STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 02/17/2025

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LITCHFORD FALLS HEALTHCARE & REHABILITATION CENTER	8200 LITCHFORD ROAD RALEIGH, NC 27615

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F 000	INITIAL COMMENTS The surveyor entered the facility on 2/11/25 to conduct a complaint survey and exited on 2/13/25. Additional information was obtained on 2/14/25 and 2/17/25. Therefore, the exit date was changed to 2/17/25. The following intakes were investigated: NC00220318, NC00226290, NC00226347, NC00226645, NC00226820, NC00227059. (Event ZFDV11) One of eleven complaint allegations resulted in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		3/6/25

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

Electronically Signed | 03/04/2025

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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to ensure a system was in place in order that a resident's advance directive not to be resuscitated was honored upon her death. This was for one of three (Resident # 8) residents reviewed for emergency responses by facility staff prior to emergency medical systems being called. The findings included: Resident # 8 was admitted to the facility on 2/28/23. Resident # 8 had multiple diagnoses which included but were not limited to stroke, history of respiratory failure, chronic kidney disease, congestive heart failure, hyperlipidemia, insomnia, polyneuropathy, atrial fibrillation, peripheral vascular disease, thyroid disorder, and pacemaker placement. Review of Resident #8's quarterly Minimum Data Set assessment, dated 12/3/24 revealed the resident was cognitively impaired.	F 578	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F578 Request/Refuse/Discontinue Treatment, For Advanced Directives. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #8 is no longer in the facility. 2. Address how the facility will identify	

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F 578	Continued From page 2 Review of physician orders, dated 6/29/24, revealed Resident # 8 had orders for DNR (Do Not Resuscitate). Review of Resident #8's 12/11/24 care plan revealed on 9/6/24 the following was added to Resident #8's care plan and remained as part of her active care plan up until discharge. "The resident has advance directive of Do Not Resuscitate Order. Honor Residents Advance Choices." On 1/31/25 at 11:14 PM Nurse # 1 documented a nursing entry noting the following information. Resident # 8 was found on the floor and a code blue was called. Every nurse in the building came to assist. Resident # 8 was a DNR. EMS was called and Resident #8 was pronounced deceased at 11:21 PM. Nurse # 1 was interviewed on 2/12/25 at 3:40 PM and reported the following information. She was assigned to care for Resident #8 on the evening shift of 1/31/25. She had administered Resident # 8's evening medications. Later she was busy with other residents when she heard a code blue called. When she arrived to Resident # 8's room. Nurse # 4 was already in the room performing chest compressions trying to resuscitate Resident # 8. She (Nurse # 1) checked the resident's record and saw Resident # 8 was a DNR and instructed Nurse # 4 to stop chest compressions because the resident was a DNR. Nurse # 4 was interviewed on 2/13/25 at 4:45 PM and reported the following information. He heard a Nurse Aide call for help for Resident # 8 on the evening of 1/31/25. He ran to the room and saw	F 578	other residents having the potential to be affected by the same deficient practice. DON and MDS RN reviewed the last 14 days of resident deaths to determine if the code status orders were honored. All code status orders were followed. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Unit Managers educated all nurses and CNAs to check the code status of the resident prior to initiating CPR. All newly hired CNAs and nurses will receive this education during orientation. For three months, DON and Unit Managers will review all deaths in the community□s daily clinical meeting 5x per week to ensure that the code status was reviewed prior to initiating CPR. Results of this review will be documented on the Advanced Directives Audit by DON and/or Unit Managers. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator and/or the Director of Nursing will report the findings of this monitoring process to the Community□s Quality Assurance Performance Improvement Committee for additional monitoring or modifications of this plan monthly for three months, or until the	

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F 578	Continued From page 3 she did not have signs of life. He instructed the Nurse Aide to call for help and he started chest compressions. Other staff came to assist. There was a folder at the nursing desk with instructions about whether residents were a full code or a DNR. After chest compressions had already been started, they realized Resident #8 was a DNR and chest compressions were stopped. The Director of Nursing was interviewed on 2/14/25 at 10:06 AM and reported the following information. There was a book at the nursing desk which has the code status of residents. The information is also located in every resident's electronic record. If the staff find a resident not responding then the staff are to assess the resident for a pulse and breathing and call for help. The code status is to be checked quickly prior to starting to resuscitate a resident. Interview with the corporate Nurse Consultant on 2/13/25 at 5:30 PM revealed the code status should be checked when a resident is found to be without a pulse and breathing. She felt Nurse # 4 intended to do good and was reacting to help the resident.	F 578	pattern of compliance is maintained. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. 5. Include dates when corrective action will be completed. Date of Compliance: March 6, 2025	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		3/6/25

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F 580	Continued From page 4	F 580		

