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F 000	INITIAL COMMENTS A complaint investigation was conducted on 4/29/24-5/1/24. Event ID# VTBE11. The following intakes were investigated NC00211835, NC00213230, NC00216005, NC0215879, NC00215513, NC00216216 , NC00214006, NC00214229, NC00215926, NC00215656, NC00212243, NC00212033 , NC00212230.. 3 of 51 the complaint allegation did result in a deficiency. 48 of 51 the complaint allegations did not result in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff and Registered Dietitian (RD) interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to indicate a resident's weight was not obtained during the previous 30-day period for 1 of 2 residents (Resident #6) reviewed who experienced a significant weight loss. The findings included: Resident #6 was admitted to the facility on 12/10/20. His cumulative diagnoses included lymphedema (swelling due to build-up of lymph fluid in the body), chronic non-pressure ulcers of the leg, depression, and a history of hypotension (low blood pressure).	F 641	Resident #6 has been discharged from the facility. Modifications of quarterly assessments for resident #6 with assessment reference dates of 3/6/24 and 3/18/24 were completed and transmitted on 5/3/24 by MDS nurse. All residents have the potential to be affected by this deficient practice. 5/7/24 the MDS nurses initiated a 100% audit of section K for all residents most recent MDS assessment to ensure accuracy of coding of residents weight. A	5/22/24

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

Electronically Signed | 05/26/2024

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F 641	Continued From page 1 Review of the resident's electronic medical record (EMR) revealed he weighed 179.7 pounds (#) on 1/5/24. There was no documented evidence that the facility obtained Resident #6's weight between 1/5/24 and 3/18/24. Resident #6's quarterly MDS assessment dated 3/18/24 reported the resident weighed 180 #. The weight used for this MDS was based on the resident's last recorded weight dated 1/5/24. His 1/5/24 weight was obtained 73 days prior to the MDS's Assessment Reference Date (ARD). An interview was conducted on 5/1/24 at 9:45 AM with the facility's Certified Dietary Manager (CDM). During the interview, the CDM confirmed he completed the Nutrition Section of Resident #6's quarterly MDS dated 3/18/24. The CDM reported he used Resident #6's 1/5/24 weight to complete the 3/18/24 MDS because it was his most recent weight. The CDM further explained, "We usually use the last available weight." A telephone interview was conducted with the facility's consultant Registered Dietitian (RD) on 5/1/24 at 9:58 AM. During the interview, the RD was asked what weight should be reported in the Nutrition Section of a resident's MDS assessment. The RD stated the Resident Assessment Instrument (instructions for completing an MDS assessment) indicated the weight reported on an MDS should be the most recent measure obtained in the last 30 days. An interview was conducted on 5/1/24 at 10:55 AM with the facility's two MDS Coordinators (MDS	F 641	modification of previous assessment was completed on or before 5/20/24 by MDS nurses for all residents noted with incorrect weight coding. 5/1/24 the Regional Director of Clinical Reimbursement completed education for MDS nurses and Assistant dietary manager related to completion of section K per RAI and CMS guidelines to include accurate coding of K0200B weight within last 30 days, K0300 weight loss and K0310 weight gain. This education will be provided by the Regional Director of Clinical Reimbursement during orientation for any newly hired MDS nurse, dietary manager or assistant manager. 5/2/24 the Registered Dietitian completed education to Assistant Dietary Manager and Dietary Manager related to completion of section K to include reviewing the procedure for completion of height, weight, weight losses and gains, including checking of date weight was entered and calculating based on closest weight to 30 and 180 days. MDS schedule to be reviewed weekly by MDS nurse to determine if weights are documented within 30 days of assessment reference date for residents with assessments scheduled. Contact Certified Nursing Assistant, Director of Nursing or Quality Assurance Nurse to obtain weight if there is not one recorded in the past 30 days. The MDS nurse will audit section K to	

