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	175221	A. BUILDING _____ B. WING _____	01/23/2023

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F 000	INITIAL COMMENTS The following citations are the result of a recertification health resurvey and complaint investigation KS00176494 and KS00176009. The 2567 was sent electronically on 02/02/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/02/2023

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

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 42 residents. The sample included 13 residents with five reviewed for activities of daily living (ADL). Based on observation, interview, and record review, the facility failed to provide dignity during dining for Resident (R) 28 who was brought to the dining room disheveled and then left unassisted while he dropped food all down the front of his shirt. This placed R28 at risk for impaired dignity and decreased psychosocial wellbeing. Findings included: - R28's Electronic Medical Record (EMR) recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), history of cerebrovascular accident (CVA- stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and depression (mood disorder characterized by persistent sadness). The "Quarterly Minimum Data Set" (MDS) dated 11/03/22 recorded R28 had a Brief interview for Mental Status (BIMS) score of four which	F 550		

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indicated severe cognitive impairment. He required extensive assistance of one staff member for dressing, and personal hygiene and he required supervision and set up assistance for eating. R28 required staff assistance for bathing. The MDS documented R28 had no rejection of cares.

R28's "Care Plan" recorded R28 had self-care deficit related to CVA. The care plan further documented R28 preferred dressing/groomed routine in the morning, required extensive assistance with dressing needs, and set up and supervision for all meals.

On 01/18/23 at 12:19 PM observation revealed R28 sat in the dining room, next to a table, in a Broda (specialty wheelchair) chair sliding forward in the seat of chair. His left arm, affected by the CVA, pressed against the table. R28 used his right arm and hand to reach across his body to fork food and bring it to his mouth. R28 dribbled mashed potatoes and macaroni and cheese from the left side of his mouth onto his shirt. No clothing protector had been provided for the resident.

On 01/19/23 at 08:07 AM observation revealed R28 in the Broda chair dressed for the day. R28's hair had not been combed, and he was being taken to the dining room.

On 01/19/23 at 08:18 AM observation revealed R28 sat in the dining room, slouched down in the seat of the Broda chair, with the table to his left side. He had no clothing protector on, and he ate independently by crossing his body with right hand and arm to eat. R28 had eggs on his shirt.

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On 01/19/23 at 08:30 AM, Administrative Staff A inquired if R28 would like a clothing protector and R28 replied he would, and a clothing protector was provided.

On 01/23/23 at 09:05 AM observation revealed R28 in the dining room, hair uncombed, in a Broda chair slouched down in the seat with shoulder at table level and slightly reclined. R28 again had been placed at the table with left side against the table. R28 had to reach across his body with right arm to eat breakfast.

On 01/19/23 at 09:25 AM Certified Medication Aide (CMA) R stated staff usually place R28 at the table, so he did not have to reach across his body to eat and did not know why he was not positioned correctly.

On 01/23/23 at 09:20 AM, Administrative Nurse D stated at times R28 comb his hair, but staff should offer a comb or comb hair for him. Administrative Nurse D verified R28 should be seated up to the table in a position in which R28 did not have to cross his body to fork food to eat.

The facility's undated, "Right to Dignity" policy, documented the facility will promote care for elders of the facility in a manner and in an environment that maintains and enhances each elder's dignity and respect in full recognition of the elder's individuality. Elders will be groomed as they wish including hair care. Each elder will be provided with independence and dignity during all dining experience regardless of the amount of assistance the elder required. Clothing protectors will be not be used unless requested by and care planned for the elder.

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F 550	Continued From page 4 The facility failed to provide dignity during dining for R28 who was brought to the dining room disheveled and then left unassisted while he dropped food down the front of his shirt. The placed R28 at risk for impaired dignity and decreased psychosocial well-being.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		

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F 582	Continued From page 5 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility had a census of 42 residents. The sample included 12 residents. Based on record review and interview, the facility failed to provide three sampled residents, Resident (R)13, R16 and R146 (or their representative) the completed Skilled Nursing Facility Advanced Beneficiary Notices (ABN) form 10055, (CMS) Centers for Medicare and Medicare Services which placed them at risk to make uninformed decisions about their skilled care Findings included: - The Medicare ABN form 10055 informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included an	F 582		

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option for the beneficiary to receive specific services listed, and bill Medicare for an official decision on payment. The form stated 1) I understand if Medicare does not pay, I will be responsible for payment, but can make an appeal to Medicare, (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for services, (3) I do not want the listed services.

The facility provided R13 the completed form 10055, which estimated the cost for the services to be able to make an informed choice whether or not the resident wanted to receive the items or services, knowing he/she may have to pay out of pocket. The facility failed to have the resident check the box if they did or did not the items or services and the resident had signed the form which she had a Brief Interview Status (BIMS) of ten indicating moderately impaired cognition, and the resident signed the form on 12/01/22 (2 days after the services ended). The resident's skilled nursing services ended on 11/30/22.

The facility provided R16 the completed form 10055, which estimated cost for the services to be able to make an informed choice whether or not the resident wanted to receive the items or services, knowing he/she may have to pay out of pocket. The facility failed to have the resident check the box if they did or did not want the items and services and had the resident sign the form which she has a BIMS of ten indicated moderately impaired cognition. The resident's skilled nursing services ended on 11/25/22.

The facility provided R146 the completed form 10055, which the estimated cost for the services to be able to make an informed choice whether or not the resident wanted to receive the items or

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services, knowing he/she may have to pay out of pocket. The facility failed to have the resident check the box if they did or did not want the services. The resident's skilled nursing services ended on 06/23/22.

On 01/19/23 at 10:30 AM, Administrative Nurse F verified the facility staff provided the resident and/or their representative the CMS form 10055 and verified the lack of documentation regarding the resident or DPOA chose if they wanted to receive the items or services or did not want to, the boxes were not checked either way.

The facility's "Medicare Denial Notices" policy, dated October 2021 documented individuals eligible for services under the Medicare Advantage Plan, will be provided information that will assist them in receiving appropriate covered services. Prior to or upon admission, a representative of the business office will review information verbally and in writing with the resident how to apply for and use Medicare and Medicaid benefits, including how to receive funds for previous payments covered by these benefits. If the stay is not covered, the resident and/or legal representative will be provided a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC)at the time of admission and will be informed of the reasons the facility has determined the stay will not be covered along with information on the resident's appeal rights. If the stay is initially covered, the resident and/or legal representative will be provided a SNF ABN and NOMNC at the time the facility determines that Medicare coverage will ending and will be informed of the reasons the facility had determined the stay will no longer be covered

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F 582	Continued From page 8 along with information on the resident's right to appeal. Resident's who exercise their appeal rights will continued to receive the same services until a determination is made by the appropriate third-party reviewer. Residents will not be billed for services provided until the appeal is processed and a determination issued. Facility Business Office and Social Services staff are responsible for providing SNF ABN's and NOMNC's to residents/responsible parties, medical records information to the review organization within the timeframe required by the regulation and informing resident's/responsible parties of the determination made by the review organization. The facility failed to provide R13, R16, and R146, or their representatives, the completed ABN 10055 form when discharged from skilled care, which placed them at risk to make uninformed decisions about their skilled care.	F 582		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		

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(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 42 residents. The sample included 13 residents with one reviewed for hospitalization. Based on observation, interviews, and record review, the facility failed to provide Resident (R) 19 with a bed hold notice upon discharge to the hospital. This placed the resident at risk for impaired rights to return to the facility and in the same room as previously resided.

