STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE ROAD EDENTON, NC 27932

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E 000	Initial Comments An unannounced recertification and complaint investigation was conducted on 3/31/2025 through 4/2/2025. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID# JBEK11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/31/2025 through 4/2/2025. Event ID#JBEK11. The following intakes were investigated NC00223711 and NC00217873. 2 of the 2 complaint allegations did not result in a deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to assess a resident for self-administration of medication for 1 of 3 residents reviewed for medication administration (Resident #10). The findings included: Resident #10 was admitted to the facility on 4/8/21 with diagnoses that included dementia without behavioral disturbances and chronic obstructive pulmonary disease.	F 554	On 4-23-25, the Director of Nursing verbally educated nurse #3 on ensuring resident takes medications as prescribed and not leaving medications at resident bedside unless a Self-Administration of Medications assessment has been completed and physician order obtained for resident to self-administer medications. On 4-18-25, the ADON completed an assessment for Medication Self	4/30/25

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

Electronically Signed | 04/25/2025

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F 554	Continued From page 1 Resident #10's care plan last reviewed 1/22/25 did not include self-administration of medication. There was not an assessment of Resident #10 in the medical record to determine if it was safe for the resident to self-administer medications. Review of the annual Minimum Data Set (MDS) dated 1/22/25 revealed Resident #10 was cognitively intact. Review of the medical record revealed a physician order dated 3/1/24 for Fluticasone-Salmeterol 250-50 MCG/ACT (micrograms per actuation) Aerosol Powder (a medication used to relax the muscles in the airways to improve breathing). Breath activated 1 puff inhale orally two times a day for shortness of breath/wheezing. On 03/31/25 at 10:36 AM Resident #10 was observed with a Fluticasone-Salmeterol inhaler sitting on her bedside table. Resident #10 reported Nurse #3 left the inhaler there for her to take because she had asked to wait. Resident #10 stated she had administered the inhaler herself, and Nurse #10 would come back to pick up the inhaler An interview was conducted with Nurse #3 on 03/31/25 at10:43 AM. Nurse #3 stated she was supposed to make sure Resident #10 administered the inhaler and rinsed her mouth out after administration. Nurse #3 stated she was supposed to get the inhaler back after the medication was administered. Nurse #3 stated she was talking to other staff in the room and forgot to get the inhaler back.	F 554	Administration for resident #10. The resident was determined “not safe” to self-administer inhaler medications. On 4-23-25, the Unit Nurse Coordinator completed an audit of all resident rooms. This audit is to ensure medications were not left at the resident bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. The audit will be completed by April 30,2025. On 4-17-25, the Staffing Development Coordinator initiated Med Pass Audits with all nurses and medication aides. This audit is to ensure the nurse and/or medication aid administered medications following the rights to medication administration and to ensure that the nurse and/or medication aid did not leave medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. The Director of Nursing will address all concerns identified during the audit to include but not limited to the education of staff. The audit will be completed by April 30, 2025. After April 30, 2025, any nurse or medication aid who has not completed the audit will complete upon next scheduled work shift. On 4-17-25, the Staffing Development Coordinator initiated an in-service with all nurses to include nurse #3 and medication aides regarding Rights of Medication Administration with emphasis	

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F 554	Continued From page 2 An interview was conducted with the Director of Nursing on 03/31/25 at 11:53 AM. The DON stated Nurse #3 should have stayed with Resident #10 and watched her take the medication. The DON further stated once Resident #10 told the nurse that she wanted to wait to take the medication Nurse #3 should have taken the medication out of the room and brought it back later. An interview was conducted with the Administrator on 04/02/25 at 05:11 PM. The Administrator stated she expected Resident #10 would have been assessed for self-administration and the medication placed in a secure location.	F 554	on administering medication per physician order to include right medication at the right time and not leaving medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. In-service will be completed by April 30, 2025. After April 30, 2025 any nurses or medication aid who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses and or medication aides will be in-serviced during orientation regarding Rights of Medication Administration. The Staffing Development Coordinator will complete 5 random Med Pass Audits with nurses to include nurse #3 and medication aides weekly x 4 weeks then monthly x 1 month. This audit is to ensure the nurse and/or medication aid administered medications following the rights to medication administration and to ensure that the nurse and/or medication aid did not leave medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. Audits will include all shifts and weekends. The Director of Nursing will address all concerns identified during the audit to include but not limited to re-education of staff. The Administrator will review the Med Pass Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Unit Nurse Coordinator will audit all	

