STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) from February 12, 2024 - February 15, 2024. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. Survey Dates: 02/12/2024 - 02/15/2024 Survey Census: 35 Sample Size: 14	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		3/31/24

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

Electronically Signed | 03/20/2024

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F 623	Continued From page 1	F 623		

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 2 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide written notification of transfer/discharge for one resident sampled for hospitalization, Resident(R) 26. The deficient practice has the potential to affect all residents at the facility who are transferred or discharged.	F 623	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?	

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F 623	Continued From page 3 Findings Include: Review of R26's Electronic Health Record (EHR) on 02/13/24 at 01:15 PM found R26 was transferred to the hospital on 12/13/23 due to altered mental status. R26 was admitted to the hospital on 12/13/23 with a diagnosis of encephalopathy (disease of the brain) which was found to be related to a reaction she had to the IV antibiotic (Cefepime) she was receiving. During RR, found R26's daughter was notified by phone of transfer and made aware of R26's clinical situation. No documentation was found R26 or her representative was notified in writing of the transfer/discharge. R26 returned to the facility on 12/19/23. On 02/14/24 at 02:16 PM interviewed Social Services Staff (SSS) 2. Inquired if SSS2 or other facility staff had provided written notification of transfer/discharge to R26 or her representative after R26 was transferred and admitted to the hospital on 12/13/23 and SSS2 stated they tell them on the phone or in person but not in writing.	F 623	On 3/11/24 the Social Services Director mailed written notification of R26s transfer to the resident and her representative. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? On 3/15/24, the Social Services Director reviewed all resident transfers and discharges in the past 30 days to ensure that written notification of transfer or discharge was provided. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? When a resident is transferred or discharged, the Social Services Director or designee provides written notice of the transfer or discharge to the resident and the resident□s representative(s). This notice is generally provided in person when the transfer or discharge is planned and is provided via mail when the transfer or discharge is unplanned. On 3/15/24, the Social Services Director and the Social Services Assistant reviewed the current procedures for providing written notice of transfer or discharge to the resident and representative(s). HOW WILL THE CORRECTIVE ACTION	

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F 623	Continued From page 4	F 623	BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/15/24, a focus audit was developed to ensure residents and their representative(s) are provided written notice when a resident is transferred or discharged. This focus audit will be conducted by the Social Services Director or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. This audit will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunities for improvement.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		3/31/24

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F 656	Continued From page 5 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop and implement a comprehensive care plan (CP) for three residents sampled of the 35 residents at the facility. Resident (R) 17, R22 and R27. R17 did not have a care plan for an indwelling urinary catheter and it's care to prevent	F 656	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?	

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F 656	Continued From page 6 urinary tract infection (UTI). R22 did not have a care plan for fall prevention after a fall with a head injury. R27 was taking an anticoagulant (blood thinner) for his diagnosis of paroxysmal atrial fibrillation (a rapid erratic heartbeat) and did not have a care plan for bleeding precautions. These deficient practices place the residents at an increase risk for injury and infection. Findings Include: (Cross reference to F880 Infection Prevention & Control) 1) Review of R17's Electronic Health Record (EHR) was done on 02/14/24 at 10:00 AM. R17 is a 77-year-old resident who was admitted to the facility on 01/15/24. R17's diagnoses include, but are not limited to, Retention of urine (unable to empty bladder of urine). Reviewed R17's CP and did not find a care plan for his indwelling urinary catheter and it's care to prevent a UTI. R17 has the following order for his indwelling urinary catheter: 16F with 10 cc balloon to dependent drainage. Change catheter PRN if dislodged or clogged and unable to clear with irrigation. every day shift every 1 month(s) starting on the 15th for 1 day(s) for Urinary Retention AND as needed for clogging or dislodging which was ordered on 01/15/24. On 02/14/24 at 11:30 AM interviewed Director of Nursing (DON). DON confirmed R17's indwelling urinary catheter use should be in his CP along with the care for the catheter to prevent a UTI. DON confirmed CP "incontinence of urine" problem which was initiated on 01/21/2024 along with "Toileting Program: offer and assist to toilet & urinal use before and after meals & therapy at HS	F 656	On 2/15/24, DON updated R27□s care plan to address anticoagulant drug use and risk for bleeding On 2/21/24, Administrator updated R22□s care plan to address the actual fall. On 2/14/24, DON updated R17□s care plan to address indwelling urinary catheter and the care to prevent UTI. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? Residents receiving an anticoagulant drug have the potential to be affected. On 3/12/24 DON reviewed all residents receiving an anticoagulant medication to ensure that each resident had a care plan to monitor for possibility of bleeding as the result of anticoagulant use. Residents who have had a fall have the potential to be affected. On 3/13/24, DON reviewed all residents care plans to ensure all residents care plan addressed the resident□s fall risk and interventions for fall prevention. Residents who have an indwelling urinary catheter have the potential to be affected. On 3/12/24 DON reviewed all residents who have an indwelling urinary catheter to ensure that each resident had care plan to that addressed the use of the indwelling catheter and the care to prevent UTI.	

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F 656	Continued From page 7 (bedtime) & PRN (as needed) his request" initiated on 01/25/2024 was an error on the CP. Requested and received copies of R17's CP and facility policy for Care Plans and indwelling urinary catheter. 2) During an observation on 02/12/24 at 08:05 AM in R27's room. Noted two large dark purple marks on his left arm. Upon closer observation the marks were bruises. R27's right arm was noted with a few small red and purple marks. A second observation made at 11:36 AM with R27 in his room, the surveyor asked what happened to your arm while pointing toward the bruises on his left arm. R27 responded I have no idea. The surveyor asked if R27 is taking a blood thinner and he responded, I think so. (Cross reference (CR)to F757 Drug Regimen is free from unnecessary drugs). EHR reviewed on 02/12/24 at 11:00 AM. MDS quarterly review dated 12/06/23. Medications. N-E. Anticoagulant coded yes (takes medication on 7 days during the look back period). CP reviewed. No problem noted for anticoagulant therapy. Physician orders reviewed. Apixaban (blood thinner) oral Tablet 5 milligram (mg). Give 1 tablet by mouth two times a day for paroxysmal atrial fibrillation (A-fib). Start date 08/28/23. The surveyor asked Charge Nurse (CN)23 on 02/15/24 at 2:29 PM, how the nursing staff monitor R27 for anticoagulant use, and if monitoring is being documented in R27's	F 656	WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? By 3/31/24, the Clinical Learning and Development Specialist and DON will re-educate the licensed nurses on the importance of developing and implementing a specific care plan that addresses: -Anticoagulant drug use and risk for bleeding, -Fall risk and including goal for fall prevention. -Indwelling urinary catheter use and interventions to prevent UTI HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/12/24, a focus audit was developed to ensure residents receiving an anticoagulant medication have a care plan that addresses the resident□s risk for bleeding. On 3/12/24, a focus audit was developed to ensure that residents who have had a fall have a care plan to include a goal for fall prevention On 3/12/24, a focus audit was developed to ensure residents with an indwelling urinary catheter have a care plan addressing the need for the indwelling	

