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	205095	A. BUILDING _____ B. WING _____	10/19/2023

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KENNEBUNK CENTER FOR HEALTH & REHABILITATION, LLC	158 ROSS RD KENNEBUNK, ME 04043

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F 000	INITIAL COMMENTS From 10/16/2023 through 10/19/2023, on-site visits were conducted at Kennebunk Center for Health and Rehabilitation for the purpose of conducting the annual Long Term Care Survey Process and investigating complaints #ME00039521, #ME00040282, #ME00040607, #ME00040733, #ME00040751, #ME00040906, #ME00041498, #ME00041844, #ME00042338, #ME00042519, #ME00042657, #ME00043155, #ME00043595, #ME00045008, and #ME00045131. It was determined that Kennebunk Center for Health and Rehabilitation was not in substantial compliance wtih 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		

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

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F 582	Continued From page 1 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on closed record review and interview, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (Form CMS -10055) (SNFABN) were provided to 1 out of 2 residents reviewed whose Medicare Part A services were discontinued. (Resident	F 582		

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F 582	Continued From page 2 #267) Finding: On 10/19/23 at 10:45 a.m. a surveyor reviewed Resident #267's medical record. Resident #267 received Medicare Part A services that ended on 6/16/23. The Medical record lacked evidence that the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) was provided to the resident so that he/she could make an informed decision to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. On 10/19/23 at 11:15 a.m. a surveyor met with the Business Office Manager and confirmed this notice was not issued prior to the end of Medicare Part A services.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		

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F 584	Continued From page 3 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition, on 2 of 4 units (Sagamore and Regina) for 1 of 1 environmental tour. Findings: 1. Regina wing - Room 15 - resident by the door, arm of wheel chair is cracked with open areas creating an uncleanable surface. 2. Sagamore wing - Room 3, the wall to the left	F 584		

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F 584	Continued From page 4 of the door upon entry has deep gouges in wall door frame. 3. Sagamore wing - Room 9 - wall between dresser and bathroom has gouges in the lower portion of the wall. 4. Sagamore wing - Room 9's bathroom - Ceiling vent full of dust and cobwebs. On 10/19/23, at 2:20 p.m.. the above finding was confirmed with the Administrator.	F 584		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to	F 626		

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F 626	Continued From page 5 discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on closed record reviews and interviews, the facility failed to permit a resident's return to facility for 1 out of 1 resident reviewed for facility-initiated discharge to the hospital (Resident #270). Findings: On 5/16/23 at 9:16 a.m., Division of Licensing and Certification received a complaint indicating on 5/15/23 the facility transferred a resident to the hospital and failed to accept return of the resident. On 10/17/23 at 9:30 a.m., a closed record review of Resident #270's showed Resident #270 was admitted to the facility on 4/15/23 with a complicated medical history. The hospital discharge summary included follow up appointments scheduled for 5/2/23 and 5/3/23 involving out of state providers. Resident #270 was transferred on 4/15/23 to the facility by ambulance "due to their inability to tolerate sitting upright for the duration of the ride".	F 626		

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F 626	Continued From page 6	F 626		

On 10/17/23 at 11:00 a.m., in an interview with the Admission Coordinator, stated that transportation was a known problem prior to admitting Resident #270. The facility reports they were told it was no longer possible to transfer resident's out of state. It was reported that the facility expected resident's family would provide transportation to medical appointments.

On 10/18/23 at 2:15 p.m., during review of the facility Admission Packet that is provided to all admissions, it states on the first page "Except in emergency, the facility will arrange for the transfer of the resident to a hospital or other health care facility when any such transfer is ordered by the attending physician or a substitute physician as specified in Section I, Paragraph 1 of this agreement."

On 10/18/23 at 3:45 p.m., during review of the provider notes, dated 5/2/23, it was stated the facility was unable to provide transportation to the follow up appointments on 5/2/23 and 5/3/23 and those appointments were missed.

