STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365883	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Augustine Manor	7801 Detroit Ave Cleveland, OH 44102

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, record review and interview, the facility failed to maintain dignity and respect at all times for Resident #62 and R448 by ensuring urinary drainage bags were covered. This affected two residents (#62 and R448) of two residents reviewed for dignity. The facility census was 188. Findings include: 1. Review of the medical record for Resident #62 revealed an admitted [DATE] with diagnoses that included quadriplegia, dysphagia, and neuromuscular dysfunction of the bladder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was alert and oriented to person, place, time, and was dependent on staff for Activities of Daily Living (ADLs). Review of the care plan dated 11/17/16 revealed Resident #62 was at risk for skin breakdown related to quadriplegia with interventions that included providing incontinence care every 2 hours and as needed. Review of the physician orders dated 02/18/24 revealed an order to provide incontinence care every two hours and as needed every shift, change catheter drainage bag every 14 days and as needed every night shift and colostomy care every shift and as needed. Observation on 05/21/24 at 9:26 A.M. revealed Resident #62 foley bag was seen from the hallway outside of his room. Observation revealed a yellow liquid substance (urine) was filled to the 700 cubic centimeter line. No privacy bag was covering the foley bag. Observation revealed multiple staff and residents walking and/or ambulating past his room. Observation and Interview on 05/21/24 at 12:15 P.M. with Licensed Practical Nurse (LPN) #611 revealed Resident #62 foley bag was seen from the hallway, uncovered, exposing the resident's urine. LPN #611 revealed foley bags were only covered when being transported outside of rooms. LPN #611 confirmed and verified the above findings. Interview on 05/22/24 at 8:24 A.M. with LPN #433 revealed Resident #62 had a stoma that was connected to a urinary drainage bag and was to be changed every 2 hours or as needed. LPN #433 revealed all urinary drainage bags were to be covered with a privacy bag. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled Toileting revised April 2023 revealed the facility and a policy in place that if a resident required assistance, staff were to follow the plan of care. Review of the document revealed the facility did not implement the policy. Review of the facility document titled Resident Rights dated June 2022 revealed the facility had a policy in place that residents had a right to a dignified existence. Review of the document revealed the facility did not implement the policy in regard to the allegation. 41749 2. During screening on 5/21/24 at approximately 9:43am, R448 was observed in bed. R448's urinary drainage bag was observed halfway filled with yellowish urine output. R448's door was open, and the uncovered drainage bag was facing the doorway, exposing R448's urine. R448's drainage bag was not covered, attached to the lower bed frame, and could easily be viewed from R448's doorway. Another surveyor confirmed the observation. Review of R448's health record revealed an admitted [DATE]. Review of R448's baseline care plan dated 5/18/24 revealed a care plan was developed related to indwelling urinary catheter. However, there was no evidence that a cover or privacy bag was addressed in the baseline care plan. Review of R448's Kardex (documentation system that gives a brief overview of individual resident care) revealed Bladder/Bowel. Catheter: the resident has 16Fr [French] 5 cc [cubic centimeter] indwelling urinary catheter. Position catheter bag and tubing below the level of the bladder and check for kinks at least q [every] shift. Empty foley catheter every eight hours and record output. Five-day bladder diary. However, there were no instructions on how to protect R448's dignity. During an interview with State tested Nursing Assistant (STNA) STNA #421 on 5/22/24 at approximately 1:05PM, STNA #421 revealed she was familiar with R448. When asked about the care and resident needs, STNA #421 stated they used the Kardex. When asked how she provided privacy for residents with catheter and urinary drainage bag, STNA#421 stated, We close the door. We have a bath blanket or sheet to put over them. We have a Foley [catheter] cover. In an interview with the Licensed Practical Nurse (LPN) #824 on 5/22/24 at approximately 1:12pm, when asked how staff including STNAs knew what kind of care they need to provide to residents, LPN #824 stated, When they [staff] come from another floor, they get a report from the aides [outgoing STNA] and they get a report from me. When asked how they would protect R448's privacy who had a catheter and was using a drainage bag, LPN #824 stated, You won't let it sit on the floor. Dignity, that's the whole purpose of that. When asked to check R448's Kardex if provision of a cover or privacy bag had been included, LPN #824 stated, No. But they know. I don't know if that's a Kardex thing. When asked how STNA would know to provide privacy bag for residents with catheters and urinary drainage bags, LPN #824 stated, They should know that. