STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48313 Based on record review, interviews, and facility policy review, it was determined that the facility failed to notify and consult with the physician regarding a need to alter treatment significantly for 1 (Resident #3) of 7 residents reviewed for nutrition and hydration. Specifically, the facility failed to inform Resident #3's physician about hospital discharge instructions and Registered Dietitian (RD) #4's recommendations related to enteral hydration. Findings included: A review of the facility's undated policy, titled, Resident Hydration and Prevention of Dehydration, indicated, The Dietitian will assess identified at risk residents for hydration adequacy as need [sic]. Minimum fluid needs will be calculated and documented, as appropriate, for at risk residents using current Standards of Practice. Another excerpt from the policy directed staff as follows: If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. Activities of daily living (ADL) status, diagnosis, individual preferences, habits, and cognitive and medical status will be considered in all interventions. Physician will be notified. Additional guidance in the policy indicated, Laboratory tests may be ordered to assess hydration if intake and symptoms indicate possible significate dehydration. If laboratory results are consistent with actual dehydration, the Physician may initiate IV [intravenous] hydration. hospitalization will be recommended, as necessary. A review of the facility's policy, titled, Nasogastric/Gastrostomy Tube Feeding, that was last updated 03/03/2014, indicated, Nasogastric/Gastrostomy feeding will supply nutrition and medication to residents who are unable to take food by mouth or receive tube feeding to supplement their intake. The policy also revealed, Additional water may be indicated to meet hydration needs. Check with physician and nutrition support specialist as needed. Review of an Admission Record revealed the facility admitted Resident #3 on 07/08/2022 with diagnoses that included traumatic subarachnoid hemorrhage (brain bleed), traumatic brain injury, acute respiratory failure, dysphagia, and fracture of the fifth and sixth cervical vertebrae and nasal bone. A review of Resident #3's Nursing Assessment, dated 07/08/2022, revealed the resident had severely impaired cognitive skills for daily decision making. The assessment indicated the resident used a percutaneous endoscopic gastrostomy (PEG) feeding tube. The assessment indicated the resident had upper and lower extremity impairments on both sides. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #'3s Baseline Care Plan, dated 07/08/2022, revealed the resident's diet order was NPO (nothing by mouth), and the resident was to receive tube feedings for nutrition. The baseline care plan did not address hydration. A review of Resident #3's Nursing Home Instructions, within the hospital discharge summary dated 07/07/2022, revealed Resident #3 was to receive 200 milliliters (mL) of water with each bolus tube feeding. A review of Resident #3's July 2022 physician orders indicated the resident was to receive enteral nutrition administered four times a day. There was no physician's order for the additional 200 mL of water with each bolus tube feeding, as recommended in the hospital discharge summary. A review of Resident #3's July 2022 Medication Administration Record (MAR) revealed there was no order for the 200 mL of water with each tube feeding bolus, four times a day, and there was no documented evidence indicating the water was provided. A review of Resident #3's Enteral Nutrition Assessment, dated 07/13/2022, revealed the resident was receiving bolus enteral nutrition, four times per day, due to dysphagia. The assessment indicated Resident #3 was receiving 608 cubic centimeters (cc) of fluid per day and the resident's estimated fluid requirement was 1950 cc per day. In the assessment, RD #4 suggested staff change Resident #3's bolus enteral feeding to a continuous enteral feeding at a rate of 55 cc per hour with water auto flushes at 40 cc per hour to provide 1980 kilocalories (kcal) and 84 grams (g) of protein per day with 1963 cc of free water. Registered Dietitian (RD) #4 also suggested adding 1 ounce (oz) of liquid protein daily for an additional 15g of protein, a multivitamin (MVI) with minerals to help with wound healing, weekly weights for four weeks, and baseline laboratory blood tests including a comprehensive metabolic panel (CMP) and prealbumin (PAB). A review of Resident #3's Progress Notes, from 07/08/2022 to 07/18/2022, revealed the physician was not notified regarding the hospital discharge instructions or RD #4's recommendations to increase fluids and complete laboratory blood tests. During an interview on 04/11/2023 at 2:15 PM, RD #4 stated she no longer worked for the facility. She said that when she made a recommendation, she would typically review it with the nurses because she was not allowed to write a physician's order. She said that while working for the facility in July 2022, she was not sure who she was supposed to notify in the facility of her recommendations because there was not a consistent unit manager or Director of Nursing (DON) because of staff turnover. She stated she did not remember what recommendations were made for Resident #3 after she completed the resident's nutritional assessment on 07/13/2022 or who in the facility she communicated with regarding her recommendations. She stated if she did not verbally communicate her recommendation, she would send the recommendation using fax or email. RD #4 could not provide written verification that she communicated her recommendations to the facility. During an interview on 04/11/2023 at 4:40 PM, Licensed Practical Nurse (LPN) #2 stated that when admitting a new resident, the physician orders were entered into the resident's record by the unit manager and confirmed with the physician, if there were questions or concerns. LPN #2 said the nurses were responsible for contacting the RD and/or physician if any questions or concerns were identified related to fluids or tube feedings. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/11/2023 at 4:58 PM, Resident #3's physician stated he no longer had any affiliation with the facility and had not worked for the facility since October of 2022. He said he no longer had access to Resident #3's information and could not answer any questions related to patient care. During an interview on 04/12/2023 at 12:40 PM, the Administrator (ADM) and DON stated they started working at the facility in September 2022. The DON said she could not speak to what staff did regarding Resident #3's care in July 2022 because the DON and the ADM were not working at the facility at that time.