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F 656	Continued From page 8 comprehensive care plan. CN23 looked in the EMR and stated I do not see it on his care plan or in the nurse's notes. 3) Observations during a tour of the facility on 02/12/24 at 08:05 AM. Noted Resident (R)22 sitting in her wheelchair at the right side of the bed eating her breakfast. Observed a large dark skin discoloration on the right side of her face that looked consistent with a bruise. Noted a bedside commode at the left side of her bed. (CR: F689 Free of Accident/Hazards/supervision/devices). Electronic Medical Record (EMR) review on 02/13/24 at 10:16 AM. Noted on 02/06/24 R22 nursing staff implemented neuro-checks for the resident after a fall. An interview with the director of nursing (DON) in her office on 02/15/24 at 11:41 AM was done. The surveyor asked if R22's care plan was updated to include a goal for fall prevention after she had a fall that resulted in a head injury on 02/06/24? The DON responded that R22 was able to ambulate independently and that her fall was an isolated incident. The leg on her bedside commode was broken and when she sat down to use the commode and she fell forward face first. We had maintenance replace her bedside commode. After the fall huddle we did the root cause analysis, and it was determined that the reason for the fall was due to the broken commode, so we did not put it on the care plan. She is not a fall risk; we did the falls tool, and she was not a fall risk. Sanford Policy enterprise Rehab/Skilled & Long-term care: Care Plan- LTC, revised dated 11/01/23 (Corporate version). Purpose: To	F 656	urinary catheter and the care to prevent urinary tract infections This focus audit will be conducted by the MDS Coordinator designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. These focus audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunity for improvement.	

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F 656	Continued From page 9 develop a comprehensive care plan using an Interdisciplinary team approach. Policy. Residents will receive and be provided with the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		3/31/24

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F 657	Continued From page 10 Based on observations and interview the facility failed to update comprehensive care plans (CP) for four residents sampled, Resident(R) 7, 17, 20 and 84. The deficient practice places all residents at risk for infection or skin breakdown. Findings Include: 1) On 02/12/24 at 02:57 PM met with R17 in his room and observed resident had a peripheral intravenous (IV) catheter on his left arm which was used to administer his IV antibiotic medication to treat his urinary tract infection (UTI). R17 also had an indwelling urinary catheter. On 02/14/24 at 10:00 AM record review of R17's Electronic Health Record (EHR) was done. R17 is a 77 year old resident who was admitted to the facility on 01/15/24. R17's diagnoses include, but are not limited to, Retention of urine (unable to empty bladder of urine) and Type 2 Diabetes Mellitus (pancreases not able to control blood sugar levels requiring insulin injections) with Diabetic Chronic Kidney Disease. At this time reviewed R17's CP and did not find a care plan for his peripheral IV catheter for IV antibiotic administration. R17 had Cefepime HCl Intravenous Solution 1 GM/50ML (Cefepime HCl) Use 1 gram intravenously two times a day for UTI for 1 Week which was ordered on 02/08/24 with the last dose to be given on 02/15/24. R17 also has Normal Saline Flush Intravenous Solution 0.9 % (Sodium Chloride Flush) Use 10 cc intravenously every shift for IV patency. Flush peripheral IV with 10 cc NS every shift as well as with 10 cc before and after IV medication administration which was also ordered on 02/08/24.	F 657	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? On 2/14/24, DON updated R17□s care plan to address IV use including the monitoring of IV site. On 2/15/24, DON updated R84□s care plan to address resident□s risk for skin breakdown. There was no information provided in the 2567 on R7 and R20 related to this citation on F657. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? Residents receiving IV medication have the potential to be affected by this practice. On 3/15/24, DON reviewed all residents currently receiving IV medications to ensure that their care plans reflected the use of the IV and the monitoring of the IV site. Residents at moderate to high risk for skin breakdown have the potential to be affected by this practice. DON will review all residents who are at moderate to high risk for skin breakdown	

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F 657	Continued From page 11 On 02/14/24 at 11:30 AM interviewed Director of Nursing (DON). Reviewed R17's CP, medications ordered for UTI (IV antibiotic) and peripheral IV catheter that were ordered and implemented on 02/08/24. Inquired of DON if R17's IV use in his left arm should be in his CP and she acknowledged this. 2) On 02/12/24 met with and interviewed R84 at 10:20 AM. Observed resident was laying on an air mattress and was receiving oxygen via nasal canula (tubing in his nose). Inquired if R84 had a pressure ulcer on his back and he denied having any but did state he had a"cyst" on his back. On 02/14/24 at 10:15 AM record review of R84's EHR was done. R87 is an 86 year old resident who was admitted on 01/24/24. R17's diagnoses include, but are not limited to,acute respiratory failure with hypoxia (not enough oxygen in the body), chronic obstructive pulmonary failure (disease that cause airflow blockage and breathing related problems) with acute exacerbation, pneumonia (infection in the lungs) and unspecified severe protein-calorie malnutrition (nutritional intake of less than 50% of recommended intake for 2 weeks or more). Review of R84's CP found he did not have a problem for risk for skin breakdown with interventions such as resident using an air mattress, Triad cream to coccyx and referral to wound clinic. R84 had a doctor's order for Triad cream to coccyx and refer to wound clinic ordered on 02/03/24. On 02/15/24 at 08:50 AM interviewed DON regarding R84's CP. DON confirmed resident did not have a CP for risk for skin breakdown.	F 657	to ensure that they have a care plan addressing this risk. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? By 3/31/24, the Clinical Learning and Development Specialist and DON will re-educate the licensed nurses on the importance of -Developing and implementing a specific care plan that addresses IV use including the monitoring of an IV site. -Using the Braden Assessments to identify residents at moderate to high risk for skin breakdown and then developing and implementing a specific care plan for skin breakdown. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/15/24, a focus audit was developed to ensure residents receiving an IV have a care plan addressing the IV use including monitoring the IV site. On 3/15/24, a focus audit was developed to ensure that residents who are at risk for skin breakdown have a care plan addressing such risk. This focus audit will be conducted by the MDS Coordinator or designee weekly for	