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 5/22/24 at approximately 3:13pm, the DON confirmed that R448's Kardex did not include the use of privacy bag. The surveyor informed the DON of the above-mentioned observation. When asked if staff should provide a cover or privacy bag for the urinary drainage bag, the DON stated, It depends if the resident requests for a privacy bag [for a resident who is inside his/her room]. The DON added, Maybe we need re-education too [for the nursing assistant that needed the re-education]. Review of the facility policy titled Maintenance of Urinary Catheters dated 10/14 revealed .When the resident is out of their [sic] room, a foley bag cover must be in place . However, the policy did not instruct how to protect the dignity of residents with urinary drainage bags while inside their rooms when visible by residents and visitors from the hallway when the door is open.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan, physician orders, and interventions of monitoring and evaluation was in place for Resident #144's hand restraint. This affected one resident (Resident #144) of two residents reviewed for restraint use. The total census was 188. Findings include: Record review of Resident #144 revealed he admitted to the facility 10/04/23 and had diagnoses including sepsis, dementia, and tracheostomy status. Review of Resident #144's comprehensive care plan revealed the resident had a tracheostomy due to respiratory failure with an intervention initiated on 10/17/23 for bilateral hand mitts at all times to prevent decannulation. Remove and provide care every two hours and as needed. The care plan had not been revised and did not include specific interventions as to how often to monitor and evaluate the use of the restraint. Review of Resident #144's restraint assessment dated [DATE] revealed he required PRN (as-needed) mitt restraints to minimize risk for pulling out tracheostomy tubing due to agitated behavior and risk for serious injury or death. Review of Resident #44's Minimum Data Set assessment dated [DATE] revealed he was rarely or never understood and did not use restraints. Review of Resident #144's nurse practitioner note dated 05/21/24 revealed the resident had an unwitnessed JP ('Jackson Pratt') drain dislodgement and was to receive a trial of mitt restraints for two hours and to remove them if there was no restlessness or agitation. Review of Resident #144's active and discontinued orders revealed no evidence the restraints were ordered. Record review of Resident #144's progress notes and assessments revealed no specific documentation of when the restraints were applied and removed, no documentation of notification made to family of restraint use, and no monitoring or evaluation of the resident while the restraint was in use. Observation of Resident #144 on 05/21/24 at 10:05 A.M. revealed he was not interviewable. He wore a mitt restraint (a restraint made to prevent the wearer from closing their fingers around an object) on his right hand. The restraint was no longer present during a follow-up observation at 4:32 P.M. Interview with Licensed Practical Nurse #937 on 05/21/24 at 4:39 P.M. revealed she recalled Resident #144 had a history of needing mitt restraints but he had not needed them recently until this morning. She did not apply the restraint this morning, but did take them off the resident at roughly 12:00 P.M. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on 05/22/24 at 2:25 P.M. confirmed Resident #144 did not receive any documented orders, monitoring, or family notification for the restraint use on 05/21/24. Review of the facility's restraint use policy updated 04/2024 revealed it stated restraints required an order when used for a period in excess of six hours. The facility was to determine the direct monitoring and supervision used during the period of restraint. Following surveyor intervention, the facility acquired a paper order dated 05/21/24 for the resident to trial hand mitts for two hours to the right hand and remove if there was no restlessness or agitation.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19864 Based on observation, interview and record review, the facility failed to provide hemodialysis care and services consistent with professional standards of practice related to the pre and post dialysis assessment and ongoing communication between the facility and the dialysis center for six (R154, R114, R98, R25, R106, R155) of six residents reviewed for dialysis. Findings include: 1.) Review of Resident #155 electronic Medical Diagnosis form indicated diagnoses of hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease (ESRD) dated 3/7/2023, dependence on renal dialysis dated 3/7/2023 and ESRD dated 8/10/2023. Quarterly Minimum Data Set (MDS) signed and locked on 12/15/23 at 3:00 p.m. indicated Resident #155 was admitted into the facility on [DATE]. The MDS also indicated that Resident #155's Brief Interview for Mental Status (BIMS) Summary Score was 15. According to online website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7984985/ assessed 