North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1075	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1810	33-07-03.2-18,1 PHARMACEUTICAL SERVICES The facility shall obtain the services of a licensed pharmacist who shall develop policies and procedures for the provision of pharmaceutical services within the facility consistent with chapter 61-03-02, state laws, and federal laws. These policies and procedures must be approved by medical staff or medical director and governing body and must include provisions for: This State Licensing Rule is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow regulations outlined in Chapter 61-03-02 Consulting Pharmacist Regulations for Long-Term Care Facilities for 1 of 1 Emergency Medication Kit (E-Kit). Failure to remove expired medications may result in residents receiving ineffective medication in an emergency. Findings include: Review of the facility policy titled "Acquisition of Medications Emergency Drug Box" occurred on 11/08/23. This policy, dated 10/11/23, stated, ". . . Responsibilities: *The Pharmacy is responsible for maintaining the emergency drug box and replacing it as needed. *A list of all equipment and rugs (sic) with expiration dates is listed on the emergency drug box. Procedure: 1. The charge nurse or a designee checks the expiration	L1810	1. No residents were effected by the deficient practice. 2. All residents who need to have a medication that is ordered after pharmacy hours, that can be taken out of the Emergency Medication Kit (E-Kit) have the potential to be affected. 3. A new Pharmacy Services Policy was developed and implemented on 11/10/23 after collaboration with the Consulting Pharmacist. A New Emergency Medication Kit (E-Kit) Policy, Responsibilities, and Procedure was developed and implemented on 11/10/23 after collaboration with the Consulting Pharmacist. A Nursing and a separate All Staff In-Service is scheduled for 12/12/23 to review new policy and procedures,	12/13/23

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/23

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L1810	Continued From page 1 date and seal on the box on each shift. . . ." Observation of the E-Kit occurred on 11/08/23 at 8:20 a.m. with a nurse (#7). The list of medications located on the locked kit identified medications with an expiration date of 8/23. The nurse (#7) indicated the night staff are to check the E-Kit for expiration dates. When opened, the E-Kit contained the following expired medications: Six tablets of Doxycycline 100 mg (milligrams), expired 08/31/23. Six tablets of Prednisone 10 mg, expired 09/30/23. During an interview on 11/08/23 at 8:42 a.m., an administrative nurse (#5) confirmed the E-Kit contained expired medications and stated she had requested pharmacy check it two months ago.	L1810	F-tags received and plan of correction that is being implemented. 4. An E-Kit Medication list and expiration dates made for quality assurance checks. A QA audit will be completed by the DON to check that nursing is checking expiration dates on E-Kit medications and are getting replaced weekly for a month, then monthly for three months, then quarterly for a year, with reports being brought to the QAPI meetings quarterly for review by the QA Committee. The Consulting Pharmacist will continue his monthly checks of the E-Kit medication Expiration dates.	

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started 11/06/23 and concluded 11/08/23.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		12/19/23

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F 655	Continued From page 1 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement a baseline care plan within 48 hours of admission for 1 of 1 new admission (Resident #130). Failure to develop and implement a baseline care plan in a timely manner may result in care that is inconsistent with residents' needs. Findings include: Review of the facility policy titled "Care Plan Policy and Procedure" occurred on 11/08/23. This policy, dated 01/01/23, stated, ". . . A baseline care plan will be started within 48 hours of a resident's admission. . . . The care plan team includes but is not limited to these departments: 1. Activities 2. Dietary 3. Social Services Designee 4. Nursing/MDS [Minimum Data Set] Coo [coordinator] 5. C.N.A. [certified nurse aide/Restorative Aide . . ." Review of Resident #130's medical record occurred on all days of survey and identified an admission date of 10/19/23. Diagnoses included hypertension, Alzheimer's disease, and unspecified urinary incontinence. The resident's	F 655	F655 - 483.21(a)(1)-(3)Baseline Care Plan 1. For Resident #130 a baseline careplan was not able to be developed as it was after 48 hours time when MDS Nurse worked, but a comprehensive careplan was implemented. The staff was educated on needs of resident from Assisted Living Facility staff and Family the day that he was admitted. This information was put onto the care cards for the CNA's the day of admission 10/19/2023. 2. All residents who are admitted to Four Seasons Healthcare Center have the potential for care that is inconsistent with the resident's needs if a baseline care plan is not implemented within 48 hours of admission. 3. A new policy for Baseline Care Plans was developed with the policy explanation and compliance guidelines required by CMS and implemented on 11/13/2023. A	

