STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41895 A. Based on closed record review, interview, and policy review, the provider failed to monitor and assess resident for frequency of bowel movements and constipation as well as identify and assess resident with significant weight loss for one of one sampled resident (2). Findings include: 1.Review of resident 2's closed medical record revealed: *He had originally been admitted on [DATE]. *His diagnoses included the following: unspecified ileus (inability of the intestine to contract normally and move waste out of the body), bowel obstruction, influenza A, history of malignant neoplasm of the large intestine, hypertension, and chronic obstructive pulmonary disease. *A [DATE] physician's progress note had report of constipation and to continue: -Bisacodyl suppository rectally daily as needed. -Milk of Magnesia 30 milliliters (ml) orally daily as needed. -Miralax 17 grams (gm) orally daily as needed. -Magnesium Oxide 400 milligrams (mg) orally twice a day. -Senna-S two tablets orally nightly. -Encourage adequate water intake. -Continue to monitor and adjust as needed. *From [DATE] through [DATE], he had only one large bowel movement (BM) in those seven days. *From [DATE] through [DATE], he received one dose of Milk of Magnesia 30 ml on the [DATE], the day he was admitted to the hospital. *From [DATE] through [DATE], there was no nursing documentation addressing his constipation or having a bowel assessment completed by nursing. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few	*From [DATE] through [DATE], he had been hospitalized for an ileus versus small bowel obstruction. *From [DATE] through [DATE], there was no BM recorded between [DATE] and [DATE] and only one medium BM in the eight days between [DATE] and [DATE]. *From [DATE] through [DATE], there was no nursing documentation addressing his constipation or having a bowel assessment competed by nursing. *On [DATE], he had been transferred to a hospital and had not returned to the facility. 2.Continued review of resident 2's medical record revealed: *A [DATE] physician's progress note reflected he had lost more than forty pounds since his [DATE] admission and had lost almost twenty pounds since [DATE]. -He had a poor appetite and complaints of nausea. -Labs had been ordered to evaluate his weight loss. -He was started on Mighty Shake supplement three times daily. -It's not clear whether his poor appetite and nausea is from the side effect of the sertraline or from the recent intestinal obstruction. *Recorded weights from [DATE] through [DATE] were: -On [DATE], his weight was 178 pounds. -On [DATE], his weight was 180 pounds. -No weights were documented for [DATE]. -On [DATE], his weight was 169 pounds. -On [DATE], his weight was 165.6 pounds. -On [DATE], his weight was 162 pounds. -On [DATE], his weight was 151 pounds. -From [DATE] through [DATE], he had a 15 percent weight loss. *Meal intake documentation from [DATE] through [DATE] and from [DATE] through [DATE] had not been documented for 104 of the 174 meals he should have been offered. *From [DATE] through [DATE], his weight loss had not been addressed in nursing documentation until [DATE] when the physician had assessed him, that was 67 days after the first noted weight loss. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-He was started on Mighty Shakes three times daily. *On [DATE] and [DATE], the registered dietician (RD) had evaluated him. -The [DATE] Dietary Evaluation reflected: --Resident 2 was on a regular National Dysphagia Diet (NDD) level 2 (foods that may be chopped or ground and were moist, soft-textured, and easier to swallow) and 4 oz Mighty Shake at each meal. --He had had an insidious weight loss due to decreased oral intake. --He was at risk of malnutrition. --Weight had been trending down over time, more recently with decreased appetite-stated food has been tasting the same, but just not feeling like eating. Added Mighty Shakes yesterday per his preference. Goals for wt [weight] in the ,d+[DATE]# [pound] range through next review. *His [DATE] care plan reflected: -He was at risk for altered bowel function. -He was at risk for alteration in nutritional status related to: Altered texture. I frequently refuse to follow the order. -He would have less episodes of constipation. -He would have been free of signs and symptoms of dehydration and malnutrition. -He would maintain his weight. Interventions included: --Monitor my bowel movements and document if I have not had a bowel movement in three days, or offer a laxative or stool softener as needed. ---I prefer to maintain a weight of ,d+[DATE] pounds. --Monitor for signs and symptoms of dehydration and weight loss. --Obtain weight as ordered. -His weight loss was not documented in his comprehensive individualized care plan. 3. Interview on [DATE] at 2:15 with dietary manager (DM) I regarding resident 2's weight loss revealed: *He ate most of his meals in his room. *She had noticed he was not eating as well because his food tray was coming back to the kitchen and the food had not been eaten. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*He did have snacks in his room, but she did not know if he was eating them. *He was on a Mighty Shake three times a day, but he was not drinking them. *The registered dietician (RD) came to the facility every Tuesday. *There was a nutrition risk meeting held every Tuesday when the RD was in the facility and residents' weights were reviewed at that time. *The RD and nursing were required to monitor resident's weights. *The RD was the one who completed all the dietary evaluations. Interview on [DATE] at 2:26 p.m. with registered nurse H regarding resident 2's constipation and weight loss revealed: *He had been able to inform staff if he had not had a bowel movement. *He had been able to inform the nurse when he had not had a bowel movement and ask the nurse for a laxative. *If a resident had not had a bowel movement for two days, then she would have administered a laxative. *The floor nurses would get a list of resident names from one of the nurse managers for the residents who had not had a bowel movement and needed to have been administered a laxative. *He had snacks in his room he could eat independently. *He was not compliant with his diet and had not liked staff to assist him. *He ate his meals in his room. *She was not sure how often he would have eaten snacks or accepted an alternate if he had not liked what was served at scheduled mealtimes. Interview on [DATE] at 3:25 p.m. with RD J regarding resident 2's weight loss revealed: *She came to the facility weekly on Tuesdays. *Since he had returned from the hospital on [DATE] she had been looking at resident 2's weights and intakes weekly. *Initially he had refused to try a dietary supplement and then in February 2023 he had agreed to try the Mighty Shakes three times a day with meals. *His intakes were 75 to 100 percent at meals times, when they were documented. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*She was responsible to complete all dietary assessments, the nutritional section of the Minimum Data Set assessment, update the resident care plans, reviewing residents' menus, educating staff, and reviewing all residents' nutritional status' in the facility. *Had not been aware his weight loss was not addressed in his comprehensive individualized care plan. *She organized and ran the monthly nutrition risk meetings where residents who were at risk or had a nutritional problem had been discussed by the interdisciplinary team. -Her Nutrition Risk meeting notes about resident 2 reflected: --On [DATE] his weights from [DATE] through [DATE]; he had been on Lasix 40 mg (a medication used to remove extra fluid from the body) daily; and his diet order with meal consumption of 75 to 100 percent. Then, --On [DATE], her notes only indicated his diet order was not entered into his electronic medical record. --On [DATE], her notes reflected his weight was 151 pounds and he had been down eleven pounds in one month, down sixteen pounds in three months, and down twenty-four pounds in six months. ---He was getting 4 ounces of Mighty Shake three times a day. ---He was on the NDD 2 diet. ---His meal intakes were at 75 percent. *She had not documented in the resident's medical record what was discussed at these meetings because she had not had the time. Continued interview on [DATE] at 8:29 a.m. with RD J regarding documentation of resident meal intakes revealed she: *Was aware meals had not been documented consistently. *Used what information was documented to complete her assessments. *Had informed administrator A and interim director of nursing (DON) B at the Nutrition Risk meetings about the missing documentation. Interview on [DATE] at 4:07 p.m. with administrator A, interim DON B, and DON C regarding resident 2's constipation and weight loss revealed: *Interim DON was training the current DON. *Resident 2 had been assessed on [DATE] by his physician and no changes had been made to his bowel regimen at that time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*The interdisciplinary team (IDT) had met each weekday morning and reviewed the dashboard on PointClickCare (the provider's electronic record keeping system). *The dashboard would have assisted the IDT by pulling information to show them which resident had not had a bowel movement in three days or if a resident had a weight loss. *They all had thought maybe the system was not working appropriately because resident 2 had only been on the list for not having a bowel movement on [DATE]. *Agreed he should have been offered a laxative on [DATE]. *They had expected the nurses to administer a laxative if the resident had not had a bowel movement in three days. *They all had not been aware meals were not being consistently documented. *Care plans were reviewed an updated when the MDS (Minimum Data Set) was completed. *His daughters had reported he might have had cancer but there was no documentation to support a cancer diagnosis. *Administrator B was aware RD J was not documenting in resident's medical records after Nutrition Risk meetings were held. *They all had agreed any member of the IDT could have documented in the resident's medical record what had been discussed in the Nutrition Risk meeting. 