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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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48313 Based on record reviews, interviews, and facility policy reviews, the facility failed to develop and implement a baseline care plan that included instructions needed to maintain hydration for 1 (Resident #3) of 7 residents reviewed. Specifically, the facility failed to develop and implement a baseline care plan for Resident #3 that included administration of water with bolus enteral feedings and failed to update the baseline care plan with Registered Dietitian (RD) #4's recommendations to increase fluids to maintain hydration. This failure resulted in Resident #3 passing away in the facility due to dehydration. It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.21 (Comprehensive Resident Centered Care Plan) at a scope and severity of J. The IJ began on [DATE] when Resident #3 was admitted to the facility and the facility did not address hydration on the resident's baseline care plan which resulted in fluids not being provided as ordered. The Administrator and Director of Nursing (DON) were notified of the IJ on [DATE] at 2:12 PM and provided the IJ Template at 2:32 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on [DATE] at 2:45 PM. The IJ was removed on [DATE] at 7:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower scope and severity of D that was not immediate jeopardy for F655. Findings include: A review of the facility's policy, titled, Plan of Care Assessments, dated [DATE], indicated, Policy: Each resident will have a Plan of Care in order to receive the care necessary to enable the resident to achieve and/or maintain the highest practical physical, mental and psychological well-being. Procedure: A head-to-toe physical assessment of each resident will be completed on admission by an assigned Licensed Nurse with input from CNAs [certified nurse aides]. The baseline Plan of Care will be implemented within 48 hours of admission to ensure the resident receives the following necessary immediate care: Initial goal based on admission orders, Physician orders, Dietary orders, Therapy services, Social services and PASARR [Preadmission Screening and Resident Review] recommendations, if applicable. The Plan of Care will be completed with [the] MDS [Minimum Data Set] assessment and Care Area Assessments are completed by all disciplines. The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan will be developed within 48 hours of the resident's admission and meets all requirements. The facility will provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. Review of an Admission Record revealed the facility admitted Resident #3 on [DATE] with diagnoses that included traumatic subarachnoid hemorrhage (brain bleed), traumatic brain injury, acute respiratory failure, dysphagia, and fracture of the fifth and sixth cervical vertebrae and nasal bone. (continued on next page)

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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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #3's Nursing Assessment, dated [DATE], revealed the resident had severely impaired cognitive skills for daily decision making. The assessment indicated the resident used a percutaneous endoscopic gastrostomy (PEG) feeding tube. The assessment indicated the resident had upper and lower extremity impairments on both sides. According to the assessment, Resident #3 had a sacral wound and was always incontinent of bowel and bladder. Review of Resident #'3s Baseline Care Plan, dated [DATE], revealed the resident's diet order was NPO (nothing by mouth), and the resident was to receive tube feedings for nutrition. The baseline care plan did not address hydration. A review of Resident #3's Nursing Home Instructions, within the hospital discharge summary dated [DATE], revealed Resident #3 was to receive 200 milliliters (mL) of water with each bolus tube feeding. The nursing home instructions were not added to the baseline care plan. A review of Resident #3's [DATE] physician orders indicated the resident was to receive enteral nutrition administered four times a day. There was no physician's order for the additional 200 mL of water, as recommended in the hospital discharge summary. A review of Resident #3's Enteral Nutrition Assessment, dated [DATE], revealed the resident was receiving bolus enteral nutrition, four times per day, due to dysphagia. The assessment indicated Resident #3 was receiving 608 cubic centimeters (cc) of fluid per day and the resident's estimated fluid requirement was 1950 cc per day. In the assessment, RD #4 suggested staff change Resident #3's bolus enteral feeding to a continuous enteral feeding at a rate of 55 cc per hour with water auto flushes at 40 cc per hour to provide 1980 kilocalories (kcal) and 84 grams (g) of protein per day with 1963 cc of free water. RD #4 also suggested adding 1 ounce (oz) of liquid protein daily for an additional 15g of protein, a multivitamin (MVI) with minerals to help with wound healing, weekly weights for four weeks, and baseline laboratory tests including a comprehensive metabolic panel (CMP) and prealbumin (PAB). Further review of the Baseline Care Plan revealed the RD recommendations were not added to Resident #3's baseline care plan. A review of Resident #3's Nurses Notes, dated [DATE] at 8:05 PM, revealed staff found Resident #3 unresponsive. The nurse noted Resident #3 was lying on the resident's back with no noted rise or fall of the chest. Staff