STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105819	A. Building B. Wing	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Hall Nursing and Rehab Center	1800 SE Hillmoor Drive Port Saint Lucie, FL 34952

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38212 Based on interview and record review, the facility failed to ensure shower preferences and schedules for 2 of 3 sampled residents reviewed for showers, Residents #25 and #40. The findings included: Resident #25 was admitted to the facility on [DATE] with diagnoses to include in part, Generalized Anxiety Disorder, Restless Leg Syndrome, Diabetes Mellitus, Hypertension, Glaucoma, Pain, and Fibromyalgia. Resident #25 had a BIMS (Brief Interview for Mental Status) of 15. The score of 15 indicates the resident is cognitively intact. On 11/06/23 at 9:18 AM, Resident #25 was interviewed, who stated she had not received a shower since her admission, and she would like to have one. The resident's shower and bathing schedules were reviewed. The documentation revealed the resident was scheduled to have a shower every Wednesday and Saturday. The documentation also revealed the resident had not received a shower in the past 30 days. No documentation was found which indicated the resident refused any showers. Resident #40 was admitted to the facility on [DATE] with diagnoses to include in part, Alzheimer's Disease, Peripheral Vascular Disease, Type 2 Diabetes Mellitus, Atherosclerotic Heart Disease, Acquired Absence of Left Leg Below the knee, Major Depressive Disorder and Edema. Resident #40 had a BIMS score of 9 indicating moderate impaired cognition. On 11/06/23 at 9:53 AM, Resident #40 was interviewed. He stated he has not had a shower for a long time. He stated he would really like to have a shower. The resident's shower and bathing schedules were reviewed. The documentation revealed the resident chooses to have showers on Wednesday, in the evening. The documentation also revealed the resident had not received a shower in the past 30 days. No documentation was found in the residents' chart to indicate the resident had refused any showers. On 11/08/23 at approximately 9:05 AM, Staff D, CNA (Certified Nursing Assistance), was interviewed. She was asked about the process for bathing and showers. She stated she would document it in the POC (Point of Care/the task section of the electronic medical record). She stated if a resident refuses a shower, then the CNA will tell the resident's nurse and they will document it in the progress notes. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/09/23 at 8:25 AM, Staff E, CNA, was interviewed. She was asked about the shower and bathing process and where documentation was found. She stated she would document it in the POC (Point of Care/the task section of the electronic medical record) She stated if a resident refuses a shower, then the CNA will tell the resident's nurse and they will document it in the progress notes. On 11/09/23 at 11:02 AM, the East Wing Unit Manager was interviewed concerning the residents shower schedule. The task section and progress notes were reviewed with the Unit Manager for Resident #25 and #40. No documentation was found for showers or refusal of showers in the past 30 days. The Unit Manager agreed there was no evidence of the residents receiving showers.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on record review and interview, the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC) letter appropriately and in a manner to afford the resident and the resident's representative the opportunity to submit an appeal to the discharge, prior to a resident being discharged from Medicare Part A Skilled services, for 1 of 3 sampled residents reviewed, Resident #261. The findings included: Record review revealed Resident #261 was admitted on [DATE]. Review of the Admission / Medicare 5-day Minimum Data Set, dated dated [DATE], revealed Resident #261 had a Brief Interview for Mental Status (BIMS) score of 03, indicating the resident had severe cognitive impairment. Resident #261's diagnoses at the time of the assessment included: Myocardial Infarction, Dementia, Major Depressive Disorder, Cognitive Communication Deficit, Psychosis and Alzheimer's Disease. It was determined that Resident was non interviewable based on resident not being able to give reasonable answers to basic questions. On [DATE] at 9:36 AM, an attempted interview was conducted with the resident, who was asked how long he had been a resident and stated, about an hour. The resident was asked about the meals that were being served and stated that he was still waiting for breakfast (breakfast had been