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F 657	Continued From page 12 Discussed R84 has an air mattress and staff are using triad cream to resident's lower back when there is a change in his skin. DON stated "The care plan has to reflect the approaches already in place." On 02/15/24 at 09:24 AM met with and interviewed Registered Nurse (RN) 23. Inquired who can add or update a resident's CP. RN23 stated the nurses can add to the care plan, this is not assigned to just one person, it would be the nurse who takes and inputs the order. The nurse can initiate the problem (risk for skin breakdown).	F 657	4 weeks, monthly for 2 months, and quarterly for 3 quarters. These focus audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunity for improvement.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,	F 676		3/31/24

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F 676	Continued From page 13 grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review the facility failed to ensure that three residents requiring maximum assistance with eating meals and snacks, were assisted by staff to eat their meal in a reasonable amount of time for three residents (R)7, R13 and R24 of five in the sample (see F550 for more information on R10 and R30). Three residents waited after their meal was placed on the table in front of them for a staff member to feed them. The staff were observed to rotate among the residents, starting to feed a resident then stopping to leave and help another resident. During the lunch observation, the time from start of the meal until the last resident completed their meal was over one hour. This deficient practice has the potential to affect the residents in the facility who require maximum assistance with eating. Findings include: 1) Electronic Medical Record (EMR) reviewed for R7 on 02/13/24 at 09:25 AM. Minimum data set	F 676	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? Upon becoming aware of these observations, on 2/15/24 the Clinical Learning and Development Specialist and DON provided immediate re-education to CNAs on the importance of being present and available during meal service and the need to provide assistance at the time the meal is delivered to residents requiring maximum assistance with eating. R24□s wife routinely assists him with his lunch and dinner meal. On 3/18/24, Administrator discussed with resident□s wife her preference for where resident□s meal should be stationed if she is not here at the time his meal is ready. Per wife□s expressed preference, R24□s care plan	

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F 676	Continued From page 14 (MDS) quarterly review dated 12/27/2023 Cognitive function. C- Brief interview for mental status (BIMS) summary score 02. Low cognitive function. Functional abilities and goals. Declined in eating, dressing, mobility from one to two. A. Eating: The ability to use suitable utensils to bring food and/ or liquid to the mouth... once the meal is placed before the resident. Coded 01: Dependent. Observed R7 in dining room on 02/14/24 at 09:03 AM, sitting alone at a table sleeping in her wheelchair. Noted 50% of her pureed meal was eaten. During an observation in the dining room on 02/14/24 at 12:27 PM. One staff was present, passing the meals to the residents. The first resident was assisted to eat at 12:45 PM. His food sat on the table in front of him since 12:27 PM. Noted R7 leaning over to the right side sleeping with her face mask on. At 1:40 PM staff (S)2 sat down to assist R7 with her meal. At 1:49 PM, R7 observed to be the last resident to finish eating her lunch and the last resident to be taken back to her room. EMR reviewed for R7 on 02/14/24 at 04:06 PM. Care plan. Problem: Resident will demonstrate the appropriate use of adaptive devices to increase ability in bed mobility, transfers & toilet by the review date. Resident requires extensive 1 staff assists for eating, 09/27/21 No changes have been made since the last review. 2) Observed R13 in the dining room sitting in her wheelchair, alone at a table waiting for her meal on 02/14/24 at 12:27 PM. At 1:03 PM noted the certified nurse aide (CNA)4 assisted R13 with her	F 676	was updated to reflect wife□s routine to assist the resident with his lunch and dinner meals and her desire for resident□s meal to remain on the service cart until her arrival HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? Residents requiring maximum assistance with eating have the potential to be affected. On 3/18/24, the Administrator reviewed all residents coded on the MDS as requiring maximum assistance with eating and ensured that their care plans correlated with their assessed need for maximum assistance. On 3/19/24, all identified residents were reviewed with direct care staff and re-education provided regarding the need to provide assistance with feeding at the time the meal is delivered. On 3/18/24 and 3/19/24, observations of residents were made to ensure that residents who require maximum assistance with eating receive assistance at the time their meal is provided. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? By 3/31/24, the Clinical Learning and	

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F 676	Continued From page 15 meal and after a couple of bites got up to go help another resident at the next table. At 1:10 PM R13 was observed with the spoon in her hand the same way as when CNA4 left her to feed another resident. At 1:16 PM CNA4 returned and restarted feeding R13. After a few minutes CNA4 got up to go feed another resident. At 1:28 PM CNA4 came back and said "do you need help" I'll be right back and went to wash her hands. EMR reviewed for R13 on 02/14/24 at 3:14 PM. MDS, Annual assessment dated 11/01/23. Cognitive function. C- BIMS summary score 08, moderately impaired. Functional Abilities and Goals. GG- self-care. A. Eating: The ability to use suitable utensils to bring food and/ or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident: Coded 02 for Substantial/ maximal assistance. Care plan. Problem: The resident has an ADL self-care performance deficit...related to (r/t) malignant neoplasm of the brain & further overall declines is expected. Resident with left hemiparesis and contractures to left upper extremities (LUE) and limited mobility to left lower extremities (LLE) and needs assistance with ... eating... 3) During an observation in the dining room on 02/14/24 at 12:35 PM. R24 was observed sitting at a dining table alone waiting for his meal. At 12:55 PM R24 observed awake with his meal on the table in front of him, still waiting for assistance with eating. At 1:26 PM CNA16 sat down to feed R24 with his meal. EMR for R24 reviewed on 02/14/2024 at 3:30 PM. MDS Significant change assessment dated 11/01/23. Cognitive Patterns. C- BIMS summary	F 676	Development Specialist and DON will re-educate all CNAs on the importance of being present and available during meal service and the need to provide assistance at the time the meal is delivered to residents requiring maximum assistance with eating. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/15/24, a focus audit was developed to ensure that residents who require maximum assistance with eating receive assistance at the time their meal is provided. This focus audit will be conducted by the HIM or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. This audit will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunities for improvement.	

