STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225667	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Cod Post Acute Care	383 South Orleans Road Brewster, MA 02631

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was experiencing a decline in condition, was on comfort measures at end of life and receiving Hospice Services, the Facility failed to ensure that nursing followed acceptable standards of practice related to complete and accurate documentation in clinical records regarding documentation of his/her decline in condition up to and including his/her death, and that an RN pronouncement had been done. Findings include: Review of the Facility Policy titled, Charting and Documentation, dated revised [DATE], indicated the following: -all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record; -all observations, medications administered, services performed, etc., must be documented in the resident's medical record; -all incidents, accidents, or changes in the resident's condition must be recorded. Review of the Facility Policies titled, Change in Condition and Change in Condition Notification, dated as revised [DATE], indicated the following: -a significant change in condition is a major decline in the resident's status that will not normally resolve itself without intervention by staff, is not self-limiting, impacts more that one area of the resident's health status and requires revision to the care plan; -the facility will monitor residents for changes in their condition, and respond appropriately to those changes; -the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the Facility Policy titled, Registered Nurse Pronouncement, dated as revised [DATE], indicated the following: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the registered nurse may conclude that death has occurred and pronounce the death of a resident when the patient has been receiving hospice services under the physician's plan of care, the death was a result of a terminal illness, there is a Do Not Resuscitate order in place, the death was anticipated according to the prognosis documented in the record, and the nurse has made a reasonable effort to contact the physician at the time of death and the effort should be documented in the medical record; -the nurse will document in the medical record: the time of the pronouncement, findings from the assessment of the patient that substantiated the conclusion that death has occurred, notification of the physician, family and funeral home, removal of the body; -nurses documentation of pronouncement should include: absence of pulses, absence of pupillary response, absence of breath sounds, attempts to reach the physician, notification of family/Next of Kin (NOK) /Health Care Proxy (HCP), and what funeral home was notified. Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Resident #1 was admitted to the Facility in [DATE], diagnoses included: displaced unspecified condyle fracture of lower end of left femur, bilateral hearing loss, moderate protein-calorie malnutrition, cerebral palsy, essential hypertension and unstageable pressure ulcer of right and left hip. Review of Resident #1's Advance Directives, documented on a Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) Record, dated [DATE], indicated Resident #1 was a Do Not Resuscitate. Review of a Physician Progress Note, dated [DATE], indicated that Resident #1's clinical status was declining, new lower extremity ulcer noted and is likely a [NAME] (terminal ulcer that develops when a person is at the end of life) ulcer due to his/her general decline, as well as decreasing nutrition and quick onset. The Note indicated that Resident #1 was declining overall, and Hospice should be considered, he/she presented with failure to thrive, was functionally declining, and had cerebral palsy, most appropriate for Hospice but HCP has not been open to this in the past. Review of a Nurse Progress Note, dated [DATE] at 7:00 P.M., indicated Resident #1 continues to decline throughout the shift, exhibiting signs and symptoms of pain and shortness of breath requiring (PRN) as needed Roxanol (highly concentrated solution of the narcotic analgesic morphine sulfate for oral administration used for the treatment of severe chronic pain) throughout the day, all PRN doses had good effect but would wear off as the 2 hour mark approached. The Note indicated that Resident #1 was noted with increased oral secretions, and hyoscyamine (used for excessive salivation) was ineffective, the physician was notified and Scopolamine (used for excessive oral secretions) patches were ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Physician Progress Note, dated [DATE], indicated that Resident #1 was on Hospice and was declining for some time, family was present and comfort care medications were discussed. The Note indicated end of life care continues, comfort care with Ativan (anti-anxiety), morphine as needed and scopolamine and Zofran (anti-emetic) as needed and to continue with Hospice care. Review of an RN Pronouncement of Death Certificate, dated [DATE] at 07:12 A.M., indicated that Resident #1 was pronounced dead at the Facility by Nurse #3. However, further review of Resident #1's Nurse Progress Notes indicated there was no documentation after [DATE] to support nursing had assessed and monitored Resident #1's decline in condition up to and including his/her death on [DATE], or that an RN Pronouncement had been completed. This was not consistent with the Facility's Change in Condition, Change in Condition Notification and Registered Nurse Pronouncement Policies. During a telephone interview on [DATE] at 5:29 P.M., Nurse #3 said that he was assigned to care for Resident #1 on [DATE], [DATE], and [DATE] during the 11:00 P.M. to 7:00 A.M. shift and he also worked the [DATE], 3:00 P.M. to 11:00 P.M. shift. Nurse #3 said he could not explain why there were no nurse progress notes in Resident #1's medical record during his shifts. Nurse #3 said that he was assigned to Resident #1 on [DATE] on the 11:00 P.M. to 7:00 A.M. (into [DATE]) shift and said he was the nurse who pronounced Resident #1 dead on [DATE] at 7:12 A.M. Nurse #3 said that he was aware of the Facility's RN pronouncement policy and said he thought he wrote a nurse progress note with his assessment of Resident #1 and said he could not explain why there was no nurse progress note in Resident #1's following the pronouncement of his/her death. During a telephone interview on [DATE] at 10:38 A.M., Nurse #4 said that she was assigned to Resident #1 on [DATE] and [DATE] during the 7:00 A.M. to 7:00 P.M. shift and [DATE] during the 7:00 A.M. to 3:00 P.M. shift. Nurse #4 said that Resident #1 was actively dying and required pain medication around the clock. Nurse #4 said that on [DATE], Resident #1 had excessive secretions and she called the physician to obtain an order for scopolamine to dry up his/her secretions. Nurse #4 said that was the last nurse progress note she wrote and said there was no need to write any further nurse progress notes for someone who was dying. During a telephone interview on [DATE] at 1:00 P.M., Nurse #5 said that he was assigned to Resident #1 on [DATE] during the 7:00 A.M. to 3:00 P.M. shift. Nurse #5 said that he was still in training and that he was expected to administer all the medications and perform all of the treatments to his assigned residents. Nurse #5 said that he was never told to write nurse progress notes for the residents assigned to him. During a telephone interview on [DATE] at 2:00 P.M., Nurse #6 said she was assigned to Resident #1 on [DATE] during the 3:00 P.M. to 11:00 P.M. shift. Nurse #6 said that Resident #1 was actively dying and that was a change in condition for him/her. Nurse #6 said that she should have written a nurse progress note about her assessment of Resident #1 and said she did not have enough time during her shift to write a nurse progress note about Resident #1's condition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an in-person interview on [DATE] at 4:05 P.M. and a subsequent telephone interview on [DATE] at 12:03 P.M., the Director of Nurses (DON) said that it was her expectation that nurses write a nurse progress note every shift with detailed assessment of a resident's change in condition. The DON said that when a resident is actively dying that is a change in condition and there should be nurse progress notes in the medical record every shift. The DON said she could not explain why there were no nurse progress notes after [DATE] in Resident #1's medical record. The DON said that it was her expectation that there be detailed nurse progress note with assessment data as indicated in the Facility's RN pronouncement policy in the medical record whenever an RN pronouncement is completed. The DON said that Resident #1's medical record did not have any nurse progress notes about an RN pronouncement and said that Nurse #3 did not follow the Facility's policy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37183 Based on record reviews and interviews, for one of three sampled residents (Resident #1) who had physician orders for wound dressing changes, the facility failed to ensure they maintained complete and accurate resident Treatment Administration Records (TAR) in the Electronic Medical Record (EMR) when Resident #1's TAR's, related to documentation of dressing changes, were not consistently completed during the months of May 2024 and June 2024. Findings include: Review of the Facility Policy, Charting and Documentation, dated as revised January 2023, indicated that all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Observations, medications administered, services performed, etc., must be documented in the resident's clinical records. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: - Date and time the procedure/treatment was provided; - Name and title of the individual(s) who provided the care; - The assessment data and/or any unusual findings obtained during the procedure/treatment; - How the resident tolerated the procedure/treatment; - Whether the resident refused the procedure/treatment; - Notification of family, physician, or other staff if indicated; - The signature and title of the individual documenting. Review of the Facility Policy, Wound Care, dated as revised January 2023, indicated the following in reference to documentation: -the type of wound care given; -the date and time the wound care was given; -the position in which the resident was placed; -the name and title of the individual performing the wound care; -any change in the resident's condition; -all assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-how the resident tolerated the procedure; -any problems or complaints made by the resident related to the procedure; -if the resident refused the treatment and the reason(s) why; -the signature and title of the person recording the data. Resident #1 was admitted to the Facility in May 2024, diagnoses included: displaced unspecified condyle fracture of lower end of left femur, bilateral hearing loss, moderate protein-calorie malnutrition, cerebral palsy, essential hypertension and unstageable pressure ulcer of right and left hip. Review of Resident #1's Physician Orders for May 2024, indicated he/she had an order, dated 5/13/24, for a dressing to his/her left hip pressure injury, for nursing to cleanse area with normal saline, pack wound with Dakins (diluted bleach solution used to cleanse wounds to prevent and treat infections) fluffed gauze, cover with dry protective dressing daily every day and evening shift. Review of Resident #1's TAR (EMR), for May 2024, indicated the treatment to the left hip pressure injury was not documented as administered by nursing on 5/18/24 during the day shift, on 5/19/24 during the day and evening shift and on 5/20/24 during the day shift, per physician orders. Review of Resident #1's Physician Orders for June 2024, indicated he/she had an order, dated 6/23/24, for a dressing to his/her left lateral distal calf, for nursing to cleanse with Dakins for 15 minutes, remove and apply alginate (a biodegradable dressing made from seaweed that absorbs exudate and forms a gel), cover with a 4 x 4 dressing, wrap with gauze daily during the day shift. Review of Resident #1's TAR (EMR) for June 2024, indicated the treatment to the left distal calf was not documented as administered by nursing on 6/29/24 during the day shift per physician orders. Review of Resident #1's Physician Orders indicated he/she had an order, dated 5/31/24, for a dressing to his/her left hip, for nursing to irrigate with normal saline, pack with alginate, apply Santyl topically, skin prep peri-wound and cover with border gauze daily during the day shift. Review of Resident #1's TAR EMR, for June 2024, indicated the treatment to the left hip was not documented as administered by nursing on 6/28/24 and 6/29/24 during the day shift per physician orders. Review of Resident #1's Physician Orders indicated he/she had an order, dated 5/31/24, for a dressing to his/her right hip, for nursing to irrigate with normal saline, pack with alginate, apply Santyl topically, skin prep peri-wound and cover with border gauze daily during the day shift. Review of Resident #1's TAR EMR, for June 2024, indicated the treatment to the right hip was not documented as administered by nursing on 6/29/24 during the day shift per physician orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 07/29/24 at 10:38 A.M., Nurse #4 said she was familiar with Resident #1 and was assigned to care for Resident #1 on 6/29/24 during the day shift. Nurse #4 said she provides treatments to the residents on her assignment. Nurse #4 said if the TAR EMR was left blank she probably did not provide a treatment to Resident #1's right hip on 6/29/24, as ordered by the physician. During a telephone interview on 7/29/24 at 2:00 P.M., Nurse #6 said she was familiar with Resident #1 and works on all the units in the facility. Nurse #6 said she provides treatments to the residents on her assignment. Nurse #6 said she would follow the physician orders and sign off the treatment as completed on the TAR EMR. Nurse #6 said when a treatment is not signed off as completed in the TAR, the treatment is considered not done. During an interview on 07/24/24 at 3:00 P.M., the Unit Manager said that it was her expectation that all treatments be provided and signed off in the TAR EMR as being provided. The Unit Manager said that if a treatment is not signed off and left blank on the TAR EMR, then the treatment is considered as not done. During an interview on 07/24/24 at 4:05 P.M., the Director of Nursing (DON) said all nurses must document treatments provided on the TAR EMR. The DON said when a treatment is provided by nursing and the corresponding documentation is not signed off as completed, then the treatment is considered as not done.