4. A policy had been requested from administrator A on [DATE] at 2:45 p.m. for a bowel policy or protocol. Interim DON B had brought in a printed page from a slide show used to educate staff after the provider's last survey in [DATE]. This printed page indicated: *Importance of Documentation of Bowel Movements -Identify Change of Conditions -Identify if resident is exhibiting signs and symptoms of dehydration or constipation *Bowel Movement Protocol -If a resident had not had a Bowel Movement in 72 hours Milk of Magnesium should be given and abdominal assessment should be completed for bowels sounds. -If not bowel movement after 24 hours of receiving Milk of Magnesium should be given a suppository. -If no bowel movement within 24 hours after suppository Primary Care Physician should be notified for further follow up. Review of the provider's [DATE] Weighing the Resident policy revealed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*The purpose of this procedure is to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident . *5. Report significant weight loss/weight gain to the nurse supervisor who will then report to the RD and physician. *7. The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria (where percentage of body weight loss = [equals] [usual weight - [minus] actual weight] / [divided by] [usual weight] x [times] 100): -1 month - 5% [percent] weight loss is significant, greater than 5% is severe. -3 months - 7.5% weight loss is significant, greater than 7.5% is severe. -6 months - 10% is significant, greater than 10% is severe. Review of the provider's [DATE] Care Planning policy revealed: *Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. *9. Care plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. B. Based on observation, interview, record review, and policy review, the provider failed to ensure timely physician notification after a fall, follow physical therapy recommendations for a restorative program, and ensure resident bathing was completed and documented for one of one sampled resident (1). Findings include: 1. Interview and observation on [DATE] at 2:58 p.m. with resident 1 and her daughter-in-law revealed: *Resident 1 had Steri-strips applied to the left side of her neck and a yellowish colored bruise extending from the left side of her forehead to below the outer area of her left eye. -There was what appeared to have been dried blood on her skin and the Steri-strips. *Her daughter-in-law stated she would be leaving soon and asked the surveyor to return to visit with resident 1 at that time. Observation and interview on [DATE] at 5:20 p.m. with resident 1 revealed she: *Got up from her bed and went into her bathroom without using her call light for assistance or her walker. *Was coming out of the bathroom, using a four-wheeled walker, and returned to her bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*Was admitted for skilled rehabilitation therapy after a stay in the hospital. *Had cancer and was planning on returning to her home. *Had fallen on the [DATE] while getting ready to attend her care conference. -Her injuries from the fall included: --Hitting her head on the floor causing a goose egg and bruise to her forehead, that was a greenish yellow in color and extended from the left side of her forehead to below the outer side of her left eye with a dark purple colored area about the size of a dime in the left outer corner of her eye. --A skin tear approximately three inches long to her right arm forearm that had been closed together with Steri-strips. There was dried blood on and around those Steri-strips. --A skin tear approximately one inch long near her jugular vein on the left side of her neck that had been closed together with Steri-strips. There was dried blood on and around the Steri-strips. --Bruising to her left clavicle in an area that was approximately three inches by five inches. --Bruising to her left hip that extended down her leg and she stated it was painful. --She indicated her four wheeled walker and wheelchair had been sitting close together and her foot got caught in the walker, and that had caused her to fall. --She stated she was bleeding all over and had to wait for a while as the nurse called the doctor because she hit her head. --She was sent to the emergency department (ED) at the hospital on that day for the injuries from her fall. Review of resident 1's medical record revealed: *She was admitted on [DATE] and her diagnoses included cancer of the pancreas and kidney, adult failure to thrive, depression, and repeated falls. *Her [DATE] Brief Interview of Mental Status (BIMS) score was a 15, meaning her cognition was intact. Review of resident 1's physician admitting medication orders revealed she had been on Apixaban (a blood thinner) and sertraline (an antidepressant). Review of resident 1's [DATE] comprehensive individualized care plan revealed: *She was at risk for falls related to her poor safety awareness, decline in functional status, and history of falls. *A [DATE] goal was to prevent further falls. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*She had poor insights to her deficits. *She used a walker as an assistive device during ambulation to prevent falls. *She was at risk for pain due to her cancer diagnosis. *Her discharge plan was to have completed rehabilitation and to have been discharged home. Review of resident 1's progress notes revealed: *On [DATE] she had a care conference scheduled. -She had fallen just prior to the care conference and was unable to attend. -Her son and daughter-in-law attended the conference. -Her discharge plan was to return home. --Her safety at home was a concern as she had multiple falls while in her home. Review of resident 1's fall records revealed: *She had numerous falls in her room prior to [DATE]. *She had fallen in her room on [DATE] at approximately 2:30 p.m. -The nurse on duty had faxed her physician on [DATE] at 2:35 p.m. and related she had a fall and had hit her head. --The nurse had not notified the physician on this fax that she was on a blood thinner. --The physician did not respond to this fax. -The nurse called another physician on [DATE] at 6:31 p.m. and received a physician's order for a non-emergent transfer to the hospital emergency department (ED) for treatment. --This was a three hour and 25-minute time span from when the fax had been sent to her physician and when the nurse called a different physician for an order to transfer to the ED. --Resident 1 left the facility at 7:10 p.m. for the ED and was seen there at 7:29 p.m. --The initial fax was responded to by that physician the next day, on [DATE] at 6:56 a.m. with an order to continue to monitor her. Interview on [DATE] at 9:00 a.m. with agency registered nurse K regarding resident falls revealed: *When a resident had a fall, she would assess them and if there was an obvious injury, she would have called the residents primary physician or the physician on call. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*A [DATE] intervention of Skilled Rehabilitation Therapy evaluation and treatment as indicated. -There was no documentation of a restorative nursing care program. *She was taking a psychoactive medication for her depression and to have been monitored for any ill effects related to the anti-depressant. *Her discharge plan was to have completed rehabilitation and to have been discharged home. Continued review of resident 1's progress notes revealed: *A [DATE] progress note from the certified nurse practitioner that indicated the following: -She had a [DATE] PHQ-9 Score (a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) of 11 (she had moderate depression). -She attributes worsening of her depression symptoms for not participating with PT (physical therapy) and OT (occupational therapy) at this time. -Increase restorative activities. -May increase her sertraline dose in the future if moving to a different hallway and increased restorative activities do not help in improving her mood. -Continue Sertraline 50 mg daily. -No dose reduction at this time as patient is dealing with major health issues and high PHQ-9 score. *On [DATE] she had a care conference scheduled. -She had fallen just prior to the care conference and was unable to attend. -Her son and daughter-in-law attended the conference. -She would be starting restorative nursing therapy as her skilled therapy had ended. -Her discharge plan was to return home. --Her safety at home was a concern as she had multiple falls while in her home. Interview on [DATE] at 10:35 a.m. with interim director of nursing (DON) B regarding restorative program for resident 1 revealed: *Resident 1's restorative program had not been added to her electronic medical record. *She indicated the restorative nursing aide might have been documenting the restorative care on paper form. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview and review of restorative medical records on [DATE] at 1:19 p.m. with restorative nursing aide F regarding resident restorative nursing care revealed: *She was the only restorative nursing aide employed at the facility. -She had one day off every two weeks. -She had 36 residents on her case load that day. -Her resident case load was assigned by the nursing department with recommendations from the skilled therapy department. *Resident 1's restorative nursing care started on [DATE], was to have been completed six times per week, and had included the following: --Walking 250 feet with stand by assist and a front wheeled walker. --Active range of motion with her upper extremities using dumbbells for 15 repetitions. --Upper extremity arm bike for 15 minutes. --Riding a NuStep bike for 15 minutes. ---Resident 1 liked to ride the NuStep bike. ---Resident 1 had not liked the other restorative programs and restorative nursing aide F had not been completing them with her. ---She would notify the nursing department if a resident had not liked to do a specific area of the restorative program. ---She had not notified anyone that resident 1 had not liked the other areas of her restorative program. *She documented resident 1's restorative nursing care on paper form. *She had received a [DATE] new nursing order transfer form from the nursing department for restorative nursing care that remained the same as the orders from [DATE]. Interview on [DATE] at 2:49 p.m. with physical therapist (PT) G regarding resident 