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F 676	Continued From page 16 score not completed. Functional abilities and goals. GG- A. Eating: Coded 01 = Dependent. Helper does all of the effort. Reviewed the Sanford Policy Activities of Daily Living for LTC. Policy revised 12/04/2023 on 02/16/24 at 4:00 PM. Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. 6. Eating: Nourishing and hydrating oneself.	F 676		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions for falls for one Resident (R)22 of one in the sample. R22 had a fall that resulted in a head injury. The deficient practice placed R22 at an increased risk for injury, (refer F656). Findings include: Observations during a tour of the facility on 02/12/24 at 08:05 AM. Noted Resident R22 sitting in her wheelchair at the right side of the bed eating her breakfast. Observed a large dark skin discoloration on the right face side of her	F 689	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? On 2/2/24, R22 was assessed for injury, her 1 cm skin tear was cleansed with normal saline and approximated with steri-strips. She was continuously monitored for injury for a three day period. On 2/2/24 the bedside commode was promptly removed and replaced.	3/31/24

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F 689	Continued From page 17 face that looked consistent with a bruise. Noted a bedside commode at the left side of her bed. Reviewed the facility matrix on 02/12/24 at 1:30 PM. Noted R22 with Alzheimer's/Dementia and a fall with injury. Electronic Medical record review (EMR) on 02/13/24 at 10:16 AM. Noted on 02/06/24 R22 Nursing staff implemented neuro-checks for the resident after a fall. Purpose: To record observations following a fall resulting in a known or head injury or any other conditions requiring neuro-check, e.g., TIA, Bell's Palsy. Use: Required when condition indicates need for neuro-check. After the completion of the initial Neuro-Check evaluation with vital signs, continue Neuro-Check evaluations every 30 minutes x4, then every 8 hours for 3 days or as directed by the provider. Date: 2/6/24 02:16. Vital signs reviewed. Oriented to person, place, and time. Level of consciousness, alert and follows commands. Pupils left-3 millimeters (mm); right-3mm. reactive to light. Hand grasps and movement. Bilateral arm's strong, Bilateral legs, weak. Quality of speech is clear. Minimum data set (MDS) quarterly review dated 01/03/24. Cognitive patterns. C-Brief interview for mental status (BIMS) summary score 13 (impaired cognitive function). Functional abilities and goals. GG-Mobility devices are a walker (and wheelchair. Self-care. Toileting: Supervision or touching assistance. Mobility requires supervision. Active Diagnosis. I- Primary medical condition debility, cardiorespiratory conditions. Neurological. Non-Alzheimer's dementia.	F 689	HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? On 2/2/24 all the bedside commodes in the facility were inspected by the Maintenance staff. All bedside commodes were deemed safe to use. Residents who have had a fall have the potential to be affected. On 3/15/24 DON reviewed residents who had a fall in the past 30 days to ensure that a Fall Tool UDA was completed. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? Quarterly inspections will be conducted by Maintenance staff on all bedside commodes. The initial facility wide inspection was completed on 2/2/24. By 3/31/24, the Clinical Learning and Development Specialist and DON will re-educate the licensed nurses on the importance of completing the Falls Tool UDA after a resident has had a fall. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?	

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F 689	Continued From page 18 Comprehensive care plan. The resident has an ADL self-care performance deficit related to (R/T) multiple medical problems ...Acute Hypoxic respiratory insufficiency with A-fib w/RVR and Dyspnea, muscle weakness & unsteadiness on feet. Revision on: 01/11/24. Interventions. Resident needs 1 staff assist with cueing for transfers, toileting, and bathing. Revision: 07/18/23. No goals for fall prevention found following her fall on 02/06/24. During an observation in the hallway with registered nurse (RN)28 on 02/14/24 at 4:25 PM. Observed R22 ambulating unassisted with her front wheel walker (FWW) from the direction of her room toward the nurse's station. The certified nurse aide (CNA) quickly approached her to help. R22 gave the CNA a couple of envelopes for the mail. The staff assisted R22 back to her room. During an interview with the director of nursing (DON) in her office on 02/15/24 at 11:41 AM. The surveyor asked if R22's care plan was updated to include a goal for fall prevention after she had a fall that resulted in a head injury on 02/06/24. The DON responded that R22 was able to ambulate independently and that her fall was an isolated incident. The leg on her bedside commode was broken and when she sat down to use the commode and she fell forward face first. We had maintenance replace her bedside commode. After the fall huddle we did the root cause analysis, and it was determined that the reason for the fall was due to the broken commode, so we did not put it on the care plan. She is not a fall risk; we did the falls tool, and she was not a fall risk. The surveyor requested a copy of her last fall's tool and care plan.	F 689	On 3/15/24, a focus audit was developed to ensure bedside commodes are safe to use This bedside commode focus audit will be conducted by the Facility Manager or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. On 3/15/24, a focus audit was developed to ensure that a Falls Tool UDA has been completed after a fall. This Falls Tool UDA focus audit will be conducted by the DON or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. These focus audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunity for improvement.	

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F 689	Continued From page 19 Reviewed the Physical therapy report progress & discharge summary dated 07/20/23 on 02/15/24 at 3:30 PM. Treatment diagnosis. Muscle weakness (generalized) Unsteadiness on feet. Impact on Burden of Care/Daily Life. Generalized supervision recommended in the room with patient being at modified independent level in bed mobility, transfers sit to stand, bed to chair and bedside commode, and ambulation with FWW in her room. Outside of her room supervision is recommended when walking with her upright rollator walker. Falls tool dated 01/02/24 reviewed (prior to the residents fall). R22 was not identified as a fall risk based on the tool. After R22's fall on 02/06/23, a Falls tool reassessment was not conducted. Reviewed the Sanford Policy enterprise Rehab/skilled & long-term care: Fall prevention and Management (Corporate version). Revised 03/29/23 on 02/16/24. Purpose ...To identify risk factors and implement interventions before a fall occurs ...To prevent further injury. Page 2 For Fallen Resident ...page 4 11. Complete the falls tool ...17. Update the care plan with any changes/new interventions.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 726		3/31/24

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F 726	Continued From page 20 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure nursing staff had the appropriate competencies to provide nursing services to assure resident safety for one of five residents (Resident (R)14) sampled for unnecessary medication. On 11/27/23 and 01/12/24, Nursing Staff (NS)36 entered erroneous medication orders of a high-risk/high-alert diuretic (Lasix) for R14. As a result of this error, R14 was administered excessive doses of the medication which could have had serious adverse consequences related to dehydration, electrolyte imbalance, and kidney damage for the resident.	F 726	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? On 2/15/24, R14□s Lasix order was updated. R14 continues to be monitored, and no adverse effects have been identified. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED?	

