bites on left wrist while outside feeding the cats. Physician on call notified. Resident sent out for preventative management. Resident R119 receiving rabies series for cat bites. Interview on 5/10/24, at 1:30 p.m. the Director of Nursing confirmed the facility failed to make certain each resident received adequate supervision that resulted in an elopement for one of three residents (Resident R140) and resulted in a cat bite for two of three residents (Residents R14 and R119). 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.11(a) Resident care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. 28 Pa. Code 201.29(d) Resident Rights.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of resident clinical records, facility policy and staff interview, it was determined the facility failed to provide consistent, and complete communication with the dialysis center for three of three residents reviewed (Residents R35, R81, and R106), and failed to have accurate physician orders and care plan for one of three residents reviewed (Resident R106). Findings include: Review of the facility policy Pre and Post Dialysis dated 4/19/24, indicated prior to departing the unit for transfer to dialysis (the clinical purification of blood by dialysis as a substitute for the normal function of the kidney), the licensed staff will complete the Dialysis Communication Form with each transfer to the dialysis clinic. Upon return to the unit, the licensed staff will complete the return portion of the Dialysis Communication Form and file in the appropriate section of the chart. If no communication form is received, please call dialysis, and have one faxed to the facility. Check thrill by palpating the shunt, then bruit with the bell of a stethoscope until a whoosh sound is heard. Report any absence of sound at the site. A review of clinical record indicated that Resident R35 was readmitted to the facility on [DATE], with diagnoses that include end stage renal disease (kidneys no longer filter waste), anemia (deficiency of healthy red blood cells in the blood), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A review of the Minimum Data Set (MDS-periodic assessment of care needs) dated 3/7/24, indicated the diagnoses remain current. A review of a physician's order dated 5/5/22, indicated Resident R35 was to receive dialysis three days a week on Monday, Wednesday, and Friday. A review of a care plan updated 3/11/24, indicated dialysis communication sheet to be sent with resident for completion by dialysis clinic to return to facility on treatment days. A review of the dialysis communication sheets from 3/25/24 through 5/8/24, indicated nine communication sheets were incomplete on 3/25/24, 4/1/24, 4/19/24, 4/22/24, 4/24/24, 4/26/24, 4/29/24, 5/1/24, 5/3/24, and 5/8/24, and two more incomplete sheets that were not dated. An interview on 5/10/24, at 9:22 a.m., Registered Nurse (RN) Employee E18 confirmed the dialysis communication sheets were incomplete. A review of the clinical record indicated that Resident R81 was readmitted to the facility on [DATE], with diagnoses that include end stage renal disease (kidneys no longer filter waste), anemia, and high blood pressure. A review of the Minimum Data Set (MDS-periodic assessment of care needs) dated 2/8/24, indicated the diagnoses remain current. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A438	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwestern Veterans Center	7060 Highland Drive Pittsburgh, PA 15206

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a physician's order dated 6/29/22, indicated Resident R81 was to receive dialysis three days a week on Monday, Wednesday, and Friday. Review of a care plan dated 6/23/22, indicated provide dialysis communication form to be sent with and returned with resident. Review of the dialysis communication sheets from 4/1/24 through 5/7/24, indicated five communication sheets for April 2024, missing (4/1/24, 4/5/24, 4/8/24, 4/10/24, 4/19/24). Interview 5/7/24 at 1:46 p.m. Registered Nurse (RN) Employee E5 confirmed the dialysis communication book was incomplete. A review of the clinical record indicated Resident R106 admitted to the facility on [DATE], with diagnoses that include diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. A review of Resident R106's MDS dated [DATE], indicated the diagnoses remain current. A review of a physician's order dated 11/28/23, indicated Resident R106 was to receive dialysis three days a week on Monday, Wednesday, and Friday. Port (a thin flexible tube that is threaded into a large vein above the right side of the heart) right upper chest. A physician order for Resident R106's AV (arteriovenous) fistula (a procedure that connects an artery to a vein in preparation for dialysis) was not present. Review of a care plan dated 3/4/24, indicated assess right upper chest dialysis port site for abnormal findings every shift and failed to include a plan of care for management of the AV fistula. Review of the dialysis communication sheets from 2/14/24 through 4/5/24, indicated seven communication sheets incomplete on 2/14/24, 3/18/24, 3/22/24, 4/5/24, and three more forms that were not dated. Interview on 5/6/24, at 11:58 a.m. Registered Nurse (RN) Employee E15 confirmed the seven communication sheets were incomplete, that Resident R106 did not have a port to the upper right chest, and had an AV fistula which was not included in the physician orders or plan of care. Interview on 5/10/24, at 1:30 p.m. the Director of Nursing confirmed the facility failed to provide consistent, and complete communication with the dialysis center for three of three residents reviewed (Residents R35, R81, and R106), and failed to have accurate physician orders and care plan for one of three residents reviewed (Resident R106). 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.11(a) Resident care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.29(d) Resident Rights