5/29/2024 indicated, BIMS is a brief cognitive screening measure that focuses on orientation and short-term word recall. It also indicated if an individual had an overall summary score of 13-15, then the individual's mental status was cognitively intact. Physician order dated 3/8/2023 and timed 3:38 p.m. indicated an order for dialysis on Monday, Wednesday, and Fridays at 5:00 a.m. Dialysis Communication form dated 3/11/2024 and 4/5/2024, that were scanned into Resident #155's electronic chart indicated the Dialysis Information section of the form was to be filled out by dialysis. However, this section was not complete and the information regarding if the resident exhibited shortness of breath, nausea/vomiting, cramping, or complaints of pain, and what medications were administered, if treatment was completed without complications, and if resident was assessed by RN to be released back to the unit from dialysis was blank. May 2024 Treatment Administrative Record (TAR) indicated an order with a start date of 3/07/2023 to monitor dialysis catheters every shift and to reinforce if needed every shift. On 5/15/2024 for the day and evening shift the signature slots were blank and there was no documentation the dialysis catheter was monitored, checked, or assessed. During an interview on 5/22/24 at 9:20 a.m., RN #818 said there are times the dialysis department would give the post Dialysis Communication form to the resident and the resident would not always give it to the nurse to review. RN #818 also said this process was not good practice. RN #818 verified she was the nurse in charge of Resident #155 on 5/15/2024 during the day and evening shift and she did not document or sign that she monitored or checked the resident's dialysis catheter on that day. RN #818 said Resident #155 was alert and oriented and would know what the nurses did post dialysis. During an interview on 5/22/2024 at 9:33 a.m., Resident #155 said the facility nurses did not monitor or assess her dialysis catheter daily nor did they do it after she returned from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 3:19 p.m., the Director of Nurses (DON) verified the Dialysis Communication Forms that were scanned into the electronic record for Resident #155 for 3/11/2024 and 4/5/2024 were not filled out completely and the post dialysis vital signs and the section that informed the nurse if the resident exhibited shortness of breath, nausea/vomiting, cramping, complaints of pain, medications administered, if treatment was completed without complications, and if resident was assessed by RN to be released from dialysis back to the unit was blank. The DON said those sections were to be completed by the dialysis department after completion of dialysis treatment to ensure the facility nurses have that information to monitor and assess the resident. She also said that her expectation for the nurse was to initial the TAR once the task was completed. During an interview on 5/22/2024 at 9:59 a.m., dialysis Facility Administrator (FA) #300 said it was not their practice to send their dialysis records to the facility. FA #300 said the facility had their own Dialysis Communication Form for them to fill out and send with the resident, and they would complete the dialysis section of the form after dialysis is complete and they would give the form to the resident to give to the nurse once they returned to the unit. FA #300 further said she witnessed Dialysis Communication forms in resident wheelchairs from several days after treatment, therefore she knew that the facility did not get the information. She also said the dialysis center did not call report to the unit or the nurse after treatment of residents because they are not affiliated with the facility, and they were a separate entity. FA #300 further said she has not talked to the facility about their nurses not receiving the post dialysis documentation from the residents because it was not the dialysis centers responsibility to ensure the facility complied. Review of the facility's policy and procedure titled, Maintenance of Clinical Records with an initial date of 12/2022 indicated In accordance with acceptable professional standards of practice, the facility must maintain medical records on each resident that are: complete, accurately documented, and readily accessible. Review of the facility's policy and procedure titled, Care of Dialysis Access Devices with a last initial date of 07/2021 indicated upon return from dialysis, the resident was to have their dialysis site assessed to ensure the dressing was in place and the area surrounding the dialysis site was to be checked for redness, swelling, warmth, bruising, pain, or drainage. 2.) Review of Resident #25 electronic Medical Diagnosis form indicated diagnoses of ESRD and dependence on renal dialysis both dated 3/21/23. Physician order dated 2/26/24 and timed 7:47 a.m., indicated an order for dialysis every Monday, Wednesday, and Friday at 5:15 a.m. An annual MDS that was signed and locked on 2/19/2024 at 1:54 p.m., indicated Resident #25 was admitted into the facility on [DATE]. May 2024 TAR indicated an order with a start date of 10/11/2023 to check bruit and thrill every day on the 7:00 a.m. - 7:00 p.m. and 7:00 p.m. - 7:00 a.m. shift. There were blank slots and no signature documentation on 5/11/2024 and 5/15/2024 for the 7:00 a.m. - 7:00 p.m. to indicate the bruit and thrill was checked. Care Plan with target completion date of 3/8/2024 indicated the resident needed hemodialysis related to ESRD. The intervention was to check bruit and thrill per orders. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dialysis Communication Forms dated 5/3/24, 5/6/2024, 5/8/2024, 5/10/2024, 5/13/2024, and 5/5/2024 indicated the Dialysis Information section of the form was not complete and the information regarding if the resident exhibited shortness of breath, nausea/vomiting, cramping, or complaints of pain, and what medications were administered, if treatment was completed without complications, and if resident was assessed by RN to be released back to the unit from dialysis was blank During an interview on 5/22/24 at 3:55 p.m., the DON verified the Dialysis Communication Forms that were scanned into the electronic record dated 5/3/24, 5/6/2024, 5/8/2024, 5/10/2024, 5/13/2024, and 5/15/2024 did not have the Dialysis Information section completed. She said the dialysis department was supposed to complete that section once the resident completed his or her dialysis treatment. She said the Dialysis Communication forms not being filled out completely, did not show a good continuity of care between the facility and the dialysis department for the residents. During an interview on 5/22/2024 at 12:55 p.m., Licensed Practical Nurse (LPN) #908 said when a resident returned from dialysis she would take the residents vital signs, and make sure the dressing on the graft or fistula was intact. She stated that she does not take the dressing to the fistula off at all, and that the dressing should stay on until the resident went back to dialysis. LPN #908 said that she has worked at the facility for about one year and she does not know how to assess or check dialysis fistulas or graft bruit and thrills. She said that the facility had not trained her on how to assess or monitor bruit or thrills since she started working there. LPN #908 also said that when the residents returned from dialysis the Dialysis Information section of the Dialysis Communication form was not always filled out completely. Review of the facility's policy and procedure titled, Maintenance of Clinical Records with an initial date of 12/2022 indicated In accordance with acceptable professional standards of practice, the facility must maintain medical records on each resident that are: complete, accurately documented, and readily accessible. Review of the facility's policy and procedure titled, Care of Dialysis Access Devices with a last initial date of 07/2021 indicated nursing was to assess bruit and thrill every shift. 3.) Review of Resident #106 electronic Medical Diagnosis form indicated diagnoses of chronic kidney disease, stage 5 dated 10/25/2022, dependence on renal dialysis dated 2/11/24 and ESRD dated 2/21/2024. Physician order dated 5/17/2024 and timed 8:13 a.m. revealed an order for dialysis on Monday, Wednesday, and Fridays at 8:30a.m. Dialysis Communication Forms dated 5/1/24, 5/3/24, 5/15/24, 5/17/24, and 5/20/24, that were scanned into Resident #106's electronic chart indicated the Dialysis Information section of the form was to be filled out by dialysis. However, this section was not complete and the information regarding if the resident exhibited shortness of breath, nausea/vomiting, cramping, or complaints of pain, and what medications were administered, if treatment was completed without complications, and if resident was assessed by RN to be released back to the unit from dialysis was blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 3:51 p.m., the DON verified the Dialysis Communication Forms that were scanned into the electronic record for Resident #106 and dated 5/1/2024, 5/3/2024, 5/15/2024, 5/17/2024, and 5/20-2024 did not have the Dialysis Information section filled out completely and the documentation that informed the nurse if the resident exhibited shortness of breath, nausea/vomiting, cramping, or complaints of pain, what medications were administered at dialysis, if dialysis treatment was completed without complications, and if the resident was assessed by RN to be released from dialysis back to the unit was blank. Review of the facility's policy and procedure titled, Maintenance of Clinical Records with an initial date of 12/2022 indicated In accordance with acceptable professional standards of practice, the facility must maintain medical records on each resident that are: complete, accurately documented, and readily accessible. 