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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F 580	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and the physician, the facility failed to notify the physician when a resident experienced nausea, vomiting, and decreased urine output following an increase in her diuretic medication. (A diuretic medication increases excretion of fluid). This was for one of four sampled residents (Resident # 1) reviewed for physician notification. The findings included: Resident # 1 was admitted to facility on 10/8/20. Resident # 1's diagnoses included congestive heart failure, stroke, hypertension, diabetes, history of pelvic fracture, and major depressive disorder. The resident also had a history of alcohol and drug use. Review of Resident # 1's 9/7/24 MDS (Minimum Data Set) assessment revealed the resident was cognitively intact. A review of Resident # 1's annual MDS, dated 11/25/24, revealed the resident was moderately cognitively impaired. Additionally, on 11/25/24, Resident # 1 was assessed as follows: She was frequently incontinent of urine and always incontinent of stool. Review of physician orders revealed an order, dated 12/10/24, for furosemide 20 mg (milligrams) every day. (Furosemide is a diuretic medication used for congestive heart failure.) Prior to the date of 12/10/24 the resident had been on a 20 mg dose of furosemide twice per day for the three days prior to 12/10/24. Prior to 12/6/24, Resident # 1 had been on a daily dose of furosemide 20 mg. This dosage had last been ordered on 10/5/24.	F 580	F580 Notify of Changes (Injury/Decline/Room, etc.) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 is no longer in the community. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Unit Managers reviewed the progress notes for the last 14 days to ensure all changes in condition have been reported to the MD. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. DON educated all CNAs to report any changes in condition to their immediate supervisor. DON educated all the licensed nurses to report all changes in condition to the MD timely for assessment and intervention including documenting in the resident record. Education to be completed by March 6, 2025. For three months, the Unit Managers will review progress notes in the Daily Clinical Meeting 5X per week to ensure MD	

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F 580	Continued From page 6 Review of Resident # 1's weight record revealed Resident # 1 weighed 145 pounds on 12/15/24. On 1/9/25 the resident weighted 159 pounds indicating a weight gain of 14 pounds since she had been weighed the previous month. On 1/9/25 the physician noted the following in the record. He was seeing Resident # 1 and the nurses had noted the resident was more irritable that day. The resident stated to the physician she felt well and denied any pain or shortness of breath. The physician noted the resident did have increased swelling in her abdomen and legs and that he would adjust her diuretic and check lab work. The physician wrote an order to increase Resident # 1's furosemide to 40 mg twice per day on 1/9/25. Nurse Aide (NA) #1 was interviewed on 2/13/25 at 4:25 PM and reported the following information. She had cared for Resident # 1 on 1/9/25, 1/10/25, and 1/11/25. On 1/9/25 and 1/10/25 Resident # 1 had vomited brown emesis once per day on her shift. On 1/11/25 the resident had vomited brown emesis twice on her shift. She recalled mentioning the emesis to Nurse # 1 and Nurse # 2. Review of Resident # 1's record revealed no documentation of the resident vomiting on 1/9/25, 1/10/25, and 1/11/25 or that the physician was notified. Nurse Aide # 2 was assigned to care for Resident # 1 on 1/16/25 on the dayshift. NA # 2 was interviewed on 2/12/25 at 11:55 AM and reported	F 580	notification as well as follow-up assessment and intervention is documented for reported changes in condition. For three months, Results of this review will be documented on the Notification of Changes Audit by DON and/or Unit Managers. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator and/or the Director of Nursing will report the findings of this monitoring process to the Community□s Quality Assurance Performance Improvement Committee for additional monitoring or modifications of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. 5. Include dates when corrective action will be completed. Date of Compliance: March 6, 2025	

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F 580	Continued From page 7	F 580		

the following information. In addition to caring for Resident # 1 on 1/16/25, she had also cared for the resident on two other days that same week. During those days she observed Resident # 1's abdomen looked more swollen than usual, and the resident did not urinate as much as she usually did. Usually the resident was a "heavy wetter" and her urine had decreased. At times the resident would go all shift and not be wet.

During the interview with NA # 1 on 2/13/25 at 4:25 PM, NA # 1 reported the following information. She had cared for Resident # 1 on the evening shift of 1/16/25 and the resident did not urinate. This was not her normal. She had also cared for Resident # 1 on the evening shift of 1/17/25. She placed the resident back in bed around 4:00 PM and saw that her brief was completely dry. That was not her normal. She (NA # 1) thought she had asked Medication Aide # 1 if anyone else was mentioning that the resident was not urinating per her norm.

Medication Aide (MA # 1) was assigned to care for Resident # 1 on 1/16/25 and 1/17/25 on dayshift. MA # 1 was interviewed on 2/12/25 at 11:31 AM and again on 2/13/25 at 10:15 AM and reported the resident always had a swollen abdomen but she did not recall anything else being different about her on 1/16/25 and 1/17/25.