were unable to obtain any vital signs. The note indicated cardiopulmonary resuscitation (CPR) was initiated twice by staff members and 911 was called due to the resident's full code status. According to the note, first responders and an emergency ambulance arrived; however, the resident remained unresponsive to CPR or other stimuli. The coroner was contacted by the staff for pronouncement of death. A review of a Forensic Autopsy Report, dated [DATE], revealed Resident #3's final cause of death was dehydration. The report indicated, Analysis of vitreous fluid (liquid from the eyeball) reveals the following: sodium = 140 mmol/L [millimoles per litre], urea nitrogen = 87 mg/dl [milligrams per decilitre], creatinine = 2.5 mg/dl, and glucose = 14.0 mg/dl, consistent with dehydration. The Resident Assessment Coordinator/MDS Nurse was not available for an interview regarding Resident #3's baseline care plan during the survey. (continued on next page)

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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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:40 PM, the Director of Nursing (DON) stated the floor nurses completed the new admission assessments if she or the unit manager were not in the facility and the floor nurses routinely completed the resident baseline care plans; otherwise, the MDS nurse completed them. The DON did not know why Resident #3's hydration needs were not assessed as she was not employed by the facility at the time of the resident's stay. The Administrator and DON were notified of the determination of IJ on [DATE] at 2:12 PM. A Removal Plan was requested. During an interview on [DATE] at 10:00 AM, the Medical Director said he started working at the facility in mid-October of 2022. He noted he was physically in the building once a week, and attended quality assurance (QA) meetings, which were held monthly. He indicated staff had been responsive and had updated him with any concerns or issues. He stated someone from the facility made him aware of the concerns which led to the IJ. He said he did not know the whole situation, but the facility was addressing the issues and he agreed with the plan. Removal Plan: The following IJ Removal Plan was provided by the facility and accepted by the State Survey Agency on [DATE] at 2:45 PM: Resident #3 did not have appropriate documentation completed in the baseline care plan (completed [DATE]) to reflect nutrition and hydration specific orders. Registered Dietitian (RD) recommendations were not implemented. This occurrence negatively impacted the resident and had the ability to affect all residents receiving enteral nutrition at that time. 1. A baseline care plan audit was completed on [DATE] by the Director of Nursing for six (6) residents with enteral feedings to ensure baseline care plans were specific to the residents and tube feeding orders for nutrition, hydration, and/or RD recommendations/interventions were included in the care plan. Six of six (, d+[DATE]) baseline care plans had dietary orders of 'NPO [nothing by mouth]' but have been corrected to include enteral nutrition and hydration orders. The Director of Nursing made this correction to ,d+[DATE] care plans. 2. Upon new admission of a resident receiving enteral feeding the Director of Nursing or designee will notify the RD via telephone call or email of the resident's physical arrival to the facility and review feeding orders to ensure appropriate nutrition and hydration for the resident. This notification will be documented in the progress notes by the notifier. Upon acceptance of a referral from the hospital and planned admission to the facility with discharge orders, the RD will be included in the notification email sent from the Marketing Liaison that is sent out to facility managers for anticipated admission. This is implemented as of [DATE]. This process will be audited by the Administrator within 24 hours of admission of a resident with a g-tube and will continue to be audited for three months to ensure compliance is achieved. If no recommendations are made at the time of admission notification, and there is no immediate concern, the RD will evaluate, remotely or in person, the resident's chart within 24 hours of admission and will document completion of the review in the progress notes. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. The Administrator and Director of Nursing immediately on [DATE] educated facility RNs and LPNs [licensed practical nurse] in person, or via telephone, on baseline care plan completion and specificity to resident to properly address hydration and nutrition for enteral feeding patients. Physician orders will be included in the dietary section of baseline care plans. As of [DATE], 100% of RNs and LPNs have been informed of the baseline care plan completion process and will sign the in-service sheet on their next scheduled shift. Ten (10) licensed nursing staff were educated in person and nine (9) via telephone. The Director of Nursing will educate new RNs and LPNs hired after [DATE] at new hire orientation of baseline care plan completion process and documentation. The MDS Coordinator is responsible for completing the baseline care plan. The MDS Coordinator was educated on [DATE] of baseline care plan specifications, to include enteral nutrition and hydration orders under dietary. 4. All enteral orders for nutrition and hydration are reviewed weekly at RISK meetings with the interdisciplinary team. This meeting has been held weekly by the Administrator and the Director of Nursing since [DATE]. 