Findings included:

- R19's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and depression (mood disorder characterized by feelings of persistent sadness).

The "Quarterly Minimum Data Set" (MDS) dated 12/04/22 recorded R19 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated

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moderate cognitive impairment. R19 required extensive assistance of one staff for most activities of daily living (ADL). R19 used a wheelchair for mobility and required extensive assistance of one staff for locomotion on and off the unit. R19 did not walk during the assessment review period. The MDS recorded R19 had no rejection of cares. The MDS documented R19 was at risk for pressure injuries and had no wounds on her feet at the time of the assessment. The MDS documented R19 received insulin (hormone used to control blood glucose levels) injections for all seven of the look back days. R19 received physical and occupational therapy each for five days during the look back period.

Further review of R19's MDS entry and discharge trackers revealed she discharged with a return anticipated on 08/1422, and readmitted on 08/15/22, discharged with return anticipated 09/09/22 and readmitted on 09/12/22, discharged with return anticipated on 09/28/22 and readmitted on 09/30/22, and discharged return anticipated on 10/18/22 and readmitted on 10/20/22.

Review of R19's clinical record lacked evidence a bed hold notice was issued to R19 or her representative upon discharge to the hospital on 08/14/22, 09/09/22, 09/28/22, and 10/18/22.

On 01/17/23 at 02:48 PM, observation revealed R19 in her wheelchair in the dining room.

On 01/23/23 at 01:23 PM, Administrative Staff B verified the facility had not given R19 a bed hold notice for her four hospitalizations during 2022.

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F 625	Continued From page 11 The facility's "Bed-Holds and Returns" policy, dated 10/2021, stated prior to transfers and therapeutic leaves, residents or their representative would be informed in writing of the bedhold and return policy. The facility failed to provide R19 with a bed hold notice upon discharge to the hospital, placing the resident at risk for impaired rights to return to the facility and in the same room as she previously resided.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		

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(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents. The sample included 13 residents with two reviewed for urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) use. Based on observation, interview, and record review the facility failed to develop a baseline care plan in a timely manner for Resident 93's urinary catheter and R194's activities of daily living (ADL) , hospice and end of life cares. This deficient practice placed at risk for unmet and uncommunicated care needs.

Findings included:

- R93 was admitted to the facility 01/16/23, with a diagnosis of malignant neoplasm (cancer) of the lung.

The "Baseline Care Plan," dated 01/18/23, lacked

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catheter care information.

The "Physician Order," dated 01/17/23, directed staff to place an indwelling urinary catheter due to resident decline, change every 30 days and as needed (prn).

The "Progress Note," dated 01/17/23 at 06:19 PM, documented the nurse placed a 18 french, 30 milliliter (ml), indwelling catheter via sterile procedure and 450 ml of straw-colored clear urine was drained.

On 01/17/23 at 03:08 PM, observation revealed R93 in a wheelchair in her room with a urinary catheter bag, with yellow drainage, on the side of her wheelchair.

On 01/23/23 at 09:45 AM, Administrative Nurse D verified staff should have documented what care was needed for R93's urinary catheter on the baseline care plan.

The "Indwelling Catheter Protocol," undated, documented the care plan for the catheter would include interventions specific enough to guide the provision of services and treatment of the catheter.

The facility failed to develop a baseline care plan in a timely manner for R93's urinary catheter, placing R93 at risk to not receive adequate care for the catheter.

-R194's Electronic Medical Record (EMR) recorded diagnoses of respiratory failure and dementia (progressive mental disorder characterized by failing memory and confusion), upon admission on 01/05/22.

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F 655	Continued From page 14 The "Admission Minimum Data Set" (MDS), dated 01/11/23, documented R194 had severe cognitive impairment, required limited to extensive assistance with activities of daily living (ADL), and had medically complex conditions. The MDS further documented R194 had condition or chronic disease that may result in a life expectancy of less than six months. The "Baseline Care Plan" was dated 01/10/23, three days after required time frame. On 01/18/23 at 10:33 AM, observation revealed R194 laid in bed with her breakfast meal on the overbed table, uneaten. The resident's upper dentures were lying in the bed next to her right shoulder. The call light was under her head pillow, not in reach, and the oxygen nasal cannula not in her nose. 01/23/23 at 09:20 AM Administrative Nurse E verified the baseline care plan had not been completed within forty-eight (48) hours of admission. The facility's "Baseline Care Plan", dated 10/2021, documented a baseline plan of care to meet the resident's immediate care needs shall be developed for each resident within forty-eight (48) hours of admission. The facility failed to develop a baseline care plan for R194 which placed the resident at risk for unmet care needs.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		

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F 656	Continued From page 15 §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 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	F 656		

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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:
The facility had a census of 42 residents. The sample included 12 residents, with two reviewed for indwelling urinary catheters (tube inserted directly into the bladder to drain urine). Based on observations, interview and record review, the facility failed to develop a care plan for Resident (R) 15's indwelling catheter as well as need for assistance with activities of daily living. This placed R15 at risk for uncommunicated and unmet care needs.

Findings included:

- R15's Electronic Medical Record (EMR) recorded diagnoses of pain, heart failure, neuromuscular dysfunction (lack of bladder control due to brain, spinal cord or nerve problems) of bladder and urinary tract infection.

The "Admission Minimum Data Set" (MDS), dated 11/21/22, recorded R15 had intact cognition, required extensive assistance of one staff for activities of daily living (ADL), had an indwelling urinary catheter and was always incontinent of bowel.

The "Urinary Incontinence/Indwelling Catheter Care Area Assessment" (CAA), dated 11/28/22, documented R15 had a catheter, required extensive assistance with ADL, and usually refused to get out of bed.

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F 656	Continued From page 17 The comprehensive care plan was to be completed by 12/05/22. The comprehensive care plan, dated 12/19/22, lacked specific documentation for ADL assistance and urinary catheter. The care plan was updated 01/12/23 to include the catheter but lacked interventions. On 01/23/23 at 09:20 AM Administrative Nurses D and E verified R15's comprehensive care plan had not been completed in the required time frame and had not encompassed the use of the indwelling urinary catheter. The facility's "Comprehensive Person-Centered Care Plan" policy, dated 10/2021, documented the comprehensive, person-centered care plan is developed within in seven days of the completion of the required comprehensive assessment (MDS). The facility failed to complete a comprehensive person-centered care plan as required, and within the required time frame, for R15, which placed the resident at risk of unmet care needs.	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	F 657		

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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:
The facility had a census of 42 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interview and record review, the facility failed to revise the care plan to include Resident (R)38 and R32's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment in reality testing medication which included targeted behavior and side effects) medication, and failed to revise R19s care plan with her change in mobility status. This placed the affected residents at risk for inadequate care or uncommunicated care needs.