Nurse # 2 had cared for Resident # 1 on 1/16/25 on the evening shift. Nurse # 2 was interviewed on 2/12/25 at 2:00 PM and again on 2/14/25 at 10:00 AM and reported she did not recall specifics of the date of 1/16/25. She did recall that Resident # 1's furosemide had been increased and they were trying to "pull off fluid" but she had not noted a large change in the

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resident or anything being reported about repetitive vomiting or low urine output in order that she know to talk to the doctor about it.

Resident # 1's Nurse Unit Manager was interviewed on 2/12/25 at 10:20 AM and reported the following information. She became the unit manager in January 2025. She knew Resident # 1's abdomen was swollen and the resident was not doing well. She also had developed a pressure sore. The resident had no family and was responsible for herself. On the date of 1/17/25 hospice staff were in the facility and the staff talked to Resident # 1's physician about a referral to hospice for the resident. Hospice did an initial meeting with Resident # 1 on 1/17/25 and Resident # 1 chose to transition to hospice care after talking with them. The plan was to admit the resident to hospice on 1/19/25.

Nurse # 1 had cared for Resident # 1 on the evening shift of 1/17/25 and reported the following information during interviews on 2/12/25 at 11:20 AM and again on 2/14/25 at 10:22 AM. She did not recall anyone mentioning any nausea, vomiting, or low urine output the resident had been having on that date or any date prior and therefore she had not talked to the physician about this. On the evening of 1/17/25 she (Nurse # 1) had administered the resident medications, and the resident was in bed and appeared okay. Within an hour of evening medications, the resident sustained a fall and was transferred to the hospital for evaluation of possible injuries due to a fall.

Review of hospital ED records, dated 1/17/25, revealed the resident was clinically dehydrated upon admission. Further review of hospital

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F 580	Continued From page 9 records from 1/17/25 through 1/26/25 revealed the resident reported to the admitting hospitalist physician reported that she had severe abdominal pain and that she had been vomiting for several days and "just felt bad." Continued review of these hospital records revealed the resident was diagnosed with multiple problems which in part included sepsis, blood loss anemia, and cirrhosis. The hospital records indicated the resident did not respond to treatment and she expired on 1/26/25. Resident # 1's facility medical physician was interviewed on 2/13/25 at 11:50 AM and again on 2/14/25 at 5:07 PM revealing the following information. Resident # 1's kidneys were "not healthy" while she resided at the facility. She also had congestive heart failure and was showing signs of heart failure on 1/9/25 when he saw her although she had no complaints on that date and was "chatty" with him. If she had been vomiting and having less urine output after he saw her, this would have been significant information for staff to have let him know. If they had let him know, he would still have kept her on the diuretic because she needed the fluid removal. The staff would have needed to monitor her. It was a fine line in trying to diurese someone and preventing dehydration when a person suffered from multiple chronic medical conditions. Resident # 1 was capable of making her own medical decision about choosing hospice on 1/17/25 and hospice had been appropriate for her. Her death appeared to have been a result of multiple organ failure.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		3/6/25

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F 684	Continued From page 10 § 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 and interviews with staff and physician, the facility failed to 1) ensure labs were drawn as ordered on a resident whose diuretic medication was increased (A diuretic medication increases excretion of fluid) and 2) ensure effective communication between Nurse Aides and Nurses so that a resident with vomiting and decreased urine output could receive nausea medication as prescribed and the physician would be made aware of the resident's lower urine output after he had increased the resident's diuretic medication. This was for one of four sampled residents (Resident # 1) reviewed for professional standards of practice. The findings included: Resident # 1 was admitted to facility on 10/8/20. Resident # 1's diagnoses included congestive heart failure, stroke, hypertension, diabetes, history of pelvic fracture, and major depressive disorder. The resident also had a history of alcoholism and drug addiction for which she had been in recovery since 2014. Review of Resident # 1's 9/7/24 MDS (Minimum Data Set) assessment revealed the resident was cognitively intact. A review of Resident # 1's	F 684	F684 Quality of Care 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 is no longer in the community. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. A. The Unit Managers reviewed all labs ordered for the last 14 days to ensure: 1.) all labs ordered had been completed, and 2.) any labs identified abnormal were communicated to the MD. B. DON and/or Unit Managers reviewed 14 days of progress notes to ensure changes in condition and reports of abnormal resident symptoms, including vomiting, bloody stool or urine, and decreased urine were documented and MD notified.	