served at 7:45 AM). A NOMNC letter, signed by Resident #261 on [DATE], documented, the Effective Date Coverage of your Current Skilled Nursing Services will end [DATE]. During an interview, on [DATE] at 1:48 PM, with Staff I, Registered Nurse (RN), when asked about the resident's cognition, Staff I replied, intermittent, there are times that he responds appropriately, and other times is incapable of answering questions. He has dementia. When asked about the resident's ability to make health care decisions, Staff I replied, he would not be able to make his own health care decisions. During an interview, on [DATE] at 9:03 AM, with Staff J, RN, when asked about the resident's cognition, Staff J replied, he is not alert and oriented. Sometimes he is alert and has confusion. Staff J further stated that Resident #261 would not be able to make health care decisions. During a interview, on [DATE] at 9:08 AM, with Staff K, Restorative Physical Therapist (RPT), when asked about the resident's cognition, Staff K replied, he is alert with confusion and oriented times ,d+[DATE], he can tell you what state he is in. During an interview, on [DATE] at 09:09 AM, with the Speech Therapist (ST), when asked about Resident #261's cognition, the ST replied, before he came here he was living with his wife until she died and then he lived alone. He has had a significant decline in cognition since he has been here. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] at 10:40 AM, with the Social Services Director, when asked about Resident #261, signing his own NOMNC, the Social Services Director replied, 2 weeks prior, I got his brothers consent that if I needed a signature that I could get it from the resident., his brother was getting ready to have a surgery and would not be available. I told him that he was going to re-class (referring to the resident being discharged from Medicare Part A) before he had his operation (the brother). The Social Services Director was unable to provide evidence of notification to the resident's responsible party brother or documentation of Power of Attorney.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38212 Based on interview, policy review and documentation, the facility failed to follow the grievance process related to missing clothing for 4 of 6 sampled residents reviewed for missing clothing, Residents #25, #72, #77 and #263. The finding included: The policy, titled, Misappropriation of Residents Property and revised 03/28/17 documented in part: Reports of misappropriation or mistreatment of resident's property are to be investigated through the resident's grievance process and documented in the progress notes through the grievance process. The policy, titled, Grievances and revised 10/30/19, documented in part: 1. When a resident or anyone acting on their behalf has a grievance a staff member shall encourage and assist the resident, or person acting on the resident's behalf, to file a grievance with the facility using the Grievance Report. 1. Resident #25 was admitted to the facility on [DATE] with diagnoses to include: Generalized Anxiety Disorder, Restless Leg Syndrome, Diabetes Mellitus, Hypertension, Glaucoma, Pain, and Fibromyalgia. Resident #25 had a BIMS (Brief Interview for Mental Status) of 15, indicating the resident is cognitively intact. On 11/06/23 at 9:25 AM, Resident #25 was interviewed, who stated she had nothing to wear because all her clothes were missing. She stated she had told the nurses and the CNA's (Certified Nursing Assistance), and no one has found her clothing, 2. Resident #263 was admitted to the facility on [DATE] with diagnosis to include: Fracture of Right Lower leg, Difficulty in Walking, Hypertension, Major Depressive Disorder, Present of Cardiac Pacemaker and History of Other Venous Thrombosis and Embolism. Resident #263 had a BIMS score of 13, indicating the resident is cognitively intact. On 11/06/23 at 2:48 PM, Resident #263 was interviewed, who stated she is missing all her clothing. She stated she had told the laundry and stated Staff C, an MDS (Minimum Data Set) Coordinator was aware of her missing clothes. She stated she was given someone's clothes to wear and this morning when she was in Physical Therapy another resident pointed at her and said, those are my clothes you are wearing. During an interview conducted on 11/07/23 at 1:46 PM, when asked the process for missing clothing, the Social Service Director (SSD) stated they would get a description of the missing items, check the inventory log for personal items, go to the laundry and try to locate the missing items, inform the laundry staff and initiate a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 