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F 554	Continued From page 3	F 554	10 resident rooms twice weekly x 4 weeks then monthly x 1 month. This audit is to ensure medications were not left at the resident bedside unless the resident had been assessed to safely self-administer medications and a physician order obtained. The Director of Nursing will address all concerns identified during the audit to include ensuring medications are administered per physician order and/or re-training of staff. The Director of Nursing will review the room audits twice weekly x 4 weeks and then monthly x 1 month to ensure all concerns are addressed. The Quality Assurance Nurse will present the findings of the Med Pass Audits and Room Audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		4/30/25

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F 623	Continued From page 4	F 623		

discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email),

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F 623	Continued From page 5	F 623		

and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of

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F 623	Continued From page 6 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide written notice of discharge or transfer including the reason for the hospital transfer to the resident and resident representative for 2 of 5 residents reviewed for hospitalization (Resident #44, Resident #114). The findings included: 1. Resident #44 was admitted to the facility on 3/23/25. Review of an incident note dated 11/26/24 revealed Resident #44 was sent to the emergency department due to complaint of left hip pain. Resident #44 was readmitted to the facility on 12/2/24. Review of the Significant Change Minimum Data Set (MDS) assessment dated 12/6/24 revealed Resident #44 had severe cognitive impairment. There was no evidence in the electronic medical record that written notification of discharge or transfer was provided to the resident or resident representative when the resident was transferred to the hospital. The Social Worker was not available for interview.	F 623	On 4-23-25, the Administrator completed and mailed a notice of transfer to resident #44's resident representative for hospital transfer November 26, 2024. On 4-25-25, the Administrator completed and mailed a notice of transfer to resident #114's resident representative for hospital transfer March 10, 2025. On 4-23-25, the Social Worker initiated an audit of all resident transfer/discharges for the past 30 days. This audit is to ensure the resident/resident representative, and the Ombudsman received written notification indicating the reason for transfer/discharge from the facility. The Social Worker will address all areas of concern identified during the audit to include providing written notification with reason of transfer to the resident/resident representative and Ombudsman and education of staff. The audit will be completed by April 30, 2025. On 4-16-25, the Administrator initiated an in-service with nurses, Social Worker, Director of Nursing (DON), and Assistant Director of Nursing (ADON) regarding Notification of Ombudsman and Resident Representative for Discharges/Transfers to include mailing a written Notice of Transfer/Discharge to the	

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F 623	Continued From page 7 An interview was conducted with the Administrator on 4/2/25 at 5:05PM. The Administrator stated the Social Worker was responsible for providing the written notice of discharge or transfer. The Administrator stated the Social Worker was new in the position and the facility had arranged for her to do onsite training at a sister facility to learn what forms and duties she was required to complete. The Administrator further stated the written notice of discharge or transfer should include the reason for the transfer and should be sent to the resident or resident representative anytime a resident is transferred to the hospital. 2. Resident #114 was admitted to the facility on 2/28/25. Review of the health status note dated 3/11/25 revealed Resident #114 was in the hospital. Review of the Admission Minimum Data Set (MDS) assessment dated 3/4/25 revealed Resident #114 had severe cognitive impairment. Resident #114 was readmitted to the facility on 3/14/25. There was no evidence in the electronic medical record that written notification of discharge or transfer was provided to the resident or resident representative when the resident was transferred to the hospital. The Social Worker was not available for interview. An interview was conducted with the Administrator on 4/2/25 at 5:05PM. The	F 623	resident/resident representative with documentation in clinical record and a copy of the Notice of Transfer/Discharge to the Ombudsman. In-services will be completed by April 30, 2025. All newly hired nurses, social workers, DON, and/or ADON will be in-serviced by the Staff Facilitator during orientation regarding Notification of Ombudsman and Resident Representative for Discharges/Transfers. The Admission Coordinator will complete an audit of 10% resident transfers/discharges utilizing the Notification Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure the resident/resident representative receives a written notification indicating the reason for transfer/discharge from the facility and that a copy of the written notification was provided to the Office of the State Long-Term Care Ombudsman. The Administrator will address all concerns identified during the audit to include the re-training of staff and mailing of Notice of Transfer as indicated. The Administrator will forward the Notification Audit Tools to the QAPI Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 623	Continued From page 8 Administrator stated the Social Worker was responsible for providing the written notice of discharge or transfer. The Administrator stated the Social Worker was new in the position and the facility had arranged for her to do onsite training at a sister facility to learn what forms and duties she was required to complete. The Administrator further stated the written notice of discharge or transfer should include the reason for the transfer and should be sent to the resident or resident representative anytime a resident is transferred to the hospital.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		4/30/25