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F 684	Continued From page 11 annual MDS, dated 11/25/24, revealed the resident was moderately cognitively impaired. Additionally, on 11/25/24, Resident # 1 was assessed as follows: She was dependent on staff for bathing. She required substantial to maximum assistance with her hygiene needs. She was frequently incontinent of urine and always incontinent of stool. She had no pressure sores. Review of nursing notes revealed an entry dated 11/3/24 at 6:32 AM noting that Resident # 1 had some emesis on the previous shift but no further emesis had been noted on the current shift. On 11/3/24 at 11:13 AM a nurse documented the resident complained of nausea. On 11/3/24 an order was obtained for Zofran 4 mg (milligrams) every eight hours as needed for nausea. A review of Resident # 1's November 2024 MAR (medication administration record) revealed the resident received the Zofran twice in November 2024. This was on 11/7/24 at 10:43 PM and again on 11/9/24 at 2:11 AM. The 11/7/24 dose was documented as administered by Nurse # 2 and the 11/9/24 dose was documented as administered by Nurse # 5. Both times there was documentation the Zofran was effective. There was no further documentation on Resident # 1's MAR that the resident received any Zofran throughout the rest of her residency. On 11/3/24 an order was also obtained for a KUB (an x-ray of the abdominal area) to be completed. Review of the KUB report, completed on 11/3/24, revealed there was no organomegaly (enlarged organs) and no bowel obstruction found.	F 684	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. A. The Unit Managers educated all nurses on lab orders to ensure: 1.) all labs ordered had been completed, and 2.) any labs identified as abnormal were communicated to the MD. Education to be completed by March 6, 2025. For three months, the Unit Managers will review labs and progress notes in the Daily Clinical Meeting 5X per week to ensure: 1.) all labs ordered had been completed, and 2.) any labs identified abnormal were communicated to the MD. For three months, Results of this review will be documented on the Quality of Care Audit by DON and/or Unit Managers. B. The Unit Managers educated CNAs and Nurses to recognize changes in condition and report abnormal resident symptoms, including vomiting, bloody stool or urine, and decreased urine to both nurses and MD notified. Education to be completed by March 6, 2025. For three months, the Unit Managers will review progress notes in the Daily Clinical Meeting 5X to ensure changes in condition and reports of abnormal resident symptoms, including vomiting, bloody stool or urine, and decreased urine were documented and MD notified.	

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F 684	Continued From page 12 Review of lab work revealed Resident # 1 had labs completed on 11/13/24 which although not all inclusive showed the following results: hemoglobin 8.8 (normal 10.9-14.3); Blood urea nitrogen 42.2 (normal 7-25) , and creatinine 1.8 (normal .60-1.20). On 11/29/24 the staff added to Resident # 1's care plan that she was at risk for complications secondary to diuretic use. Two of the interventions listed on the care plan included drawing labs as ordered and observing for signs and symptoms of fluid imbalance or fluid overload. Review of physician orders revealed an order, dated 12/10/24, for furosemide 20 mg (milligrams) every day. (Furosemide is a diuretic medication used for congestive heart failure.) Prior to the date of 12/10/24 the resident had been on a 20 mg dose of furosemide twice per day for the three days prior to 12/10/24. Prior to 12/6/24, Resident # 1 had been on a daily dose of furosemide 20 mg. This dosage had last been ordered on 10/5/24. Review of Resident # 1's weight record revealed Resident # 1 weighed 145 pounds on 12/15/24. On 1/2/24 at 10:46 AM the facility wound nurse noted she was asked to assess the resident who had previously had some MASD (moisture associated skin damage). The treatment nurse further noted the resident had a 1.5 cm (centimeter) X 1.5 cm area of skin breakdown, and that the physician was notified with a treatment started. According to progress notes, the Wound NP (Nurse Practitioner) began seeing the resident on 1/3/24 to oversee the pressure	F 684	For three months, Results of this review will be documented on the Quality of Care Audit by DON and/or Unit Managers. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. A. The Administrator and/or the Director of Nursing will report the findings of this monitoring process to the Community□s Quality Assurance Performance Improvement Committee for additional monitoring or modifications of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. 5. Include dates when corrective action will be completed. Date of Compliance: March 6, 2025	

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sore care.

Review of Resident # 1's weight record revealed Resident # 1 weighed 159.0 pounds on 1/9/25 indicating a weight gain of 14 pounds since she had been weighed the previous month.

On 1/9/25 the physician noted the following in the record. He was seeing Resident # 1 and the nurses had noted the resident was more irritable that day. The resident stated to the physician she felt well and denied any pain or shortness of breath. The physician noted the resident did have increased swelling in her abdomen and legs and that he would adjust her diuretic and check lab work.

On 1/9/25 the physician wrote lab orders for a complete blood count, a comprehensive metabolic panel, and a thyroid stimulating hormone to be completed on 1/10/25. The physician also wrote an order to increase Resident # 1's furosemide to 40 mg twice per day.

Review of Resident # 1's record revealed the lab work, which was ordered on 1/9/25, was never completed.

Nurse Aide (NA #1) was interviewed on 2/13/25 at 4:25 PM and reported the following information. She had cared for Resident # 1 on 1/9/25, 1/10/25, and 1/11/25. On 1/9/25 and 1/10/25 Resident # 1 had vomited brown emesis once per day on her shift. On 1/11/25 the resident had vomited brown emesis twice on her shift. She recalled mentioning the emesis to Nurse # 1 and Nurse # 2.