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F 655	Continued From page 2 initial care plan included a dietary care plan but lacked information related to other care areas necessary to ensure proper care and meet the resident's needs. During an interview on the morning of 11/08/23, an MDS nurse (#1) confirmed staff failed to develop a baseline care plan within 48 hours of Resident #130's admission.	F 655	paper copy of a Baseline Care Plan will be available at the Nurses station for admitting nurses to implement if MDS nurse or Director of Nursing is not present at time of admission. 4. a. The MDS nurse and Director of Nursing will be responsible for ensuring the Baseline Care Plan is initiated. b. The Baseline Care Plan Summary is reviewed with the resident and/or family and signed, copy given to them and one for their charts. c. A Baseline Care Plan Tracking Log will be completed each Month for new admissions for a year by the MDS Nurse. The results of the tracking log will be brought to the QAPI Meetings quarterly by the MDS nurse to review for the QAPI Committee. d. A Nurse/CMA/CNA meeting is scheduled for 12/12/2023 to review the new Baseline Care Plan Policy, new Baseline paper care plan, Baseline care plan summary, and getting information to staff to use for care of new residents.	
F 657 SS=D	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.	F 657		12/13/23

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F 657	Continued From page 3 (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 observation, record review, review of facility policy, and resident and staff interview, the facility failed to review and revise care plans to reflect residents' current status for 3 of 13 sampled residents (Resident #12, #14, and #15). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plan" occurred on 11/08/23. This policy, dated 06/20/18, stated, ". . . It is the policy of this facility that an individualized activity care plan be developed and maintained for each resident . . . This plan contains activities that the resident	F 657	1. Resident #12 was interviewed by the Activities coordinator to find out what individualized activities were important to her so they could be added to her care plan. The new assessment on individualized activities specific to her interests and designed to meet the needs and enhance the well-being of resident #12 who does not like to leave her room for group activities very often will be updated annually or more often if a change in condition occurs. Resident #15s' care plan was updated by the MDS nurse to show the problems, goals, and interventions related to the use of the pommel cushion and padded heel	

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F 657	Continued From page 4 enjoys . . . activity plans are reviewed and/or revised as necessary but at least quarterly. . . ." - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included dementia and psychotic disorder. The current care plan stated, " . . . I enjoy watching TV (television), enjoy my phone, like to read some. Church is important to me. I like to watch the news. . . ." The comprehensive Minimum Data Set, dated 01/31/23, identified keeping up on the news and having magazines, books and newspapers available to her as being very important. During an interview on 11/06/23 at 1:17 p.m. Resident #12 was lying in bed and stated, ". . . I wish they had more things to do, they have no crafts and I like puzzles, reading the newspaper, magazines or books and playing cards too . . ." Resident #12's care plan lacked individualized activities specific to her interests and designed to meet her needs and enhance her well-being. -Review of Resident #14's medical record occurred on all days of survey. Diagnoses included a history of prostate cancer and a urostomy (an artificial passage that directs urine away from the bladder). During an interview on 11/07/23 at 8:40 a.m., a certified nurse aide (CNA) (#2) stated Resident #14 has a urostomy with a drainage bag. The CNA stated the resident can empty the bag himself but sometimes asks for help. Observation on the morning of 11/08/23 showed	F 657	rings implemented by nursing as preventative measures. Resident #14s' care plan was updated by the MDS nurse to show the problems, goals, and interventions related to the urostomy present on admission. 2. All residents' who live at Four Seasons Healthcare Center are at risk to have decreased continuity of care due to failure to communicate the updates or revisions on a care plan limiting staff's ability to care for all residents. 3. A new Comprehensive Care Plan policy with Explanation and Compliance Guidelines was developed and implemented on 11/10/23 by the DON and IDT with education being given to all Nursing staff on 12/12/23. A new communication form is being developed for Nursing staff to fill out prior to the MDS/Care conferences/ or with any new interventions that work or don't work to be put on the care plan by the MDS nurse when started or discontinued by nursing staff. All Nursing staff will be in-serviced on 12/12/23 on specifics of Policy, Procedures, Guidelines, Forms that are implemented or being implemented. All other staff will be in-serviced also on 12/12/23 on State Survey Tags with plan of correction that was written. 4. A QA audit will be completed by the	