11/08/23 at approximately 12:05 PM with Staff A, who identified herself as a Laundry Employee. She was asked what the process was for missing clothing for the residents and stated they are notified about the missing clothing from different sources. She stated they will search the clothing for the patient's name which is written on the back of the clothing. She stated they will go to the resident and ask for a description or ask the family for description. She stated they usually can find the items. If they are unable to find the items, then their SSD will write a grievance. On 11/08/23 at 12:10 PM, the BOM, (Business Office Manager) was interviewed. She was asked about her role regarding the inventory of property for the resident and stated when the family brings in any new clothing, she will send it to the laundry department to mark with the resident's name. She stated when a new resident is initially admitted then the nurse or CNA completes the inventory sheet. The documentation was reviewed for Residents #25, #72, #77 and #263, and an inventory log was not located in the EMR (Electronic Medical Record) On 11/08/23 at 12:16 PM, the SSD was given the names of the 4 residents who have missing inventory logs and missing clothing. On 11/08/23 at approximately 12:21 PM Staff B, an LPN (Licensed Practical Nurse) was asked about the inventory sheet. Staff B showed a blank inventory sheet to the surveyor and stated this is filled out when a resident is admitted to the floor. She stated it lists everything they brought with them. Then the inventory sheet is scanned into the EMR. On 11/08/23 at approximately 12:29 PM, Staff C was interviewed, who stated he was aware of Resident #263 missing clothing, and he had spoken to her many times. He stated the Laundry / Maintenance Director was also aware of the missing clothing. He stated the Laundry / Maintenance Director was not at the facility this week. On 11/08/23, the SSD was asked to provide evidence of the written grievance initiated that same day. Review of the grievances for Residents #25 and #263's missing clothing revealed it was dated 11/08/23, lacked the name of the individual initiating the grievance and the relationship, documented the date of conclusion as 11/09/23, and documented the SSD would continue to monitor and look for articles of missing clothing. 25404 3. During an additional interview on 11/07/23 at 1:46 PM, when asked the process for missing clothing, the Social Services Director (SSD) stated they would get a description of the missing items, check the inventory log for personal items, go to the laundry to try to locate the missing items, inform the laundry staff, and initiate a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/23 at 11:28 AM, Resident #72 stated his clothes had gone missing. When asked if he had reported the missing items to anyone, the resident stated he first reported it to the Activity Director. Resident #72 further explained he also spoke with the housekeeping manager, who was very nice and let him go through the laundry, but they could not find the clothes. When asked what was still missing, Resident #72 explained that he brought into the facility 12 shirts, and he is down to about 6. He described the shirts as very brightly colored. The resident stated he also had 6 pairs of shorts, and he was down to the blue pair he was wearing at that time. Resident #72 stated he just wears them in the shower and washes them that way. Review of the record revealed Resident #72 was admitted to the facility on [DATE]. Review of the Admission MDS assessment dated [DATE], documented the resident had a BIMS score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact. Further review of this MDS documented it was very important for the resident to choose what clothes to wear and to take care of his personal belongings and things. Review of the facility grievance log lacked any entry for Resident #72 related to missing clothing. The record lacked any inventory of personal items. During an interview on 11/08/23 at 3:48 PM with the Activity Director, when asked if she had any knowledge of missing clothing for Resident #72, the Activity Director stated about a week after his admission to the facility, the resident approached her and stated he was missing clothing. The Activity Director stated she took a description of the items, wrote it on a sticky note, and gave it to the Housekeeping Manager. When asked if she was aware of what happened after that, the Activity director stated she was unaware. During an interview on 11/08/23 at 3:53 PM, when asked if she was aware of any missing items for Resident #72, the