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Review of Resident # 1's record revealed no documentation of the resident vomiting on 1/9/25, 1/10/25, and 1/11/25.

On 1/14/25 the Wound NP noted she was seeing Resident # 1 for wound care. The Wound NP documented the following. The resident's sacrum pressure sore was worsening with eschar, slough, and odor. There had been treatment changes that day made. On that date the wound bed measured 5 cm (centimeters) X 4.5 cm X 0.2 cm and was 80% slough and 20 % granulation. The Wound NP further noted, "If the sacral wound does not start to improve, or is she starts to develop more wounds, consider as possible end of life and initiate hospice discussion."

Medication Aide (MA # 1) was assigned to care for Resident # 1 on 1/16/25 and 1/17/25 on dayshift. MA # 1 was interviewed on 2/12/25 at 11:31 AM and again on 2/13/25 at 10:15 AM and reported the following information. She did not recall Resident # 1 having any further vomiting and nausea since she had undergone the KUB in November 2024. The resident's abdomen was normally swollen, and she (MA # 1) did not recall it appearing worse the last week of the resident's residency or anything different on 1/16/25 and 1/17/25.

Nurse Aide # 2 was assigned to care for Resident # 1 on 1/16/25 on the dayshift. NA # 2 was interviewed on 2/12/25 at 11:55 AM and reported the following information. In addition to caring for Resident # 1 on 1/16/25, she had also cared for the resident on two other days that same week. During those days she observed Resident # 1's abdomen looked more swollen than usual, and the resident did not urinate as much as she

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usually did. Usually the resident was a "heavy wetter" and her urine had decreased. At times the resident would go all shift and not be wet. She did not want to get out of bed as much as she usually did.

During the interview with NA # 1 on 2/13/25 at 4:25 PM, NA # 1 reported the following information. She had cared for Resident # 1 on the evening shift of 1/16/25 and the resident did not urinate. This was not her normal.

Nurse # 2 had cared for Resident # 1 on 1/16/25 on the evening shift. Nurse # 2 was interviewed on 2/12/25 at 2:00 PM and again on 2/14/25 at 10:00 AM and reported she did not recall specifics of the date of 1/16/25. She did recall that Resident # 1's furosemide had been increased, and they were trying to "pull off fluid" but she had not noted a large change in the resident. She recalled one time when she cared for the resident, the resident had vomited, and she gave her Zofran but did not recall when that was or if it coincided with dates after her diuretic had been increased. She did not know about any missing lab work for the resident.

Nurse Aide # 3 had cared for Resident # 1 on the dayshift of 1/17/25. NA # 3 was interviewed on 2/13/25 at 3:17 PM and reported the following information. She had cared for the resident routinely since she had been employed at the facility for eight months. She had not noted any big change in the resident on 1/17/25. The resident had no nausea and vomiting on 1/17/25. The resident's stomach always appeared swollen, and she (NA # 3) had not noticed any change.

On 1/17/25 at 5:08 PM the facility social worker

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noted the interdisciplinary team had met about the resident's current health condition and the resident was referred to hospice with the resident's permission. Hospice visited the resident on that date (1/17/25) and there were plans to admit to hospice on 1/19/25.

Resident # 1's Nurse Unit Manager was interviewed on 2/12/25 at 10:20 AM and reported the following information. She became the unit manager in January 2025. She knew Resident # 1's abdomen was swollen, a KUB had been done in earlier months, and the resident was not doing well. She also had developed a pressure sore. The resident had no family and was responsible for herself. On the date of 1/17/25 hospice staff were in the facility doing education training with staff and inquired if there might be residents who might need their services. Resident # 1 was not doing well. The staff talked to Resident # 1's physician about a referral to hospice for the resident. Hospice did an initial meeting with Resident # 1 on 1/17/25 and Resident # 1 chose to transition to hospice care after talking with them. The Unit Manager further reported no one had caught that the 1/9/25 labs were not done while the resident was at the facility and prior to doing a hospice referral. The lab order was in the computer, but it had not been written in the lab draw book so that the phlebotomist would know to draw the lab.

On 1/17/25 at 10:04 PM Nurse # 1 noted in a nursing entry the following information. The resident had been found on the floor after sustaining a fall. The resident's vital signs were within normal limits. She had sustained a skin tear to her finger and a small laceration to her nose. The physician was notified, and the

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resident was sent to the ER for evaluation following the fall.

During the interview with NA # 1 on 2/13/25 at 4:25 PM, NA # 1 reported the following information. She had cared for Resident # 1 on the evening shift of 1/17/25. She placed the resident back in bed around 4:00 PM and saw that her brief was completely dry. That was not her norm. She thought she had asked Medication Aide # 1 if anyone else was mentioning that the resident was not urinating per her norm. Later that evening she sustained a fall from the bed and EMS was called.