On 10/18/23 at 4:00 p.m., during review of the provider notes dated 5/15/23, it was stated Resident #270 was transferred to the hospital on 5/15/23 for further evaluation and stated "The transfer or discharge is necessary to meet the resident's welfare or medical needs and the resident's welfare or medical needs cannot be met in the facility". This form remains unsigned by the resident. Unable to locate confirmation the resident received it.

On 10/18/23 at 4:30 p.m., in an interview with the Director of Nursing, stated Resident #270 never should have been admitted due to the complexity

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F 626	Continued From page 7 of the out of state medical care along with the known transportation issues that the facility has, that left them unable to meet resident's medical needs.	F 626		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise a care plan to reflect the current	F 657		

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F 657	Continued From page 8	F 657		

needs for 3 of 27 residents reviewed in the areas of transmission-based precautions and respiratory care (#51, #173, #176); and failed to revise the care plan after each assessment for 1 out of 3 sampled residents (#39) receiving in-house therapy services.

Findings:

1. On 10/16/23 at 11:16 a.m., a surveyor observed a personal protective equipment (PPE) station with signage advising of the need for transmission-based precautions (TBP) outside of Resident #51's room. A review of Resident #51's clinical record revealed a history and physical, dated 6/25/23, which noted the diagnosis of Vancomycin Resistant Enterococcus (VRE) in the resident's urine. A review of Resident #51's care plan noted the last revision was completed on 9/2/23 and did not include the need to use TBP when providing care for the resident.

On 10/18/23 at 12:15 p.m., in an interview with a surveyor, the Director of Nursing confirmed that Resident #51 required TBP and was not included on the care plan.

2. On 10/16/23 at 3:04 p.m., a surveyor observed Resident #173 was using oxygen. A review of the clinical record noted a diagnosis of Chronic Obstructive Pulmonary Disease and a physician's order, dated 10/4/23, which stated "O2 (oxygen) via nasal cannula, titrate to keep O2 saturations greater than 90% every shift. A review of Resident #173's care plan, dated 9/28/23, did not include the resident's need for oxygen.

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F 657	Continued From page 9	F 657		

On 10/18/23 at 10:15 a.m., in an interview with a surveyor, the Director of Nursing confirmed that the care plan did not include Resident #173's oxygen therapy.

3. On 10/19/23 at 10:00 a.m., a surveyor observed a PPE station with signage advising of the need for TBP outside of Resident #176's room. A review of Resident #176's clinical record revealed the results of a urine culture, dated 10/16/23, were VRE. A review of Resident #176's care plan, last revised on 10/10/23, had not been updated to include the need for TBP when providing care.

On 10/19/23 at 12:38 p.m., in an interview with a surveyor, the Director of Nursing confirmed that Resident #176 required TBP and was not included on the care plan.

4. On 10/17/23 at 8:34 a.m. in an interview with Resident #39, discovered they had fallen during a transfer and had broken both legs. Record review of Resident #39 progress notes in the Electronic Medical Record (EMR) found the fall occurred on 7/9/23.

5. On 10/17/23 at 9:04 a.m. this surveyor reviewed Resident #39's care plan that was active on 7/9/23 and found "Transfer extensive assist with stand lift, (a partial mechanical lift), from bed to wheelchair. Use Hoyer (a total mechanical lift) if unsafe to use stand lift."

6. On 10/17/23 at 2:18 p.m. this surveyor met with the Director of Nursing about the incident and confirmed a stand lift was not used during the transfer on 7/9/23 but therapy had cleared resident to transfer with 2 people assisting for