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F 657	Continued From page 5 a urostomy to the lower left side of Resident #14's abdomen. Resident #14's current care plan lacked problems, goals, and interventions related to the urostomy. - Review of Resident #15's medical record occurred on all days of survey. Observations throughout the survey showed a pommel cushion (a padded cushion used to help with positioning) in Resident #15's wheelchair, and when in bed, the CNAs applied padded heel rings To Resident #15's legs. During an interview on the morning of 11/07/23, a CNA (#2) stated the heel rings helped to keep Resident #15's heels elevated and off the mattress. Resident #15's current care plan lacked problems, goals, and interventions related to the pommel cushion and padded heel rings.	F 657	MDS Nurse to check 5 care plans weekly until all current residents care plans show individualized specific interest, goals, and interventions. Then audits will go to 5 residents checked monthly every three months, then 5 residents quarterly thereafter for a total of one year. New residents who are admitted will be added into the rotation after their comprehensive care plan is initiated. The results will be brought the the quarterly QAPI meetings to be discussed by the MDS nurse.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and staff interview, the facility failed to follow professional standards of practice for 1 of 1 insulin administration observed during medication	F 658	1. Nurse #6 was observed to prime an insulin pen pointed sideways, rather than pointed up, before administering the insulin to a resident.	12/13/23

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F 658	Continued From page 6 administration. Failure to properly prepare an insulin pen may result in a resident receiving an inaccurate dose of insulin. Findings include: Review of the policy "Insulin Pen" occurred on 11/07/23. This policy, dated 10/31/23, stated ". . . h. Prime the insulin pen: i Dial 2 units by turning the dose selector clockwise. ii With needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. . . ." Observation on 11/07/23 at 12:01 p.m. showed the nurse (#6) primed an insulin pen pointed sideways, rather than pointed up, before administering the insulin to a resident. During an interview on 11/08/23 at 8:04 a.m., an administrative staff member (#5) stated confirmed the nurse failed to prime the pen correctly when told of the insulin observed primed sideways.	F 658	2. All resident who receive insulin in the facility have the potential to be at risk of receiving an inaccurate dose of insulin if the insulin pen is not primed according to the policy and procedure/ manufacturers instructions. 3. The current Insulin Pen Policy and Procedure was reviewed by the DON on 11/10/23 with no changes made, it is current with manufacturers recommendations. All Nursing staff in-service will be held on 12/12/23 to review the policy and procedure on Insulin Pen use. All Staff in-service 12/12/23 to review State Survey results and corrections being made on F-Tags. 4. A QA Assessment was developed by the DON on Insulin Pen procedure and all nursing staff will be required to be watched and checked off that they are able to complete per policy/procedure. A QA audit will be completed by the DON/Nurse Designee weekly on all nurses until all current nursing staff are observed. Then monthly 5 nurses monthly for 3 months, then 5 nurses quarterly, with results reported during the QAPI meetings held quarterly by the DON. New nursing Staff will be educated on the Insulin Pen Policy and Procedure on orientation with QA Assessment done and placed in their file.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		12/13/23