41749 4.) During observation and interview with R154 on 5/21/24 at approximately 5:05pm, R154 stated he goes to dialysis (a treatment for people whose kidneys are failing). R154 stated, Yes, three times [a week] Monday, Wednesday, Friday. When asked about his dialysis access site, R154 showed the surveyor his right upper arm. The site was covered with a dressing and secured with a tape. R154 stated he would get weighed at the dialysis unit. When asked if staff had been checking his vital signs when he returned from dialysis, R154 stated, No. R154 explained that staff checked him in the morning before but not after his dialysis treatment. Review of R154's Medical Diagnosis in Point Click Care (PCC, healthcare software and electronic health record) included end stage renal disease (kidney failure) and dependence on renal dialysis. Review of R154's quarterly Minimum Data Set (MDS), a federally mandated assessment tool) dated 4/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. In the section related to Special Treatments and programs, revealed R154 had received dialysis. Review of R154's care plan with a Review Start Date of 3/19/24 revealed The resident needs hemodialysis r/t [related to] CKD [chronic kidney disease]. Hx [history of] left nephrectomy [surgery to remove a kidney or part of a kidney]. The interventions included check bruit [audible vascular sound associated with turbulent blood flow] and thrill [vibratory sensation felt on skin overlying an area of turbulence] every shift in right arm . Encourage resident to go for the scheduled dialysis appointments .Monitor vital signs per protocol and PRN [as needed], focusing on BP [blood pressure]. Notify MD of significant abnormalities . Monitor/document/report prn any s/sx [signs and symptoms] of infection to access site .No BP draws to right arm d/t [due to] fistula [a connection that is made between an artery and a vein for dialysis access .Resident has dialysis on M-W-F [Monday, Wednesday, Friday] [at] [name of dialysis center] . However, R154's care plan did not identify and include specific parameters for R154's blood pressure, weight and other vital signs. Review of R154's May 2024's Orders revealed the following: - Ensure dialysis communication folder is in resident's possession one time a day every Mon, Wed, Fri (start date 4/26/24) - Resident has dialysis on M-W-F at (name of dialysis center) 4:45 (am) (start date 3/27/24) (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Epoetin Alfa-epbx solution [epogen, medication used to treat anemia caused by chronic kidney disease] 10000 units/ml. Use 0.75 ml intravenously one time a day every Mon, Wed, Fri for anemia to be given in dialysis (start date 5/22/23) - No BP draws to right arm d/t fistula placement (start date 5/19/23) - Check Bruit and thrill every shift in right arm (start date 5/19/23) - Monitor Dialysis catheter every shift and reinforce if needed. Right subclavian every shift (start date - 5/19/23). However, the orders did not indicate R154's individualized dialysis prescription including the length of dialysis treatment time and resident's target weight. It did not address the specific parameters for blood pressure, weight and other vital signs. Review of R154's May 2024 Medication and Treatment Administration Records (MAR/TAR) revealed the following: - R154 received dialysis on 5/1, 5/3, 5/6, 5/8, 5/10, 5/13, 5/15, 5/17 and 5/2024. - Bruit and thrill checked every shift - Epoetin Alfa-epbx solution 10000 units/ml. Use 0.75 ml intravenously one time a day every Mon, Wed, Fri for anemia to be given in dialysis was marked given on 5/3, 5/6, 5/8, 5/10, 5/13, 5/15, 5/17, 5/20 and 5/22/24. Further review of R154's May 2024 MAR and TAR revealed no indication that blood pressure was monitored after dialysis treatment. Review of R154's [name of dialysis] SNF [skilled nursing facility] Dialysis Services Communication Forms [form completed for residents receiving dialysis in the unit] revealed incomplete assessments and Epogen had not been documented as administered on 5/1, 5/3, 5/6, 5/8, 5/10, 5/13, 5/15 and 5/17/24 during dialysis. Further review of the dialysis services communication forms revealed the following: 5/1 - post (dialysis) treatment BP = 110/56 5/10 - no pre and post treatment vital signs. The section additional notes indicated patient did not bring this [form] on Monday. 5/15 - post treatment BP = 136/103 5/17 - pretreatment BP = 161/80 and post treatment BP = 167/90 Review of R154's progress notes revealed no monitoring of R154's BP after dialysis on 5/1, 5/15 and 5/17/24 and no documentation that the physician or nurse practitioner had been notified of R154's blood pressure readings. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Licensed Practical Nurse (LPN) #922 on 5/22/24 at approximately 2:30pm, LPN #922 stated she was familiar with R154. When asked about the care for the dialysis access site and dressing changes, LPN #922 stated, No. That is strictly dialysis. When asked when she would monitor the vital signs and weight, LPN #922 stated, If it requires to or something is going on. LPN #922 stated, Night shift gets him [ready] for dialysis. When asked how care was coordinated and communicated when there are changes in condition, LPN#922 stated, I notify the NP [nurse practitioner] and a progress note. Absolutely. In an interview with the DON on 5/22/24 at approximately 2:47pm, the DON stated the dialysis staff [from the dialysis center] were different from the dialysis staff providing the treatment on the ventilator section of the nursing home. The DON stated that for the residents with ventilators or tracheostomy who received dialysis, [They are] coming from a different [name of dialysis center] location. Our staff will go back with them and they will complete [the dialysis communication form] together. They start early. When asked about the pre and post dialysis weight, the DON stated, For consistency they get weighed [pre and post dialysis] over there [by dialysis staff]. The DON stated that if there was no pre weight on the communication form, They [dialysis staff] didn't take it. When asked about orders for VS parameters, the DON stated that it would depend on the physician. 