5. Baseline care plan audits to be completed by the Director of Nursing with 72 hours of admission for residents with enteral feedings to ensure care plans are specific to resident and include feeding orders for nutrition, hydration, and/or RD recommendations. If negative findings or missing information is identified, the DON will correct at the time of discovery. Audits to be turned in to the Administrator on a weekly basis for three months, reviewed at weekly RISK meeting, and monthly Quality Assurance Meeting. Quality Assurance team members include the Administrator, Director of Nursing, Infection Prevention, Business Office, Social Services, Marketing, Therapy, Activities, Maintenance, Dietary, Medical Records, MDS, Wound Nurse and Human Services. The Medical Director and RD review meeting notes on their following visit. If errors in baseline care plan audits are identified, QA team will discuss an extension of the audits at month three completion. Twelve (12) Quality Assurance team members met at 4:40 PM on [DATE] to review Immediate Jeopardy concerns and action plan for removal of immediacy. Members present: Administrator, Social Services, Business Office, Director of Nursing, Human Resources, Medical Records, Wound Nurse, Therapy, Activities, Maintenance. Responsibilities of Administrator, Director of Nursing and Unit Manager for action plan audits were reviewed. QA team was educated that when an error or missing information is identified in baseline care plan audits, the DON will rectify at the time of discovery. 6. The Medical Director was informed of the Immediate Jeopardy and concern areas on [DATE]. The Medical Director was informed of the action plan for removal and agrees with the resolution plan. 7. All corrections were completed on [DATE]. 8. The immediacy of the IJ was removed on [DATE]. Onsite verification of Removal Plan: (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was removed on [DATE] at 7:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began at 2:45 PM on [DATE], when staff were informed the Removal Plan was accepted by the State Survey Agency. Verification of licensed staff education was performed. A total of 10 of the 19 staff (three day shift nurses; three evening shift nurses; two night shift nurses; and two other staff, non-nursing) were interviewed in person and/or via telephone. All staff who were interviewed stated they received education regarding ensuring baseline care plans were updated to reflect resident nutrition and hydration needs including physician orders for enteral nutrition and hydration and RD recommendations. Staff indicated that the DON and unit manager would be notified regarding order discrepancies. A review was completed of the facility's audit of six residents receiving enteral feedings for accuracy and appropriate nutrition and hydration interventions. The review revealed interventions were included in baseline and interdisciplinary care plans. A review was completed of the facility's attendance sheet for RISK meetings. Monthly audits of new admission orders and RD recommendations remains ongoing. The Medical Director was interviewed and confirmed he was informed of the IJ.

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48313 Based on record review, interviews, and facility policy review, it was determined that the facility failed to ensure 1 (Resident #3) of 7 residents reviewed for assisted nutrition and hydration received adequate fluid intake to maintain proper hydration. Specifically, the facility failed to transcribe discharge orders from the hospital for water with bolus enteral feedings for Resident #3 and failed to implement recommendations from Registered Dietitian (RD) #4 to increase Resident #3's fluids to maintain hydration. This failure resulted in Resident #3 passing away in the facility due to dehydration. It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. The IJ began on [DATE] when Resident #3 was admitted to the facility and the hospital discharge orders were not transcribed accurately which resulted in fluids not being provided as ordered. The Administrator and Director of Nursing (DON) were notified of the IJ on [DATE] at 2:12 PM and provided the IJ Template at 2:32 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on [DATE] at 2:45 PM. The IJ was removed on [DATE] at 7:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower scope and severity of D that was not immediate jeopardy for F692. Findings included: A review of the facility's undated policy, titled, Resident Hydration and Prevention of Dehydration, indicated, The Dietitian will assess identified at risk residents for hydration adequacy as need [sic]. Minimum fluid needs will be calculated and documented, as appropriate, for at risk residents using current Standards of Practice. The policy indicated, Nursing will assess for signs and symptoms of dehydration during daily care. Another excerpt from the policy directed staff as follows: If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. Activities of daily living (ADL) status, diagnosis, individual preferences, habits, and cognitive and medical status will be considered in all interventions. Physician will be notified. Additional guidance in the policy indicated, Laboratory tests may be ordered to assess hydration if intake and symptoms indicate possible significate dehydration. If laboratory results are consistent with actual dehydration, the Physician may initiate IV [intravenous] hydration. hospitalization will be recommended, as necessary. Nursing will monitor and document fluid intake and the Dietitian will be kept informed of status. Interdisciplinary team will update care plan and document resident response to interventions until team agrees that fluid intake and related factors are resolved. (continued on next page)