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F 641	Continued From page 2 Nurse #1 and MDS Nurse #2) and the Regional Director of Clinical Reimbursement. During the interview, the Regional Director of Clinical Reimbursement reviewed Resident #6's quarterly MDS dated 3/18/24. When asked, the Regional Director of Clinical Reimbursement reported the facility would typically use "the most recent weight closest to 30 days" of the MDS's Assessment Reference Date. She confirmed the weight used to complete the Nutrition Section of Resident #6's 3/18/24 MDS was based on his 1/5/24 weight. An interview was conducted on 5/1/24 at 11:18 AM with the facility's Regional Director of Operations. During the interview, concern was shared with her regarding the use of a 1/5/24 weight to complete the Nutrition Section of Resident #6's quarterly MDS dated 3/18/24. The Regional Director of Operations stated it was preferable to obtain a more recent weight for a resident within 30 days of the MDS date, if possible. If that was not possible, a dash (-) should have been placed in the blank intended for a weight obtained within 30 days of the MDS assessment.	F 641	include validation of resident's weight entry for accuracy before closing of assessment. Audit will be completed by MDS nurse five times a week for four weeks, then three times per week for two months to ensure accuracy of coding for section K of MDS. The Administrator and/or Director of Nursing will review the MDS audits monthly for three months to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or Director of Nursing will review the plan during the monthly Quality Assurance and Performance Improvement meeting and the audits will continue at the discretion of the Quality Assurance and Performance Improvement Committee. Indicate dates when corrective action will be completed: May 22, 2024	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		5/22/24

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F 692	Continued From page 3 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff, Registered Dietitian (RD), and Nurse Practitioner (NP) interviews and facility and hospital record reviews, the facility failed to obtain and monitor a resident's monthly weight in February 2024 to identify when a resident's weight loss began and allow for the early assessment and initiation of nutritional interventions. This occurred for 1 of 2 residents (Resident #6) reviewed with a significant weight loss. The findings included: Resident #6 was admitted to the facility on 12/10/20. His cumulative diagnoses included lymphedema (swelling due to build-up of lymph fluid in the body), chronic non-pressure ulcers of the leg, depression, and a history of hypotension (low blood pressure). The resident's current plan of care included the following areas of focus, in part: --Resident #6 was at a nutritional risk related to his history of marginal intake with a potential for weight loss, elevated BMI, diagnoses, and increased nutritional needs for wound healing	F 692	Resident #6 has been discharged from the facility. All residents have the potential to be affected. All residents will have current weight obtained by 5/21/24 by certified nursing assistant or licensed nurse unless resident preference prevents, provider and or Registered Dietician notified of any weight refusals not already known. 5/2/24 the Director of Nursing and Quality Assurance Nurse reviewed the weight system. As a result of the review the Director of Nursing assigned a dedicated Certified Nursing Assistant to obtain weekly and monthly weights to ensure consistency. 5/2/24 the Director of Nursing completed education for dedicated Certified Nursing Assistant and one back up Certified Nursing Assistant to include process of obtaining weights, documentation of	

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F 692	Continued From page 4 (Revised on: 9/21/23). The planned interventions included: monitor/record/report to his provider signs/symptoms of malnutrition such as emaciation (abnormal thinness), muscle wasting, and significant weight loss such as a loss of 3 pounds in 1 week, more than 5 percent (%) of his weight in 1 month, more than 7.5% in 3 months, or more than 10% in 6 months. Resident #6's EMR documented the following: --On 12/13/23, his weight was 180.2# (obtained via a total mechanical lift scale) and on 12/14/23, the resident's weight was documented as 176.4# (also obtained via a total mechanical lift scale). --On 1/3/24, the resident's laboratory results included an albumin level of 2.9 g/dL (low). --On 1/5/24, Resident #6's monthly weight was documented to be 179.7#. No additional weights were recorded for this resident during the remainder of January. A review of the resident's Meal Intake Record from January 2024 was conducted. The record included documentation of 90 meals during the month of January with the following results: --4% of the meals were refused; --10% of the meals were reported to have 0 - 25% of the meal eaten; --21% of the meals were reported to have 26 - 50% of the meal eaten; --30% of the meals were reported to have 51 - 75% of the meal eaten; --34% of the meals were reported to have 76 - 100% of the meal eaten. Documentation on Resident #6's January 2024 Medication Administration Record (MAR) revealed he refused the liquid protein supplement one time during the month.	F 692	weights, reporting of weights to interdisciplinary team and reporting resident refusals to obtain weight to the Director of Nursing, Unit Manager and/or Quality Assurance Nurse. 5/2/24 the Director of Nursing completed education for Unit Managers and Quality Assurance Nurse to include if a resident refuses to have weight obtained they are to speak with resident to see if resident will allow weight to be obtained and if resident continues to refuse to have weight obtained the provider is to be notified, refusal is to be documented in medical record and plan of care is to be updated to indicate the resident preference. The Director of Nursing and/or Quality Assurance Nurse will review weights weekly x 4 weeks, then monthly x 2 months to ensure weights have been obtained and documented consistently and will adjust the plan as necessary to maintain compliance. The Director of Nursing and/or Quality Assurance Nurse will review the plan during Quality Assurance and Performance Improvement meetings and the audits will continue at the discretion of the Quality Assurance and Performance Improvement Committee. Indicate dates when corrective action will be completed: May 22, 2024	