Housekeeping Manager in Training stated she spoke with the resident today after receiving a grievance. When told Resident #72 had reported the missing items to the Activity Director about a week after his admission, about five or six weeks ago, and she had passed on the information on to the Housekeeping Manager, the Housekeeping Manager in Training stated she was fairly new and the Housekeeping Manager was on vacation this week. The Housekeeping Manager in Training and District Manager, who was present during this interview, agreed there should have been a grievance done from the initial report of missing items. On 11/09/23 in the afternoon, the SSD was asked to provide evidence of the written grievance for the missing clothing of Resident #72, even if it had not yet been resolved. Review of the grievance for Resident #72's missing clothing, dated 11/08/23, lacked the name of the individual initiating the grievance and relationship, the staff member's name and title, and the individual(s) designated to take action on this grievance. This form also documented the date of conclusion by 11/09/23, yet also documented I will continue to monitor and look for the above mentioned articles after the description of missing clothing. 4. During an interview on 11/06/23 at 10:11 AM, Resident #77 stated her daughter brought in a huge bag of clothing, about $800 worth, this weekend (11/04/23 or 11/05/23) and put them on top of the dresser. The resident explained that she went to therapy, and upon return to her room about 75% of it was gone. When asked if she had told anyone, Resident #77 stated, I told everyone who came into my room. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the record revealed Resident #77 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Admission MDS dated [DATE] documented the resident had a BIMS score of 14, indicating she was cognitively intact. This MDS also documented it was very important for the resident to choose her clothes and to take care of her personal belongings. Review of the grievance log lacked any documented grievance for Resident #77 related to clothing. The record lacked any inventory of personal items. During an interview on 11/08/23 at 1:38 PM, both Staff B, Licensed Practical Nurse (LPN), and the East Unit Manager, denied any knowledge of missing clothing for Resident #77. During an interview on 11/08/23 at 4:01 PM, the Housekeeping Manager in Training explained she heard about the missing clothing that day. After providing the same description that was provided to the surveyor on 11/06/23, the manager agreed the process should have been started over the weekend when she informed staff of the missing items.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to ensure Level II PASARRs (Preadmission Screening and Resident Reviews) for 2 of 2 sampled residents requiring a Level II assessment (Resident #99 and #103). The findings included: 1. Review of the record revealed Resident #99 was admitted to the facility on [DATE]. Review of the Level I PASRR Screen, completed on 08/24/23 by the transferring hospital, documented diagnosis of mental illness in Section I, along with an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. This screening also documented Resident #99 may not be admitted to an Nursing Facility, and to use the form to request a Level II PASRR due to a diagnosis of or suspicion of a Serious Mental Illness. The record lacked any documented Level II PASRR evaluation. During a side-by-side review of the Level I PASRR on 11/07/23 at 1:58 PM, the Social Services Director (SSD) agreed with the need of a Level II PASRR evaluation, and the lack of this Level II in the record. The SSD was asked to locate and provide the Level II PASRR evaluation. On 11/09/23 at 11:12 AM, the SSD provided evidence of the submission to request the Level II evaluation, after surveyor intervention, as he was unable to locate a previously completed Level II PASARR. 38893 2. Review of the Level I PASRR Screen for Resident #103, completed on 09/08/23 by the transferring hospital, documented a diagnosis of mental illness in Section I, along with an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. Individual may not be admitted to an Nursing Facility. Use this form and required documentation to request Level II PAASRR evaluation because there is a diagnosis of or suspicion of: Serious Mental Illness. Further review of Resident #103's health records revealed that there was no Level II PASRR evaluation completed. During an interview, on 11/07/23 at approximately 1:30 PM, with the Social Services Director, the Social Services Director acknowledged that a Level II should have been submitted. On 11/07/23 at 4:30 PM, the Social Services Director reported that he had submitted documentation to KEPRA for Level II PASRR.