1's therapy and restorative nursing care revealed: *Restorative nursing care was to assist residents in maintaining their current level of functioning. *When a resident was discharged from skilled nursing therapy, the therapist would develop a restorative program for the nursing department to implement for that resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Depending on the restorative program required, the program should have been started right away, within a couple of days, or a week. *Resident 1 had been discharged from skilled therapy on [DATE] as she had reached her highest level of functioning. -There had been a restorative nursing program written for her on [DATE]. --He would have expected her restorative nursing program to start within a week or 10 days after [DATE]. -Resident 1's restorative program started on [DATE] that was 11 days after PT G had written the restorative program. Interview on [DATE] at 11:16 a.m. with administrator A, interim DON B, and DON C regarding resident 1's restorative nursing care program revealed: *Administrator A's expectation was that: -Restorative nursing would have been set up within a week or two of a resident that was discharged from skilled therapy. -All areas of resident 1's restorative program should have been implemented. --If there had been any issues with resident 1's restorative program it should have been brought to someone's attention. -Interim DON B indicated when a physician order for restorative nursing was received, a nurse would enter the order in the computer, educate the restorative aide as to the order, and clarify the order if needed for frequency of visits or an increase of the restorative nursing care. -Both administrator A and interim DON B's expectations for resident 1's [DATE] physician ordered restorative nursing care should have been started on or about [DATE]. Review of the provider's [DATE], Restorative Nursing policy revealed: *Policy: -Generally restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech therapy. *Procedures: -3. Implementation of a Restorative nursing program may also occur following a course of physical, occupation or speech therapy. In these cases, the therapist will: provide resident specific training to the appropriate staff members; assist the Restorative team in establishing initial Restorative goals; and suggest interventions/approaches. (continued on next page)

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	435039	A. Building B. Wing	03/23/2023

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-8. Measurable objectives and interventions must be documented in the resident's care plan and medical record. -10. Restorative nursing staff will document the program performed on the Point of Care Kiosks/computers. -11. A physician's order is not needed for a Restorative Nursing Program. Review of the provider's revised [DATE] Following Physician Orders policy revealed: *Policy: -To correctly and safely receive and transcribe physician's orders so correct order is followed/administered. *Procedure: -1. All physician's orders will be received by a licensed nurse, therapist, or dietitian. -2. Orders may be received through written communication in the resident's chart, verbally, by Fax, electronically entered into PCC, or per the telephone. -6. If the order is for a medication or treatment, it should be entered in the MAR/TAR [medication administration record/treatment administration record]. 3. Interview on [DATE] at 9:50 a.m. with resident 1 revealed she: *Had not had a bath for about ,d+[DATE] weeks and would prefer a bath over a shower. *Had not liked to complain. Review of resident 1's documented bathing records from [DATE] through [DATE] revealed: *She had received a shower on [DATE], [DATE], [DATE], [DATE] and a bed bath on [DATE]. -The next documented bathing record was on [DATE]. -That was 20 days between receiving a bath or shower from [DATE] until [DATE]. Interview on [DATE] at 12:25 p.m. with interim DON B and administrator A regarding bathing of resident 1 revealed: *They thought she had received one the week before [DATE] but could not find any documentation to support that. *They were not aware that her preference would have been for a bath rather than a shower. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*They had started asking what preferences residents had upon their admission, they were unsure of the date of when that had started. -Resident 1 had no bathing preferences identified on her admission. Interview on [DATE] at 10:35 a.m. with director of nursing (DON) C and administrator A regarding bathing for resident 1 revealed: *Bathing documentation was completed in each resident's electronic medical record. *They had identified an issue with the bathing documentation not being completed. *Agreed there was no bathing documentation to support resident 1 had received a bath for 20 days. *When a resident refused a bath, it would have been documented. -There was no documentation to support resident 1 had refused a bath. Review of the provider's [DATE] Bathing policy revealed: *POLICY -The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The resident has the right to choose timing and