Findings included:

- R38's Electronic Medical Record (EMR) recorded diagnoses of Alzheimer's disease

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(progressive mental deterioration characterized by confusion and memory failure.)

R38's "Admission Minimum Data Set" (MDS), dated 11/10/22, recorded R38 had Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognition impairment. The MDS recorded R38 required limited assistance of one staff for most activities of daily living (ADLS.) The MDS recorded R38 received an antipsychotic medication for all seven days of the look back period.

The "Psychotropic Care Area Assessment" (CAA), dated 11/17/22, recorded the resident was able to make her needs know with a diagnosis of Alzheimer's. The CAA documented the resident received Black box medications (BBW-black box warning is the strictest and most serious type of warning that the FDA gives a medication due to the serious or life-threatening side effects or risk) but lacked any other information.

The "Medication Care Plan," dated 11/17/22 recorded the resident received BBW medication and referenced the "Medication Administration Record" in the EMR. The care plan lacked specific information related to the Seroquel use which included targeted behaviors and side effects to monitor.

The "Physician's Order," dated 11/22/22, directed the staff to administer Seroquel (antipsychotic) 25 milligrams (mg), at bedtime for a diagnosis of Alzheimer's.

On 1/17/22 at 04:00 PM, observation revealed R38 sat in a wheelchair at the dining room table playing bingo with other residents. Continued

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observation revealed Certified Nurse Aide N attempted to get the resident to use the toilet and the resident refused multiple times.

On 01/19/23 at 09:40 AM, Administrative Nurse D verified the residents care plan did not have individualized interventions for the resident's behaviors or use of the Seroquel.

The facility's "Care Plans, Comprehensive Person- Centered" policy, dated October 2021 documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for the resident. The assessment of the residents are ongoing and care plans are revised as information about the resident and the residents condition change.

The facility failed to update R38's care plan with antipsychotic medication use, placing the resident at risk for increased behaviors.

- R32's Electronic Medical Record (EMR) documented diagnoses of recurrent depression (mood disorder characterized by persistent sadness), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety disorder (a group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats).

The "Quarterly Minimum Data Set" (MDS), dated 11/17/22, documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired decision making. The MDS documented R32 required supervision for eating, transfers, limited staff assistance for dressing, and

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extensive staff assistance for toileting, mobility, transfers. The MDS documented R32 received antipsychotic medications seven days of the lookback period.

The "Medication Care Plan," dated 11/28/22, directed staff to see the electronic "Medication Administration Record" (MAR) for the Black Box Warnings (BBW- highest warning for side effects), administer medications as ordered, and monitor for side effects and effectiveness. The care plan directed staff to obtain and monitor labwork as ordered, report results to the physician, and follow up as indicated. The care plan lacked specific information including target behaviors for antipsychotic medication.

The "Physician Order," dated 05/22/22, directed staff to administer Seroquel (antipsychotic), 12.5 milligrams (mg) in the afternoon for sundowning (restlessness, agitation, irritability, or confusion that can begin or worsen as daylight begins to fade).

R32's medical record lacked monitoring for target behaviors for the use of Seroquel.

R32's EMR lacked an Abnormal Involuntary Movement Scale (AIMS) since 10/2021 (over one year ago).

The "Pharmacist Review," dated 10/17/22, recommended the facility update R32's chart with a more recent AIMS (last 10/2021) and stated the need to monitor target behaviors for Seroquel.

On 01/18/23 at 08:42 AM, observation revealed Certified Medication Aide (CMA) R administered medications to R32 who took the pills whole

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without problems.

On 01/23/23 at 09:20 AM, Administrative Nurse D verified staff should have completed an AIMS quarterly, and target behaviors. Administrative Nurse D said the Seroqul, with a BBW, should be placed on the care plan.

The facility's "Care Plans, Comprehensive Person- Centered" policy, dated October 2021 documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for the resident. The assessment of the residents are ongoing and care plans are revised as information about the resident and the residents condition change.

The facility failed to update R32's care plan with antipsychotic medication use, placing the resident at risk for increased behaviors.

- R19s' Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and depression (mood disorder characterized by feelings of persistent sadness).

The "Quarterly Minimum Data Set" (MDS) dated 12/04/22 recorded R19 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R19 required extensive assistance of one staff for most activities of daily living (ADL). R19 used a wheelchair for mobility and required extensive

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assistance of one staff for locomotion on and off the unit. R19 did not walk during the assessment review period. The MDS recorded R19 had no rejection of cares. The MDs documented R19 was at risk for pressure injuries and had no wounds on her feet at the time of the assessment. The MDS documented R19 received insulin injections for all seven of the look back days. R19 received physical and occupational therapy each for five days during the look back period.

The "ADL Care Plan," dated 12/04/22, directed staff to provide limited to extensive assistance for transfers, depending on time of day and if R19 chose to wear her leg braces. The care plan also directed staff to use the total lift at times with two staff members. For ambulation, the care plan stated R19 was able to walk with assistance of a staff member and used her wheelchair for her primary locomotion. The care plan had not been updated to inform staff R19 no longer ambulated and now used the wheelchair full time.

On 01/18/23 at 08:40 AM, observation revealed R19 self-propelled her wheelchair, with her arms, in the hall to the dining room with her toes barely touching on the floor.

On 01/23/23 at 08:48 AM, Therapy Director GG stated R19 had used a wheelchair since 2020 and the facility had provided different wheelchairs as she gained weight and had to get a larger one approximately one year ago. She stated R19 cannot walk due to her knees give out.

On 01/23/23 at 950 AM. Administrative Nurse E verified staff should updated the care plan to reflect R19's current mobility status.

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F 657	Continued From page 24 The facility's "Using the Care Plan" policy, undated, documented changes in the resident's condition would be reported to the MDS coordinator so a review of the resident's care plan could be made. The facility failed to revise R19's care plan to reflect current mobility, placing the resident at risk for inadequate care and/or uncommunicated care needs.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform	F 660		

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required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based

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on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 42 residents. The sample included 13 residents with one reviewed for discharge. Based on interviews, and record review, the facility failed to establish a discharge plan with goals for Resident (R) 42. This placed R42 at risk for uncommunicated care needs and inappropriate discharge.

Findings Included:

- R42's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), right femur (thigh bone) fracture, and depression (mood disorder characterized by feelings of persistent sadness).