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F 679	Continued From page 7 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff and resident interview, the facility failed to provide individualized, meaningful activities for 1 of 13 sampled residents (Resident #12) dependent on staff for activity participation. Failure to implement an individualized activity program to meet the interests/needs of dependent residents may have a negative effect on their overall well-being. Findings include: Review of the facility policy titled, "Activity Program" occurred on 11/08/23. This policy, dated June 2018, stated, ". . . It is the policy of this facility that an ongoing program of activities to designed to meet the needs of each resident. . . . 1) This facility's activity program is designed to meet the interests and the physical, mental and psychosocial well-being of each resident. . . ." During an interview on 11/06/23 at 1:17 p.m. Resident #12 was in her room alone, in bed and stated, ". . . I wish they had more things to do, they have no crafts and I like puzzles, reading	F 679	1. Resident #12s' will have an activities assessment completed by the Activities Coordinator to ensure that her specific individualized interests/needs are met acccording to her choice of activities to support her physical, mental, and psychological well-being as she is dependent on staff and prefers to stay in her room most days. 2. All residents who are admitted or live in the facility that don't have the ability to attend activities on their own without help from staff have the potential to be affected. 3. The current Activity Program Policy and how activities are being charted is being reviewed for updates to meet the current nursing home standards for resident activity requirements. If updates are needed the policy and charting forms will be updated prior to the all staff meeting on 12/12/23 where the Policy and Charting will be reviewed with staff	

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F 679	Continued From page 8 the newspaper, magazines or books and playing cards too . . ." Review of Resident # 12's medical record occurred on all days of survey. The current care plan stated, " . . . I enjoy watching TV (television), enjoy my phone, like to read some. Church is important to me. I like to watch the news. . . ." The comprehensive Minimum Data Set, dated 01/31/23, identified keeping up on the news and having magazines, books and newspapers available to her as being very important. During an interview on 11/07/23 at 9:35 a.m. a certified nurse aide (#3) stated, Resident #12 does not get out of bed very often and is in her room alone the majority of the time. The Activity Participation Logs identified the following: * September 1-30, 2023 - 15 days with no activities. * October 1-31st, 2023 - 29 days with no activities. The activity log failed to include activities important to Resident #12. Observations on all days of survey showed Resident #12 in bed, alone in her room, including for meals. Observation showed no newspapers, magazines or books in the resident's room. During an interview on 11/08/23 at 10:02 a.m., Resident #12 was in her room alone, in bed, and stated, "I love reading the newspaper. The [area newspaper] was my priority. Before I sat down to breakfast I always read it. I'm missing out on so much that's going on and I also don't get to see	F 679	by DON and Activities Coordinator. 4. A QA form is being developed to check that all residents activity needs are being met, charting of one-to-one visits is individualized to the resident activity interests, and the they are completed per current activity care plan by the Administrative Assistant (CMA, CNA), with results being reported at the quarterly QAPI meetings. The QA form will be completed weekly on 5 residents until all residents are audited, then will go to 5 residents monthly for three months, then 5 residents quarterly and on new residents after the comprehensive care plan is established.	

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F 679	Continued From page 9 the obituaries. I also like to read the [local county newspaper]." The resident indicated the facility received the [area newspaper], however she had to go to up front to read the newspaper, stated, "That's a lot of hassle for the staff." When asked if staff provided 1:1 visits with her in her room, Resident #12 stated, "No, they don't have time for that. I wish they had more time to just even visit with me." During an interview on 11/08/23 at 10:40 a.m. an Activity staff member (#5) confirmed the facility received the two specific newspapers the resident liked to read and agreed the facility failed to provide individualized activities for Resident #12.	F 679		
F 684 SS=D	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 review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide care and services to maintain the resident's highest level of well-being for 1 of 1 sampled resident (Resident #14) with a transfer to the emergency room (ER) for a change in health status. Failure to monitor and assess the resident's condition on	F 684	1. For Resident #14 who now has a new diagnosis of CHF, No longer a diagnosis of Lung Cancer, but also came back on oral antibiotics for Pneumonia. The resident's charting is to reflect if he has any new changes in status, including abnormal vital signs, weights, lung sounds, refusal of	12/13/23