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F 726	Continued From page 21 Findings include: (Cross Reference to F756- Drug Regime Review, Report Irregular, Act On and F757- Drug Regime is Free from Unnecessary Medication) According to Medline Plus (National Library of Medicine), "Lasix is a strong diuretic ("water pill") and may cause dehydration and electrolyte imbalance..." On 02/13/24 at 03:25 PM conducted a record review of R14's Electronic Health Record (EHR). Review of the physician orders documented two physician orders: First order: Lasix Oral Tablet 80 MG (Furosemide) Give 1 tablet by mouth daily, one time a day every Mon, Wed, Fri for edema (excessive fluid accumulation) WEIGHT GOAL < 200 lbs then reduce to M,W,F AND Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema. (Started 11/26/23; Discontinued 01/11/24) Second order: Lasix Oral Tablet 80 MG (Furosemide) Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema (excessive fluid accumulation) WEIGHT GOAL < 200 lbs then reduce to M,W,F AND Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema. (Started:01/11/24) Review of the Medication Administration Records documented two orders for Lasix 80 mg, from 11/27/24 to current, and the medication was documented as given for both orders:	F 726	All residents that are receiving a diuretic have the potential to be affected. On 3/12/24, the DON reviewed all residents receiving a diuretic to ensure proper dose of the medication was being administered. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? By 3/31/24, the Clinical Learning and Development Specialist and DON will re-educate licensed nurses regarding: -Diuretic drug use, normal dose range, and potential consequences of the medication if not given properly -The proper handling of the electronic medical record system's medication alerts -The proper protocol for accurately entering medication orders into the electronic medical record, including orders for high alert medications. -The double check protocol for electronic medical record entry of medication orders. Each night, the night shift charge nurse will review all new resident medication orders obtained within the last 24 hours for any irregularities Each month, the Pharmacy Consultant will review all diuretic orders to ensure the proper dose of the medication is being administered.	

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F 726	Continued From page 22 -Lasix 80 mg (Furosemide) Give 1 tablet by mouth one time a day every other day for edema. (Started: 11/27/23 at 12:00 PM; Discontinued: 01/11/24 at 06:48 AM) -Lasix 80 mg (Furosemide) Give 1 tablet by mouth one time a day for edema weight goal < 200 lbs then reduce to M,W,F (Monday, Wednesday, Friday). (Started: 11/27/23 at 07:15 AM; Discontinued: 01/11/24 at 06:48 AM) On 01/12/24, the Lasix ordered were re-ordered and changed to: -Lasix 80 mg (Furosemide) Give 1 tablet by mouth one time a day for edema weight goal < 200 lbs then reduce to M,W,F. (Started: 01/12/24 at 07:15 AM) -Lasix 80 mg (Furosemide) Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema. (Started: 01/12/24 at 12:00 PM) Review of R14's MARS documented from 11/26/23 to 01/11/24, R14 was administered Lasix 80 mg daily and Lasix 80 mg on M,W,F. On M,W,F from 11/26/23 to 01/11/24 there were 20 (twenty) incident of R14 receiving a total daily dose of Lasix 160 mg, which is an excessive dose. On the remaining days, R14 was administered Lasix 80 mg. From 01/12/24 to 02/15/24, there were 15(fifteen) incidents where R14 was administered a total daily dose 160 mg of Lasix, which is an excessive dose. R14 did not receive additional doses of the medication on the remaining days.	F 726	HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/12/24, a focus audit was developed to ensure residents taking a diuretic are receiving the correct dose This focus audit will be conducted by the DON or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. These focus audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunity for improvement.	

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F 726	Continued From page 23	F 726		

Review of R14's Cardiologist (C)9 report dated 11/07/23 (faxed to the facility on 11/08/23 at 02:41 PM) documented, the "Physician comments/non-medication orders:" was an order which included, Furosemide (Lasix) 80 mg PO (by mouth) if/when wt (weight) is less than or equal to 200 # (pounds), reduce to MWF (Monday, Wednesday, Friday).

Review of the progress notes documented a communication/visit with physician written by Nursing Staff (NS)14, on 01/11/24 at 06:49 AM, documented," This order is outside of the recommended dose or frequency. Lasix Oral Tablet 80 MG (Furosemide) Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema WEIGHT GOAL < (less than) 200 lbs. (pounds) then reduce to M,W,F AND Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema". Further review of the progress notes did not contain documentation addressing the recommendation dose or frequency of the order for Lasix was addressed by nursing, a physician, or the pharmacist.

On 02/15/24 at 01:04 PM, conducted a concurrent interview and record review of R14's EHR with Physician (P)5. P5 reviewed R14's order for Lasix as written in the physician's order. After reading the order, P5 confirmed he/she was unaware of the order entry error, R14 had been receiving more than 80 mg of Lasix since the original order (11/27/23), and stated, "We are lucky the resident could have been harmed." P5 confirmed R14 receiving 160 mg of Lasix in one day is an excessive dose and not what C9 intended in the original recommendation.

On 02/15/24 01:47 PM, conducted a concurrent

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F 726	Continued From page 24	F 726		

interview and record review of R14's EHR with NS36. Reviewed R14's progress note written on 11/26/23 by NS36 which documented the order for Lasix is outside the recommended dose. Inquired what action NS36 took after this note was generated. NS36 confirmed she is unaware of why that type of note comes up sometimes and did not follow through with clarification regarding the order or clarify the order with P5 or Pharmacist (PHARM)1. Asked NS36 to explain and demonstrated to process, facility procedure, for entering medication orders into the EHR and if the entry orders required P5 to sign the order electronically. NS36 reviewed the physician orders and confirmed NS36 entered both medication orders for Lasix 80 mg into R14's EHR, then notified P5 of the order. NS36 explained, there are two ways nursing staff can enter orders electronically, as a verbal order or as a prescriber order. If an order is entered as a verbal order, the physician is required to electronically sign/verify the order. However, if the order is input as a prescriber order an electronic signature/verification by the physician is required for the order to be valid; the order will be generated to the pharmacy initiating the resident's medication supply and will appear on the MAR (with the start date and time). NS36 reviewed the Lasix order and confirmed it was input as a prescriber order. NS36 explained, after the order was entered (as a prescriber order), it was printed and left in P5's inbox for review. NS36 confirmed that unless the physician has an issue with the order, no further actions are taken. NS36 reported getting confused about whether to input an order as a verbal order or as a prescriber order when orders are received from consultant physicians. Reviewed R14's medication orders and C9's medication recommendations for Lasix

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F 726	Continued From page 25 and inquired about the entry error. NS36 could not identify that by using "AND" instead of "THEN" was the reason the order for Lasix 80 mg was duplicated, resulting in R14 receiving excessive doses of Lasix. During interviews with multiple anonymous direct care staff, staff reported charge nurses are usually the only direct care registered nurse scheduled, although there are licensed practical nurses (LPNs), the LPNs are responsible for medication pass only. At the time of the survey the facility census was 35 residents and the anonymous direct care staff explained the lack of staffing, especially during the day, affects the quality of care they can provide.	F 726		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		3/31/24