R42's "Admission Minimum Data Set" (MDS) dated 10/02/22 recorded R42had a Brief Interview for mental Status (BIMS) score of 15 which indicated he was cognitively intact. He required supervision with set up help for activities of daily living (ADL). The MDS recorded R42 was at risk for pressure injuries, received ointments or medication to areas other than his feet and had

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two physician visits with three order changes during the 14 day look back period. The MDS documented the residnet participated in the assessment and goal setting. The MDS further recorded the resident expected to remain in the facility and had no active discharge plan.

R42's "Baseline Care Plan" (no comprehensive care plan developed), dated 09/27/22, documented R42 had diabetic neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness) to both feet, was on a diabetic diet, had full dentures, and was independent with activities of daily living (ADLs). R42's goal was to improve functioning.

The "Admission Note," dated 09/27/22, documented R42 arrived at the facility on 09/26/2022 at 06:20 PM. He was transported to his room in a wheelchair. He was a smoker; staff accompanied him out to smoke a couple of times, and he gave his cigarettes to the nurse. R42 stated that he walked with a cane but did not have one. The note stated R42 had foot pain caused by neuropathy. A Wander Guard bracelet (body alarm which alerts when a residnet nears a door or exit) was placed on R42's forearm due to a high risk of elopement (when a resident leaves the facility without staff knowledge or supervision).

The "Progress Note," dated 10/12/22, documented staff contacted R42's emergency contacts and asked them to provide either an ankle brace or a high-top tennis shoe for the resident's foot-drop issue.

The "Progress Note," dated 10/30/22 at 11:06

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PM, documented at approximately 08:00 PM, R42 started yelling at a confused female resident that kept trying to enter his room. At 08:30 PM, staff heard a door slam and noticed R42's door was closed. He was angry and stated that she was bothering him. R42 stated he was depressed and despondent and the information was relayed to oncoming staff.

The "Physician Order," dated 11/4/22, directed Physical Therapy (PT) to evaluate R42 for a four-wheel walker and if he qualified, order a four-wheel walker due to weakness.

The "Physician Note," dated 11/10/22, documented R42 has been using increased amount of pain medication and ordered pain management consult for chronic complaints of pain to low back and hips and would refer to psychiatry also. R42 was a recovering alcoholic, and the facility was looking into sober house living. R42 applied for disability due to back pain.

The "Progress Note," dated 11/14/22, documented R42 discharged to a facility in another town today. All belongings were sent with him and he was agreeable and excited to go. R42 was transported by facility van accompanied by staff.

The EMR lacked a capitulation of stay, a comprehensive care plan which included a discharge plan, and information regarding the transfer out of the facility.

On 01/18/23 at 09:33 AM, Administrative Nurse E stated she assisted with the transfer of the resident to another nursing home. She stated R42 had some mental health issues.

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F 660	Continued From page 29 Administrative Nurse E verified staff should have completed a comprehensive care plan with goals and a recapitulation of R42's stay at this facility. On 01/18/23 at 09:38 AM, Social Services X stated R42 did not have therapy while here, so staff did not provide a recap of his stay. Social Services X stated the physician assistant asked her to look into rehabilitation facilities for R42. She verified the facility had not documented any transfer assistance given to R42. The facility's "Discharge Summary and Plan" policy, date 10/2021, stated when a resident's discharge is anticipated, a discharge summary and post discharge plan would be developed to assist the resident to adjust to his/her new living environment. The Discharge summary would include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of discharge. The policy stated every resident would be evaluated for his/her discharge needs and would have a personalized post discharge plan. A member of the interdisciplinary team would review the final post-discharge plan with the resident and family at least 24 hours before the discharge. The facility failed to establish a discharge plan with goals for R 42. This placed R42 at risk for uncommunicated care needs and inappropriate discharge.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes,	F 661		

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but is not limited to, the following:
(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 42 residents. The sample included 13 residents with one reviewed for discharge. Based on interviews, and record review, the facility failed to complete a recapitulation of Resident (R) 42 stay at the facility. This placed R42 at risk for uncommunicated care needs and missed health care opportunities.

Findings Included:

- R42's Electronic Medical Record (EMR)

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recorded diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (mood disorder characterized by feelings of persistent sadness).

R42's "Admission Minimum Data Set" (MDS) dated 10/02/22 recorded R42had a Brief Interview for mental Status (BIMS) score of 15 which indicated he was cognitively intact. He required supervision with set up help for activities of daily living (ADL). The MDS recorded R42 was at risk for pressure injuries, received ointments or medication to areas other than his feet and had two physician visits with three order changes during the 14 day look back period. The MDS documented the resident participated in the assessment and goal setting. The MDS further recorded the resident expected to remain in the facility and had no active discharge plan.

R42's "Care Plan" dated 09/27/22, documented R42 had diabetic neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness) to both feet, was on a diabetic diet, had full dentures, and was independent with activities of daily living (ADLs). R42's goal was to improve functioning.

The "Admission Note," dated 09/27/22, documented R42 arrived at the facility on 09/26/2022 at 06:20 PM. He was transported to his room in a wheelchair. He was a smoker; staff accompanied him out to smoke a couple of times, and he gave his cigarettes to the nurse. R42 stated that he walked with a cane but did not have one. The note stated R42 had foot pain

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caused by neuropathy. A Wander Guard bracelet (body alarm which alerts when a resident nears a door or exit) wasexit) was placed on R42's forearm due to a high risk of elopement (when a resident leaves the facility without staff knowledge or supervision).

The "Progress Note," dated 10/12/22, documented staff contacted R42's emergency contacts and asked them to provide either an ankle brace or a high-top tennis shoe for the resident's foot-drop issue.

The "Progress Note," dated 10/30/22 at 11:06 PM, documented at approximately 08:00 PM, R42 started yelling at a confused female resident that kept trying to enter his room. At 08:30 PM, staff heard a door slam and noticed R42's door was closed. He was angry and stated that she was bothering him. R42 stated he was depressed and despondent and the information was relayed to oncoming staff.

The "Physician Order," dated 11/4/22, directed Physical Therapy (PT) to evaluate R42 for a four-wheel walker and if he qualified, order a four-wheel walker due to weakness.

The "Physician Note," dated 11/10/22, documented R42 has been using increased amount of pain medication and ordered pain management consult for chronic complaints of pain to low back and hips and would refer to psychiatry also. R42 was a recovering alcoholic, and the facility was looking into sober house living. R42 applied for disability due to back pain.

The "Progress Note," dated 11/14/22, documented R42 discharged to a facility in

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another town today. All belongings were sent with him and he was agreeable and excited to go. R42 was transported by facility van accompanied by staff.

The EMR lacked a capitulation of stay, a comprehensive care plan which included a discharge plan, and information regarding the transfer out of the facility.

On 01/18/23 at 09:33 AM, Administrative Nurse E stated she assisted with the transfer of the resident to another nursing home. She stated R42 had some mental health issues. Administrative Nurse E verified staff should have completed a comprehensive care plan with goals and a recapitulation of R42's stay at this facility.

