STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225687	A. Building B. Wing	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Commons Nursing & Rehabilitation Center	169 Valentine Road Pittsfield, MA 01201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation, interview, record and policy review, the facility failed to ensure that one Resident (#156) out of a total sample of 36 residents was assessed to self-administer medication prior to allowing self-administration of his/her medications. Findings include: Review of the facility policy titled Self Administration of Medication, revised June 30, 2021, indicated the following: -If the resident wishes to self-administer, the Nurse will determine the interdisciplinary team (IDT) will determine the resident's ability to safely self-administer. {sic} -Upon admission the Self-Administration of Medications Informed Consent and Assessment Tool will be completed. Resident #156 was admitted to the facility in May 2022. Review of the Resident's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 13 out of 15 on the Brief Interview of Mental Status (BIMS) indicating he/she was cognitively intact. During an observation and interview on 1/2/24 at 10:03 A.M., the surveyor observed Resident #156 in his/her room and on his/her bedside table was a medication cup containing multiple pills. The surveyor observed there to be no Nurse in the room and no Nurse near the Resident's room. Resident #156 said that he/she usually takes the medications by him/herself. Review of the most recent Quarterly Assessment Packet completed by nursing indicated the Resident did not wish to self-administer his/her own medications. On 1/4/24 at 8:30 A.M., the surveyor observed Resident #156 in his/her room and no Nurse was present in the room and/or visible in the hallway. The surveyor also observed a medication cup containing multiple pills on the Resident's bedside table. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/4/24 at 8:34 A.M., Nurse #2 said she had given Resident #156 his/her medications earlier and had left the medication cup with medications at the Resident's bedside. Nurse #2 also said she should not have left medication at the Resident's bedside as she did not believe the Resident had been assessed to be able to independently take his/her medications. She further said there was an assessment that was required before a resident was allowed to independently self-administer medications. During an interview on 1/4/24 at 9:21 A.M., Unit Manager (UM) #1 said when a Resident wishes to self-administer medications there is an assessment that needs to be completed and a self-administration consent form signed, but Resident #156 did not have the self-administration consent done. UM #1 said nursing should not have left any medication with the Resident, and that the Nurse should have remained in the room until all medications had been administered to the Resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42761 Based on observation, interview, record and policy review, the facility failed to notify the Physician/Non-Physician Practitioner (NPP- Nurse Practitioner) and Dietitian of a severe weight loss of greater than 7.5 percent (%) in less than three months for one Resident (#193) out of a total sample of 36 residents. Specifically, the facility failed to notify the NPP and Dietitian of the Resident's severe weight loss when the Resident had been previously identified as being at nutritional risk. Findings include: Review of the facility's policy titled Nutrition Management, dated 12/5/08 and revised 6/6/22, indicated: -The purpose was to provide nutritional care and services to each resident, consistent with the resident's comprehensive assessment . to recognize, evaluate, and address the nutritional needs of every resident, including, but not limited to, the resident at risk or currently experiencing impaired nutrition . -Staff will consistently observe and monitor residents for changes . -Consult with the Dietitian when .unplanned weight loss or gain (greater than three pounds (lbs) from last recorded weight and/or 5% in one month, 7.5% in three months, and 10% in six months. Review of the facility's policy, titled Physician Notification, dated 11/11/09 and revised September 2011, indicated: -The purpose was to communicate a change in a resident's condition to the Physician and initiate interventions as needed . -Upon identification of a change in condition, the Protocols for Physician Notification may be used as a reference to help determine urgent or routine notification. -Clinician judgment and resident baseline should always be the primary determinate of the timing of Physician notification. -If clinical findings indicate routine notification, notify the Physician as soon as possible during normal business hours. -Document . Physician notification and response . interventions. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #193 was admitted to the facility in April 2023 with diagnoses of Type Two Diabetes Mellitus (DM II - condition when high blood sugar levels result due to the body not making enough insulin hormone) and Depression (disorder characterized by loss of interest in activities, causing impairment in daily life). Review of Resident #193's Nutrition Care Plan, initiated 4/7/23, indicated: Notify Physician . if persistent weight loss . occurs. Review of a Physician's Progress Note, dated 8/2/23, indicated Resident #193's appetite had been poor. Review of Resident #193's Dietitian Note, dated 9/28/23, indicated the Resident's weight was 204.5 pounds (lbs). Review of Resident #193's Minimum Data Set (MDS) Assessment, dated 12/13/23, indicated the following: -The Resident was cognitively intact as exhibited by a Brief Interview for Mental Status Score (BIMS) of 14 out of 15 possible points. -The Resident had experienced a weight loss of 5% or more in one month or 10% or more in six months. -The Resident was not on a Physician prescribed weight loss regimen. Review of Resident #193's Dietitian Note dated 12/18/23, indicated the Resident's weight was 172 lbs as of 12/1/23 (15.89% loss). During an interview on 1/2/24 at 2:35 P.M., Resident #193 said he/she had recently experienced unplanned weight loss and that he/she was not able to eat very much. The Resident said he/she had been over 200 lbs a few months before, but now weighed around 176 lbs. On 1/3/24 at 8:45 A.M., the surveyor observed Resident #193 positioned upright in his/her bed with a breakfast meal positioned in front of him/her on a rolling bedside table. The Resident was observed to not be eating. During an interview on 1/3/23 at 3:12 P.M., Unit Manager (UM) #3 said the NPPs worked in the facility daily and staff would notify the NPPs of a resident's change in status needing assessment. UM #3 said if a resident had a significant change in their weight, staff would notify the NPP. UM #3 further said she did not think Resident #193 had any significant loss or gain in weight, but if he/she had, staff were required to notify the NPP. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/23 at 3:44 P.M., the NPP said she worked in the facility five days per week and that if she needed to leave the facility, staff were able to contact her by phone and email. The NPP said weight loss was discussed at the facility's daily morning meetings and that she attended those meetings, but weight loss had not been discussed as a concern at these meetings for Resident #193. The NPP said Resident #193 did have a problem with fluid overload which could result in some fluctuations in weight, but she was not aware that the Resident had experienced a change in weight from 204.5 lbs to 172 lbs. The NPP said she was concerned that she was not notified of Resident #193's change in weight and that this was important so she could assess the Resident's needs which may have included a change in treatment to support his/her nutritional status. During and interview on 1/5/24 at 1:25 P.M., the Dietitian said facility staff were supposed to notify her if a resident experienced significant weight loss, but they did not notify her of Resident #193's severe weight loss after a weight of 172 had been obtained and recorded on 12/1/23. The Dietician further said she identified the Resident's weight loss when she saw the Resident on 12/18/23 and reviewed the Resident's record. Please refer to F692.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interviews, records reviewed and policy review, the facility failed to accurately complete Minimum Data Set (MDS) Assessments for two Residents (#114 and #232), and failed to ensure timely completion of Section C (Cognitive Patterns) and Section D (Mood) within the required timeframe for four Residents (#113, #173, #167 and #93), out of a total sample of 40 residents (including 36 active and four closed records). Specifically, 1. For Resident #114, the facility failed to ensure that staff coded the use of Oxygen (O2) therapy on a Quarterly MDS Assessment, as required. 2. For Resident #113, the facility failed to ensure Sections C and D were completed during the assessment reference period, as required. 3. Resident #173, the facility failed to ensure Sections C and D were completed during the assessment reference period, as required. 4. For Resident #232, the facility failed to accurately code the Resident's discharge status on his/her Discharge MDS Assessment when the Resident was discharged home from the facility. 5. For Resident #167, the facility failed to ensure Sections C and D were completed during the assessment reference period, as required. 6. For Resident #93, the facility failed to ensure Sections C and D were completed during the assessment reference period, as required. Findings include: Review of the facility policy titled Care Planning, revised 10/28/22, included the following: -The Resident Assessment Instrument (RAI) process will include direct observation and communication with the resident as well as communication with licensed and non-licensed staff members on all shifts. -each team member is responsible for the timely completion, as well as the accuracy of each of their assigned sections as follows: --Section C . Social Worker or designee --Section D . Social Worker or designee -Residents will be interviewed . unless their ability to make self understood is noted as rarely/never understood . (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	-Interviews will be completed on, or up to 2 days before the Assessment Reference Date (ARD- last day of the seven day timeframe for the assessment period). -The staff member who conducted the interview will document the results in the respective section of the MDS and sign for the completion of the interview in Section Z. Review of the RAI 3.0 User's Manual, dated October 2023 indicated the following: -ARD refers to the specific endpoint for the observation (or look-back) periods in the MDS assessment process. -The facility is required to set the ARD. -Most of the MDS 3.0 items have a 7-day look-back period . If a resident has an ARD of July 1, 2011, then all pertinent information starting at 12:00 A.M. on June 25th and ending on July 1st at 11:59 P.M. should be included for MDS 3.0 coding. 1. Resident #114 was admitted to the facility in June 2021, with diagnoses including hypoxemia (an abnormally low concentration of Oxygen in the blood) and was Oxygen (O2) dependent. Review of the Respiratory Care Plan, dated 12/8/22, indicated Resident #114 was Oxygen dependent and included the following intervention: -administer O2 as ordered. Review of the MDS Assessment, with an ARD of 10/10/23, indicated Resident #114 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and did not utilize Oxygen during the assessment reference period. Review of the October 2023 Treatment Administration Record (TAR) documentation indicated continuous O2 was administered to Resident #114 daily from 10/1/23 through 10/31/23. On 1/2/24 at 3:11 P.M., the surveyor observed Resident #114 lying in bed. O2 was being administered via a nasal cannula (pronged tube inserted into the nose to allow Oxygen to be administered). During an interview at the time, Resident #114 said he/she had been on O2 since prior to admission to the facility and that the nursing staff at the facility managed the oxygen therapy for him/her. During an interview on 1/5/24 at 4:46 P.M., Nurse #8, who had worked with Resident #114, said that he/she was O2 dependent and required continuous O2 daily. Review of the January 2024 Physician's orders included the following order: -administer continuous O2 . On 1/9/24 at 1:22 P.M., the surveyor and MDS Nurse #2 reviewed Resident #114's medical record. MDS Nurse #2 said Resident #114 was receiving O2 during the assessment reference period of the 10/10/23 MDS Assessment, that O2 was not coded, and it should have been coded. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	2. Resident #113 was admitted to the facility in May 2019, with diagnoses including Aphasia (language disorder that affects a person's ability to communicate), Major Depression and Dementia (progressive condition with impairment of memory and intellectual functioning) with Behavioral Disturbance. Review of the MDS Assessment, with an ARD of 9/19/23, indicated Resident #113 had unclear speech, was sometimes able to make self understood and sometimes understands. Further review of the MDS Assessment indicated Sections C and D were crossed out (lines throughout the assessment sections) and were not completed. On 1/3/24 at 12:23 P.M., the surveyor observed Resident #113 seated in the dining room on the unit during the lunch meal. He/she was seated with other residents and smiled and waved to the surveyor during the observation. During an interview on 1/4/24 at 11:55 A.M., MDS Nurse #2 said that Sections C and D were crossed out prior to closing the MDS assessment dated [DATE], for Resident #113, because the sections were not completed within the required ARD timeframe. MDS Nurse #2 further said that Social Services was responsible for completing Sections C and D. 3. Resident #173 was admitted to the facility in November 2022 with diagnoses including Anxiety, Psychosis (mental disorder characterized by a disconnection from reality) and Major Depression. Review of the MDS Assessment, with an ARD of 10/10/23, indicated Resident #173 had unclear speech, was sometimes able to make self understood and sometimes understands. Further review of the MDS Assessment indicated Sections C and D were crossed out and not completed. On 1/3/24 at 3:15 P.M., the surveyor observed Resident #173 lying in bed with his/her eyes open. The Resident said Hi to the surveyor during the observation. During an interview on 1/4/24 at 11:55 A.M., MDS Nurse #2 said that Sections C and D were crossed out prior to closing the MDS Assessment for Resident #173, dated 10/10/23, because the sections were not completed within the required ARD timeframe. During an interview on 1/9/24 at 12:59 P.M., Social Worker (SW) #1 said if the information required on an MDS Assessment was obtained after the ARD timeframe, the Social Workers obtain the information on paper but that it could not be entered into the MDS Assessment. SW #1 said for the Residents with Sections C and D crossed out, the assessment information was not obtained during the assessment reference period, as required. 