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F 657	Continued From page 10 quite a while at that point. 7. On 10/17/23 at 4:00 p.m. this surveyor reviewed the original Rehab Department Recommendations form for Resident #39 to Nursing dated 3/7/23 that stated, Extensive Assist with 2 staff. Minimum assist from wheelchair. Limited assist from bed. Stand lift was no longer checked. 8. On 10/18/23 at 10:35 a.m. this surveyor reviewed provider note located in Resident #39's EMR dated 3/21/23 that documented resident "able to transfer with minimal assistance/contact guard" Another Provider note dated 4/11/23 documented "transfers improved today. PT attributes inconsistent transfers likely to post dialysis weakness." 9. On 10/18/23 at 10:45 a.m. this surveyor reviewed the care plan, including revisions since 3/7/23, and failed to locate any changes in transfer orders for Resident #39 making it unclear to staff on 7/9/23, if resident transfers should continue to utilize a stand lift or take post-dialysis weakness into consideration and use a Hoyer lift. Met with Regina Unit Manager and they were also unable to locate documentation that the care plan had been updated following the physical therapy assessment and recommendation on 3/7/23 or after. On 10/18/23 at 1:43 p.m. this surveyor met with the Director of Nursing and confirmed that the care plan had not been updated to reflect the changed recommendation from Therapy on or after 3/7/23.	F 657		
F 660 SS=E	Discharge Planning Process	F 660		

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F 660	Continued From page 11 CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning	F 660		

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F 660	Continued From page 12 to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to develop and	F 660		

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implement a safe discharge plan that focused on a resident's discharge goals, preparation, and effective transition of care for 5 out of 6 sampled residents discharged from the facility. (#25, #168, #268, #269 and #271)

Findings:

1. On 10/16/23 at 9:30 a.m. a surveyor reviewed closed records for Resident #171 in response to a complaint received at the Department of Licensing and Certification on 8/3/22. Review found Resident #271 was admitted on 7/14/22 and discharged to home on 7/30/22. Discharge orders included orders for home health services. The medical record lacked evidence that home health services was located. Resident #271 was readmitted to acute care on 8/1/22 with sepsis.

2. On 10/16/23 at 9:50 a.m., a surveyor reviewed closed records for Resident #269 in response to a complaint received at the Department of Licensing Certification on 10/18/22. Review found Resident #269 was admitted on 9/16/22 and discharged to home on 10/3/22. Discharge orders included an order for home health services. The medical record lacked evidence that home health services were confirmed.

Resident #259 medical record stated that on 10/2/22, Resident #269 refused to leave the facility when transportation arrived. Provider Note, dated 10/3/22, states "Patient anxious about d/c (discharge) and unsure how (they) will do at home." And "Pt (Patient) will need extensive help at home".

Resident #269 was readmitted to acute care

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F 660	Continued From page 14 10/3/22 following a fall at home. 3. On 10/16/23 at 10:12 a.m., a surveyor reviewed closed records for Resident #268 in response to a complaint received at the Department of Licensing and Certification on 1/12/23. Review found Resident #268 was admitted to facility on 12/15/22. Provider notes from the Emergency Department (ED) on 12/28/22 showed Resident #268 had a new vertebral compression fracture with increased pain limiting mobility. The facility failed to reevaluate the discharge plan following this new diagnosis and change in Resident #268's condition as requested by the family. The family initiated a discharge to the ED on 1/8/23 rather than follow the facility planned discharge to home. 4. On 10/16/23 at 11:30 a.m., a surveyor observed Resident #168 sitting on the edge of the bed in Room 107. The residents had their belongings in a plastic bag and was wearing slipper socks and no shoes. In an interview, the resident stated that insurance ran out on Sunday (10/15/23) and they were ready to go home today. An Uber had been arranged for resident. The resident was observed being discharged into the rain with no shoes. When a surveyor brought this to the attention of the Administrator, a pair of slippers was provided to the resident. A surveyor observed the LPN reading the discharge plan to resident at the inside front entrance of facility as resident was leaving. After completion of discharge teaching, this surveyor asked the resident for confirmation that they understood what medications were ordered or what they needed to do once they got home. Resident	F 660		

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stated no at which point the LPN lifted the rolling walker seat and reminded resident the list of medications was there and to call when they got home if they needed any new prescriptions. Spoke with facility Social Services following this discharge and Social Services confirmed home health services had been verified for this resident and Adult Protective Services would be notified because they did not consider this a safe discharge.