On 01/18/23 at 09:38 AM, Social Services X stated R42 did not have therapy while here, so staff did not provide a recap of his stay. Social Services X stated the physician assistant asked her to look into rehabilitation facilities for R42. She verified the facility had not documented any transfer assistance given to R42.

The facility's "Discharge Summary and Plan" policy, date 10/2021, stated when a resident's discharge is anticipated, a discharge summary and post discharge plan would be developed to assist the resident to adjust to his/her new living environment. The Discharge summary would include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of discharge.

The facility failed to complete a recapitulation of R 42's stay at the facility, placing R42 at risk for uncommunicated care needs and missed health

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F 661	Continued From page 34 care opportunities.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 42 residents. The sample included 13 residents with five reviewed for activities od daily living (ADL). Based on observation interview, and record review the facility failed to provide Resident (R) 28 with the requires personal hygiene and dressing assistance he required. The facility further failed to provide consistent bathing per resident preferences for R28, R35, and R38. This placed the affected residents at risk for impaired dignity increased risk for skin issues and other complications. Findings included: - R28's Electronic Medical Record (EMR) recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), history of cerebrovascular accident (CVA, stroke-CVA) (stroke) - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and depression (mood disorder characterized by persistent sadness). The "Quarterly Minimum Data Set" (MDS) dated 11/03/22 recorded R28 had a Brief interview for	F 677		

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Mental Status (BIMS) score of four which indicated severe cognitive impairment. He required extensive assistance of one staff member for dressing, and personal hygiene and he required supervision and set up assistance for eating. R28 required staff assistance for bathing. The MDS documented R28 had no rejection of cares.

R28's "Care Plan" documented the resident required extensive assistance of one staff for bathing, two times a week in the mornings.

Review of the "Bathing Record" R28 lacked documented showers on the following dates:
09/23/22 to 10/10/22 (16 days)
10/17/22 to 10/28/22 (12 days)
11/11/22 to 11/18/22 (7 days)
12/09/22 to 12/30/22 (22 days)
The record review did not reveal refusals from the resident.

On 01/18/23 at 12:19 PM observation revealed R28 sat in the dining room, next to a table, in a Broda (specialty wheelchair) chair sliding forward in the seat of chair. His left arm, affected by the CVA, pressed against the table. R28 used his right arm and hand to reach across his body to fork food and bring it to his mouth. R28 dribbled mashed potatoes and macaroni and cheese from the left side of his mouth onto his shirt. No clothing protector had been provided for the resident.

On 01/19/23 at 08:07 AM observation revealed R28 in the Broda chair dressed for the day. R28's hair had not been combed, and he was being taken to the dining room.

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On 01/23/23 at 09:05 AM observation revealed R28 in the dining room, hair uncombed, in a Broda chair slouched down in the seat with shoulder at table level and slightly reclined. R28 again had been placed at the table with left side against the table. R28 had to reach across his body with right arm to eat breakfast.

On 01/23/23 at 09:20 AM, Administrative Nurse D stated residents should not go an extended amount of time without baths. Staff are to document refusals and try to reschedule for another day, and bathing should be done as resident preferences and care plans.

The facility's "Assisting an Elder with a Shower Bath", undated policy documented all elders residing in this facility will receive care, treatment, and service according to the elder's individualized care plan. Based on the individual elder's comprehensive assessment, staff will ensure that each elder's abilities in activity of daily living include showering will not diminish unless circumstances of the elder's clinical condition demonstrated that the decline is unavoidable.

The facility failed to provide R28 with the required personal hygiene assistance and consistent bathing per resident preference which placed the resident at risk for impaired dignity, increased risk for skin issues and other complications.

- R35's Electronic Medical Record (EMR) recorded diagnoses of renal insufficiency (kidney failure) diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), hip fracture, anxiety

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(mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and depression (mood disorder characterized by persistent sadness).

The "Quarterly Minimum Data Set" (MDS) dated 12/27/22 recorded R35 had a Brief interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. The MDS recorded R35 had no rejection of cares. R35 required limited assistance of one staff for most ADL including bathing, and extensive assist from one staff with toileting and personal hygiene. The MDS recorded R35 had alone fall resulting in major injury since the last assessment. R35 received an antidepressant (medication used to treat depression), antianxiety medication (used to treat anxiety) and a opioid (narcotic pain medication) for all seven days of the look back period.

R35's "Care Plan" recorded supervision for all bathing need two times a week. The care plan further documented to provide sponge bath when a full bath or shower can not be tolerated.

Review of the "Bathing Record" R35 lacked documented showers on the following dates:
09/08/22 to 10/03/22 (24 days) R35 refused on 09/12/22, 09/19/22, 09/27/22 and 09/30/22.
10/04/22 to 10/24/22 (20 days) R35 refused on 10/07/22, 10/13/22 and 10/17/22.
10/25/22 to 11/07/22 (12 days)
11/14/22 to 12/05/22 (20 days) R35 refused on 11/17/22, 11/18/22, 11/21/22, 11/24/22, and 12/01/22.

On 01/18/23 at 12:22 PM R35 was in the dining room in a wheelchair with foot pedals. She had a

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chicken breast on her plate, that was partially tore apart, but she had not eaten any of it.

On 01/23/23 at 09:20 AM, Administrative Nurse D stated residents should not go an extended amount of time without baths. Staff are to document refusals and try to reschedule for another day, and bathing should be done as resident preferences and care plans.

The facility's "Assisting an Elder with a Shower Bath", undated policy documented all elders residing in this facility will receive care, treatment, and service according to the elder's individualized care plan. Based on the individual elder's comprehensive assessment, staff will ensure that each elder's abilities in activity of daily living include showering will not diminish unless circumstances of the elder's clinical condition demonstrated that the decline is unavoidable.

The facility failed to provide R35 with the required personal hygiene assistance and consistent bathing per resident preference which placed the resident at risk for impaired dignity, increased risk for skin issues and other complications.
- R38's Electronic Medical Record (EMR) recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and muscle weakness.

R38's "Admission Minimum Data Set" (MDS), dated 11/10/22, recorded R38 had Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognition impairment. The MDS recorded R38 required limited assistance of one staff for bathing and most activities of daily living.

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The "Activities of Daily Living (ADL) Care Plan," dated 12/15/22 indicated the R38 was at risk for ADL self-care deficit due to diagnose of Alzheimer's. The care plan recorded the resident required limited to extensive assistance of one staff with bathing two times a week at night. The care plan recorded staff would provide the resident a sponge bath if R38 could not tolerate a shower.

R38's "Bathing Report" and bath sheets documented the resident received a bath on Wednesday and Friday evening shift.