frequency of bathing activity. Bathing preferences are asked upon admission and during quarterly care conference. C. Based on closed record review, interview, and policy review, the provider failed to ensure timely family/representative notification when resident had a change in condition for one of one resident (3). Findings include: 1. Closed record review for resident 3 revealed: *He had died in the facility on [DATE]. *On [DATE] he had become lethargic with complaints of not feeling well and hurting all over. *On [DATE] he was seen by his physician and a chest x-ray was ordered and completed. *On [DATE] he was started on Augmentin for right upper and left lower lobe infiltrates (pneumonia). *On [DATE] he became short of breath and his oxygen saturation was seventy-seven percent on room air (normal oxygen saturation is ninety-five to one hundred percent). *The physician had assessed him and wrote new orders to discontinue Augmentin, start Doxycycline, resume Duonebs, discontinue Tramadol, start Rocephin intravenously (IV) daily, and draw labs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*On [DATE] at 4:00 a.m. he was found in his bed with no vital signs present. *There was no documentation his family or representative had been notified of his change of condition until after his death. Interview on [DATE] at 2:44 p.m. with RN H regarding resident 3's change of condition revealed: *She had been working on [DATE] when his physician came to assess him. *She was not the nurse in charge of his care on [DATE] but had assisted with getting the IV started and mixed the Rocephin for administration. *She had not known if any of the nursing staff had attempted to contact his family when residents' condition changed. *It was an expectation nursing staff contact a resident's family or representative when a resident had a change of condition. *Resident 3 had a daughter who came to the facility after his death. Interview on [DATE] at 9:30 a.m. with Interim DON B regarding resident 3's change of condition revealed: *She was unsure if any of the nursing staff had attempted to contact resident 3's family or representative when he had a change of condition. *She expected nursing staff to document in the resident's medical record when they contacted residents' family or representatives. *After he died the facility initially could not get a hold of his representative because there had not been a working phone number in his medical record. *His daughter was contacted by social service director D on the morning of [DATE] via social media and was asked to call the facility. *The daughter then called the facility and was informed of his death. Review of the provider's [DATE] Notification of Change of Condition policy revealed: *The facility will provide care to residents and provide notification of resident change in status. *1. The facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: -b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) . 43844

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41895 Based on observation, interview, record review, and policy review the provider fail to ensure nursing staff were competent and had sufficient training for: *Monitoring and assessing one of one sampled resident (2) for frequency of bowel movements and constipation. *Assessing one of one sampled resident (2) with significant weight loss. *Timely notification of a physician for one of one sampled resident (1) after a fall resulting in significant injury and requiring transportation to an emergency department. *Initiating a restorative nursing program timely for one of one sampled resident (1). *Timely notification of family/representative for one of one sampled resident (3) with a significant change of condition. Findings include: 1. Review of resident 2's closed medical record revealed: *On [DATE] he had reported complaints of constipation to his physician. *From [DATE] through [DATE] he had only one large bowel movement in those seven days. *There had been no nursing documentation addressing his constipation or having a bowel assessment completed by nursing. *From [DATE] through [DATE], he had been hospitalized for an ileus versus small bowel obstruction. Refer to F684, finding A1. 2. Review of resident 2's closed medical record revealed: *A [DATE] physician's progress note reflected he had lost more than forty pounds since his [DATE] admission and had lost almost twenty pounds since [DATE]. *Meal intake documentation from [DATE] through [DATE] and from [DATE] through [DATE] had not been documented for 104 of the 174 meals he should have been offered. *From [DATE] through [DATE], his weight loss had not been addressed in nursing documentation until [DATE] when the physician had assessed him, that was 67 days after the first noted weight loss. *On [DATE] and [DATE], the registered dietician (RD) had evaluated him. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Refer to F684, finding A2. 