42761 4. Resident #232 was admitted to the facility in September 2023 with a diagnosis of Sepsis (serious condition resulting from complications of an infection). Review of a Nursing Progress Note dated 10/26/23, indicated Resident #232 was discharged from the facility to his/her home on 10/26/23. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of Resident #232's MDS Assessment, dated 10/26/23, indicated the Resident was discharged on [DATE], and that the Resident's discharge status indicated discharge to a Short-Term General Hospital. During an interview on 1/8/24 at 12:20 PM, MDS Nurse #2 said Resident #232 was discharged to home from the facility on 10/26/23. MDS Nurse #2 further said the Resident had not been discharged to the hospital and the MDS assessment dated [DATE], was not coded accurately, as required. 42690 5. Resident #167 was admitted to the facility in April 2022. Review of a Quarterly MDS Assessment, with an ARD of 12/1/23, indicated the following: -Section C was blank, indicating it had not been completed. -Section D indicated yes was selected, and that the resident mood interview should be conducted. Further review of Section D indicated the mood assessment had not been completed as evidenced by dash marks. During an interview on 1/3/24 at 1:27 P.M., MDS Nurse #1 said that Sections C and D are dashed out when the interviews with the resident (or staff assessment if the resident was unable to be interviewed) have not been completed within the required time frame. MDS Nurse #1 said that the Social Service Department was responsible for completing Sections C and D interviews and that they had not been completed at the time the MDS Assessment needed to be closed out and locked for Resident #167, therefore they were dashed out and considered incomplete. 45435 6. Resident #93 was admitted to the facility in November 2015. Review of a Quarterly MDS Assessment with an ARD of 11/29/23, indicated the following: -Section C was dashed out, indicating it had not been completed. -Section D was dashed out, indicating the mood assessment had not been completed. During an interview on 1/4/23 at 2:11 P.M., MDS Nurse #2 said Sections C and D had been dashed out by the MDS Nurse on 12/13/23, because the interviews were not done for Resident #93 during the required interview period. MDS Nurse #2 said that Section C and D should have been completed by the Social Worker. During an interview on 1/4/23 at 2:22 P.M. Social Worker #1 said that Sections C and D had not been completed and the data entered into the electronic system within the required timeframe.

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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. 42741 Based on interviews and record reviews the facility failed to provide or arrange for services that accepted standards of practice dictate should have been provided for two Residents (#6 and #193), out of a total sample of 36 residents. Specifically, 1. For Resident #6, the facility staff failed to document where subcutaneous (under the skin) injections of Insulin (medication used to treat Diabetes [chronic, metabolic disease characterized by high blood sugar levels]) was administered on the Resident's body, putting the Resident at risk for lipohypertrophy (a lump of fatty tissue under the skin caused by repeated injections in the same area) development. 2. For Resident #193, the facility staff failed to obtain a Pulmonology consult as ordered when the Resident had a history of malignant (potentially deadly condition that will likely worsen with time) breast cancer, was identified to have nodular (growth of abnormal tissue) lesions (area in an organ or tissue which has been damaged due to disease) in both lungs with potential for metastasis (spreading of cancer cells from one area to another) and a Pulmonology consult was ordered to rule out malignancy. Findings include: 1. Review of the Institute for Safe Medication Practices information sheet titled Lantus (brand name of Insulin Glargine), (C)2013, indicated the following: -Change (rotate) the injection site with each dose. Review of the facility policy Insulin, Injectable Administration Protocol, effective 5/18/22, indicated the following: -Rotate the site of injection to avoid lipohypertrophy. -Document site after every injection. -Click on History, prior to administration to determine last injection site used, choose new injection site as specified in the electronic health record (EHR). Resident #6 was admitted to the facility in January 2021, with a diagnoses including Type II Diabetes Mellitus (DM II - when the pancreas does not produce enough insulin to maintain normal blood glucose [sugar] levels). Review of the Resident's January 2024 Physician Active Orders Report, indicated the Resident utilized Insulin Glargine (long-acting Insulin) twice daily via subcutaneous injection. (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 the December 2023 Medication Administration Record (MAR) and January 2024 MAR, indicated the Resident received the twice daily injections of Insulin as ordered. Further review of the December 2023 and January 2024 MARs, did not indicate the injection sites on the Resident's body where the Insulin injection was administered twice daily for the dates documented. During an interview on 1/9/24 at 8:16 A.M., Nurse #2 said the Insulin injection sites are documented on the MAR in the EHR. Nurse #2 said when the Insulin injection is administered, the Nurse should document the injection site. Nurse #2 further said the Resident's injection site history should be reviewed prior to giving the next Insulin injection to make sure the injection site was being rotated. Nurse #2 reviewed the EHR and was unable to show the surveyor where the history of past injections sites should have been in the EHR. Nurse #2 was unable to find any documented injection sites for the Resident. During an interview on 1/9/24 at 10:21 A.M., Unit Manager (UM) #1 said there should be documentation completed each time the Resident received his/her Insulin injections so that the next Nurse would be able to utilize a different part of the Resident's body for the injection. UM #1 further said that the injection sites were important to document to ensure the sites were rotated and since this information was not documented, she would be unable to determine where Resident #6 received his/her Insulin injections for the month of December 2023 and January 2024. 42761 2. Resident #193 was admitted to the facility in April 2023 with diagnoses including Asthma (chronic lung disease making it harder for one to breathe) and malignant neoplasm (abnormal growth of tissue characteristic for cancer) of the breast. Review of Resident #193's Hospital Discharge Summary, dated 7/20/23 indicated: -Imaging CT (computed tomography: computerized x-ray imaging) C (chest)/A (abdomen)/P (pelvis) was noted for multifocal (more than one) ill-defined (common, non-specific characteristic that suggests a malignant process) nodular lesions in both lungs suspicious for atypical (unusual) Pneumonia however metastasis was another differential. -The Resident needed a Pulmonology follow-up to rule out malignancy. -Please follow-up with Primary Care Physician (PCP) to send referrals to Pulmonologist to look for these lesions much better in outpatient settings. -Resident will follow-up with PCP on the nodular lesions noted on CT. Review of Resident #193's NPP (Non-Physician Practitioner/ Nurse Practitioner) Visit Note, dated 7/21/23, indicated: -The Resident's CT of the C/A/P completed at the hospital was noted for multifocal ill-defined nodular lesions in both lungs suspicious for atypical Pneumonia, possible