The "November Bathing Report" documented the resident received a bath/shower on the following days:
Admit to the facility 11/12/22
11/16/22
11/20/22

The "December Bathing Report" documented the resident received a bath on the following days:
12/03/22 (12 days no bath/shower)
12/16/22 (12 days no bath or shower)
12/18/22
12/20/22
12/30/22 (9 days no bath/shower)

The "January Bathing Report" documented the resident received a bath/shower on the following days:
01/10/23 (10 days no bath/shower)
01/13/23
01/14/23
01/17/23

On 1/17/22 at 04:00 PM, observation revealed

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ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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F 677	Continued From page 40 R38 sat in a wheelchair at the dining room table playing bingo with other residents. Continued observation revealed resident's hair appeared uncombed, and Certified Nurse Aide M attempted to get the resident to use the toilet and the resident refused. On 01/19/22 at 09:40 AM, Administrative Nurse D verified the residents have scheduled bath/shower days and the aides document on shower sheets, and in the electronic health records; if the resident refused, the aides would inform the charge nurse who would talk to the resident and document in the electronic health record the resident reason for refusal. The facility's "Assisting an Elder with a Shower/Bath" policy, undated, documented the residents in the facility would receive care, treatment and services according to the residents individualized care plan. Based on the individual resident's comprehensive assessment, staff would ensure that each resident's abilities in Activities of Daily Living (ADLs) include showering would not diminish unless circumstances of the resident's clinical condition demonstrate the decline was unavoidable. The facility failed to provide the necessary care and bathing services for R38, placing the resident at risk for poor hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		

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assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 42 residents. The sample included 13 residents with five reviewed for activities of daily living (ADL). Based on observation, interviews, and record review, the facility failed to ensure appropriate wheelchair positioning for Resident (R) 19 whose feet dangled in an unsupported, dependent position while she sat in her wheelchair. This placed R19 at increased risk for medical complications and/or injuries.

Findings included:

- R19s' Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and depression (mood disorder characterized by feelings of persistent sadness).

The "Quarterly Minimum Data Set" (MDS) dated 12/04/22 recorded R19 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R19 required extensive assistance of one staff for most activities of daily living (ADL). R19 used a wheelchair for mobility and required extensive assistance of one staff for locomotion on and off the unit. R19 did not walk during the assessment review period. The MDS recorded R19 had no rejection of cares. The MDS documented R19

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F 684	Continued From page 42	F 684		

was at risk for pressure injuries and had no wounds on her feet at the time of the assessment. The MDS documented R19 received insulin injections for all seven of the look back days. R19 received physical and occupational therapy each for five days during the look back period.

The "ADL Care Plan," dated 12/04/22, directed staff to provide limited to extensive assistance for transfers, depending on time of day and if R19 chose to wear her leg braces. The care plan also directed staff to use the total lift at times with two staff members. For ambulation, the care plan stated R19 was able to walk with assistance of a staff member and used her wheelchair for her primary locomotion.

The "Physical Therapy (PT) Plan," dated 01/17/23, stated PT staff worked with R19 five times weekly for 30 days and treatment would include wheelchair management training. The plan stated R19 was a long-term care resident who presented with reported decline by staff resulting in need for skilled therapy to address decline in ability to perform functional activities without physical assistance, ADL participation, functional mobility, and postural alignment. R19 reported increased caregiver assistance.

On 01/17/23 at 02:48 PM, observation revealed R19 sat in a wheelchair in the dining room with both feet dangling. While seated at the dining table, her toes barely touched the floor and both lower legs were a darker reddish color.

On 01/18/23 at 08:40 AM, observation revealed R19 self-propelled her wheelchair, with her arms, in the hall to the dining room with her toe only

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F 684	Continued From page 43 touching on the floor. On 01/23/23 at 08:50 AM, observation revealed R19 sat in her wheelchair with toes only touching the floor and her heels approximately five inches from the floor. On 01/18/23 at 11:30 AM, R19 stated the wheelchair seat was too high, and if her feet could reach the floor, she would use them to propel the wheelchair. On 01/18/23 at 01:14 PM, PT HH stated R19 had used the current wheelchair for a few months. On 01/23/23 at 08:48 AM, Therapy Director GG stated R19 had used a wheelchair since 2020 and the facility had provided different wheelchairs as she gained weight and had to get a larger one approximately one year ago. She stated R19 cannot walk due to her knees give out. Upon interviewing the resident, R19 stated she might be able to feel her feet if they touched the floor. On 01/23/23 at 950 AM. Administrative Nurse D verified the resident should have been provided a wheelchair that did not allow her feet to dangle. The facility's "Wheelchair Positioning" tool, undated, directed staff to assess wheelchair fit and treat head to toe: leg length, seat height, transfer needs and mobility needs. The facility failed to assess and provide R19 with an appropriately fitted wheelchair, placing the resident at increased risk for medical complications and/or injuries.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 44 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: The facility identified a census of 42 residents. The sample included 13 residents with seven reviewed for accidents and/or falls. Based on observation, record review, and interviews the facility failed to ensure interventions identified to prevent falls were implemented for Resident (R)35 and failed to identify and implement interventions to prevent further falls for R36. This placed the residents at risk for further falls and fall related injuries. Findings included: - R35's Electronic Medical Record (EMR) recorded diagnoses of renal insufficiency (kidney failure) diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), hip fracture, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and depression (mood disorder characterized by persistent sadness). The "Quarterly Minimum Data Set" (MDS) dated 12/27/22 recorded R35 had a Brief interview for	F 689		

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Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. The MDS recorded R35 had no rejection of cares. R35 required limited assistance of one staff for most activities of daily living (ADL) including bathing, and extensive assist from one staff with toileting and personal hygiene. The MDS recorded R35 had one fall resulting in major injury since the last assessment. R35 received an antidepressant (medication used to treat depression), antianxiety medication (used to treat anxiety) and an opioid (narcotic pain medication) for all seven days of the look back period.

R35's "Care Plan" documented an actual fall on 12/17/22. The care plan intervention directed staff to send R35 to the emergency room. On 12/19/22 the care plan initiated the use of a foot cradle to keep sheets and blankets from getting tangled up into R35's feet and legs.

The "Progress Note," dated 12/17/22 at 09:20 AM, documented R35 laid on her right side with her feet wrapped up in the blanket. It appeared that the resident was trying to get out of bed without assistance and got tangled up in her blankets at her feet. R35 complained of right hip pain with movement. Order received for STAT (immediate) right hip x-ray.

The "Progress Note" dated 12/17/22 at 02:02 PM, documented R35 had been transported to an emergency room for evaluation and treatment of impacted fracture of the right femoral (thigh bone) neck.

On 01/18/23 at 08:05 AM, observation revealed R35 remained in bed. Further observation revealed no foot cradle was on the bed as

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indicated in the care plan.

On 01/19/23 at 10:43 AM observation revealed R35's bed was unmade and no foot cradle was present on the bed.

01/23/23 at 09:20 AM Administrative Nurses D and E verified the fall on 12/17/22 resulted in a femur fracture and a foot cradle should be on the bed as the care plan intervention directed.