43844 3. Review of resident 1's fall records revealed: *She had fallen in her room on [DATE] at approximately 2:30 p.m. *The nurse on duty had faxed her physician on [DATE] at 2:35 p.m. and related she had a fall and had hit her head. *The nurse had not notified the physician on this fax that she was on a blood thinner. -The physician did not respond to this fax. *The nurse called another physician on [DATE] at 6:31 p.m. and then received a physician's order for a non-emergent transfer to the hospital emergency department (ED) for treatment. -This was a three hour and 25-minute time span from when the fax had been sent to her physician and when the nurse called a different physician for an order to transfer to the ED. Refer to F684, finding B1. 4. Review of resident 1's medical records revealed the following: *Her [DATE] comprehensive individualized care plan included: -A [DATE] intervention of Skilled Rehabilitation Therapy evaluation and treatment as indicated. -There was no documentation of a restorative nursing care program. *A [DATE] progress note from the certified nurse practitioner that included, Increase restorative activities. *On [DATE] she had a care conference note that included she would be starting restorative nursing therapy as her skilled therapy had ended. Interview and review of restorative medical records on [DATE] at 1:19 p.m. with restorative nursing aide F regarding resident restorative nursing care revealed her restorative nursing care started on [DATE]. Refer to F684, finding B2. 5. Review of resident 3's closed medical record revealed: *He had died in the facility on [DATE]. *On [DATE] he had become lethargic with complaints of not feeling well and hurting all over. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	*On [DATE] he was seen by his physician and a chest x-ray was ordered and completed. *On [DATE] he was started on Augmentin for right upper and left lower lobe infiltrates (pneumonia). *On [DATE] he became short of breath and his oxygen saturation was seventy-seven percent on room air (normal oxygen saturation is ninety-five to one hundred percent). *The physician had assessed him and wrote new orders to discontinue Augmentin, start Doxycycline, resume Duonebs, discontinue Tramadol, start Rocephin intravenously (IV) daily, and draw labs. *There was no documentation his family or representative had been notified of his change of condition until after his death. Refer to F684, finding C1.

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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** 41895 Based on record review, interview, and policy review, the provider failed to ensure an effective system for monitoring and accounting for disposition of medications upon resident death (3) and/or resident transfer (2). Findings include: 1. Review of resident 3's closed medical record revealed: *He had died on [DATE]. *A quantity for ten medications on two forms titled Medication Disposition, those medications were: -Escitalopram 20 mg (milligram), quantity left was 30. -Amox/Clav ,d+[DATE] mg tablets, quantity left was 16 tablets. -Doxycycline hyclate 50 mg, quantity left was 30. -Gabapentin 600 mg, quantity left was 30. -Gabapentin 600 mg, quantity left was 29. -Iprat/albut 0XXX,d+[DATE] mg 3 ml (milliliters), quantity left was 90 ml. -Ceftriazone 1 G (gram)/NS (normal saline) 100 ml, quantity left was 4. -Levothyroxine 150 mcg (microgram) tablets, quantity left was 23 tablets. -Omeprazole 20 mg capsules, quantity left was 24. -The form had not been filled out completely and had not indicated the disposition of those medications. -The form had no date or staff signature. 2. Review of resident 2's closed medical record revealed: *He was transferred to the hospital on [DATE] and had not returned to the facility. *A quantity for four medications on a form titled Medication Disposition, those medications were: -Sertraline 50 mg tablets, quantity left was 27 tablets. -Losartan 50 mg tablets, quantity left was 8 tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unidentified medication listed by prescription number, quantity left was 1. -Hydrocortisone 2.5 % (percent) cream, quantity left was 30 gm (gram). -The form had not been filled out completely and had not indicated the disposition of those medications. -The form had no date or staff signature. 3. Interview on [DATE] at 1:47 p.m. with interim director of nursing (DON) B and DON A revealed: *When a resident had been discharged or died the medication aide was to remove the medications from the cart and complete the Medication Disposition form. *The nurse would remove the any controlled medications and puts them in a lock box in the medication room to be destroyed by DON B and ADON A. *The medications were then to have been placed into a bin in the medication room with a copy of the Medication Disposition form to have been returned to the pharmacy for destruction. *The pharmacy would have only documented the destruction of those medications if the facility had sent the Medication Disposition Form with the medications. *The Medication Disposition forms should have been filled out completely to indicate where those medications went and who had completed the form. 4. Review of the provider's undated Continued Care LTC [long-term care] Pharmacy Medication Returns policy revealed the medications should have been put into a box for return with a filled out manifest.