Nurse # 1 had cared for Resident # 1 on the evening shift of 1/17/25 and reported the following information during interviews on 2/12/25 at 11:20 AM and again on 2/14/25 at 10:22 AM. She did not recall anyone mentioning any nausea and vomiting problems the resident had been having. She also was not aware the resident had missed lab work or why it was not done. She was aware there had been a decision to transition the resident to hospice care. On the evening of 1/17/25 she (Nurse # 1) had administered the resident medications and the resident was in bed and appeared okay. Within an hour of evening medications, the resident sustained a fall and was transferred to the hospital for evaluation of possible injuries due to a fall.

Review of hospital ED (emergency department) records for the date of 1/17/25 revealed the following information was documented. The resident's vital signs were 95.7 rectal (Rectal temperature readings are one degree higher than oral readings and thus the resident's temperature would have equated to 94.7 orally), pulse 93,

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blood pressure 107/56, respirations 12 and pulse oximetry 98 %. The resident was assessed to have an unstageable sacral pressure sore with no purulent drainage. Lab work revealed a white blood count of 22.7 (normal 3.6-11.2; elevated levels can at times indicate infection), hemoglobin 8.5, sodium level 131 (normal 136-145), Blood urea nitrogen 69, and Creatinine 3.17. The resident's lactic acid was 1.5 and bilirubin was 0.5, which were both considered normal. The resident was noted to have a large abdomen and appeared clinically dehydrated. The resident's rectal exam in the ED was guaiac negative (meaning no blood in the stool). EMS had reported the resident had coffee ground emesis in route to the hospital. Further review of hospital records for the dates of 1/17/25 through 1/26/25 revealed the following information. A CT (computerized tomography) scan was completed which showed large scale ascites and cirrhosis which had previously not been diagnosed. The admitting hospitalist physician noted a history was obtained from the resident who reported severe abdominal pain and that she had been vomiting for several days and "just felt bad." Brown emesis was noted in the resident's mouth and in her throat. The physician noted she met the criteria for sepsis based on her white blood count and that urine and blood cultures were sent. She was also diagnosed with dehydration and acute kidney injury secondary to vomiting and dehydration. On 1/26/25 the resident expired in the hospital. A hospital expiration note included the following information. The resident had acute blood loss anemia, cirrhosis, kidney injury, and bacteremia likely secondary to an infected pressure sore. Regardless of antibiotics and efforts to stabilize her, her condition had deteriorated, and she expired after an ethics committee met and

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F 684	Continued From page 19 discussed that comfort care should be provided. Resident # 1's facility medical physician was interviewed on 2/13/25 at 11:50 AM and again on 2/14/25 at 5:07 PM and reported the following information. Resident # 1's kidneys were "not healthy" before being identified in the hospital as having kidney injury. Resident # 1 also had low albumin levels, and albumin helps to keep the fluid volume within the vascular system. With multiple chronic illnesses, Resident # 1 could have gotten dehydrated quickly. When he saw Resident # 1 on 1/9/25 she did not complain of nausea and vomiting at that time. She was "chatty" and had not shown signs of cirrhosis. She had a diagnosis of congestive heart failure and when he saw her on 1/9/25 she was showing signs of heart failure. She needed to be diuresed. There was a fine line in diruresing residents with congestive heart failure and making sure they did not get dehydrated when there were other medical conditions affecting them. If lab work had been done as ordered it would not have made a difference in her outcome. She appeared to have multiple organs which failed causing her demise. She had been capable of making her decision to transition to hospice services on 1/17/25, and her medical condition indicated she had been hospice appropriate.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		3/6/25

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F 686	Continued From page 20 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Wound Nurse Practitioner (NP), and Physician, the facility staff failed to communicate effectively with the Wound NP, who was assessing and overseeing the care of Resident # 1's pressure sore, to ensure timing of dressing changes and the use of a cleansing agent was done per the Wound NP's plan of care for Resident # 1's pressure sore. This was for one of one sampled resident (Resident # 1) with a pressure sore. The findings included: Resident # 1 was admitted to facility on 10/8/20. The residents diagnoses in part included stroke, hypertension, diabetes, history of pelvic fracture, and congestive heart failure. Review of Resident # 1's 11/25/24 annual Minimum Data Set assessment coded the resident as moderately cognitively impaired, as needing substantial to maximum assistance with her hygiene needs, as being always incontinent of bowel, and as being frequently incontinent of bladder. The resident was coded with no pressure sores. On 11/29/24 staff added to Resident # 1's care plan that the resident was at risk for pressure sore development due to chronic health	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 is no longer in the community. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. DON and the Unit Managers reconciled the last 14 days of Wound Nurse Practitioner Plans of Care Reports with the Facility Wound Nurse transcribed plans of care to ensure they match. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. DON educated the Facility Wound Care Nurse to transcribe orders from Wound Nurse Practitioner Plan of Care Report	