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's policy, titled, Nasogastric/Gastrostomy Tube Feeding, that was last updated [DATE], indicated, Nasogastric/Gastrostomy feedings will be given as ordered by the physician. Nasogastric/Gastrostomy feeding will supply nutrition and medication to residents who are unable to take food by mouth or receive tube feeding to supplement their intake. The policy also included the following guidance, Additional water may be indicated to meet hydration needs. Check with physician and nutrition support specialist as needed. Review of an Admission Record revealed the facility admitted Resident #3 on [DATE] with diagnoses that included traumatic subarachnoid hemorrhage (brain bleed), traumatic brain injury, acute respiratory failure, dysphagia, and fracture of the fifth and sixth cervical vertebrae and nasal bone. A review of Resident #3's Nursing Assessment, dated [DATE], revealed the resident had severely impaired cognitive skills for daily decision making. The assessment indicated the resident used a percutaneous endoscopic gastrostomy (PEG) feeding tube. The assessment indicated the resident had upper and lower extremity impairments on both sides. According to the assessment, Resident #3 had a sacral wound and was always incontinent of bowel and bladder. Review of Resident #'3s Baseline Care Plan, dated [DATE], revealed the resident's diet order was NPO (nothing by mouth), and the resident was to receive tube feedings for nutrition. The baseline care plan did not address hydration. A review of Resident #3's Nursing Home Instructions, within the hospital discharge summary dated [DATE], revealed Resident #3 was to receive 200 milliliters (mL) of water with each bolus tube feeding. A review of Resident #3's [DATE] physician orders indicated the resident was to receive enteral nutrition administered four times a day. There was no physician's order for the additional 200 mL of water, as recommended in the hospital discharge summary. A review of Resident #3's [DATE] Medication Administration Record (MAR) revealed there was no order for the 200 mL of water with each tube feeding bolus, four times a day, and there was no documented evidence indicating the water was provided. A review of Resident #3's Enteral Nutrition Assessment, dated [DATE], revealed the resident was receiving bolus enteral nutrition, four times per day, due to dysphagia. The assessment indicated Resident #3 was receiving 608 cubic centimeters (cc) of fluid per day and the resident's estimated fluid requirement was 1950 cc per day. In the assessment, RD #4 suggested staff change Resident #3's bolus enteral feeding to a continuous enteral feeding at a rate of 55 cc per hour with water auto flushes at 40 cc per hour to provide 1980 kilocalories (kcal) and 84 grams (g) of protein per day with 1963 cc of free water. RD #4 also suggested adding 1 ounce (oz) of liquid protein daily for an additional 15g of protein, a multivitamin (MVI) with minerals to help with wound healing, weekly weights for four weeks, and baseline laboratory tests including a comprehensive metabolic panel (CMP) and prealbumin (PAB). (continued on next page)

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #3's physician visit progress note, dated [DATE], revealed the physician recommended a complete blood count (CBC) laboratory test related to the resident's history of mild thrombocytosis (low blood platelet count) and leukocytosis (high white blood cell count). There was no concern related to Resident #3's hydration status indicated in the note and no recommendation related to the resident's hydration status. Review of the entire medical record, including progress notes from [DATE] through [DATE], indicated the facility did not implement the recommendations made by RD #4. A review of Resident #3's Nurses Notes, dated [DATE] at 8:05 PM, revealed staff found Resident #3 unresponsive. The nurse noted Resident #3 was lying on the resident's back with no noted rise or fall of the chest. Staff were unable to obtain any vital signs. The note indicated cardiopulmonary resuscitation (CPR) was initiated twice by staff members and 911 was called due to the resident's full code status. According to the note, first responders and an emergency ambulance arrived; however, the resident remained unresponsive to CPR or other stimuli. The coroner was contacted by the staff for pronouncement of death. A review of a Forensic Autopsy Report, dated [DATE], revealed Resident #3's final cause of death was dehydration. The report indicated, Analysis of vitreous fluid (liquid from the eyeball) reveals the following: sodium = 140 mmol/L [millimoles per litre], urea nitrogen = 87 mg/dl [milligrams per decilitre], creatinine = 2.5 mg/dl, and glucose = 14.0 mg/dl, consistent with dehydration. During an interview on [DATE] at 12:50 PM, Licensed Practical Nurse (LPN) #1 stated she cared for Resident #3 the day the resident died . She indicated Resident #3 was their usual self, lying in bed with their eyes open or closed, the resident did not speak or respond to stimuli, and required total assistance for all care. She said she administered medications for the resident through the gastrostomy tube around 5:00 PM or 5:30 PM and checked the gastrostomy tube for gastric residual volume. LPN #1 said she administered the