5. A surveyor observed notice that Resident #25 was listed on the dry erase board as a planned discharge to home on 10/18/23 with a neighbor providing transportation. On 10/18/23 at 10:55 a.m., a surveyor interviewed Resident #25 who stated that therapy thought they should stay but insurance said they were ready to go home. Resident #25 confirmed they live alone but have a neighbor who helps. Review of Resident #25's hospital discharge paperwork indicated that prior to admission at the facility, an assessment at the hospital found Resident #25 "deemed unsafe to return home."

On 10/18/23 at 11:23 a.m., a surveyor interviewed Social Services and confirmed that home health services were verified for Resident #25. When asked about the hospital documentation indicating it was unsafe for this resident to return home, I was told that Adult Protective Services would be notified.

On 10/19/23 9:00 a.m., in an interview with the Director of Nursing regarding the discharges reviewed in response to complaints and the three discharges observed during survey; confirmed the facility was unable to provide documentation that these residents had a safe discharge.

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow doctor's orders and their own Weight Policy & Procedure to document weights for 4 out of 4 residents (#6, #13, #26 and #53) with daily or weekly weight orders. Findings: 1. On 10/19/23 at 11:00 a.m.. a surveyor reviewed Resident #6 physician orders located in the Electronic Medical Record (EMR) and found an order dated 4/15/23 to obtain "Daily Weights for a diagnosis of Congestive Heart Failure (CHF)." Daily weights were not recorded for sampled months of 9/23 and 10/23. No documentation found with an explanation for the missing weights. 2. On 10/19/23 at 11:30 am.. a surveyor reviewed Resident #13 physician orders located in the EMR and found an order dated 4/19/23 "one-time weekly weight, do every Monday for CHF." Weights were not recorded weekly for the months of 5/23, 6/23, 7/23 and 8/23. No documentation found with an explanation for the missing weights.	F 684		

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3. On 10/19/23 at 11:40 a.m., a surveyor reviewed Resident #53 orders located in the EMR and found an order dated 6/22/23 for weekly weights. Weekly weights were not done for sampled months of 8/23, 9/23 and 10/23. No documentation found with an explanation for the missing weights.

4. On 10/19/23 at 11:49 a.m., a surveyor reviewed Resident #26 care plan located in the EMR, dated 8/25/23 said to" obtain weights per facility protocol."

Review of facility "Weight Policy & Procedure" issued 06/2008 and revised 1/2023, states in Procedure #2. "After initial weight, new admissions will be weighed weekly for the first 4 weeks". Procedure #5 "Significant weight changes will have verification of weight for accuracy and documentation purposes."

Review of Resident #26 documented weights in the EMR are:
8/16/23 - 95 pounds (Discharge Weight from York Hospital)
8/24/23 - 111.6 pounds (Admission weight at facility)
9/18/23-87.6 pounds
9/20/23-89.6 pounds
10/3/23-93.2 pounds

No documentation found that showed the facility verified the admission weight when it was 16.6 pounds different from the discharge weight. No documentation that facility documented weekly weights for the first 4 weeks. No documentation in resident's EMR with an explanation for refusals.

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F 684	Continued From page 18 On 10/19/23 at 12:14 p.m., in an interview with RN#1, surveyor and RN#1 were unable to locate ordered weights for Resident #6, #13 and #26. RN #1 stated that a CNA comes in at 6:00 a.m. to get the days weights and the nurse let's them know who needs a weight if it's not a normal monthly weight. They showed me the location of the monthly weight binder at the nurse's station. On 10/19/23 at 1:00 p.m., in an interview with RN #2, stated the weights can be entered by the CNA or the nurse. On 10/19/23 at 1:10 p.m., in an interview with Nurse Practioner #1 (NP#1) stated when asked that they sometimes must find the nurse to learn a resident's weight for daily or weekly weights. On 10/19/23 at 1:15 p.m., in an interview with Certified Nurse Aide (CNA #1) stated that CNAs get the weights, usually on night shift, and give them to the nurse who usually enters the weight into the EMR. On 10/19/23 at 2:14 p.m., in an interview with Director of Nursing stated she was surprised there was an issue with the weights. The faciliyt spoke with the CNA that comes in early to do weights and learned they did not know the CNA should document the weight beyond giving it to the nurse.	F 684		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		

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care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to provide respiratory services as directed by physician orders related to oxygen use and monitoring for 2 of 2 residents reviewed for oxygen therapy (#51, #173).