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F 757	Continued From page 26 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure resident's drug regimen is free from excessive dose of a medication and to adequately monitor use of an anticoagulant (blood thinner) for two of five residents (Resident (R)14 and R27 sampled for unnecessary medications. As a result of a medication entry error, R14 was administered excessive dose of a high alert/high risk diuretic (Lasix) medication. The deficient practice has the potential for serious adverse consequences related to dehydration, electrolyte imbalance, and kidney damage. R27 had multiple bruises on his upper extremities with an unknown origin and placed at increased risk of bleeding. Findings include: 1) Observation on 02/12/24 at 08:05 AM in R27's room. The resident was sitting in his wheelchair at his bedside finishing the morning meal. Noted two large dark purple marks on his left arm. Upon closer observation appeared to be bruises. R27 right arm was noted with a few small red and purple marks. A second observation with R27 in his room at 11:36 AM surveyor asked what happened to your arm while pointing toward the bruises on his left arm. R27 responded I have no idea. The surveyor asked if R27 is taking a blood thinner and he responded, I think so. 11:41 AM. Electronic medical record (EMR) reviewed. Apixaban (blood thinner) oral Tablet 5 MG. Give 1 tablet by mouth two times a day for	F 757	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? On 2/15/24, R14□s Lasix order was updated. On 2/15/24, DON updated R27□s care plan to address anticoagulant drug use and risk for bleeding HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? All residents that are receiving a diuretic have the potential to be affected. On 3/12/24, the DON reviewed all residents receiving a diuretic to ensure proper dose of the medication was being administered. No discrepancies found. All residents receiving an anticoagulant drug have the potential to be affected. On 3/12/24 DON reviewed all residents receiving an anticoagulant medication to ensure that each resident had a care plan to monitor for possibility of bleeding as the result of anticoagulant use. No other	

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F 757	Continued From page 27 paroxysmal atrial fibrillation (A-fib), (rapid heart rate). Start date 08/28/2023. 02/14/2024 at 11:00 AM EMR reviewed. Minimum data set (MDS) quarterly review date 12/06/2023. Section C-Cognitive. Brief interview for mental status (BIMS) score 15- cognitively intact. Section GG-Functional abilities and goals: Mobility-3, Partial to moderate assistance. Section N- Medications. E. Anticoagulant coded yes. Comprehensive Care plan reviewed. No problem noted for anticoagulant therapy. Progress notes reviewed. No notes found to describe when the bruises were identified. Physician skilled nursing facility (SNF) notes reviewed. 02/11/2024- Extremities show no evidence of edema. 01/05/2024- Skin warm and dry no rash. 12/27/2023-Skin warm and dry with good texture and turgor, no rash. Bruising or discoloration was not documented. 02/14/2024 at 5:05 PM. Medication administration observation with Registered Nurse (RN)28. After giving the Apixaban to R27 and leaving the room surveyor asked RN28 what happened to the resident noting the large bruising on his left arm. RN28 responded that the resident moves around in bed a lot and bumps into the side rails. 02/15/2024 at 8:15 AM medication administration observation with Licensed Practice Nurse (LPN)2. After giving the Morning medications to R27, asked LPN2 what happened to R27, since he has such big dark bruises on his arms did, he have an accident? LPN2 responded that the bruising is caused by his wristwatch.	F 757	residents were identified WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? By 3/31/24, the Clinical Learning and Development Specialist and DON will re-educate the licensed nurses regarding: -Diuretic drug use, normal dose range and potential consequences of the medication if not administered properly -Proper handling of medication alerts -Anticoagulant drug use- monitoring including risk for bleeding Each night, the night shift charge nurse will review all new resident medication orders obtained within the last 24 hours for any irregularities Each month, the Pharmacy Consultant will review all diuretic orders to ensure proper dose of the medication is being administered; and will review anticoagulant orders to ensure proper monitoring of the medication HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/12/24, a focus audit was developed to ensure: -Residents taking a diuretic are receiving the correct dose	

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F 757	Continued From page 28 02/15/24 at 2:29 PM Charge Nurse (CN)23. The surveyor asked how the nursing staff monitor R27 for anticoagulant use and what caused the large bruises on his left arm. CN23 looked into the EMR and stated he has been working with physical therapy and I know he likes to wear a watch that fits loose on his arm and might be causing bruises. The surveyor asked if there is any documentation in the progress notes about the bruises, when they started or what might have caused them? CN23 stated I do not see it in the notes. The surveyor asked CN23 if it is on R27's care plan, the monitoring for anticoagulant use? CN23 looked at the care plan and stated, no, I do not see it on his care plan. 02/15/24 at 02:49 PM observation in R27's room with R28 who was in bed awake. RN28 measured the bruising on his left arm. The bruise on the top was Four and a half centimeters (cm) X four cm, and the bottom (close to the wrist) measured 14cm X four cm. 02/16/2024 at 09:30 AM Sanford Policy enterprise Rehab/Skilled & Long-Term Care: Medication Drug Regimen review- reviewed. Date reviewed/ revised: 02/10/2023. Purpose ...To identify the potential for adverse events. Definitions. Drug Regimen review is a process that includes both medication reconciliation and a review of all medications Rx, OTC, vitamins, herbals, etc.) a resident is currently using to identify and prevent potentially clinically significant medication issues. 2) (Cross Reference to F756- Drug Regime	F 757	-Residents receiving an anticoagulant medication have a care plan that addresses the resident□s risk for bleeding. This focus audit will be conducted by the DON or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. These focus audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunity for improvement.	

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F 757	Continued From page 29 Review, Report Irregular, Act On and F726 Competent Nursing Staff)	F 757		

According to Medline Plus (National Library of Medicine), "Lasix is a strong diuretic ("water pill") and may cause dehydration and electrolyte imbalance..."

On 02/13/24 at 03:25 PM conducted a record review of R14's Electronic Health Record (EHR). Review of the physician orders documented two physician orders:

First order: Lasix Oral Tablet 80 MG (Furosemide) Give 1 tablet by mouth daily, one time a day every Mon, Wed, Fri for edema (excessive fluid accumulation) WEIGHT GOAL < 200lbs then reduce to M,W,F AND Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema.
(Started 11/26/23; Discontinued 01/11/24)

Second order: Lasix Oral Tablet 80 MG (Furosemide) Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema (excessive fluid accumulation) WEIGHT GOAL < 200lbs then reduce to M,W,F AND Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema.
(Started:01/11/24)

Review of the Medication Administration Records documented two orders for Lasix 80 mg, from 11/27/24 to current, and the medication was documented as given for both orders:

-Lasix 80 mg (Furosemide) Give 1 tablet by mouth one time a day every other day for edema.
(Started: 11/27/23 at 12:00 PM; Discontinued: 01/11/24 at 06:48 AM)

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-Lasix 80 mg (Furosemide) Give 1 tablet by mouth one time a day for edema weight goal < 200 lbs then reduce to M,W,F (Monday, Wednesday, Friday).
(Started: 11/27/23 at 07:15 AM; Discontinued: 01/11/24 at 06:48 AM)

On 01/12/24, the Lasix ordered were re-ordered and changed to:

-Lasix 80 mg (Furosemide) Give 1 tablet by mouth one time a day for edema weight goal < 200 lbs then reduce to M,W,F.
(Started: 01/12/24 at 07:15 AM)

-Lasix 80 mg (Furosemide) Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema.
(Started: 01/12/24 at 12:00 PM)

Review of R14's Cardiologist (C)9 report dated 11/07/23 (faxed to the facility on 11/08/23 at 02:41 PM) documented, the "Physician comments/non-medication orders:" was an order which included, Furosemide (Lasix) 80 mg PO (by mouth) if/when wt (weight) is less than or equal to 200 # (pounds), reduce to MWF (Monday, Wednesday, Friday). The order for Lasix by C9 does not exceed Lasix 80 mg a day. However, when the medication order was entered, Nursing Staff (NS)36 used "AND" which came out on the MAR as two orders for Lasix 80 mg.