medications and the resident's bolus feeding through the gastrostomy tube per gravity with no concerns. She noted that at 8:00 PM the certified nurse aide (CNA) reported to her that Resident #3 was not breathing. She and other staff started CPR and called 911. During an interview on [DATE] at 1:50 PM, CNA #7 stated she provided care for Resident #3 the day the resident died . She said Resident #3 required total assistance with all activities of daily living (ADLs). CNA #7 said she provided Resident #3 with incontinence care around 4:30 PM on [DATE]. She stated the resident's eyes were open, but did not respond when she explained what care she was going to provide, but that was not unusual. CNA #7 said that after she delivered room trays around 6:00 PM or 6:30 PM she was going to check on Resident #3, but bypassed Resident #3 because the nurse was in the room administering medications for the resident. She noted the next time she went to check on Resident #3 was at 8:00 PM. CNA #7 said at that time the resident felt cold and did not appear to be breathing, so she went to get the nurse and the nurse started CPR and called 911. (continued on next page)

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	425132	A. Building B. Wing	04/13/2023

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:15 PM, RD #4 stated she no longer worked for the facility. She said that when she made a recommendation, she would typically review it with the nurses because she was not allowed to write a physician's order. She said that while working for the facility in [DATE], she was not sure who she was supposed to notify in the facility of her recommendations because there was not a consistent unit manager or DON because of staff turnover. She stated she did not remember what recommendations were made for Resident #3 after she completed the resident's nutritional assessment on [DATE] or who in the facility she communicated with regarding her recommendations. She stated if she did not verbally communicate her recommendations, she would send the recommendations via fax or email. RD #4 could not provide written verification that she communicated her recommendations to the facility. During an interview on [DATE] at 4:58 PM, Resident #3's physician stated he no longer had any affiliation with the facility and had not worked for the facility since October of 2022. He said he no longer had access to Resident #3's information and could not answer any questions related to patient care. Three attempts to contact Resident #3's admitting registered nurse (RN) were made via telephone on [DATE] at 2:00 PM, on [DATE] at 3:44 PM, and on [DATE] at 7:24 PM. Messages were left each time, but the admitting RN did not return any of the calls. During an interview on [DATE] at 12:40 PM with the Administrator (ADM) and Director of Nursing (DON), they both stated they started working at the facility in [DATE]. The DON stated she was not aware of any care concerns related to Resident #3. The ADM said she became aware of concerns regarding Resident #3 after receiving multiple calls from Resident #3's family member but could not elaborate on the issues because she was not present when the resident was in the facility. The DON said that when a resident was admitted to the facility, the admitting nurse needed to verify the orders and have the physician review them. Then the unit manager or DON was responsible for entering the admission orders into the electronic record. She said the floor nurses completed the new admission assessment if she or the unit manager were not in the building. She said physician orders for the type of enteral formula needed to be in place. If there were concerns, then nursing staff contacted her directly. The DON said if a resident was receiving enteral nutrition, she would expect nursing staff to assess if the resident was tolerating the enteral feeding. The DON said she could not speak to what staff did regarding Resident #3's care in [DATE], because the DON and the ADM were not working at the facility at that time. The ADM and DON were notified of the determination of IJ on [DATE] at 2:12 PM. A Removal Plan was requested. During an interview on [DATE] at 10:00 AM, the Medical Director said he started working at the facility in mid-October of 2022. He noted he was physically in the building once a week, and attended quality assurance (QA) meetings, which were held monthly. He indicated staff had been responsive and had updated him with any concerns or issues. He stated someone from the facility made him aware of the concerns which led to the IJ. He said he did not know the whole situation, but the facility was addressing the issues and he agreed with the plan. Removal Plan: (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following IJ Removal Plan was provided by the facility and accepted by the State Survey Agency on [DATE] at 2:45 PM: Discharge orders from the hospital were not properly transcribed at the time of admission for Resident #3. This negatively impacted the resident by failing to provide appropriate nutrition and hydration to the resident. Inaccurate order entry of enteral feeding orders had the ability to affect all residents receiving enteral nutrition at that time. 1. The Administrator and Director of Nursing immediately on [DATE] educated licensed RNs and LPNs, in person and via telephone, on the process of new admission orders being transcribed into the electronic medical record at the time of or prior to admission for residents admitted from the hospital. Facility policy created and implemented for medication