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F 684	Continued From page 10 an on-going basis may have resulted in worsening respiratory symptoms and a delay in treatment. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 517, stated, ". . . Pulse . . . As age increases, the average pulse rate gradually decreases . . . Older Adult . . . Pulse Average (and Ranges) . . . 70 (60-100) . . ." Page 532 stated, ". . . Blood Pressure . . . The American College of Cardiology and the American Heart Association (Cifu & Davis, 2017) define normal blood pressure as systolic less than 120 mmHg [millileters of mercury] and diastolic less than 80 mmHg . . . Above those values, intervention is recommended. . . ." Page 538 stated, ". . . Normal oxygen saturation is 95% to 100% . . ." Review of the facility policy titled "Notification of Changes Policy" occurred on 11/08/23. This policy, dated 04/10/23, stated, ". . . The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: . . . Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health . . . Circumstances that require a need to alter treatment. . . ." Review of the facility policy titled "Vital Signs and Weights" occurred on 11/08/23. This policy, dated 05/22/23, stated, ". . . Nurses entering vital	F 684	medications/treatments. Then updates to the Providers and family on changes in condition should be made and documented. 2. All residents who are admitted or live in this facility who have a change in condition should have the potential to be affected by not providing the care and services to maintain the resident's highest level of well-being. 3. A new policy with explanation and compliance guidelines for vital signs, along with a new policy with compliance guidelines for weight monitoring with collaboration with the Dietician will be implemented on 12/12/23. The Notification of Changes Policy was reviewed by the DON 11/10/23. Education on all these policies will be given the Nursing and All Staff in separate staff meeting on 12/12/23 by the DON. General Chart Documentation Guidelines information will be provided to staff who completed any charting on residents. Education on Pneumonia, Handouts on Charting presented by Cyndi Syders, Vaaler Insurance. Communication using Nursing Huddle Forms to be filled out when there is a change in conditions, Nurse Communication book use and New Form implementation for follow up on faxes, changes in condition, labs will be reviewed 12/12/23 by DON to Nursing staff also. Nurses will be doing PRN and Scheduled Nebulizer Treatments to complete assessments prior to treatment	

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F 684	Continued From page 11 signs and wights [sic] are responsible for comparing the current to the previous vital signs and weights and taking appropriate action when variances are noted . . . Charge nurses are to notify dietary manager and DON [director of nursing] of any weight changes of 5% in 30 days or 10% in 180 days . . . Update MD [medical doctor] for any areas of concerns relating to weight gain/loss PRN [as needed] . . . Nursing judgment must be used when resident health status changes. These residents will have vital signs/weights done more frequently as warranted by nursing policies, nursing judgments, and MD orders. . . ." Review of Resident #14's medical record occurred on all days of survey. Diagnoses included a history of lung cancer and pneumonia. Resident #14's medical record identified the following weight gain: 09/05/23 133.0 pounds (Lbs) 09/12/23 137.5 Lbs 09/19/23 143.0 Lbs 09/26/23 148.5 Lbs 10/04/23 151.5 Lbs (13% weight gain in 30 days) 10/10/23 155.5 Lbs (13% weight gain in 30 days) 10/17/23 158.5 Lbs (10% weight gain in 30 days) 10/23/23 164.5 Lbs (10% weight gain in 30 days) 10/27/23 170.0 Lbs *The record lacked evidence facility staff notified the physician of the resident's weight gain Resident #14's physician's orders included: Check Full set of Vitals every shift while awake for Edema, Abnormal lung sounds (start date 10/25/23). *10/25/23: Evening shift BP 178/80, Pulse 114,	F 684	and after the treatments to ensure effectiveness and need to update providers. All PRN Medication follow up needs to be completed by nurses, education will be given on this also. 4. DON will develop and complete a QA audit on change in condition, abnormal vital signs, and abnormal weights, if provider and family was notified of change. This will be done weekly on 5 residents for four weeks, then monthly on 10 residents for three months, then quarterly on 15 residents for a year and reported on quarterly at the QAPI meetings by the DON.	