Review of R14's MARS documented from 11/26/23 to 01/11/24, R14 was administered Lasix 80 mg daily and Lasix 80 mg on M,W,F. On M,W,F from 11/26/23 to 01/11/24 there were 20

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F 757	Continued From page 31	F 757		

(twenty) incident of R14 receiving a total daily dose of Lasix 160 mg, which is an excessive dose. On the remaining days, R14 was administered Lasix 80 mg. From 01/12/24 to 02/15/24, there were 15(fifteen) incidents where R14 was administered a total daily dose 160 mg of Lasix, which is an excessive dose. R14 did not receive additional doses of the medication on the remaining days. A nursing standard of practice related to medication administration, it is acceptable practice to administer a medication up to one hour prior to or 1 hour after the ordered administration time. The timeframe which R14 could have been administered the first dose of the medication is between 07:00 AM and 10:00 AM and the administration timeframe for the second dose is 12:00 PM. It could not be confirmed but R14 could have received two dose of the medication within minutes, which would increase the potential for R14 to be affected by the negative side effects of an excessive dose of Lasix.

Review of the progress notes documented a communication/visit with physician written by Nursing Staff (NS)14, on 01/11/24 at 06:49 AM, documented," This order is outside of the recommended dose or frequency. Lasix Oral Tablet 80 MG (Furosemide) Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema WEIGHT GOAL < (less than) 200 lbs. (pounds) then reduce to M,W,F AND Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema". Further review of the progress notes did not contain documentation addressing the recommendation dose or frequency of the order for Lasix was addressed by nursing, a physician, or the pharmacist.

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F 757	Continued From page 32	F 757		

On 02/15/24 at 01:04 PM, conducted a concurrent interview and record review of R14's EHR with Physician (P)5. P5 reviewed R14's order for Lasix as written in the physician's order. After reading the order, P5 confirmed he/she was unaware of the order entry error, R14 had been receiving more than 80 mg of Lasix since the original order (11/27/23), and stated, "We are lucky the resident could have been harmed." P5 confirmed R14 receiving 160 mg of Lasix in one day is an excessive dose and not what C9 intended in the original recommendation.

On 02/15/24 01:47 PM, conducted a concurrent interview and record review of R14's EHR with NS36. Reviewed R14's progress note written on 11/26/23 by NS36 which documented the order for Lasix is outside the recommended dose. Inquired what action NS36 took after this note was generated. NS36 confirmed she is unaware of why that type of note comes up sometimes. NS36 confirmed entering both orders for Lasix in the EHR.
Reviewed and compared the Lasix 80 mg order input by NS36 to the "Communication to Physician" form faxed from C9's office with NS36. Reviewed R14's Medication Administration record for January and February 2024, which documented two orders for Lasix 80 mg, one scheduled to be administered in the AM (7am to 10AM) and the second dose between 12:00 PM and 01:00 PM. NS36 confirmed the order input was an error, not ordered according to C9's recommendation, and R14 received excessive dose of Lasix from 11/27/23 to current. NS36 confirmed R14 could have been harmed by the excessive dose of Lasix the resident was administered.

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On 02/16/24 at 09:38 AM, conducted a telephone interview with PHARM1. During this interview, PHARM1 had access to the facility's residents, personal notes, and pharmacy database with facility notes. PHARM1 confirmed the last MMR completed for the facility was completed on 01/19/24 via EHR remotely and was on-site at the facility on 01/20/24. PHARM1 reported the MRR process includes a review of the resident's physician's orders, review of progress notes, vitals PRN (as needed), and labs PRN. Inquired if PHARM1 could review R14's physician's orders and review the order for:

Lasix Oral Tablet 80 MG (Furosemide)
Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema (excessive fluid accumulation)
WEIGHT GOAL < 200lbs then reduce to M,W,F AND Give 1 tablet by mouth one time a day every Mon, Wed, Fri for edema.

Inquired if PHARM1 had reviewed the order and identified any irregularities with the medication order as written. PHARM1 reviewed personal notes, notes on the pharmacy database (both personal and pharmacy database notes were not available to this surveyor for review) and accessed R14's EHR. PHARM1 reviewed the order as written, confirmed the "order did not sound right" and the one portion of the order which should have been questioned, but was not, was why the resident was also receiving a second dose of Lasix 80 mg on Monday, Wednesday, and Friday. PHARM1 confirmed it is uncommon for a resident to receive more than 80 mg of Lasix, especially in the long-term care setting, especially because residents of this population are at a greater risk to be negatively affected by

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F 757	Continued From page 34 the side effects of an antidiuretic and are at greater risk for harm. After further review, PHARM1 confirmed R14 was administered excessive doses of Lasix from 11/27/23 to present and the excessive doses were not identified during his/her monthly MRR but should have been.	F 757		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		3/31/24

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F 880	Continued From page 35 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility staff failed to perform hand hygiene	F 880	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE	