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F 686	Continued From page 21 conditions, cognitive impairment, immobility, and the inability to turn and reposition self independently. Staff were directed on the care plan to assess the resident for breakdown. On 1/2/25 at 10:46 AM the Facility Wound Care Nurse documented the following in a nursing entry. She had been asked to assess Resident # 1, who had previous moisture associated skin damage to the sacrum and had been receiving treatment with Zinc (a barrier cream). Upon assessment on 1/2/25 the resident had an unstageable wound to the sacrum measuring 1.5 cm X 1.5 cm (centimeters). The physician was made aware and a treatment was initiated. On 1/2/25 an order was entered into the record to clean the pressure sore with normal saline or wound cleanser and apply silver alginate. Then the pressure sore was to be covered with a dressing daily. On 1/3/25 Resident # 1 was seen by the Wound Nurse Practitioner who documented the following information. Resident # 1 had a pressure sore which measured 1.5 cm X 1.5 cm X 0.1 cm. The wound bed contained 20 % granulation tissue (healthy tissue), 20 % epithelial tissue, and 60 % slough (unhealthy tissue). The Wound Nurse Practitioner documented the treatment recommendation plan was as follows: The pressure sore would be cleansed with wound cleanser, silver alginate would be applied to the base of the wound, the dressing would be secured with a border gauze, and the dressing would be done three times per week and PRN (as needed.) Review of Resident # 1's orders and January	F 686	only. Education to be completed by March 6, 2025. For three months, DON and the Unit Managers will reconcile Wound Nurse Practitioner Plans of Care Report with the Facility Wound Nurse transcribed plans of care to ensure they match. This will be done 2X per week in the Daily Clinical meeting to identify and correct any plans of care that do not match Wound NP plans of care. For three months, Results of this review will be documented on the Prevent Pressure Wounds Audit by DON and/or Unit Managers. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator and/or the Director of Nursing will report the findings of this monitoring process to the Community□s Quality Assurance Performance Improvement Committee for additional monitoring or modifications of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. 5. Include dates when corrective action will be completed. Date of Compliance: March 6, 2025	

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2025 TAR (treatment administration record) revealed no updated orders to reflect the dressing changes should be changed to every three days. The daily dressing changes remained in effect.

On 1/7/25 the Wound NP again saw Resident # 1 and documented the following information in a progress note. The sacrum pressure sore measured 1.5 cm X 1.5 cm X 0.1 cm. The wound bed continued to have 20 % granulation tissue, 20 % epithelial tissue, and 60% slough. The Facility Wound NP did not change the treatment recommendations from her previous recommendations, which she had made on 1/3/25 for dressing changes three times per week and as needed.

On 1/8/25 Resident # 1's care plan was updated to reflect she had developed a pressure sore. The care plan directed "referral to wound physician as indicated" and "treatment per TAR."

On 1/14/25 the Wound NP documented she assessed the resident again. The Wound NP noted the following information. The pressure sore measured 5 cm X 4.5 cm X 0.2 cm. The wound bed had 80 % slough and 20 % granulation tissue. The wound was "worsening" and included "eschar, slough, and odor." The facility Wound NP further documented, "If sacral wound does not start to improve, or if she starts to develop more wounds, consider as possible end of life and initiate hospice discussion." The facility Wound NP further changed the treatment recommendations to the following: The wound was to be cleansed with a 0.125 % Dakin's solution (Dakins is a special cleaning agent for wounds which can help prevent infection and odor. It consists partially of diluted sodium

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hypochlorite which is commonly known as bleach); after cleansing with Dakins, Santyl (an enzymatic debriding agent) was to be added to the base of the wound and calcium alginate was also to be added; the pressure sore was then to be covered with a bordered gauze and changed every three days and as needed.

Review of orders revealed the Wound NP's recommendations were not followed in the entirety. An order was entered into the electronic record on 1/14/25 to cleanse the wound with normal saline or wound cleanser. Then Santyl was to be applied to the wound bed following by calcium alginate and a dry dressing. There was no mention of cleaning the wound with the Dakin's solution. The order was also again entered as a daily dressing change rather than the three times per week as the Wound NP had noted. This order remained in effect until the resident's discharge to the hospital on 1/17/25.

According to facility progress notes, on the date of 1/17/25, Resident # 1 sustained a fall and was transferred to the hospital. Prior to her transfer to the hospital a hospice referral was made and Resident # 1 elected to have hospice services, which were scheduled to begin 1/19/25.

The Facility Wound Nurse was interviewed on 2/12/25 at 8:50 AM and reported the following. She had been a wound care nurse for 10 years. Resident # 1's wound was worsening similar to other residents who she had seen in the end stage of their life. She (the Facility Wound Nurse) usually made rounds with the Wound NP and wrote the Wound NP's treatment recommendations as they saw residents together. Then she (the Facility Wound Nurse) would enter

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the orders following wound rounds into the electronic record. When the Wound NP initially saw Resident # 1 on 1/3/25, she (the Facility Wound Nurse) thought the Wound NP said to perform the dressing changes every day. She (the Facility Wound Nurse) did not realize the recommendation had been for three times per week. When the Wound NP saw Resident # 1 on 1/14/25 and recommended using Dakin's on the pressure sore, she (the Facility Wound Nurse) did not think that both Santyl and Dakin's could be used at the same time in the wound bed. She recalled mentioning this to the Wound NP and thought that the Wound NP then gave directions that the wound could be cleaned with wound cleanser or saline. It was her understanding that Dakin's did not have to be used in the care of Resident # 1's pressure sore while it was being treated with Santyl and that the dressing changes should be continued as daily.