admission orders, licensed RNs and LPNs educated on this policy. Policy created [DATE], titled, 'Medication Admission Orders.' Policy intent: It is the policy of [name of facility] to provide the pharmacy with current, accurate resident information upon admission to ensure legal and safe medication and enteral nutrition dispensing. Please reference this policy on pg. 3. As of [DATE], 100% of RNs and LPNs have been informed that the Director of Nursing transcribes hospital orders for new admissions. Ten (10) licensed nursing staff were educated in person and nine (9) via telephone. The Director of Nursing will educate new RNs and LPNs hired after [DATE] at new hire orientation of new admission orders. If the Director of Nursing is not present, the Unit Manager completes this. This is for all weekday, weekend, and off-hours admissions. 2. Licensed RNs and LPNs educated immediately on [DATE], in person and via telephone, on the process of receiving and implementation of Registered Dietician (RD) recommendations for current and new admitting resident with enter feed orders. Nursing staff educated that physician is notified of RD recommendations from the DON or Unit Manager at the time of receiving the recommendation. The RD turns in recommendations directly at the end of her weekly visit or communicates them via telephone or email for any immediate concerns. As of [DATE], 100% of RNs and LPNs have been informed that the Director of Nursing or Unit Manager informs the physician of RD recommendations at the time of receipt, and recommendations are received on a weekly basis or as needed. A progress note is entered by the Director of Nursing that the MD has been notified and new recommendation has been implemented. Ten (10) licensed nursing staff were educated in person and nine (9) via telephone. The Director of Nursing will educate new RNs and LPNs hired after [DATE] at new hire orientation of new admission orders. Licensed RNs and LPNs educated that if an order looks incorrect or insufficient regarding nutrition and hydration of residents with g-tubes, to immediately notify the Director of Nursing for clarification. 3. Audit completed on [DATE] of six (6) residents receiving enteral feedings by RD to ensure all residents are receiving adequate and appropriate nutrition and hydration via enteral feeding. One recommendation was made and given directly to the DON, who notified the physician and put new orders in the electronic medication administration record (EMAR). The DON documented recommendation receipt in the progress notes. The remaining five residents were noted to have orders for adequate nutrition, hydration, and energy for enteral feeding of residents. 4. All enteral orders for nutrition and hydration are reviewed weekly at RISK meetings with interdisciplinary team. This meeting has been held weekly by the Administrator and Director of Nursing since [DATE]. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. New admission audits for residents on enteral feedings to be completed with 24 hours of admission by the Director of Nursing for three months to ensure orders are transcribed accurately. Audits to be turned in to the Administrator on a weekly basis, reviewed at weekly RISK meetings, and monthly Quality Assurance meetings. Quality Assurance team members include the Administrator, Director of Nursing, Infection Prevention, Business Office, Social Services, Marketing, Therapy, Activities, Maintenance, Dietary, Medical Records, MDS, Wound Nurse and Human Resources. The Medical Director and RD review meeting notes on their following visit. If negative findings or missing information is identified, the DON will correct at the time of discovery. If errors in admission orders audit are identified, QA team will discuss an extension of audits at month three completion. Twelve (12) Quality Assurance team members met at 4:40 PM on [DATE] to review Immediate Jeopardy concerns and action plan for removal of immediacy. Members present: Administrator, Social Services, Business Office, Director of Nursing, Human Resources, Medical Records, Wound Nurse, Therapy, Activities, Maintenance. Responsibilities of Administrator, Director of Nursing and Unit Manager for action plan audits were reviewed. QA team was educated that when an error or missing information is identified on admission orders or RD/Physician notification of recommendation, DON will rectify at time of discovery. 6. The Medical Director was informed of Immediate Jeopardy and concern areas on [DATE]. The Medical Director was informed of the action plan for removal and agrees with the resolution plan. 7. All corrections were completed on [DATE]. 8. The immediacy of the IJ was removed on [DATE]. Onsite verification of Removal Plan: The IJ was removed on [DATE] at 7:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began at 2:45 PM on [DATE], when staff were informed the Removal Plan was accepted by the State Survey Agency. Verification of licensed staff education was performed. A total of 10 of the 19 staff (three day shift nurses; three evening shift nurses; two night shift nurses; and two other staff, non-nursing) were interviewed in person and/or via telephone. All staff who were interviewed stated they received education regarding ensuring admission orders were transcribed accurately, RD recommendations were communicated to the DON and unit manager with follow-up with the physician for implementation, and order discrepancies were to be clarified with the DON and unit manager. A review was completed of the facility's Medication Admission Orders policy and verified the policy was created. A review was completed of the facility's audit of six residents receiving enteral feedings for accuracy of appropriate nutrition and hydration. It was verified that one recommendation was made and the DON notified the physician, put new orders into the EMAR, and documented in the progress notes. A review was completed of the facility's sign in sheet for the facility's RISK meetings. Monthly audits of new admission orders and RD recommendations remains ongoing. The Medical Director was interviewed and confirmed he was informed of the IJ.