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F 656	Continued From page 9 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to update the care plan to reflect the change in smoking status for 1 of 1 sampled resident (Resident #33). The findings included: Resident #33 was admitted to the facility on 10/30/20 with diagnoses that included nicotine dependence. The quarterly Minimum Data Set (MDS) assessment dated 3/6/25 indicated Resident 33 was unable to answer questions to perform an adequate BIMS assessment. Resident #33 was coded as having impairment on one side to upper extremity and lower extremity.	F 656	On 4-17-25, the MDS Coordinator updated the care plan for resident #33 to accurately reflect smoking status/safety. On 4-23-25 the MDS Coordinator initiated an audit of all residents who smoke or desire to smoke to ensure the resident is care planned accurately for smoking status and safety, the care plan is person centered with measurable objectives and timeframes to meet the resident's needs. The Director of Nursing will address all concerns identified during the audit to include updating the care plan when indicated and/or education of staff. The audit will be completed by April 30, 2025.	

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F 656	Continued From page 10 The comprehensive care plan for Resident #33 was last updated on 3/10/25. The care plan included in part the focus area of Resident #33 is a safe smoker. The interventions included to evaluate residents' continued ability to smoke safely on a consistent and regular basis. Review of Resident #33's most recent smoking evaluation dated 3/28/25 revealed the resident required supervised smoking due to his being an unsafe smoker and requires direct supervision whole smoking because he allows lit material to fall outside of the ashtray. This evaluation was completed by Nurse #4. Attempts to interview Nurse #4 by phone were unsuccessful. An interview was conducted with the MDS Coordinator on 4/1/25 at 1:05 PM. She indicated staff took turns going out with the residents on smoking duty. The MDS Coordinator stated she had observed Resident #33 on 3/28/25 and did not see any indication his smoking status had changed. She stated the interdisciplinary team reviews the 24-hour report in the standup meeting every morning and the stand down meeting in the evening. The MDS Coordinator stated the change in smoking status was supposed to be placed on the 24-hour report so it would be discussed in stand-up/stand down meeting and care plan updated at that time. MDS Coordinator stated the 24-hour report was part of the electronic medical record and it was populated by the information the nurses place on the report. The MDS Coordinator stated she must have overlooked Resident #33's smoking assessment on 3/28/25. The MDS Coordinator stated she was responsible	F 656	On 4-17-25, the Staffing Development Coordinator initiated an in-service with all nurses regarding Care Plans with emphasis on the responsibility of the nurse to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident’s medical, nursing, and mental/psychosocial needs to include but not limited to resident’s smoke status/safety. In-service will be completed by April 30, 2025. After April 30, 2025, any nurse who has not completed the in-service will be in-serviced prior to the next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Care Plans. The Director of Nursing will review all newly identified residents who smoke or desire to smoke weekly x 4 weeks then monthly x 1 month using the Care Plan Audit Tool. This audit is to ensure the resident is care planned accurately for smoking status/safety, the care plan is person centered with measurable objectives and timeframes to meet the resident’s needs. The Director of nursing will address all concerns identified during the audit to include updating the care plan when indicated and/or re-training of staff. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Director of Nursing will forward the results of Care Plan Audit Tool to the	