5.) During observation on 5/21/24 at approximately 5pm, revealed R98 eating in the dining room. On 5/22/24 at approximately 9:53am, R98 was observed seating in his wheelchair by the waiting area of the dialysis center and was dozing off. When he opened his eyes, the surveyor asked R98 how his treatment went. R98 stated it was okay. Review of R98's electronic health record in PCC revealed an admitted [DATE]. R98's diagnoses included end stage renal disease and dependence on renal dialysis. Review of R98's quarterly MDS dated [DATE] revealed a BIMS score of 15. In the section Special Treatment and Programs revealed R98 had received dialysis. Review of R98's care plan with a review start date of 3/19/24 revealed, The resident needs hemodialysis r/t renal failure. Right AVF. The interventions included Administer medications per order .Check RAVF [right arteriovenous fistula] for bruit and thrill per orders .Do not draw blood or take B/P in R arm: AVF .Encourage resident to go for the scheduled dialysis .Fluid restriction as ordered .Monitor labs and report to doctor as needed .Monitor vital signs per protocol/PRN. Notify MD of significant abnormalities .Monitor/document report PRN any s/sx of infection to access site: Redness, swelling, warmth or drainage . Monitor/document/report PRN for s/sx of the following: bleeding, hemorrhage, bacteremia, septic shock . Monitor/document/report PRN new/worsening peripheral edema . Review of R98's Orders revealed the following: - Vitals Q (every) month and PRN. Notify MD/NP for temp (greater than) 100, HR (heart rate) (greater than) 110 or (less than) 55, SBP (systolic blood pressure) (greater than) 160 or (less than) 90, SpO2 (oxygen saturation) (less than) 92% on currently ordered O2, or for any acute change in condition every day shift (start date 6/1/24) - Ensure dialysis communication folder is in resident's possession one time a day every Mon, Wed, Fri (start date 4/26/24) (continued on next page)

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	365883	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Augustine Manor	7801 Detroit Ave Cleveland, OH 44102

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Renal Carb (carbohydrates) controlled diet, minced and moist texture, moderately thick consistency (start date 2/26/24) - Resident had dialysis on M-W-F at 4:45am one time a day every Mon, Wed, Fri for ESRD (start date 2/26/24) - 1500 ml (milliliter) Fluid restriction 960 ml DTY (dietary) 360 ml B (breakfast) and L (lunch) 240 ml D (dinner), 540 ml NSG (nursing) 270 ml q shift (start date 2/23/24) - Check RAVF bruit and thrill every shift (start date 2/23/24) - Do not draw blood or take B/P in right arm: AVF (start date 2/23/24) Further review of R98's Orders revealed that the facility failed to indicate individualized dialysis prescription including R98's dialysis length of treatment time and resident's target weight. Review of R98's May 2024 MAR revealed that R98 received dialysis on 5/1, 5/3, 5/6, 5/8, 5/10, 5/13, 5/15, 5/17, 5/20 and on 5/22/24. However, there was no indication of R98's vital signs monitoring including blood pressure and heart rate after dialysis treatment. Review of R98's Dialysis Communication Tool in PCC revealed the following: - No completed communication tool on 5/1, 5/6 and 5/8/24. - 5/3/24: BP = 84/54. The section changes since last dialysis was left blank. - 5/13/24: PR = 54 - 5/17/24: BP = 171/72 - Dialysis information (to be filled out by dialysis) was left blank on 5/10, 5/13, 5/15 and 5/17/24. Review of R98's Dialysis Services Communication Form and Post Treatment Report revealed missing communication forms for 5/3, 5/10 and 5/13/24, and had incomplete assessments on 5/1 and 5/8/24. Review of R98's progress notes revealed no monitoring of R98's BP and heart rate after dialysis on 5/3, 5/13 and 5/17/24 and that physician or nurse practitioner was notified regarding his vital signs. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint interview with the Dialysis Facility Administrator (FA) #300 and the Manager of Clinical Services (MCS) #301 on 5/22/24 at approximately 9:57am, FA #300 stated that access site care is before initiation of treatment. When asked about her expectation from nursing home staff after a resident received dialysis, FA#300 stated, CVC [central venous catheter], do not touch. For fistula and graft, no blood draw. The dressing on the site [fistula and graft] can be removed the next day if they had a late treatment. But generally, [it can be removed] the same day. When asked about the vital signs monitoring, FA#300 stated, Pre [dialysis treatment], every half hour and as needed. FA#300 stated that they monitor the weight pre and post dialysis treatment. FA#300 added, That's how much fluid is removed from the patient. When asked about the communication form, FA#300 stated, We complete the same form that were sent with the residents. FA#300 stated, We have a dietician that communicates weekly, discuss lab [laboratory] works weekly ad as needed, weight gain and nutritional needs. When asked if they review the communication form the nursing home, the FA#300 stated, RNs and PCT [patient care technician] review it. They take into consideration the last set of vitals [vital signs]. We do our own set of vitals. When asked about the expectation from the nursing staff after dialysis related to the access sites, FA#300 stated, Verify that the dressing is intact. [For fistula and graft] they have a dressing over the site. We don't want the same dressing when the resident comes back [for dialysis]. FA#300 explained, The residents are bringing the [communication] form and the resident take it back. It is not our responsibility that the nurses get it. I see forms [from previous dialysis treatment] sitting in the residents' wheelchairs [when they come back for the next treatment]. If they did not receive [the communication forms], they can call us. During an interview with the DON on 5/22/24 at approximately 3:34pm, when asked about the process of dialysis communication, the DON stated, Basically when a resident comes back, they email and also call. There is a dialysis communication form down at [name of dialysis center] and that goes into detail. The DON stated that the [name of dialysis center] dialysis communication forms were scanned in the residents' medical record. The surveyor informed the DON of R98's missing communication forms. When asked about the importance of completing those communication forms including the post treatment assessment, the DON stated, You want to monitor after dialysis and assess. The DON stated that resident's weight would be checked by the dialysis nurse to determine how much weight was taken off during the procedure. The DON added that the dialysis nurse would complete another form [Fluid and BP Management Report] during dialysis days. Review of R98's May 2024 Fluid and BP Monitoring Report forms contained pre and post BP, pre and post weight, target weight (weight without the excess fluid that builds up between dialysis treatments), weight loss, IDWG (excessive interdialytic weight gain, usually related to an overload of sodium and water) and UFR (ultrafiltration rate, composite metric of IDWG, treatment time and postdialysis weight, calculated with each dialysis). Review of the same records revealed that R98's target weight was 85.5 kg (kilogram). Further review of 5/1 to 5/20/24 forms revealed that R98's post wt (post dialysis weight) had been out of range ranging from 86.1 to 89.4 kg. 6.) During screening on 5/21/24 at approximately 1:48pm, R114 was observed in bed. R114 stated she had a good lunch. Review of R114's EHR record in PCC revealed an admitted [DATE]. R114's diagnoses included end stage renal disease and anemia in chronic kidney disease and dependence on renal dialysis. Review of R114's MDS dated [DATE] revealed a BIMS score of 4, indicating severe cognitive impairment. In the section Special Treatment and Programs revealed R114 had received dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R114's care plan with a review start date of 1/30/24 revealed, The resident needs hemodialysis d/t ESRD. The Interventions included Check for bruit and thrill per orders .Do not draw blood or take B/P in arm with graft .Encourage resident to go for the scheduled dialysis appointments .Medications per order .Monitor labs and report to doctor as needed .monitor vital signs as ordered. Notify MD of significant abnormalities . monitor/document/report PRN and s/sx of infection to access site .Monitor/document/report PRN for s/sx of renal insufficiency .Monitor/document/report PRN for s/sx of the following: bleeding, hemorrhage, bacteremia, septic shock .Monitor/document/report PRN new/ worsening peripheral edema .offer meals prior to dialysis . Review of R114's Orders revealed the following: - 1500 ml F/R (fluid restriction) 960 ml DTY 360 ml B and L 240 ml D, 540 ml NSG 270 ml q shift (start date 4/2/24) - Epoetin Alfa Injection Solution 10000 unit/ml. Use 1 ml intravenously one time a day every Mon, Wed, Fri for anemia to be administered during dialysis (start date 4/3/24) - Monitor dialysis catheter every shift and reinforce if needed (start date 4/2/24) - Renal Carb controlled diet, regular texture, thin consistency (start date 4/2/24) - Resident has dialysis at 4:45 (am) on M-W-F at (name of dialysis center) (start date 4/3/24) - Vital signs: Notify MD/NP for HR (greater than) 110 or (less than) 55, SBP (greater than) 160 or (less than) 90 .or for any acute change in condition (start date 4/3/24) Further review of R114's Orders revealed that the facility failed to indicate R114's dialysis prescription including the length of dialysis treatment time and resident's target weight. Review of R114's May 2024 MAR and TAR revealed the following: - R114 received dialysis on 5/1, 5/3, 5/6, 5/8, 5/10, 5/13, 5/15, 5/17 and 5/20/24. - VS