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A review of Resident #6's February 2024 Meal Intake Record was conducted. The record included documentation of 61 meals during the month of February with the following results:
--3% of the meals were refused;
--7% of the meals were reported to have 0 - 25% of the meal eaten;
--30% of the meals were reported to have 26 - 50% of the meal eaten;
--25% of the meals were reported to have 51 - 75% of the meal eaten;
--36% of the meals were reported to have 76 - 100% of the meal eaten.

Documentation on Resident #6's February 2024 MAR revealed he refused the liquid protein supplement four (4) times during the month.

There was no documented evidence that the facility obtained Resident #6's weight during the month of February 2024.

Review of the resident's EMR revealed Nurse Practitioner #1 (NP #1) saw Resident #6 for follow-up on 3/18/24. A progress note dated 3/18/24 reported the resident was seen due to staff concerns regarding the resident's decreased appetite and depressed mood. The NP #1 documented he was also being followed by psychiatric services. NP #1's assessment and plan indicated the dose of his antidepressant medication (duloxetine) would be increased from 40 mg to 60 mg daily. The progress note from NP #1's visit reported the resident's weight was 179.7# (his last recorded weight from 1/5/24).

Resident #6's most recent Minimum Data Set (MDS) was a quarterly assessment dated

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3/18/24. The quarterly MDS revealed the resident had intact cognition and did not have any behaviors or rejection of care. He required substantial/maximum assistance for eating. The Nutrition Section of the MDS assessment reported Resident #6 weighed 180# (his last recorded weight from 1/5/24).

On 3/19/24, NP #1 wrote a progress note to indicate Resident #6 was again seen regarding his refusal of medications. The resident's medications were reviewed with "few changes on meds made due to pt [patient] request" and education was provided to him. The discontinued medications included 20 mg furosemide (a diuretic) scheduled to be given to the resident once daily for bilateral leg edema.

On 3/22/24, NP #1 wrote a progress note to indicate Resident #6 was again seen upon his family's request. Staff reported the resident was not eating or drinking well. A notation made in NP #1's progress note dated 3/22/24 described the resident's lips as "dry and looks dehydrated." At that time, Resident #6 was reported to have declined any lab work being done or being sent out to the hospital for further evaluation. The resident's weight was noted in the NP's progress note as 179.7# (his last recorded weight from 1/5/24).

On 3/25/24, Resident #6 was weighed, and his weight was recorded in the EMR to be 152.9# (obtained via a total mechanical lift scale). The 3/25/24 weight was indicative of a significant weight loss (26.8#) of 14.9% in the last 80 days compared to his last recorded weight of 179.7# on 1/5/24. His current weight loss also represented a significant weight loss of 15.5% in

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the past 6 months (compared to his 9/6/23 weight of 181.0#).

Resident #6 continued to be followed-up by NP #1 with a visit for his blood pressure conducted on 3/27/24. At that time, NP #1's progress note indicated the resident's weight was 152.9#.

A Nursing progress note dated 3/31/24 at 10:05 AM reported the resident was suspected as being depressed and continuing to have a poor appetite. An on-call provider was contacted on 3/31/24 with new orders received to administer 7.5 mg mirtazapine each night for 7 days and 1000 milliliters (ml) of 0.9% normal saline solution to be given intravenously (IV) as 100 ml per hour for hypovolemia (low blood volume). Mirtazapine is an antidepressant which also acts as an appetite stimulant. Another Nursing progress note dated 3/31/24 at 12:18 PM reported the resident refused to receive the intravenous fluids as ordered. The order for the IV fluids was subsequently discontinued.