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oxygen (O2) saturations (sats) 90%. The record failed to identify vital signs obtained on the night shift of 10/25/23
*10/26/23: Day Shift BP 155/102, Pulse 115, O2 sats 95%; Evening Shift BP 146/88, Pulse 74, O2 sats 91%; Night Shift BP 168/83, Pulse 100, O2 sats 99%
*10/27/23: Day Shift BP 160/106, Pulse 118, O2 sats 91%; Evening Shift BP: 170/100, Pulse 116, O2 sats 91%

Resident #14's nurses' notes and medication administration record (MAR) identified the following:
*10/18/23 at 3:45 p.m.: ". . . [physician] here to see resident for recertification of nursing homecare. . . . Lungs, heart, bilateral lower extremities assessed with wheezing noted in lungs and 2-3 plus edema in BLE [bilateral lower extremities]. Resident did voice that he felt like he had a cold coming on. . . . Start PRN DuoNeb [bronchodilators that relax muscles in the airways and increase air flow to the lungs] treatments for wheezing/SOB [shortness of breath], monitor oxygen saturations when SOB. . . ."
*10/20/23 at 4:41 a.m. PRN nebulizer administered for "complaints of tight chest and phlegm, audible wheeze"
*10/23/23 at 1:33 a.m.: ". . . Apply Oxygen at 2 liters per nasal cannula or mask as needed for oxygen saturations below 90%. Notify MD per request for SOB. O2 is at 93% RA [room air]. Resident requested O2 for one hour. He is now back on RA . . ."
*10/23/23 at 6:49 a.m. PRN nebulizer administered, no rationale documented
*10/24/23 at 6:28 a.m. and 2:26 p.m., PRN nebulizers administered, no rationale

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documented with either administration
*10/25/23 at 5:59 a.m. PRN nebulizer administered for "complained of shortness of breath. Oxygen level 80%. Nebulizer given and O2 2L nasal canula [sic] applied." The medical record lacked evidence of physician notification at this time.
*10/25/23 at 8:46 a.m.: ". . . Resident complain of shortness of breath, a 2 L [liters] of oxygen and a nebulizer was administered. The resident pull [sic] out the nebulizer and the oxygen tubing indicating they are not helping him breath [sic]. His 02 [oxygen] reading was 88. The head of his bed was elevated and he later put back his oxygen tubing. Crackles was [sic] noted while he breath [sic] in and out. He is being monitor [sic]. . . ."
*10/25/23 at 13:15 p.m.: ". . . Resident was assess [sic] and I notice [sic] a [sic] increase in his weight, and also discover [sic] a 1-2+ edema. He is still complaining of shortness of breath. A 2L of oxygen has been administered. . . ."
*10/25/23 at 3:20 p.m.: ". . . [physician] called back to be updated on resident after message left by nursing. . . . Resident has increased complaints of shortness of breath and not feeling quite right. Resident refuses to leave oxygen on or to finish a prn nebulizer treatment. . . . Day shift nurse assessed resident and reported the following abnormal lung sounds throughout all fields, bilateral lower extremity pitting edema of 2-3 plus, shortness of breath, weight is up significantly in the last 2 days. Reccomendations [sic]: New orders received to start Lasix [a diuretic] 40 mg [milligrams] orally daily, K+ [potassium] 20 meq [milliequivalent] orally daily, Daily weights in am [morning], monitor blood pressures and oxygen saturations every shift