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on observation, interview and record review, the facility failed to provide tube feeding per physician's orders for 2 of 2 sampled residents reviewed (Residents #66, and #93). The findings included: 1. Record review revealed Resident #66 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Non-Alzheimer's Dementia, and Hemiplegia (weakness on one side). The annual Minimum Data Set (MDS) assessment, reference date 10/03/23, indicated a Brief Interview for Mental Status score (BIMS) of 06, indicating Resident #66 was cognitively impaired. No mood and behavior issues were recorded in this MDS. This MDS recorded Resident #66 was on tube feeding. Review of physician orders were as follows: 09/07/23: NPO (nothing by mouth) diet. 09/09/23: enteral feed two times a day Jevity 1.5 75ml/hr for 20 hours via g-tube. Turn on at 2pm and turn off at 10 AM. Review of nutrition progress note dated 09/08/23 written at 4:34 PM indicated Resident #66 was readmitted with significant weight loss of 3.8% in 1 week, 6.3% in 19 days, 9.1% in 90 days, 12.3% in 180 days. Discussed weight loss with nursing, resident tolerating increased rate of Jevity 1.5. Resident remains NPO. Receives Jevity 1.5 as noted above. Recommend Jevity 1.5 75ml/hr [ml per hour] for 20 hours, 200 ml water flush q [every] 4 hours which will provide 2250 kcal, 96 g [grams] protein, 2340 ml free water. With house stock protein 30ml QD [daily] (60 kcal, 15 g protein) and expedite liquid (100 kcal, 10 g protein) enteral feeding will provide 2410 kcal, 121g protein, 2340 ml free water plus medication flushes which will exceed 100% estimated needs. Labs reviewed above, hypoalbuminemia noted, will exceed 100% protein needs via enteral feeding. Review of most recent weights were as follows: 09/18/23, 122.4 Lbs (pounds), 10/02/23 129.8 Lbs, 11/03/23 121.6 Lbs which is a 6.32% weight loss in 1 month (from 10/2-11/3/23). Review of care plans, revised/revision date 10/05/23 indicated Resident #66 required feeding tube related Dysphagia (difficulty swallowing), also has aphasia (loss ability to understand or express speech), and dementia. Intervention included to Provide feeding and flushes as ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further care plan review revealed Resident #66 was at risk for decreased nutritional status & dehydration related to decreased Mobility, Dementia, Dependent on enteral feeds as sole source of nutrition support, Dysphagia, NPO. Intervention included monitor by mouth (PO) intakes and to Provide feeding and flushes as ordered. During observations of Resident #66 on the following dates: 11/06/23 at 9:11 AM, 11/06/23 at 9:35 AM, 11/07/23 at 8:06 AM and 11/08/23 at 8:53 AM, it was revealed the facility failed to follow the tube feeding rate. During those observations the tube feeding rate was at 70ml/hr. On 11/08/23 at 8:58 AM, an interview was conducted with the dietitian who voiced she had made recommendation to increase the feeding rate to 75ml/hr on 09/08/23 because Resident #66 was experiencing some weight loss. The dietitian voiced increasing the rate would potentially benefit Resident #66 as it could help to improve weight loss. The Dietitian voiced the current tube feeding rate should have been at 75 ml/hr. At 9:03 AM, the surveyor advised the dietitian to accompany the surveyor for an observation of Resident #66. During that time, the dietitian acknowledged that the rate was at 70 ml/hr, and voiced it has been at 75ml/hr. During this time the surveyor advised the dietitian to get the attending nurse to intervene. She immediately went to get the attending nurse who was in the hallway. At 9:05 AM, the attending nurse, Staff F, Licensed Practical Nurse (LPN), came, donned gloves and gown, and agreed the rate was observed at 70ml/hr. During this time, she was observed talking to Resident #66. Staff F stated, while she was in the room, she was going to disconnect the tube feeding. Staff F was observed to disconnect the feeding at 9:08 AM, remove her gown, and go to the bathroom to wash her hands. During this time, the surveyor asked Staff F if she was done with Resident #66, who voiced yes, she was done. She stated she was going to administer medications to Resident #66 later and would reconnect the feeding at 2:00 PM. When the surveyor asked at what time the feeding should be disconnected, Staff F looked at her watch and stated at '10 AM'. The surveyor pointed to the fact that the tube feeding was discontinued earlier than the