A review of Resident #6's March 2024 Meal Intake Record was conducted. The record included documentation of 80 meals during the month of March with the following results:
--19% of the meals were refused;
--29% of the meals were reported to have 0 - 25% of the meal eaten;
--17% of the meals were reported to have 26 - 50% of the meal eaten;
--5% of the meals were reported to have 51 - 75% of the meal eaten;
--30% of the meals were reported to have 76 - 100% of the meal eaten.

A review of Resident #6's EMR included his

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March 2024 MAR. The March MAR revealed Resident #6 refused his liquid protein supplement 24 times during the month.

The resident's EMR included a progress note dated 4/1/24 which revealed he was seen by NP #1 due to his decrease in appetite, depressed mood, and refusal of medications. Resident #6 was reported to be refusing intravenous fluids, medications, labs, and/or hospitalization. An NP's progress note dated 4/2/24 reported that upon receiving input from a family member, Resident #6 agreed to be transferred to the hospital Emergency Department (ED) on 4/2/24 for evaluation and treatment.

A review of Resident #6's EMR revealed there were no additional nutritional assessments or notes documented by the facility's RD since the resident's last review dated 9/19/23. It was also noted there were no Dietary Progress Notes documented by the Certified Dietary Manager (CDM) for Resident #6 within the past 6 months.

A review of Resident #6's Hospital Emergency Department (ED) Provider Notes indicated his recent history included failure to thrive and decreased oral intake. His hospital Discharge Summary dated 4/11/24 included the following note: " ...Unclear what his weight trend [was] but BMI 21 ..."

An interview was conducted on 4/30/24 at 11:27 AM with NP #1. During the interview, NP #1 reported the resident was his own Responsible Party (RP) and he refused several interventions during the last few weeks of his stay at the facility. His refusals included medications, intravenous fluids, and hospitalization She also reported the

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resident had verbalized to her that he was depressed, and both she and the nursing staff thought his poor oral intake may have been related to depression. When asked if the facility did what they could to encourage the resident's oral intake, the NP stated, "I think so ...We were trying our best."

An interview was conducted on 4/30/24 at 2:44 PM with Nurse Aide (NA) #5. NA #5 reported she was routinely assigned to care for Resident #6 on first shift from 7:00 AM - 7:00 PM. The NA stated the resident could feed himself but required "a set-up with meals." The NA reported that when she delivered meals to Resident #6, he would say, "Just leave it there, I'll eat it." However, when she returned to pick up the meal tray, she noticed he wasn't eating very much so she would try to leave a few food items that were safe to keep on his bedside tray table. She reported sometimes Resident #6 would snack between meals. Upon inquiry, the NA stated the resident did not refuse care.

An interview was conducted on 4/30/24 at 3:00 PM with Nurse #12. Nurse #12 reported she was typically assigned to care for Resident #6 on first shift from 7:00 AM - 7:00 PM. During the interview, the nurse recalled the resident wouldn't eat or drink much but when his family member asked him about it, he said he did fine. Nurse #12 added, "but his body didn't lie." She reported the resident was obviously losing weight and did not appear to be well hydrated. The nurse stated she shared her concerns with NP #1.

An interview was conducted on 5/1/24 at 3:10 PM with Nurse #13. Nurse #13 also reported Resident #6 resided on her usual hall assignment

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and she was very familiar with him. The nurse recalled the resident was refusing several medications in his last few weeks at the facility. She reported he "seemed to be very depressed," and the resident stated he thought the medications were making him worse. Upon inquiry, Nurse #13 reported Resident #6 could feed himself. She added that both she and his NA would frequently try to help him with feeding, but the resident simply did not want to eat.

An interview was conducted on 5/1/24 at 9:45 AM with the facility's Certified Dietary Manager (CDM). During the interview, the CDM reported he did not have a February 2024 weight for Resident #6. When asked, the CDM reported that if a resident's monthly weight reflected a significant weight loss, the resident would be reviewed in the next weekly Risk Meeting. The CDM stated he thought he had seen Resident #6 a couple of times within the last several months to obtain his food preferences. However, he acknowledged these interactions with the resident were not documented and he could not provide any additional details on when the interactions occurred or what information was obtained. When asked if any trials of nutritional supplements were attempted, the CDM stated the only supplement Resident #6 received was a liquid protein supplement administered by the nursing staff (initiated in September 2023).