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F 656	Continued From page 11 for updating the care plan after the change in Resident #33's smoking status. An interview was conducted with the DON on 04/01/25 at 01:13 PM. The DON stated that the 24-hour report was reviewed every morning in the morning meeting. She stated the nurse was responsible for making sure the change to Resident #33's smoking status was communicated on the 24-hour report. The DON stated Nurse #4 should have updated the care plan to reflect the resident's status.	F 656	Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to obtain a physician order for the management of a peripherally inserted central catheter (PICC) for 1 of 2 residents reviewed for intravenous antibiotic use (Resident #41). The findings included: Resident #41 was admitted to the facility on 2/29/24 with diagnoses that included obstructive uropathy (disorder that occurs when urine flow is blocked in the urinary tract), urinary tract infection, and diabetes.	F 694	On 4-2-25, a physician order was obtained for the management of a peripherally inserted central catheter (PICC) for resident #41 by the Unit Nurse Coordinator. On 4-21-25 the Director of Nursing (DON) initiated an audit of all residents with orders for intravenous catheter to ensure a physician order was obtained for the management of a peripherally inserted central catheter (PICC) line to include flushes. The DON will address all concerns identified during the audit to include obtaining a physician order when	4/30/25

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F 694	Continued From page 12 Review of Resident #41's active March 2025 Physician Orders revealed an order dated 3/26/25 for Piperacillin-Sodium Tazobactam Solution (antibiotic), administer 4.5 grams intravenously every 12 hours for 10 days. There were no orders for a PICC line. An interview was completed on 4/1/25 at 2:32 pm with Nurse #2 who revealed she received the PICC line placement order and intravenous antibiotic order from the Physician on 3/26/25. Nurse #2 stated she entered the order for the intravenous antibiotic so the pharmacy would fill and send the medication as soon as possible. Nurse #2 revealed the Unit Nurse Coordinator normally followed up and entered the orders for the PICC line and the management of it. Nurse #2 stated she was unsure why the orders were not entered that day (3/26/25). Nurse #2 stated she knew from previous experience to flush the PICC line prior to medication administration and after medication administration. A nursing progress note dated 3/26/25 by Nurse #3 stated at 11:30 am vascular wellness placed a PICC line in the Resident #41's left upper arm per the Physician's order. The note revealed the antibiotic was administered to Resident #41 per Physician's order. Resident #41 had a care plan initiated 3/26/25 for a urinary tract infection requiring intravenous antibiotics with interventions that included medications as ordered by the Physician, enhanced barrier precautions, and monitor for redness or drainage around PICC line site. An observation on 4/1/25 at 12:49 pm with Resident #41 revealed a single lumen (1 port)	F 694	indicated and education of the staff. Audit will be completed by 4/30/25. On 4-21-25 the Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding management of a peripherally inserted central catheter (PICC) line to include flushes and clarifying order when no order is in place. In-service will be completed by 4/30/25. After 4/30/25, any nurse who has not received the education will complete prior to next scheduled work shift. All newly hired nurse will be educated during orientation. The Unit Nurse Coordinator will audit all residents with orders for intravenous catheters to ensure a physician order was obtained for the management of a peripherally inserted central catheter (PICC) line to include flushes weekly x 4 weeks then monthly x 1 month utilizing the peripherally inserted central catheter (PICC) line Audit Tool. This audit is to ensure physician order was obtained for the management of a peripherally inserted central catheter (PICC) line to include flushes. The Assistant Director of Nursing (ADON) will address all concerns identified during the audit to include obtaining a physician order when indicated and re-education of staff. The Director of Nursing will review the peripherally inserted central catheter (PICC) line Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.	