The Wound NP was interviewed on 2/12/25 at 1:10 PM and reported the following information. When she assessed Resident #1's sacral pressure sore on 1/14/25, she noted the pressure sore had significantly worsening. She changed the treatment but felt there might be something terminal with the resident's health that was contributing to the pressure sore worsening so quickly. It was not typical to see such a decline. The resident's cognition also seemed to be getting worse and on 1/14/25 the resident was resistive to wound care as the dressing was changed. She (the Wound NP) recalled that the Facility Wound Nurse mentioned that she did not think Dakin's solution and Santyl worked together. At the time, she (the Wound NP) had not intended that the pressure sore wound bed be packed with both Santyl and Dakin's, and the use

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F 686	Continued From page 25 of the Dakin's was only for cleansing purposes. At the end of wound rounds at the facility, she (the Wound NP) always placed a note in the resident's record with her assessments and recommendations. This was entered the day she saw residents or no later than the following day. She also verbally told the Facility Wound Nurse the treatments she recommended and the Wound Nurse would enter the orders. She also prepared a full wound report with recommendations for every resident she sees on wound rounds. She did not see Resident # 1 again following 1/14/25 and did not know there had continued to be a question about using Dakin's and that the recommendation was not followed. Resident # 1's primary physician was interviewed on 2/13/25 at 11:50 AM and again on 2/14/25 at 5:07 PM. According to the physician Dakins solution is primarily used to control odors in the wound. According to the physician, the resident was hospice appropriate and had multiple organ failure soon following the development of the pressure sore and prior to her expiration.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		3/6/25

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F 842	Continued From page 26 §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842		

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F 842	Continued From page 27 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the medical record was complete regarding circumstances of a fall and assessments following a fall when a resident was injured. This was for one of four (Resident # 5) residents reviewed for falls. The findings included: Record review revealed Resident # 5 resided at the facility from 1/27/25 until 2/8/25. A review of the record revealed one nursing note on 2/8/25 at 10:00 AM which read, "Resident wife notified facility that resident was being admitted to hospital." There was no documentation of acute problems or a fall on 2/8/25 before this note on 2/8/25 at 10:00 AM. Review of the resident's record revealed an entry two days later on 2/10/25 at 10:49 AM by the Minimum Data Set assessment nurse which noted the interdisciplinary team had reviewed a	F 842	F842 Resident Records □ Identifiable Information 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #5 is no longer in the community. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. DON and/or Unit Managers reviewed the last 14 days of falls to ensure that the medical record for each fall is complete regarding circumstances of the fall and assessment following the fall when a resident was injured.	

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F 842	Continued From page 28 fall the resident sustained on 2/8/25 when he attempted to walk to the bathroom and fell. The note indicated the resident had been sent to the emergency room on 2/8/25. There was no documentation in the 2/10/25 nursing entry about when the resident fell on 2/8/25 or any assessment of injuries following the fall. Nurse # 5 was interviewed on 2/11/25 at 3:50 PM and reported the following information. She had cared for Resident # 5 on the night shift which ended on 2/8/25 at 7:00 AM. Resident # 5's Nurse Aide had recently checked on the resident prior to the resident being found on the floor around 6:10 AM to 6:20 AM on 2/8/25. She had assessed the resident and found him to have a hematoma on his head and the resident complained of pain. He was transferred to the hospital for evaluation. Interview with the facility's Nurse Consultant on 2/17/25 at 5:02 PM revealed documentation of circumstances of a fall and assessment should be in a resident's record.	F 842	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Unit Managers educated the Nurses to ensure that the medical record for each fall is complete regarding circumstances of the fall and assessment following the fall when a resident was injured. Education to be completed by March 6, 2025. For three months, the Unit Managers will review progress notes in the Daily Clinical Meeting 5X per week to ensure that the medical record for each fall is complete regarding the circumstances of the fall and the assessment following the fall when a resident was injured. For three months, Results of this review will be documented on the Resident Records Audit by DON and/or Unit Managers. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator and/or the Director of Nursing will report the findings of this monitoring process to the Community□s Quality Assurance Performance Improvement Committee for additional monitoring or modifications of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI Committee can modify this plan to	

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F 842	Continued From page 29	F 842	ensure the facility remains in substantial compliance. 5. Include dates when corrective action will be completed. Date of Compliance: March 6, 2025	