A telephone interview was conducted on 5/1/24 at 9:58 AM with the facility's consultant Registered Dietitian (RD). During the interview, the RD reviewed her notes for Resident #6 and reported she had completed a nutritional assessment for him in September of 2023. The RD stated that no other issues had been brought to her attention

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about Resident #6 since that time. She reported no one had told her the resident was having a poor intake and "we missed the February weight." The RD further explained she did not become aware of a concern for this resident until his 3/25/24 weight became available. When the RD saw his March weight, Resident #6 had already been discharged to the hospital. The RD reported the facility had gone through a transition with their procedures for obtaining monthly weights for its residents. For a few months, the Unit Managers had taken the lead for obtaining and documenting the residents' weights. However, the facility recently recognized there was an issue with missing resident weights, so the process was again revised. When asked, the RD stated all newly admitted residents were weighed upon admission to the facility, weekly for 4 weeks (or until his/her weight was stable), and monthly thereafter. The RD reported the facility's policy indicated residents' weights should be obtained at least monthly.

An interview was conducted on 5/1/24 at 8:25 AM with the Restorative NA who currently assumed responsibility for obtaining residents' weights. During the interview, the Restorative NA reported she has been obtaining the residents' weekly and monthly weights since the end of March 2024 and documenting these weights in the facility's electronic medical records. The NA reported if a resident either lost or gained 5 pounds compared to his/her previous monthly weight, she would reweigh the resident the following day. If a resident refused to be weighed, she would let the facility's Director of Nursing, RD, and nurse on the hall about the refusal. When asked what prompted Resident's #6's weight to be obtained on 3/25/24, the NA stated she weighed the

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	345434	A. BUILDING _____ B. WING _____	C 05/01/2024

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resident on that date to get his March monthly weight. The NA reported since there wasn't a February weight for this resident, she would not have noticed that he had a significant weight loss and therefore, she would not have alerted the RD or nurse of a weight loss at that time. Upon further inquiry as to whether Resident #6 was resistant to being weighed, the NA stated to her knowledge, Resident #6 did not refuse to be weighed.

An interview was conducted on 5/1/24 at 11:18 AM with the Regional Director of Operations. During the interview, the Director stated: "It was identified in the QAPI [Quality Assurance and Performance Improvement Process] and review of the February data that the center failed to document weights and refusals to obtain weights." She also reported that as a result, "there was a systemic change in the monitoring of the weights. A new process was implemented by the DON [Director of Nursing] and increased monitoring was noted with At Risk Meetings and routine QAPI [review]." The facility's Plan of Correction (POC) related to obtaining residents' weights was provided and reviewed. When asked, the Regional Director of Operations acknowledged the POC did not include all the information required for an acceptable plan of correction.

An interview was conducted on 5/1/24 at 1:13 PM with the facility's Director of Nursing (DON). At that time, the DON discussed the facility's procedures for obtaining resident weights. The DON reported all newly admitted residents were weighed upon admission to the facility, weekly for 4 weeks, and then monthly (depending on his/her clinical presentation and/or weight history). The

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F 692	Continued From page 13 DON stated the NA completing monthly weights was educated to report a resident's weight change to the RD and DON if the change was more than 5% in 30 days, 7.5% in 3 months, or 10% in 6 months. The DON reported that any resident with a significant weight change would be reviewed so the change could be addressed and monitored. She also reported if a resident refused to be weighed, this refusal needed to be reported to a nurse so it could be documented in the resident's progress notes. The DON reported she understood the facility's POC related to obtaining resident weights did not contain all the required components. An interview was conducted on 5/1/24 at 12:05 PM with the facility's Interim Administrator in the presence of the Regional Director of Operations. During the interview, the Regional Director of Operations confirmed she had informed the Administrator of the concern regarding a failure to monitor Resident #6's weight. When asked, the Administrator acknowledged he was aware the POC provided by the facility related to this topic did not include all the information required for an acceptable plan of correction.	F 692		
F 695 SS=D	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 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.	F 695		5/22/24