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while awake. . . . TED hose to bilateral lower extremities for edema. . . ." The record identified the TED hose were unavailable from 10/25/23 until the resident's hospital transfer on 10/27/23. The record also identified staff failed to obtain a daily weight on 10/26/23, and the most recent weight at this time was obtained on 10/23/23.
*10/25/23 at 4:14 p.m.: ". . . Resident notified of new orders from [physician] to help with his shortness of breath, bilateral pitting edema in lower extremities, and weight gain. Resident is not really happy about having to make [sic] more medications, but if it makes him feel better, he will try it. Resident encouraged to elevate his feet in between meals to help reduce edema. Resident voiced understanding, but then will in another sentence say he isn't going to lay down today as it is hard to breath. Residents head of his bed is elevated to assist to breathe easier, oxygen is available, but is not wanting to use it. . . ."
*10/25/23 at 4:28 p.m.: ". . . Resident removed oxygen at 1450 [2:50 p.m.]. This writer went to check on the status of interventions per PCP [primary care provider]. At 1455 [2:55 p.m.] this writer went back to see the resident to let the resident know PCP was aware and would be giving new orders. This writer encouraged the resident to put oxygen back on, resident stated "That thing doesn't work" referring to the oxygen concentrator. Oxygen is able to be felt through nasal cannula by this writer. Resident also states "That damn thing gets turned off and on all day and it doesn't work either". Encouraged resident to elevate legs instead of sitting at the edge of bed with legs hanging down. Resident refused at this time to elevate legs. . . ."
*10/25/23 at 8:26 p.m.: ". . . Resident is now in

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bed and legs are elevated. . . . Denies SOB. 1st dose of lasix was administered this evening. Residents cough is wet, productive. . . ."
*10/26/23 at 6:27 a.m. PRN nebulizer administered, no rationale documented
*10/26/23 at 5:12 p.m. PRN nebulizer administered for "Resident SOB"
*The medical record lacked evidence staff obtained a weight, monitored/assessed the resident's respiratory status and edema, or updated the physician regarding the resident's abnormal vital signs on 10/26/23.
*10/27/23 at 1:17 p.m. PRN nebulizer administered, no rationale documented
*10/27/23 at 1:52 p.m.: ". . . Resident using accessory muscles and having SOB. Crackles to upper lobes bilateral. Lower lobes diminished, poor air exchange. Resident did allow neb [nebulizer] treatment at 1330 [1:30 p.m.], resident reports ineffective. Resident did allow oxygen to be placed via nasal cannula at 3-4lpm. Oxygen 87% RA. Oxygen after O2 90%. Elevated BP [blood pressure] 160/106. Elevated pulse 118. PCP notified at this time. Will await interventions. Resident is resting well in bed. Legs elevated. . . ."
*10/27/23 at 2:40 p.m.: ". . . [physician's assistant] called back on fax received from day shift charge nurse. . . . Weight increase from BLE edema, chest congestion, SOB, wheezing, oxygen use at 2L/NC [nasal cannula]. Resident had nebulizer treatment, Lasix, and potassium added to his daily medications this week by [physician] . . . Resident assessed with audible expiratory wheezes noted upper lobes, use of accessory muscles with breathing, oxygen per nasal canula at 2L/NC. Pulse and blood pressure elevated as he is talking about needing to get

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home but is slid down in bed with chin tucked against his chest. Repositioned and started to breathe easier. . . . New orders receive [sic] to give him an extra dose of Lasix 40 mg orally today at 4pm. . . . If resident does not improve with extra Lasix, use of oxygen, PRN nebulizer treatments nurse may send him to the ER for evaluation anytime this weekend. . . ."
*10/27/23 at 3:36 p.m.: ". . . residents sister called saying the resident does not sound ok. She wondered whether he has a pneumonia. Resident experiencing SOB. Lasix increased. Will continue to monitor. On O2 2L . . ." The record lacked evidence of updates to/communication with Resident #14's family prior to this note.
*10/27/23 at 7:18 p.m.: ". . . 1915 [7:15 p.m.]: Resident sent to the ER by Ambulance for SOB. Pitting edema. Resident did not respond to Lasix 40 mg one time order. He continued to decline. . . ."
The resident was hospitalized from 10/27/23 to 11/02/23. He returned with orders for Cefdinir (an antibiotic) for diagnosis of pneumonia and Lasix for a diagnosis of congestive heart failure.

The MAR failed to identify when staff administered oxygen except one occasion on 10/23/23, although nurse's notes after that date referenced the use of oxygen by staff.

During an interview on the morning of 11/08/23, an administrative nurse (#5) confirmed Resident #14's medical record lacked evidence of ongoing assessment/monitoring by staff related to his change/decline in respiratory status.