The facility's "Managing Falls and Fall Risks" policy, dated 10/2021, documented based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to prevent the resident from falling and to try to minimize complications from falling.

The facility failed to ensure an intervention identified to prevent falls was implemented for R35 which placed the resident at risk for further falls and fall related injuries.

- R36's Electronic Medical Record (EMR) recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hip fracture, history of cerebrovascular accident (CVA-stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and psychotic disorder (mental disorder characterized by a disconnection from reality).

The "Significant Change Minimum Data Set" (MDS) dated 01/08/23 recorded a Brief Interview for Mental Status (BIMS) could not be conducted. Per staff interview. R36 had short- and long-term

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memory problems. He had inattention, alter levels of consciousness and disorganized thinking. The MDS recorded R36 had no rejection of cares. R36 required limited to extensive assistance of one staff for most activities of daily living (ADL) including bathing. The MDS recorded R36 had one fall resulting in minor injury since the last assessment. R35 received an antidepressant (medication used to treat depression) and an opioid (narcotic pain medication) for all seven days of the look back period.

The "Care Plan" documented R36 had moderate risk of falls related to confusion, gait, balance, and unaware of safety needs. The "Care Plan" further documented an actual fall on 11/11/22. The fall intervention, dated 11/26/22, directed staff to place R36 on a hospital bed. The care plan lacked further instruction.

The "Progress Note" on 11/11/22 at 11:46 AM, documented R36 fell at approximately 09:12 AM, was witnessed by staff hitting the right hip on the floor; a mobile x-ray was ordered immediately.

The "Progress Note" on 11/11/22 at 01:12 PM, documented the report from mobile x-ray of right femur impact fracture and possible superior pubic ramus (pelvic bone) nondisplaced fracture .

On 01/17/23 at 04:04 PM, observation revealed R36 in the dining room, seated in a wheelchair. R36 independently wheeled out of the dining room knocked over a wet floor sign and staff came and removed the sign. R36 then went to the sunroom door and ran into the partially closed door, then staff redirected R36 to the hall which he resided.

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F 689	Continued From page 48 On 01/23/23 at 09:20 AM Administrative Nurses D and E verified the fall on 11/11/22 resulted in a femur fracture. They furtehr verified the care plan lacked an intervention until 11/26/22 and the intervention was non-specific on the use of a hospital bed. The facility's "Managing Falls and Fall Risks" policy, dated 10/2021, documented based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to prevent the resident from falling and to try to minimize complications from falling. The facility failed to ensure interventions were identified and implemented to prevent falls for R36 which placed the resident at risk for further falls and fall related injuries.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		

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(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 42 residents. The sample included 13 residents with five reviewed for unnecessary medication. Based on observation, interviews, and record review, the facility failed to act upon the recommendations of the Consultant Pharmacist (CP) to monitor and report abnormal findings when Resident (R) 19's blood glucose levels were outside acceptable parameters and failure to administer R19's as needed (PRN) insulin (medication used to lower blood glucose levels) for elevated blood glucose levels. This placed the affected residents at risk for medical complications related to the medication regimen.

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Findings included:

- R19s' Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and depression (mood disorder characterized by feelings of persistent sadness).

The "Quarterly Minimum Data Set" (MDS) dated 12/04/22 recorded R19 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R19 required extensive assistance of one staff for most activities of daily living (ADL). R19 used a wheelchair for mobility and required extensive assistance of one staff for locomotion on and off the unit. R19 did not walk during the assessment review period. The MDS recorded R19 had no rejection of cares. The MDs documented R19 was at risk for pressure injuries and had no wounds on her feet at the time of the assessment. The MDS documented R19 received insulin injections for all seven of the look back days.

The "Medication Care Plan," dated 12/04/22, directed staff to administer diabetic medications as ordered by the physician, monitor for side effects and document effectiveness, and obtain fasting blood glucose as ordered by the physician.

The "Physician Order," dated 11/03/22, directed staff to administer Novolog insulin (fast acting insulin), 10 units, every two hours PRN for a blood glucose greater than 500 milligrams (mg) per deciliter (dL). The order directed staff to notify

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the physician if R19's blood glucose was greater than 500

The "January 2023 Medication Administration Record (MAR)" documented blood glucose checks four times daily and the following were greater than 500:
1/1/23= 502
1/2/23 = 540
1/4/23= 537
1/5/23= 575, 524
1/10/23= 506
1/11/23= 567
1/12/23= 571
1/13/23=541
1/17/23= 547, 533, 561
1/19/23= 569. 521
1/20/23= 550. 550, 563
1/21/23= 542, 536
1/22/23= 579
The MAR documented PRN Novolog was administered five times in January on 01/02, 01/19, 01/20, 01/21 and 01/22/23.

The "Pharmacist Consultant Review," dated 09/20/22, recommended the facility ensure staff notify the physician of blood glucose greater than 500.

The "Pharmacist Consultant Review," dated 10/17/22, recommended the facility ensure staff notify the physician of blood glucose greater than 500.

The "Pharmacist Consultant Review," dated 01/13/23, recommended the facility ensure staff notify the physician of blood glucose greater than 500, administer Novolog PRN and document.

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F 756	Continued From page 52 On 01/18/23 at 07:54 AM, Licensed Nurse (LN) G obtained R19's blood glucose level of 392. On 01/23/23 at 09:28 AM, Administrative Nurse D verified staff should have notified the physician for the greaten then 500 blood glucose levels and write a progress note for documentation of the notification. Administrative Nurse D verified the facility had not followed the pharmacist recommendations. The facility's "Consultant Pharmacist Services" policy, undated, documented the consultant pharmacist would submit a written report of the findings of the monthly drug regimen review. The policy documented the facility had a policy and procedure in place to ensure the drug regimen review findings were acted upon and completed within the specific time frames outlined for each step in the process. The facility failed to act upon the recommendations of the CP to monitor and report abnormal findings when R 19's blood glucose levels were outside acceptable parameters and failure to administer R19's PRN insulin for elevated blood glucose levels, placing the resident at risk for continued high blood glucose levels.	F 756		
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	F 757		

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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

§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:
The facility identified a census of 42 residents. The sample included 13 residents with five reviewed for unnecessary medication. Based on observation, interviews, and record review, the facility failed to monitor and report abnormal findings when Residnet (R) 19's blood glucose levels were outside ordered parameters and further failed to administer R19's as needed (PRN) insulin (medication used to lower blood glucose levels) for elevated blood glucose levels. The facility further failed to monitor bowel movements for R35 and R36. This placed the affected residents at risk for medical complications related to the medication regimen.

Findings included:

- R19s' Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or

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the body cannot respond to the insulin), and depression (mood disorder characterized by feelings of persistent sadness).