were checked one time a day on Mon, Wed, Fri at 6am - dialysis catheter was monitored every shift except on 5/11 and 5/15/24 - Epoetin Alfa-epbx solution 10000 units/ml. Use 0.75 ml intravenously one time a day every Mon, Wed, Fri for anemia to be given in dialysis was marked given on 5/3, 5/6, 5/8, 5/10, 5/13, 5/15, 5/17, 5/20/and 5/22/24. Further review of R154's May 2024 MAR and TAR revealed no indication that VS were monitored after dialysis treatment. Review of R114's May 2024 Dialysis Communication Tool revealed R114's heart rates were as follows: 5/6/24 = 49 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/8/24 = 49 5/10/24 = 51 5/15/24 = 50 5/17/24 = 51 5/20/24 = 52 5/22/24 = 52 Review of R114's progress notes revealed no indication that the physician or nurse practitioner was notified of R114's heart rate on the above-mentioned dates. During an interview with the Registered Nurse (RN) #818 on 5/22/24 at approximately 1:32pm, RN#818 stated, [R114] gets hemo [hemodialysis]. When asked about the care for her access site, RN#818 stated, So for her, we just assess her access site. When she gets showers, we cover it. When asked when would nurses monitor R114's vital signs and weights, RN#818 stated that nurses would document in PCC and added, Before she leaves [for dialysis] and after [she comes back from dialysis. The weight for sure, we do pre [dialysis] weight before she goes down. We document pain. It would be the night shift nurse [who prepares the communication form]. They complete it because they send her down. Her [night shift] nurse, she medicates her, do her pre dialysis assessment and at that point the aide takes her to dialysis. They pack her food. When asked if nurses would complete an assessment including the VS and the dialysis access site upon return from dialysis treatment, RN#818 stated, [R114] returns on day shift. We would collect the communication tool. I like to look at it. I check the vitals [vital signs]. I asked how they feel, make sure they did not have pain at the [dialysis access] site. We don't have a particular piece [post dialysis note] in PCC. RN#818 added, That would be every shift vital signs. When asked to whom they would report complications or issues, RN#818 stated, Nephrologist and primary [physician]. We follow the primary [doctor]. When asked about R114's VS parameters and when nurses would notify the physician, RN#818 stated, [R114] is very hypotensive [low blood pressure]. [R114] gets Midodrine for low blood pressure [routine]. We don't have [VS] parameters for her. [R114] blood pressure is low. She runs like that. When asked if VS parameters would be important especially with R114 being hypotensive, RN#818 stated, For sure. Having parameters would be efficient. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with RN#825 on 5/22/24 at approximately 2:05pm, RN#825 confirmed that night shift nurses prepared the dialysis communication tool. RN#825 stated, We get the vitals when they come back from [name of dialysis center]. [Name of main clinician at the dialysis center] she calls me. If there is something going on I tell the nurse and I make the changes for the nurse. [Name of main clinician] is good in letting us know. Sometimes, if there is bleeding, we monitor. When asked if nurses would complete an assessment when a resident returns from dialysis, RN#825 stated, No. The only time is when there is something acute going on. When asked when should nurses notify physician or NP related to VS, RN#825 stated, That is just nursing. We would call for anything below 100 for the systolic to make sure. When asked if nurses should notify physician about low heart rate, RN#825 stated, Yes, any below 60. When asked about the care provided to the dialysis access site, RN#825 stated, We are not allowed to take anything off. If the dressing comes off, we put it back, intact. Tape it up. No labs [and] no blood pressure [on the access site]. When asked if nurses would document assessment after a resident returned from dialysis, RN#825 stated, We document if there is something going on. Review of facility's policy titled Care of Dialysis Access Devices dated 7/21 revealed, 1. Upon return from dialysis, ensure fistula is assessed. Remove dressing if no active bleeding .2. Once dressing is removed, assess site for redness, swelling, bruising and pain. 3. Leave the fistula open to air. 4. Assess bruit and thrill every shift . Review of facility's policy titled Renal Residents with Dialysis dated 2/16 revealed, .7. Nursing staff to monitor for complications related to dialysis and ESRD, such as potential for bleeding, alteration in fluid volume, potential for infection, alteration in nutrition, alteration in skin integrity and the effect of dialysis r/t [related to] medications. 8. Nurse will assess hemodialysis site for s/sx [signs and symptoms] of infection, and to monitor for a bruit and thrill if indicated. 9. Resident will be monitored for s/sx of complications from dialysis upon their return to the facility. 10. The nurse will notify the MD [medical doctor] and the responsible party for any change in the resident's condition. 11. Nurse to communicate with dialysis via communication tool.