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F 694	Continued From page 13 PICC line (form of intravenous access that can be used for a prolonged period for the administration of medications) was located in the left upper arm with antibiotic medication infusing. An interview was completed on 4/1/25 at 1:03 pm with Nurse #1 who was assigned to administer Resident #41's antibiotic medication on 4/1/25. Nurse #1 stated she did notice that PICC line management orders were not entered, but she stated she flushed the PICC line before and after the antibiotic medication was administered. She stated she knew from previous experience that the PICC line required to be flushed prior to the antibiotic to make sure it was not clogged and after the medication was completed to make sure all the medication was administered. Nurse #1 stated she did not know if other orders were required for Resident #41's PICC line use and management. A telephone interview was completed on 4/1/25 at 3:05pm with the facility's Physician. The Physician revealed he recalled providing the verbal order for the PICC line placement and intravenous antibiotic for Resident #41. The Physician stated it was his expectation the facility entered the orders for the PICC line and its management in the Resident's electronic medical records. An interview was completed on 4/2/25 at 10:43 am with the Director of Nursing (DON). The DON stated the Unit Nurse Coordinator, and the (ADON) assisted floor nurses with entering resident treatment and medication orders. The DON stated the facility did not have standing orders for PICC line use and management. The DON revealed physician orders for the use and	F 694	The Director of Nursing will forward the results of peripherally inserted central catheter (PICC) line Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the peripherally inserted central catheter (PICC) line Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 694	Continued From page 14 management of Resident #41's PICC line should have been entered when order for the intravenous antibiotic was entered. The DON was unable to state how the orders were missed for Resident #41's PICC line and the management of it. An interview was completed on 4/2/25 at 4:45 pm with the facility Administrator. The Administrator stated she felt it was a break in communication between nursing staff as to who was going to enter the orders for Resident #41.	F 694		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to restrict the fluid intake for a resident with End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids) as ordered by the physician for 1 of 1 sampled resident reviewed for dialysis (Resident #114). The findings included: Resident #114 was admitted to the facility on 2/28/25 with diagnoses that included chronic congestive heart failure, chronic pulmonary edema, and dependence on renal dialysis.	F 698	On 4-2-25, the ADON clarified the order for fluid restriction for resident #114. The electronic medication administration record (eMAR) was updated to reflect the amount to be provided by dietary with meals and nursing staff each shift. On 4-23-25 the Unit Nurse Coordinator initiated an audit of all residents with orders for fluid restriction. This audit is to ensure the order reflects the amount to be provided by the dietary department with meals and by nursing staff each shift. The Director of Nursing will address all concerns identified during the audit to	4/30/25

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F 698	Continued From page 15 Review of Resident #114's care plan initiated on 2/28/25 identified the resident was at risk for complications due to hemodialysis, End Stage Renal Disease (ESDR). Resident is on 1500 ml (milliliters)/day restriction. The interventions to this problem included providing diet as ordered and fluid restriction as ordered by the physician. Review of the medical record revealed a physician's order dated 3/4/25 for 1500 ml fluid restriction: Nurse to give 240ml per shift every day and night shift. Review of the admission Minimum Data Set (MDS) dated 3/4/25 revealed Resident #114 had severe cognitive impairment with no behaviors. Resident #114 was independent with eating and required staff assistance for setting up her tray. She was receiving hemodialysis. Review of the March 2025 medication administration record (MAR) revealed an order dated 3/4/25 for Fluid Restriction: Nurse to give 240 ml per shift every day and night shift. Nursing staff initialed as provided through 3/10/25 when Resident went to the hospital. The order was discontinued on 3/14/25 when Resident #114 reentered the facility after a hospital stay. Resident #114 was discharged to the hospital on 3/10/25 and readmitted to the facility on 3/14/25. The hospital discharge summary dated 3/14/25 specified under diet that Resident should not have more than 1400 ml of fluid per day. Review of Resident #114's physician orders revealed no order was entered on 3/14/25 for the 1400 ml per day fluid restriction.	F 698	include but not limited to clarifying the order and updating eMAR when indicated. The audit will be completed by April 30, 2025. On 4-23-25, the Unit Nurse Coordinator initiated an audit of all admissions/readmissions for the past 30 days. This audit is to identify any resident with recommendations for fluid restrictions to ensure the order is transcribed to the eMAR and accurately reflects the amount to be provided by the dietary department with meals and by nursing staff each shift. The audit will be completed by April 30, 2025. On 4-21-25, the Staffing Development Coordinator initiated an in-service with nursing staff regarding Fluid Restrictions with emphasis on (1) ensuring the order is transcribed to the eMAR and accurately reflects the amount to be provided by the dietary department and by nursing staff each shift, (2) documentation of amount provided and (3) notification of the provider when the resident exceeds recommended amount per 24hrs for further recommendations. The in-service will be completed by April 30, 2025. After April 30, 2025, any nurse who has not completed the in-service will complete it prior to the next scheduled work shift. All newly hired nurses will be educated during orientation. The Unit Nurse Coordinator will audit 10% of new admissions/readmissions with recommendations for fluid restriction or	