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F 880	Continued From page 36 (hand washing or using a hand sanitizer) between glove use, when providing perineal care (washing the genital and anal area) for resident (R) 17 who has an indwelling urinary catheter. This deficient practice places all residents who have an indwelling urinary catheter at risk for a urinary tract infection (UTI). Findings Include: (Cross reference to F656 Develop/implement Comprehensive Care Plan) On 02/14/24 at 10:50 AM observed Certified Nurse Aide (CNA) 8 perform perineal (peri) care for R17. CNA8 gathered her supplies, placed a barrier and made sure R17 was comfortable. CNA8 performed hand hygiene and put on clean gloves before performing peri care. Once CNA8 was done with cleaning R17's genital area she took off her gloves and was about to put on a new pair of gloves. Inquired if CNA8 was going to perform hand hygiene and she asked me "Do you want me to wash my hands?" CNA8 was told hand hygiene has to be performed after each glove change. During observation noted CNA8 had not brought hand sanitizer with the supplies she gathered to perform peri care. On 02/14/24 at 11:30 AM interviewed Director of Nursing (DON) regarding R17's CP which did not include his indwelling urinary catheter and urinary catheter care. DON confirmed R17's indwelling urinary catheter use should be in his CP along with the care for the catheter. Inquired if staff are expected to perform hand hygiene for each glove change and she confirmed this. Requested and received a copy of the facility's indwelling urinary catheter care policy. Requested to meet with	F 880	RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? On 2/15/24 DON provided re-education to CNA#8 on the importance of performing hand hygiene between glove use when providing pericare. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? All residents requiring assistance with pericare have the potential to be affected. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? On 2/14/24, the Clinical Learning and Development Specialist re-educated CNAs on the importance of performing hand hygiene between glove use. By 3/31/24, the Clinical Learning and Development Specialist and Infection Preventionist will re-educate CNAs on the importance of performing hand hygiene between glove use. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?	

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F 880	Continued From page 37 facility educator and DON arranged this. On 02/14/24 at 11:45 AM interviewed RN28 who is the facility educator. Inquired if staff are trained to do hand hygiene between glove use and she confirmed this. Requested peri care and hand hygiene training provided for CNA's. On 02/15/24 at 11:50 AM reviewed training records for CNAs providing peri care and hand hygiene. CNA8 is not listed on either training as having completed the trainings. At this time inquired of RN28 why CNA8 had not received the training and she stated CNA8 was a newer staff, had started in August 2023 and received the training during orientation. Concurrent review of facility's indwelling urinary catheter care policy titled Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen- Assisted Living, Rehab/Skilled which was reviewed and revised on 02/10/2023 states Procedure: Catheter Care- Indwelling Catheter Equipment Hand sanitizer Towel and washcloth or disposable wipes Mild soap or other cleansing solution, peri-wash or disposable wipes Incontinent care products Personal Protective Equipment (PPE) if applicable	F 880	On 3/15/24, a focus audit was developed to ensure that CNAs are performing proper hand hygiene between glove use. This focus audit will be conducted by the Infection Preventionist or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. These focus audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunity for improvement.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 881		3/31/24

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F 881	Continued From page 38 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor one Resident's antibiotic that was prescribed prophylactically (to prevent an infection) and without an end date. Resident (R)25 was prescribed an antibiotic on 12/23/23 to prevent a respiratory infection. This deficient practice has the potential to affect residents in the facility who are on antibiotics at a risk for the development of an antibiotic resistant organism. Per the Centers for Disease Control and Prevention (CDC, October 21) on Antibiotic use ...anytime antibiotics are used, they can cause side effects and contribute to antibiotic resistance ...unnecessary antibiotic use happens when a person is prescribed antibiotics when there not needed ... Findings include: Facility matrix reviewed on 02/12/24 at 1:30 PM. R25 with documented antibiotics (ABX), respiratory (RESP) and Infections-RESP noted on the matrix. Electronic medical record reviewed on 02/13/24 at 08:44 AM. Physicians order. Azithromycin Oral Tablet 250 milligram (mg). Give 2 tablets by mouth in the evening every Mon, Wed, Fri for prophylaxis for respiratory infection. Started 12/23/2023. EMR reviewed on 02/15/24 at 3:08 PM . Minimum data set (MDS) admission assessment	F 881	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? On 2/26/24, the Infection Preventionist secured documentation from R25□s pulmonologist demonstrating why an antibiotic has been prescribed without an end date. The resident□s care plan was reviewed and found to include his use of an antibiotic to address his respiratory condition. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? On 3/19/24, the Director of Nursing performed a review of all residents currently on antibiotics to ensure that there is physician justification for use of any antibiotic prescribed prophylactically or for an indefinite period. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?	

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F 881	Continued From page 39 dated 12/12/23 reviewed. Active Diagnosis- I. Primary medical condition. Non-Traumatic Brain Dysfunction. Neurological: Non-Alzheimer's dementia. Pulmonary: Asthma, chronic obstructive pulmonary disease. Medications- N. High-risk drug classes: Use and indication. Antibiotic-is taking and Indication coded yes. Interview with the director of nursing (DON) on 02/15/24 at 11:39 AM . The surveyor asked why R25 is on Azithromycin without having a fever greater than (>) 102 or respiratory rate (RR) 25 breaths per minute or a productive cough. The DON stated that it was established before he came in to the facility, there was discussion, and it was determined when he came. It was because he has asthma with a cough and the family wanted him to take the medication so his cough would not turn into an infection. It was determined when he was at an acute care hospital then he came in with it. The surveyor noted that he has been on the antibiotic for 2 months and the duration on his orders states "indefinitely" and asked if R25's antibiotic prophylaxis is in line with the facility's antibiotic stewardship program. The DON replied "no," but the family insisted that he needed to be on antibiotics. The surveyor request documentation from the physician that will justify the reason the resident on Erythromycin three times per week. Interview and concurrent record review with Registered Nurse (RN)23 in the nurse's station on 02/15/24 at 2:35 PM. The surveyor asked when R25 was admitted, was the antibiotic ordered by the physician and if so, is there a progress note stating the reason for the antibiotic since it is not indicated for use. RN23 looked in	F 881	By 3/31/24, the Clinical Learning and Development Specialist and Infection Preventionist will re-educate licensed nurses regarding the need for physician justification for an antibiotic prescribed prophylactically or for an indefinite period. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/19/24, a focus audit was developed to ensure that there is documented physician justification for any antibiotic prescribed prophylactically or for an indefinite period. This focus audit will be conducted by the Infection Preventionist or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. These focus audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunity for improvement.	

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F 881	Continued From page 40	F 881		

the EMR and stated he already had the order from the Hospice provider. His main diagnosis was something respiratory.

Reviewed the Antibiotic Stewardship plan guide for long term care locations. Revised Dec. 2023 on 02/15/24 at 1:30 PM. . Page 4 Antibiotic stewardship in nursing homes. When residents in nursing homes receive unnecessary or inappropriate antibiotics, they are susceptible to potential harms from antibiotic overuse such as ...infection with antibiotic-resistant organisms. Page 20 Appendix C: Loeb Criteria (a minimum set of signs and symptoms which indicate that a resident of a facility has an infection and needs an antibiotic, used to guide antibiotic therapy when diagnostic testing is not available or feasible). ...Suspected Lower Respiratory tract infection. At least one of the following: Fever > 102 and at least one of the following: Respiratory rate > 25, Productive cough. Afebrile resident with COPD and > 65 years and new or increased cough with purulent sputum production ...