ordered time '10 AM. Staff F revealed she can disconnect the feeding one hour before, the dietitian who was present during that time then informed Staff F that the feeding should have been disconnected at 10 AM. 38893 2. Resident #93 was admitted to the facility on [DATE] and admitted under Hospice services on 11/01/22. According to a Quarterly MDS, Resident #93 was not assessed for cognition due to the resident not being able to complete the interview, due to cognitive impairment. Resident #93's diagnoses at the time of the assessment included: Anemia, Hypertension, Diabetes Mellitus, Hyperlipidemia, Non-Alzheimer's Dementia, Hemiplegia, Cerebral Atherosclerosis, Encephalopathy, Diverticulitis of large intestine with perforation, Cyst of kidney, Dysphagia, Gastrostomy status, non-pressure chronic ulcer of back, and history of COVID 19. Review of Resident #93's physician orders included: 10/20/22: NPO [nothing by mouth] diet, NPO texture. 10/30/23: Enteral Feed - two times a day for nutritional support Glucerna 1.5 at 50ml/hr [mls per hour] x 18 hours via g-tube; On at 5pm, off at 11am. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105819	A. Building B. Wing	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Hall Nursing and Rehab Center	1800 SE Hillmoor Drive Port Saint Lucie, FL 34952

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care plan, dated 10/28/22 with a revision date of 08/21/23, documented, I have a feeding tube r/t [related to] Dysphagia, currently under Hospice care, Diagnoses of cerebral atherosclerosis, dementia without behaviors dysphagia, diabetes mellitus, hypertension, 10/30/2022 admitted under Hospice care, related to diagnosis of cerebral atherosclerosis / dementia without behavior. The goals of the care plan included: o Resident's feeding tube will remain patent through the review date - with a target date of 11/15/23. o I will maintain nutrition comfort through eternal / flushes as able through next review - with a target date of 11/15/23. Interventions to the care plan included: o NPO as ordered o Provide feeding & flushes as ordered o Site care as ordered. Review of the care plan initiated on 08/23/23, documented, Resident is at risk for decreased nutritional status & dehydration related to Dementia, Dependent on enteral feeds as sole source of nutrition support, Dysphagia, Hospice services, NPO. The goal of the care plan was documented as, Resident will tolerate tube feeding flushes as ordered through the review date with a target date of 11/15/23. Interventions to the care plan included: o Provide supplements as ordered o Provide tube feeding/water flushes as ordered o RD/DTR to evaluate as needed. On 11/06/23 at 3:05 PM, Resident #93 was observed up in chair with tube feeding not initiated. A 1000 ml container of Glucerna 1.5 was noted hanging on the pole with approximately 200 ml remaining in the container. The date mark on the container documented the feeding was initiated on 11/05/23 at 6:00 PM. At a rate of 50 ml/hr, the resident should have received 1000 ml of the supplement. On 11/07/23 at 7:49 AM, Resident #93 was observed in bed with tube feeding (TF) initiated at 50 ml/hr. the date mark on 1000 ml container documented that it was initiated on 11/06/23 at 2115 (9:15 PM) with 700 ml remaining in container. At a rate of 50 ml/hr, the resident should have received 550 ml from the container of supplement. (continued on next page)

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	105819	A. Building B. Wing	11/09/2023

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident's electronic health records showed there was no documentation to justify the resident not to receive the complete regimen of TF order. In order for the resident to receive the full regimen, the tube feeding would have to continue for an additional 8 hours. During an interview, on 11/08/23 at 6:46 AM with Staff L, LPN, when asked about any diversions to a resident's tube feeding order, Staff L replied, there should be notes in progress notes - CNAs sometimes have it stopped for ADLs [Activities of Daily Living]. Staff L stated that the ADL care provided by the CNAs would take 'up to 30 minutes.' During an interview, on 11/09/23 at 10:13 AM, with the Diet Tech, when asked what the volume of feeding provided by enteral methods is based on, the Diet Tech replied, based on estimated needs calculator to ensure she receives proper nutrition and hydration. If there is a problem they would have to speak with the doctor. They can hold the feeding during the day for ADL care. The Diet Tech acknowledged the concerns and confirmed that the resident was not receiving the feeding as ordered.