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48313 Based on record review, interviews, and facility policy review, it was determined that the facility failed to provide pharmaceutical services that assured the accurate administering of drugs to meet the needs of 1 (Resident #3) of 7 residents reviewed for medication administration. Specifically, the facility failed to ensure Resident #3 was administered routine medication at the correct time. Findings included: A review of the facility's policy titled, Medication Administration, undated, indicated, Staff will not administer medications except under the order of a physician. A review of the facility's policy titled, Medication Administration Times, dated [DATE], indicated, Staff will administer medications according to times administration as determined by the physician. Staff will begin medication administration within 60 minutes before the designated time of administration and will be completed with administration within 60 minutes after the designated times. A review of the facility's policy titled, Documentation, revised [DATE], indicated, The Resident clinical record is a concise account of the events of the Residents stay. The record reveals all necessary care, medical, physical, and social needs. Review of an Admission Record revealed the facility admitted Resident #3 on [DATE] with diagnoses that included traumatic subarachnoid hemorrhage (brain bleed), traumatic brain injury, acute respiratory failure, dysphagia, hyperglycemia, hypertension, and fracture of the fifth and sixth cervical vertebra and nasal bone. A review of Resident #3's Nursing Assessment, dated [DATE], revealed the resident was severely cognitively impaired and had a feeding tube. Review of Resident #3's Baseline Care Plan, dated [DATE], revealed the resident's diet order was nothing by mouth (NPO), and he/she was receiving tube feeding for nutrition. A review of Resident #3's [DATE] Medication Administration Record (MAR) revealed the following medications were scheduled to be given at 9:00 PM: - atorvastatin calcium (medication used to treat high cholesterol) tablet 80 milligrams (mg), give one tablet via gastrostomy tube (G-tube), - Bisacodyl suppository (medication used to treat constipation) 10 mg, insert one suppository rectally, - amantadine hydrocholoride (HCL) syrup (medication used to treat muscle hypertonicity) 50 mg/5 milliliter (ml), give 10 ml via G-tube two times a day (scheduled at 6:00 AM and 9:00 PM), and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- enoxaparin sodium (medication used to treat and prevent blood clots) 40 mg/0.4 ml, inject 40 mg subcutaneously two times a day (scheduled at 9:00 AM and 9:00 PM). The MAR indicated Licensed Practical Nurse (LPN) #1 administered the 9:00 PM doses of medication to Resident #3. A review of Resident #3's Progress Notes, dated [DATE] at 8:05 PM and written by LPN #1, revealed staff found Resident #3 unresponsive. The nurse noted the resident to be lying on their back with no noted rise or fall of the chest. Staff were unable to obtain any vital signs. Cardiopulmonary resuscitation (CPR) was initiated twice by staff members and 911 was called due to the resident's full code status. First responders and emergency ambulance arrived; however, the resident remained unresponsive to CPR or other stimuli. The coroner was contacted by the staff, and Resident #3 was pronounced dead. A review of Resident #3's Medication Admin [Administration] Audit Report revealed LPN #1 documented the above medications were administered at 10:26 PM on [DATE] (after the resident had expired). During an interview on [DATE] at 12:50 PM, LPN #1 stated she cared for Resident #3 the day the resident died and worked from 3:00 PM to 11:00 PM. She said she administered medication to the resident around 5:00 PM or 5:30 PM. She indicated the resident was lying in bed and was their usual self. LPN #1 stated the resident required total assistance with all care. She said Resident #3's medications were given through the G-tube at approximately 5:00 PM or 5:30 PM. She said the medications were administered with no problems. She said she gave the resident all the medications for the evening including his/her 9:00 PM medications at 5:00 or 5:30 PM. She confirmed she documented the progress note that was made on [DATE] at 8:05 PM. She stated she typically would give evening and bedtime medications together if she were delayed. She said on that day she had to pass medications to 44 residents, and it was very busy with a lot of things going on. LPN #1 would not elaborate on what was taking place that evening. During an interview on [DATE] at 10:15 AM, the Administrator (ADM) and Director of Nursing (DON) stated they were not aware Resident #3 received their 9:00 PM medications with the evening medication. They stated they expected staff to give medications at the correct time. The DON acknowledged giving doses of medication too closely together could cause potential problems.