Findings:

1. On 10/16/23 at 11:16 a.m., a surveyor observed an oxygen concentrator set at 3 liters/minute in use next to Resident #51's bed. A review of the clinical record revealed a physician's order, dated 9/22/23, which stated "Oxygen 2-5 liters per minute via nasal cannula as needed for shortness of breath. Indicate O2 (oxygen) saturation." A review of Resident #51's medication and treatment administration records found no documentation of when oxygen was in use or what the saturation levels were.

2. On 10/16/23 at 3:04 p.m., a surveyor observed an oxygen concentrator set at 1 liter/minute and in use next to Resident #173's bed. A review of the clinical record revealed a physician's order, dated 10/4/23, which stated "Oxygen via nasal cannula, titrate to keep O2 saturation greater than 90% every shift." A review of Resident #173's medication and treatment administration records found no documentation of when oxygen was in use, what the saturation levels were, or when oxygen tubing was to be changed.

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F 695	Continued From page 20 On 10/18/23 at 10:15 a.m., in an interview with a surveyor, the Director of Nursing confirmed the findings.	F 695		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide food that accommodated resident preferences for 2 out of 3 residents (#3 and #13) sampled about the food choices available. Findings: On 10/17/23 at 11:30 a.m., in an interview with Resident #13, stated he/she has repeatedly asked for ice cream as a snack and hamburgers as a meal alternative and has not received them. Resident #13 stated their goal is to gain weight because they have lost a lot of weight and that is why they are at the facility. Resident #13 would like more sugar snacks like ice cream and cookies, but they never get them. Dessert is frequently fruit cocktail. On 10/17/23 at 12:00 p.m., a surveyor observed	F 806		

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Resident #13 ask the Regina Unit Helper for some ice cream. This surveyor walked with the Regina Unit Helper to get some ice cream and met the Head Chef in the hallway. The Regina Unit Helper asked for ice cream for Resident #13 and was told ice cream is no longer stocked and they would have to go buy some at the store. At this time, a surveyor asked the Head Chef if a resident would be able to order a hamburger as a meal replacement. They stated yes, but not right away and it would be after meal service was finished.

On 10/17/23 at 12:30 pm, in an interview with Resident #3 about the food and snacks they enjoy. Resident #3 stated ice cream and cakes. Resident #3 stated she did not enjoy the food at this facility. Resident #3 was unaware that ice cream was no longer available from the facility but stated they weren't surprised. At this time, a surveyor observed Resident #3 send her lunch back and ask for one of her soup cups to be warmed up instead.

On 10/19/23 at 10:00 a.m., during an interview with Activity Director stated that residents complain about the snacks available. Oreos were given as an example of a snack that was no longer purchased but residents enjoy. The activities department purchases snacks for residents when they can and tries to offer beverages on the hydration cart that are not usually available. They stated food is very important to these residents and they try to offer activities around making and eating food. They were unaware that ice cream was no longer stocked for residents.

On 10/19/23 at 10:14 a.m., a surveyor observed

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F 806	Continued From page 22 the resident freezer at the central nurse's station and found 9 personal tubs of ice cream that were labeled with residents name but no facility provided ice cream for resident's who do not have anyone to bring them outside food. On 10/19/23 at 2:45 p.m., in an interview with the Administrator about observations of a resident not being able to procure ice cream for a snack, the Administrator agreed this was a reasonable snack and they do provide ice cream but was unable to explain why the Head Chef stated there was no ice cream anymore, why no one went to buy the resident ice cream, or why they were not offered an alternative snack. The Administrator then stated they were trying to minimize the snacks so residents would eat their meals which would be a healthier option. The quality of the snacks and food in general has been a known issue and the facility meets with residents about the food and snacks available.	F 806		