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F 695	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner (NP) interviews, the facility failed to provide a physician's order for the use of a BIPAP (bilevel positive airway pressure) machine treatment for 1 of 1 resident (Resident #11) reviewed for respiratory services. Findings included: Resident #11 was readmitted to the facility on 2/21/24 and discharged on 3/12/24. Her diagnoses included chronic obstructive pulmonary disease (COPD), sleep apnea, congestive heart failure. Records review revealed the hospital's discharge summary, dated 2/21/24, indicated the recommendation to continue using the BIPAP (bilevel positive airway pressure) machine with specific inspiration and expiration settings at night. Review of Resident #11's admission Minimum Data Set assessment, dated 2/27/24, indicated that the resident was cognitively intact. The Special Treatment and Programs section of this assessment was not coded for BiPAP. Review of Resident #11's plan of care, dated 3/7/24, indicated resident's altered respiratory status, difficulty breathing, related to COPD and congestive heart failure, with interventions, not including CPAP or BIPAP treatment. Review of Resident 11's current physician orders revealed no order for BIPAP treatment.	F 695	Resident #11 has been discharged from the facility. All residents requiring BiPAP and CPAP therapy have the potential to be affected. 5/2/24 the Director of Nursing and Quality Assurance Nurse completed an audit of all residents requiring the use of BiPAP and CPAP therapy. No negative findings. 5/2/24 the Director of Nursing completed education for licensed nurses to include that upon admission/readmission resident orders for BiPAP and CPAP are to be verified with the physician or nurse practitioner. Once orders are verified, they are to be placed on the Medication Administration Record for application, administration and documentation of therapy for the resident. 5/2/24 the Director of Nursing completed education for the Nursing Supervisors, Unit Managers and Quality Assurance nurse to include new admission/readmission charts are to be audited for orders for BiPAP and/or CPAP therapy. Audit to include verification of order for therapy and placement of therapy on Medication Administration Record. The Nursing Supervisors, Unit Managers and/or Quality Assurance Nurse will audit all new admission / readmission charts within 48 hours for orders for BiPAP	

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F 695	Continued From page 15 Review of Resident 11's Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no entry to apply BIPAP treatment. On 4/30/24 at 10:15 AM, during an interview, Nurse Practitioner (NP #1) expected the physician order from the discharge summary, dated 2/21/24 for BiPAP treatment at night to have been transcribed and followed. NP #1 indicated that due to COPD, sleep apnea and congestive heart failure, it would be beneficiary for Resident #11 to use the BiPAP machine, and the order should have been included in Resident #11's medical records. On 5/1/24 at 1:45 PM, during the phone interview, Nurse #2 indicated that at admission, on 2/21/24, the BiPAP machine was ready for Resident #11 in her room. The resident used the BiPAP in the past, required assistance to apply the face mask of breathing machine and could remove it herself. Nurse #2 stated there should be a physician order for BiPAP treatment in the medical records, but she did not see the orders in Resident #11's medical records or in the MAR. As the admission nurse for Resident #11, Nurse #2 was responsible for transcribing the BiPAP order. On 5/1/24 at 12:10 PM, during the phone interview, Nurse #3 indicated that Resident #11 had the BiPAP machine in her room, but Nurse #3 did not recall seeing any orders regarding the BiPAP treatment in medical records or in the MAR. On 5/1/24 at 2:20 PM, during an interview, the Director of Nursing indicated that there should	F 695	and/or CPAP therapy to include verification of order for therapy and placement of therapy on Medication Administration Record. Audit will be completed five times per week x 4 weeks and then weekly x 2 months to ensure administration of BiPAP and/or CPAP therapy. The Director of Nursing will review results of new admission/readmission chart audits monthly for three months to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Director of Nursing will review the plan during Quality Assurance and Performance Improvement meetings and the audits will continue at the discretion of the Quality Assurance and Performance Improvement Committee. Indicate dates when corrective action will be completed: May 22, 2024	

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F 695	Continued From page 16 have been physician's order for BiPAP treatment in the medical records, transcribed into MAR. On 5/1/24 at 2:30 PM, during an interview, Assistant Administrator expected to have the physician's order for breathing machine treatment in place at admission.	F 695		