metastasis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Will request Pulmonology follow-up to rule out malignancy. Review of Resident #193's July 2023 Physician's orders indicated: -Please send for Pulmonology consult, dated 7/26/23. Review of Resident #193's NPP Visit Note, dated 8/9/23, indicated: -The Resident had CT of the chest, abdomen, and pelvis which noted multifocal ill-defined nodular lesions in both lungs concerning for atypical Pneumonia versus metastatic disease. -The Resident had remote history of breast cancer. -Will refer Resident to Pulmonologist to evaluate lesions found in both lungs. Review of Resident #193's clinical record included no evidence that a Pulmonology consult had been obtained, as ordered. During an interview on 1/3/24 at 3:43 P.M., the NPP said she wrote an order in July 2023 for facility staff to obtain a Pulmonology consult for Resident #193. The NPP accessed her computer and said she did not see anything pending in the system for this Pulmonology consult or that a Pulmonology consult had already been obtained for the Resident, as ordered. During an interview on 1/3/24 at 4:16 P.M., the Respiratory Therapist (RT) said the facility had a Pulmonologist that came in the facility every Friday, but he was not sure if the Pulmonologist had seen Resident #193 or if the Resident was seen outside of the facility by a Pulmonologist after the consult was ordered. The RT said he would check to see whether the Resident had been seen by a Pulmonologist and get back to the surveyor. During a follow-up interview with the RT on 1/3/24 at 5:00 P.M., the RT said he did not locate any evidence that Resident #193 had been seen for a Pulmonology consult. During an interview on 1/5/24 at 11:50 A.M., the NPP said she ordered the Pulmonology consult for Resident #193 in July 2023 based on the Resident's CT results and that given the CT results, she felt it was most appropriate for the Resident to meet with a Pulmonologist. The NPP further said that the Pulmonology consult had not been obtained as ordered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45435 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services for one Resident (#108) out of a total sample of 36 residents, with limited range of motion (ROM) to prevent further decrease in ROM. Specifically, for Resident #108, the facility staff failed to re-assess the Resident's condition relative to hand contractures upon return from a hospitalization , and resume Occupational Therapy (OT) when the Resident had known bilateral hand contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity, and rigidity of joints), increasing the risk for further decrease in ROM, impaired skin integrity, and infection. Findings include: Resident #108 was admitted to the facility in February 2023, with diagnoses including Quadriplegia (paralysis that affects all four limbs and body from the neck down) and Respiratory Failure (condition that develops when the lungs cannot get enough oxygen into the blood, and unable to expel carbon dioxide making it difficult for the individual to breathe). Review of the Minimum Data Set (MDS) Assessment, dated 12/13/23, indicated the Resident's Brief Interview for Mental Status (BIMS) Assessment score was 15 out of 15 indicating intact cognitive function. Further review of the MDS Assessment indicated the Resident was dependent for all activities of daily living (ADLs), had impairment of upper and lower extremities, had a tracheostomy (an opening in the trachea [windpipe] from outside the neck) tube and used a ventilator (medical device that replaces or supports normal breathing lung function). Review of the Occupational Therapy (OT) Treatment Encounter Note, dated 8/29/23, indicated the following: -Patient encountered and completed sustained gentle stretch of bilateral wrists and digits (fingers) for application of current orthotics (a support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body). -Right upper extremity wrist passive ROM within functional limits and digits including thumb able to open for comfort when donning (putting on) orthotic, however patient refused splints this date saying they are uncomfortable and caused pain. -Consulted with Registered Occupational Therapist (OTR) certified in ultrasound who stated we can attempt modalities (a method of treatment) again for comfort and tolerance of orthotics. Patient verbalized understanding. Left wrist noted in flexion (bent) with thumb joint fixed in flexion. -Applied skin protectors (palm guards) to bilateral palms this date for infection control and skin integrity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Interdisciplinary Progress Notes indicated Resident #108 was transferred to the hospital on 8/30/23 and returned to the facility on [DATE]. Review of the Occupational Therapy Discharge Summary, dated 9/4/23, indicated the reason for discharge from OT was due to the Resident's discharge to the hospital. On the following dates and times: -1/2/24 at 3:40 P.M. -1/3/24 at 11:22 A.M. -1/4/24 at 8:55 A.M. -1/5/24 at 7:07 a.m. -1/9/24 at 7:58 A.M., the surveyor observed the Resident lying in bed, hands elevated on pillows, and no hand splints or skin protectors (palm guards) were in place (being used). During an interview on 1/9/24 at 8:30 A.M., Certified Nurses Aide (CNA) #3 said the Resident did not wear hand splints or palm guards. During an interview on 1/9/23 at 8:39 A.M., Rehabilitation Services Staff #2 said the Resident was at risk for worsening contractures and impaired skin integrity without hand orthotics. During an interview on 1/9/24 at 9:10 A.M., the Resident said that he/she had tried wearing the palm guards, and would be willing to wear them, but had not seen the palm guards and does not know where they went since he/she went out to the hospital in September. During an interview on 1/9/24 at 9:24 A.M., Rehabilitation Services Staff #1 said every new admission and re-admission to the facility should have been screened by Rehabilitation Therapy but Resident #108 had been missed. Rehabilitation Services Staff #1 said the Resident should have been re-assessed by Rehabilitation Therapy when he/she returned to the facility, and his/her therapy program should have resumed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observation, interview and record and policy review, the facility failed to notify and solicit the assistance of the appropriate authorities for one Resident (#283), out of four sampled residents, when the Resident left the facility, did not return as indicated, and was unable to be contacted by facility staff. Specifically, the facility staff failed to notify the Police Department when Resident #283 was considered missing for failing to return to the facility from a leave of absence (LOA), and the facility could not verify the Resident whereabouts, care, or safety. Findings include: Review of the facility policy titled, Elopement Prevention and Response revised April 24, 2023, included but was not limited to: -Elopement: when a resident leaves the premises or a safe area without knowledge (i.e., an order for discharge or leave of absence) -Elopement Response: >At first notice that the resident does not seem to be in his/her usual/immediate living space, the resident is considered missing. >If the facility search is unsuccessful, the individual in charge will carry out the following steps . Step B: Notify the Police Department. Resident #283 was admitted to the facility in December 2023, with the following diagnoses: Osteomyelitis (infection of the bone) and status post amputation (surgical removal) of right great toe, and was admitted to the facility for wound care and intravenous (IV- through the vein) antibiotics to be administered through a peripherally inserted catheter line (PICC line - a long, thin tube inserted through a vein in the arm and passed through to the larger veins near the heart). Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of a Nursing Progress Note, dated 12/30/23 at 9:17 P.M., indicated the following: -Resident left the facility at 7:40 A.M., via cab to seek help from friend in the community on filing paperwork. -Staff attempted to contact the Resident at 4:30 P.M. and 8:30 P.M. and left messages on his/her voice mail. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff attempted to contact both of the Resident's emergency contacts without response. -As of 9:17 P.M., Resident had not returned to the facility. During an observation and interview on 1/2/24 at 1:57 P.M., the surveyor observed the Resident's name on his/her bedroom door and the Resident's personal belongings on his/her side of the room. During an interview at the time, Certified Nurses Aide (CNA) #8 said the Resident never came back to the facility after leaving to go to an appointment, still had not returned and the facility staff did not know where the Resident was located. During an interview on 1/3/24 at 10:16 A.M., the Director of Nurses (DON) said Resident #283 left the faciity on [DATE] and never returned. The DON said the facility attempted to reach the Resident by telephone multiple times, however they were unable to reach him/her. The DON said the facility staff did not contact the Police because the Resident was young, alert, and oriented, and able to make his/her own decisions. The DON further said the Resident did not indicate that he/she would not be returning to the facility. During an interview on 1/3/24 at 11:08 A.M., the Administrator and the DON spoke with the survey team regarding Resident #283, and said that they were not aware that the Resident was not returning on 12/30/23, did not currently know his/her whereabouts, and indicated that he/she was alert, oriented, and able to make his/her own decisions. The Administrator and the DON said when the Resident did not return to the facility, the facility staff attempted to contact him/her, his/her emergency contacts and notified the Resident's Primary Care Physician (PCP) in the community but did not notify the Police. During an interview on 1/5/24 at 1:58 P.M., Unit Manager (UM) #2 said she had not seen the Resident since 12/28/23, and at that time, the Resident expressed concern about returning to his/her apartment and that he/she planned to remain in the facility until after his/her appointment scheduled with the Wound Clinic on 1/4/24 at 9:00 A.M. UM #2 further said that on 12/28/23, the Resident still had his/her PICC line inserted (in place), in the event he/she needed additional medications. During an interview on 1/5/24 at 2:25 P.M., Nurse #6 said Resident #283 approached her at 7:25 A.M. on 12/30/23, and said he/she needed to go to a friend's house to complete paperwork and that he/she planned to return (to the facility) in a few hours. Nurse #6 said the Resident left with no medications, PICC line was still in place, and his/her wound dressing was scheduled to be changed later on 12/30/23. Nurse #6 said she was familiar with Resident #283 and that he/she had left the faciity on Christmas night for a few hours and returned back to the facility. Nurse #6 said the Resident did not voice at any time that he/she did not plan on returning to the facility on [DATE]. She said she became concerned when the Resident did not return and placed a call to him/her at 4:30 P.M., and again at 8:30 P.M., on 12/30/23, but the phone went directly to voicemail. Nurse #6 said she also called his/her two emergency contacts and left messages but did not receive any return calls from either emergency contact. She said she called the Resident a third time at 11:00 P.M., with no success in reaching him/her. Nurse #6 said she notified the Nursing Supervisor that her attempts to reach the Resident were unsuccessful. Nurse #6 said that the Nursing Supervisor told her she did not consider the Resident an elopement because he/she was self-responsible. Nurse #6 further said that she worked again on 12/31/23, but did not attempt to contact the Resident on 12/31/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/24 at 12:47 P.M., Nurse #1 said she was working as the Nursing Supervisor in the building on 12/30/23, when Nurse #6 notified her the Resident did not return from his/her LOA. Nurse #1 said she was not familiar with the Resident, so she researched his/her clinical and personal information in the computer and notified the DON. Nurse #1 said she also notified the facility's on-call Provider (Physician) that the Resident had a PICC line in place.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 42761 Based on observation, interview, record and policy review, the facility failed to provide adequate nutritional care and services for two Residents (#193 and #60), out of a total sample of 36 residents. Specifically, the facility failed to: 1. Re-evaluate Resident #193's nutritional needs, identify a severe weight loss, monitor weights as ordered, and accurately monitor meal intake percentages when the Resident had been identified as having a poor appetite, being at nutritional risk, and had experienced a severe weight loss greater than 7.5 percent (%) in less than three months; and 2. For Resident #60, a) provide nutritional supplements as ordered, and b) maintain an accurate weight record in the Electronic Medical Record (EMR) in order to identify significant weight loss timely and monitor and assess meal intakes consistently when the Resident was identified at nutritional risk and experienced severe weight loss. Findings include: Review of the facility's policy, titled Nutrition Management, dated 12/5/08 and revised 6/6/22, indicated: -The purpose was to provide nutritional care and services to each resident, consistent with the resident's comprehensive assessment . to recognize, evaluate, and address the nutritional needs of every resident, including, but not limited to, the resident at risk or currently experiencing impaired nutrition . -Staff will consistently observe and monitor residents for changes . -Consult with the Dietitian when .unplanned weight loss or gain (greater than three pounds [lbs]) from last recorded weight and/or 5% in one month, 7.5% in three months, and 10% in six months. -Document oral intake routinely through meal observations. -Monitor weights as ordered, at minimum monthly . 1. Resident #193 was admitted to the facility in April 2023 with diagnoses of Type Two Diabetes Mellitus (DM II), Edema (swelling caused by too much fluid trapped in the body's tissues), Hypertension (high blood pressure), Obesity, and Depression. Review of Resident #193's Mood Care Plan, initiated 4/4/23, indicated the Resident had a history of Anxiety and Depression, and to monitor for changes in appetite. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #193's Nutrition Care Plan, initiated 4/7/23, indicated: - The Resident was at risk for unmet nutritional needs and that he/she would consume adequate amounts of food to maintain a stable weight pattern. - Notify Physician . if persistent weight loss . occurs. - Weights were to be monitored as ordered. - Intake at all meals was to be monitored and recorded. - The Dietitian and Physician were to be notified of any decline. Review of an active Physician's order, dated 7/20/23, indicated: - Torsemide (diuretic medication used to treat edema) five milligram (mg) tablet at 8:00 A.M. Review of a Physician's Progress Note, dated 8/2/23, indicated Resident #193's appetite had been poor and the Resident had experienced several hospitalization s over the previous few months. Review of two active Physician's orders, dated 8/11/23, indicated: - Two gram (gm - metric unit of mass) sodium, carb (carbohydrate) controlled regular diet with thin liquids. - Obtain weight upon admission and monthly. Review of Resident #193's Dietitian Note, dated 9/28/23, indicated the Resident's weight was 204.5 lbs. and that the Resident's weight fluctuated with fluid status changes. Review of Resident #193's September 2023 Meal Intake Day Report indicated: -No meal intake had been recorded for any meal from 9/23/23 through 9/28/23 and on 9/30/23. -No meal intake had been recorded for the dinner meal on 9/29/23. Review of Resident #193's weight record indicated the Resident weighed 204.5 lbs. on 9/21/23 and 9/25/23.: Further review of the Resident's weight record indicated no evidence weights were obtained in October 2023, or November 2023, as ordered. Review of Resident #193's Meal Intake Day Report indicated for October 2023, November 2023, and December 2023, that staff was not consistently monitoring and assessing meal intakes to determine what further intervention was needed for the Resident's nutritional needs. Review of two Physician's Orders, dated 12/4/23, indicated: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order initiated 7/20/23 and discontinued 12/4/23 for four ounces (oz) VHC (Very High Calorie) Boost (dietary supplement drink) three times per day. -Four oz VHC Boost three times per day. Review of Resident #193's Weight Record indicated the Resident weighed 172 lbs. on 12/1/23 (15.89% loss since 9/21/23). Review of Resident #193's Minimum Data Set (MDS) Assessment, dated 12/13/23, indicated the following: -The Resident was cognitively intact as exhibited by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points. -The Resident had experienced a weight loss of 5% or more in one month/10% or more in six months. -The Resident was not on a Physician prescribed weight loss regimen. Review of the Dietitian's Weight Report, dated 12/15/23, indicated Resident #193 required a re-weigh due to a weight loss of 32 lbs. Review of Resident #193's Dietitian Note, dated 12/18/23, indicated the Resident's weight was 172 lbs. on 12/1/23 and that a re-weigh was requested. Review of Resident #193's clinical record on 1/2/24 indicated no evidence a re-weigh had been obtained. During an interview on 1/2/24 at 2:35 P.M., Resident #193 said he/she had recently experienced unplanned weight loss and that he/she was not able to eat very much. The Resident said he/she had been over 200 lbs. a few months before, but now thought he/she weighed around 176 lbs. On 1/3/24 at 8:45 A.M., the surveyor observed Resident #193 positioned upright in his/her bed with a breakfast meal positioned in front of him/her on a rolling bedside table. The Resident was not eating. During an interview on 1/3/24 at 2:01 P.M., Certified Nurses Aide (CNA) #5 said residents at the facility were to be weighed monthly unless directed otherwise. CNA #5 said once a resident's weight was obtained, she would alert the Nurse to the weight and that if a re-weigh was needed, the Nurse would alert the CNAs. CNA #5 also said the CNAs were responsible to record meal percentage intakes for all residents, all meals, unless directed otherwise and the meal percentage intakes was recorded in the computer. CNA #5 said she worked at the facility full time, that she cared for Resident #193 often, that the Resident did not refuse being weighed, and that the Resident was supposed to be weighed monthly. CNA #5 further said she did not recall being asked to re-weigh Resident #193 recently. During a follow-up interview on 1/3/24 at 2:49 P.M., CNA #5 said she had just been asked to re-weigh Resident #193 and that the Resident's weight was 179 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/3/24 at 3:12 P.M., Unit Manager (UM) #3 said it was the CNAs responsibility to obtain the residents' weights and report them to the Nurse. UM #3 said the Nurses then recorded the weights on paper, gave them to the UM, who then gave them to an administrative staff member to record in each resident's EMR. UM #3 said a three pound weight variance from a previous weight would indicate the need for a re-weigh and the administrative staff member would alert the UM if a re-weigh was needed. UM #3 said if a significant change in weight was identified for a resident, staff would notify the Dietitian and the Non-Physician Practitioner (NPP: Nurse Practitioner) so that the resident could be assessed for the weight change and new interventions put in place if indicated. UM #3 said she was not aware of Resident #193 having any significant weight loss and that she thought the Resident's weight had been pretty stable. The surveyor and UM #3 reviewed Resident #193's weight record in the EMR and UM #3 said no weights had been recorded for October 2023 or November 2023, and that the weight variance from 9/21/23 to 12/1/23 may not have been accurate. UM #3 said she thought the weights were recorded somewhere on paper, and went to the nurses' station desk and obtained a folder that included papers with residents' weights. UM #3 located a paper that indicated Resident #193's weight was 177 lbs. in November 2023, she showed the paper to the surveyor and said the weight must not have gotten entered into the Resident's EMR. UM #3 said she was unable to locate evidence that Resident #193's weight was obtained in October 2023, as ordered. The surveyor reviewed the Dietitian's request for re-weigh on 12/18/23 with UM #3, and UM #3 said there was no evidence this re-weigh had been done. UM #3 further said a weight should have been obtained and recorded for Resident #193 in October 2023, that November's weight should have been entered into the EMR, significant weight change should have been identified with the November 2023's weight of 177 lbs, a re-weigh should have been obtained, and if the weight loss was accurate, the Dietitian and NPP should have been consulted to assess the Resident. During an interview on 1/3/24 at 3:44 P.M., the NPP said Resident #193 was at nutritional risk, had a history of fluid overload, and was being treated with a diuretic medication to manage the fluid overload. The NPP also said Resident #193 was being treated for anxiety and Depression and that the Resident was not very motivated to do anything. The NPP said she worked in the facility five days per week and attended morning meetings daily where the interdisciplinary team (IDT) discussed residents with weight loss, but she had not been made aware by facility staff that Resident #193 had experienced a significant weight loss. The surveyor and the NPP reviewed the Resident's weights and the NPP said although she did not feel the weight loss was harmful to the Resident, it was not a planned weight loss. The NPP said she did not know that the Resident's weight had decreased from 204.5 lbs. on 9/21/23 to 172 lbs. on 12/1/23, that if she knew this, she would have assessed the Resident and possibly considered treatment with an appetite stimulant, if appropriate. On 1/4/24 at 8:46 A.M., the surveyor observed Resident #193 positioned upright in his/her bed with a breakfast meal positioned in front of him/her on a rolling bedside table. The surveyor observed the Resident eat a bite of food, put his/her utensils down, and look out the window. During a follow-up interview on 1/4/24 at 2:10 P.M., UM #3 provided copies of Resident #193's Meal Intake Day Reports for September 2023 through December 2023 and reviewed them with the surveyor. UM #3 said all percentages were to be recorded by the CNAs and that recording meal percentages was one of the processes required to monitor a resident's nutrition. UM #3 said recording meal percentages should have been done for Resident #193, as required, but it was not. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/5/24 at 1:25 P.M., the Dietitian said staff at the facility had not been obtaining residents' weights as ordered, re-weights were not consistently reported back to her or recorded in the residents' records, and that meal percentage intakes also had not been consistently recorded. The Dietitian said not having consistent or accurate meal percentages and weights significantly impacted her ability to accurately assess the residents' dietary needs. The Dietitian said she saw Resident #193 on 12/18/23, identified the significant weight loss through reviewing the Resident's recorded weights from 9/25/23 and 12/1/23, and requested the Resident be re-weighed to determine whether the weight loss was accurate, but this was not done. The Dietitian said she expected a re-weigh for a resident would be obtained the same day it was requested, or on the following day. During an interview on 1/5/24 at 2:14 P.M., the Director of Nurses (DON) said re-weighs requested for residents should be obtained within a couple days of the request and entered into the residents' EMRs. The DON said obtaining weights for all the residents in the facility has been a struggle for staff. 44129 2. Resident #60 was admitted to the facility in October 2023 with diagnoses including: Pneumonia (lung infection), Covid-19, Anemia (lower than normal amount of healthy red blood cells), Kidney Failure (status post kidney transplant), Congestive Heart Failure (CHF-condition where the heart's capacity to pump blood cannot keep up with the body's need), HTN (hypertension/ high blood pressure), and Hyperkalemia (too much potassium in the blood). Review of the MDS assessment, dated 10/13/23, indicated the following: -The Resident had moderate cognitive impairment as evidenced by a BIMS score of 10 out of 15 points. -The Resident was independent with eating. -The Resident was on a therapeutic diet. -The Resident's weight was 121 lbs. Review of the Dietitian's Progress Note, dated 11/2/23, indicated the following: -Serum Alb (albumin) = 2.3 (normal range 3.4 to 5.4 g/dL [grams per deciliter]) which indicates depleted visceral protein stores. -Will begin 4 oz. VHC Boost 3 times (x) per day to provide an additional 33 grams protein. Review of the MDS Assessment, dated 12/11/23, indicated the following: -The Resident was cognitively intact as evidenced by a BIMS score of 15 out of 15 total possible points. -The Resident was independent with eating but required staff assistance with setting up his/her meals. (continued on next page)

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	225687	A. Building B. Wing	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Commons Nursing & Rehabilitation Center	169 Valentine Road Pittsfield, MA 01201

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Resident was on a therapeutic diet. -The Resident's weight was 101 lbs. which indicated a significant weight loss (weight loss of 5% or more in the last month or 10% or more in the last six months) and was not on a prescribed weight loss program. Review of the Resident's Nutrition Care Plan, initiated on 10/16/23 and revised on 12/15/23, included the following: >The Resident was at risk for altered nutrition secondary to CHF, HTN, Kidney Transplant, Sepsis (a life-threatening response to an infection) from Pneumonia, Depression, and cognitive decline. >The Resident utilized a mechanically altered diet (food that is ground, chopped, mashed, or puree so food is easy to chew and swallow) per recommendations of the Speech Therapist (ST) and included the following interventions: -Resident will consume adequate amounts of food to maintain stable weight pattern through next review -Monitor intake at all meals, offer alternate choices as needed -Alert Dietitian and Physician to any decline -Document intake percentages of solids and fluids, offer snacks in between meals if appropriate -Weigh per Physician's order on the same scale, notify Physician and Dietitian if persistent weight loss, gain . Review of the Dietitian's Progress Note, dated 12/15/23, indicated the following: -Weight 10/10/23 = 120.6 lbs. -Weight 12/4/23 = 101 lbs. -A re-weigh has been requested. Review of the January 2024 Physician's orders included the following: -Obtain weight upon admission and monthly, initiated 10/10/23. -VHC Vanilla Boost 8 oz. box twice daily, may substitute flavor, initiated 10/7/23 and discontinued 10/16/23. -VHC Boost 4 oz. three times per day, initiated 11/2/23 Review of the Dietitian's Progress Note, dated 1/2/24, indicated the following: -Current weight 104 lbs. indicated a significant weight loss of 13.8% since 10/7/23. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Review of the Medication Administration Record (MAR) indicated the following: -October 2023: Resident did not receive his/her VHC Boost five times. The Boost supplement was not administered twice due to not being available, and no documentation indicating why it was not administered the other three times. -November 2023 MAR indicated the Resident did not receive his/her VHC Boost 14 times. The Boost supplement was not administered 13 times due to not being available, and no documentation indicating why it was not administered the other one time. -December 2023 MAR indicated the Resident did not receive his/her VHC Boost five times. The Boost supplement was not administered those five times due to not being available. Further review of the October 2023, November 2023 and December 2023 MARs indicated Nurse #4 was the scheduled Nurse consistently documenting that the VHC Boost supplement was not available to be administered to Resident #60. During an observation and interview on 1/2/24 at 12:04 P.M., the surveyor observed the Resident seated in a wheelchair near the nurses' station. The Resident was very thin in appearance. The Resident said he/she knew that he/she had been losing weight, and was not sure whether he/she received any nutritional supplements that increased his/her caloric intake since he/she had lost weight. During an interview on 1/5/24 at 2:11 P.M., Nurse #4 said there were many times when nursing staff did not have access to the VHC Boost supplement. He said the supplements were kept in locked cabinets near the kitchen and that the VHC Boost supplements were not kept on the nursing unit. Nurse #4 said that he was too busy taking care of the residents to leave the unit or to find someone to unlock the cabinets. During an interview on 1/5/24 at 3:54 P.M., UM #1 said all of the Boost supplements including VHC Boost was brought up to the units from the kitchen, and the dietary staff bring up what was needed. UM #1 further said a supply of the VHC Boost was kept in the medication room on the unit and the dietary staff routinely stock the Boost supplements on the units. During an interview on 1/5/24 at 4:09 P.M., the NPP said that she was unaware that Resident #60 missed multiple doses of VHC Boost supplements. The NPP said if a resident missed multiple doses of any medications she expected to be notified by the facility staff. The NPP said if she had been made aware that a medication was unavailable, she would have been able to order an alternative treatment. During an interview on 1/5/24 at 4:35 P.M., the Food Service Director (FSD) said the Boost supply was kept in a storage room near the kitchen, and if the units needed more they would contact the kitchen to request a delivery. The FSD further said there were no limits to what the units could request, and there was someone available in the kitchen seven days per week from 5:00 A.M. until 8:00 P.M., to bring the Boost supplements to the nursing units when requested. During an interview on 1/9/24 at 12:56 P.M., the DON said there were no issues for any of the nursing units with regards to obtaining VHC Boost. The DON said the process was for staff to call the kitchen for the supplements as needed, and if the supplement was unavailable, the staff would alert the ordering Physician to order something different. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Review of the vital signs section of the EMR indicated the following recorded weights for Resident #60: -10/10/23 = 120.6 lbs. -11/2/23 = 106 lbs. (found on paper document at the nurses station after surveyor inquiry; represents a 12.% weight loss in one month) -12/4/23 = 101.0 lbs. (16.25% weight loss in just under two months) -1/2/24 = 104.0 lbs. During an interview on 1/4/24 at 11:06 A.M., Nurse #4 said all of the Resident's weights were recorded in the EMR. The surveyor and Nurse #4 reviewed the Resident's weights in the EMR, and he said that the Resident did not have a recorded weight in November 2023. Nurse #4 further said if a Resident refused to be weighed, the Nurse should document the refusal in a progress note. During an interview on 1/4/24 at 1:21 P.M., UM #2 said the goal was to obtain monthly weights for all residents during the first week of each month and have the administrative staff data entry the weights into the EMR and a separate spreadsheet. The surveyor and UM #2 reviewed the Resident's EMR, and she said the Resident's November 2023 weight was never recorded and she was not sure why, as his/her weight did appear on the UM's written report that was given to the administrative assistant. During an interview on 1/4/24 at 3:31 P.M., the Administrative Assistant said she maintained weight spreadsheets for each unit on her computer. The Administrative Assistant said the DON requested for any resident that had a weight change of three pounds or more, to be highlighted and given back to the DON who then disseminates the information to the UMs to obtain re-weights for the residents with variances. During an interview on 1/5/24 at 9:38 A.M., the NPP said she was not notified by nursing staff of the Resident's severe weight loss and was unaware of the Resident's actual weight loss percentage, however she had been treating the Resident for overall symptoms of failure to thrive (a syndrome of weight loss, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function and low cholesterol). The NPP said that she obtained most of the clinical information required to treat a resident from the EMR, including weights, but there had been circumstances where weights had not been entered into the EMR. During an interview on 1/9/24 at 10:38 A.M., the surveyor and UM #2 reviewed the Dietitian's Progress Note dated 12/15/23, which indicated the Resident's weight on 10/10/23 was 120.6 lbs., his/her weight on 12/4/23 was 101 lbs., and that the Dietitian had requested the facility staff obtain a re-weigh for Resident #60. UM #2 said there was not a re-weigh recorded in the EMR for 12/15/23. UM #2 then located a weight of 103.3 lbs. obtained on 12/15/23, written on a weight sheet in her office. UM #2 further said the weights were obtained by 12/14/23 and given to the Administrative Assistant by 12/15/23 for data entry. Review of the CNA Meal Documentation in the EMR for October 2023, November 2023, December 2023 and to current date of January 2024, indicated that staff was not consistently monitoring and assessing meal intakes to determine what further intervention was needed for the Resident's nutritional needs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/4/24 at 5:20 P.M., CNA #2 said it was the responsibility of the CNAs to record every resident's meal intake in the EMR. During an interview on 1/9/24 at 9:35 A.M., CNA #4 said CNAs were required to document all of the residents' meal intake in the computer and that it was important that meal intake was completed in order for clinical staff such as Nurses, Doctors, Nurse Practitioners and Dietitians to make treatment decisions as well as to have a record of a person's overall status. The surveyor and CNA #4 reviewed the Resident's meal intake reports and CNA #4 said they were incomplete, and that the clinical staff would be unable to determine the Resident's meal intake if they looked at the information because there was not enough information.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation, interview, record and policy review, the facility failed to ensure that the Oxygen flow rate (measurement of how much Oxygen is being administered) was set at the correct liters per minute (LPM - the amount of oxygen flow that is being received) for one Resident (#156), out of a total sample of 36 residents. Specifically, the facility staff failed to ensure that the Resident's oxygen flow rate was maintained at 2 LPM as prescribed by the Physician, putting him/her at risk for adverse outcomes like hypercapnia (failure of the body to remove carbon dioxide in the blood) and Respiratory Failure (condition that results when the blood does not have enough oxygen or too much carbon dioxide). Findings include: Review of the facility policy titled Oxygen Administration, Revised November 3, 2016, indicated the following: -Verify Physician's order of Oxygen administration . Updated AARC Clinical Practice Guidelines at https://www.aarc.org/wpcontent/uploads/2014/08/08.07.1063.pdf, titled Precautions and/or Possible Complications indicated the following: -There is a potential in some spontaneously (without assist) breathing hypoxemic (low blood oxygen levels) patients with hypercapnia and Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe) that oxygen administration may lead to an increase in PaCO2 (carbon dioxide). -Undesirable results or events may result from noncompliance with Physician's orders or inadequate instruction in Oxygen therapy. Resident #156 was admitted to the facility in May 2022 with a diagnosis of COPD. During an observation and interview on 1/2/24 at 10:02 A.M., the surveyor observed the Resident to be lying in bed receiving Oxygen via nasal cannula (tubing that sits just inside the nostrils/nose to deliver Oxygen) set at 4 LPM. Resident #156 said he/she usually had his/her Oxygen flow set to 2 to 2.5 LPM. Review of the Resident's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 13 out of 15 on the Brief Interview of Mental Status (BIMS) assessment indicating he/she was cognitively intact. Review of the Resident's January 2024 Active Physician Orders Report indicated the following order: -Continuous Oxygen Administration every shift. -Rate: 2 LPM continuous. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Route: Nasal Cannula with a start date of 6/9/23. During an observation on 1/3/24 at 2:35 P.M., the surveyor observed the Resident to be lying in bed receiving Oxygen via nasal cannula set to 4 LPM. During an observation and interview on 1/4/24 at 8:35 A.M., the surveyor and Nurse #2 observed Resident #156 lying in bed receiving Oxygen via nasal cannula set to 4 LPM. The surveyor and Nurse #2 reviewed the Resident's Physician's orders after the observation, and Nurse #2 said the Resident was ordered for Oxygen at 2 LPM continuous. Nurse #2 said that having the Resident's Oxygen set at 4 LPM put him/her at risk for having an increase of PaCO2 retention (hypercapnia). She further said if the Resident was utilizing a higher Oxygen flow rate, the Physician should have been made aware and an order should have been put into place for the higher Oxygen flow rate.