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F 698	Continued From page 16 Resident #114 was discharged to the hospital on 3/23/25 and was readmitted to the facility on 3/28/25. Review of the medical record revealed a physician order dated 3/28/25 for No Added Salt diet, Regular texture and thin consistency fluids. Resident #114 was ordered a 1200 ml a day fluid restriction. The order was received and processed by the Unit Nurse Coordinator. Review of the MAR from 3/14/25 to 4/2/25 revealed no entry for nursing staff to document fluid intake for Resident #114. An interview was conducted with the Unit Nurse Coordinator on 04/02/25 at 01:22 PM. The Unit Nurse Coordinator stated once she entered the fluid restriction order for Resident #114 on 3/28/25, she put the information on the dietary sheet and took it to the kitchen. The Unit Nurse Coordinator stated she did not have a discussion with the dietary department about the fluid distribution. The Unit Nurse Coordinator was unable to state why she did not consult with the dietary department about Resident #114's fluid distribution for nursing staff. She stated a breakdown of the fluid distribution for nursing should go on the MAR. The Unit Nurse Coordinator stated the nurse taking off the fluid restriction order was responsible for putting the fluid distribution on the MAR. An interview was conducted with Nurse #2 on 4/2/25 at 11:05 AM. Review of the electronic medical record with Nurse #2 revealed she was unaware of the change in Resident #114's fluid	F 698	newly written orders for fluid restriction weekly x 4 weeks then monthly x 1 month utilizing the fluid restriction audit tool. This audit is to ensure the nurse transcribed the order accurately to the eMAR to include the amount to be provided by the dietary department with meals and by nursing each shift, the nurse documents amount provided, the provider is notified when the resident exceeds fluid limit with documentation in the electronic record. The Director of Nursing will address all concerns identified during the audit to include clarifying the order, update eMAR when indicated and re-training of staff. The Director of Nursing will review the fluid restriction audit weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will present the findings of the Fluid Restriction Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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restriction volume. She stated once an order for fluid restriction was received it was the nurse's responsibility to complete the dietary notification slip and give it to the dietary staff. Nurse #2 stated Dietary had a chart that explained the amount of fluid the resident was to receive from dietary and nursing. Nurse #2 stated she had been giving Resident #114 240 milliliters (ml) of fluid every day and night shift. Nurse #2 stated it was the nurse's responsibility to enter the order for nursing fluid intake on the Medication Administration Record (MAR). Nurse #2

An interview was conducted with the Dietary Manager (DM) on 4/2/25 at 11:10 AM. The DM stated she was aware that Resident #114's fluid restriction had changed. The Dietary Manager stated she received a dietary notification slip on 3/28/25. The Dietary manager stated dietary had been putting 1,080 milliliters (ml) of fluid divided between breakfast, lunch and dinner.

An observation of a discussion was conducted of Nurse #2 and the Dietary Manager on 4/2/25 at 11:13 AM. Nurse #2 and the Dietary Manager discussed the distribution of fluids for Resident #114 over 24 hours. Nurse #2 indicated to the Dietary Manager that Nursing would only be able to give the resident 120 ml of fluid if dietary was sending out 1,080 ml with meals. Nurse #2 stated that the amount of fluid was not sufficient for Resident #114's medication pass. The Dietary manager removed 240 ml from her dietary fluid distribution so that nursing would have enough fluids to administer with medications.

An interview was conducted with the Director of Nursing on 4/2/25 at 11:20 AM. Resident #114's medical record was reviewed during the interview

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and revealed a physician order for 1500 ml fluid restriction prior to the resident going to the hospital on 3/10/25. Further review revealed Resident #114 did not have an order entered on the MAR for fluid restriction when she came back to the facility on 3/14/25. The DON stated the order must have fallen off the orders, because Resident #114 had a fluid restriction order with distribution for nursing staff prior to her going to the hospital. Continued review of the medical record revealed there was no order for fluid intake from nursing for Resident #114 for the 1200 ml fluid restriction entered on 3/28/25. The DON stated an order for fluid restrictions should have been entered by the nurse who received the order. She stated the nurse, and dietary would collaborate and discuss the amount of fluid from dietary and nursing. The DON stated an order was then entered on the MAR to reflect the amount of fluid to be provided by nursing staff. The DON stated the updated fluid restriction order had not been entered correctly by the Unit Nurse Coordinator on 3/28/25, so that information did not trigger on the 24-hour report. The DON further stated that the Unit Coordinator did not collaborate with the dietary department for Resident #114's fluid restriction breakdown so there was no nursing order for the amount of fluid to be provided by nursing staff.

An interview was conducted with the Administrator on 04/02/25 at 05:10 PM. The Administrator stated she expected that dietary and nursing would communicate so that fluid restrictions would be validated.