The "Quarterly Minimum Data Set" (MDS) dated 12/04/22 recorded R19 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R19 required extensive assistance of one staff for most activities of daily living (ADL). R19 used a wheelchair for mobility and required extensive assistance of one staff for locomotion on and off the unit. R19 did not walk during the assessment review period. The MDS recorded R19 had no rejection of cares. The MDs documented R19 was at risk for pressure injuries and had no wounds on her feet at the time of the assessment. The MDS documented R19 received insulin injections for all seven of the look back days.

The "Medication Care Plan," dated 12/04/22, directed staff to administer diabetic medications as ordered by the physician, monitor for side effects and document effectiveness, and obtain fasting blood glucose as ordered by the physician.

The "Physician Order," dated 11/03/22, directed staff to administer Novolog insulin (fast acting insulin), 10 units, PRN for a blood glucose greater than 500 milligrams (mg) per deciliter (dL). The order directed staff to notify the physician if R19's blood glucose was greater than 500

The "January 2023 Medication Administration Record (MAR)" documented blood glucose checks four times daily and the following were

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greater than 500:
1/1/23= 502
1/2/23 = 540
1/4/23= 537
1/5/23= 575, 524
1/10/23= 506
1/11/23= 567
1/12/23= 571
1/13/23=541
1/17/23= 547, 533, 561
1/19/23= 569. 521
1/20/23= 550. 550, 563
1/21/23= 542, 536
1/22/23= 579
The MAR documented PRN Novolog was administered five times in January on 01/02, 01/19, 01/20, 01/21 and 01/22/23.

The "Pharmacist Consultant Review," dated 09/20/22, recommended the facility ensure staff notify the physician of blood glucose greater than 500.

The "Pharmacist Consultant Review," dated 10/17/22, recommended the facility ensure staff notify the physician of blood glucose greater than 500.

The "Pharmacist Consultant Review," dated 01/13/23, recommended the facility ensure staff notify the physician of blood glucose greater than 500, administer Novolog PRN and document.

On 01/18/23 at 07:54 AM, Licensed Nurse (LN) G obtained R19's blood glucose level of 392.

On 01/23/23 at 09:28 AM, Administrative Nurse D verified staff should have notified the physician for the greater then 500 blood glucose levels,

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followed the insulin order, and make a progress note for documentation of the notification.

The facility's "Blood Glucose Monitoring Policy and Protocol," undated, stated each physician order for bedside blood glucose testing would include physician notification parameters and medication holding parameters as applicable. The policy directed staff to follow the physician orders if the resident's glucose result was outside the physician ordered parameters and document any abnormal results in the clinical record. The policy stated if the resident had a diagnosis of hyperglycemia, insulin would only be administered upon the order of a physician.

The facility failed to monitor and report abnormal findings when R19's blood glucose levels were outside acceptable parameters and further failed to administer R19's PRN insulin, placing R19 at risk for complications resulting from high blood glucose levels.
- R35's Electronic Medical Record (EMR) recorded diagnoses of renal insufficiency (kidney failure) diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), hip fracture, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and depression (mood disorder characterized by persistent sadness).

The "Quarterly Minimum Data Set" (MDS) dated 12/27/22 recorded R35 had a Brief interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. The MDS recorded R35 had no rejection of cares.

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R35 required limited assistance of one staff for most ADL including bathing, and extensive assist from one staff with toileting and personal hygiene. The MDS recorded R35 had alone fall resulting in major injury since the last assessment. R35 received an antidepressant (medication used to treat depression), antianxiety medication (used to treat anxiety) and an opioid (narcotic pain medication) for all seven days of the look back period.

R35's "Care Plan" documented R35 had impaired cognitive function/dementia or impaired thought processes. The care plan directed staff to administer medications as ordered and monitor/document for side effects and effectiveness.

The "Physician Order" dated 05/30/22, directed staff to monitor antidepressant medication for side effects such as headache, nausea, vomiting, diarrhea, dry mouth, dizziness, constipation (difficulty passing stools), and fatigue every shift.

The "Physician Order" dated 12/23/22 ordered colace (stool softner) 100 milligrams (mg) one capsule every 12 hours as needed for constipation.

The "Physician Order" dated 12/23/22 ordered Bisacodyl rectal suppository (laxative given into the rectum) 10 mg suppository rectally every 24 hours as needed for constipation.

The "Bowel Movement" record review revealed lack of recorded bowel movements (BM) from 11/05/22 to 11/14/22 (10 days) and 11/21/22 to 11/26/22 (six days). The record review further lacked documentation of bowel movements

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12/04/22 to 12/11/22 (seven days) and 12/27/22 to 12/31/22 (five days).

The record review lacked evidence of nursing intervention including medication administration per orders to treat constipation.

On 01/18/23 at 08:05 AM, observation revealed Certified Medication Aide (CMA) R administer R35 medications. R35 was cooperative with medication administration.

On 01/19/23 at 02:50 PM Licensed Nurse (LN) G reported the computer system sends an alert out for residents who have not had a bowel movement every two to three days. LN G stated she would start the facility standing order for constipation. LN G also stated she would notify the physician if the resident continued without bowel movements following interventions.

On 01/23/23 at 09:20 AM Administrative Nurse D stated the bowel movement flag on the computer system for nurses and nurse aides of residents who have not had a bowel movement in 48 hours, and it was the responsibility of all clinical staff to monitor and respond those alerts and lack of BM. Administrative Nurse D stated he was not aware of length of time of no bowel movement recorded or lack of documentation of treatment for R35.

The facility failed to identify and respond to the lack of BM for R35, which placed the resident at risk for constipation and bowel obstruction.

- R36's Electronic Medical Record (EMR) recorded diagnoses of dementia (progressive mental disorder characterized by failing memory,

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confusion), hip fracture, history of cerebrovascular accident (CVA, stroke-CVA) (stroke) - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and psychotic disorder (mental disorder characterized by a disconnection from reality).

The "Significant Change Minimum Data Set" (MDS) dated 01/08/23 recorded a Brief Interview for Mental Status (BIMS) could not be conducted. Per staff interview. R36 had short- and long-term memory problems. He had inattention, alter levels of consciousness and disorganized thinking. The MDS recorded R36 had no rejection of cares. R36 required limited to extensive assistance of one staff for most ADL including bathing. The MDS recorded R36 had one fall resulting in minor injury since the last assessment. R35 received an antidepressant (medication used to treat depression) and an opioid (narcotic pain medication) for all seven days of the look back period and antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions.

The "Care Plan", dated 12/19/22, documented R36 at times had loss of bowels related to irritable bowel syndrome (IBS), and directed staff provide peri-hygiene with each incontinent episode.

The "Bowel Movement" record review revealed R36 lacked documentation of a bowel movement for 11/22/22 through 11/27/22 (six days). The record lacked interventions to treat constipation (difficulty passing stools).

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The "Physician Order", dated 11/16/22 directed staff to administer docusate sodium (medication used to soften stool) capsule 100 milligrams (mg) two times a day for constipation.

The facility's undated "Standing Order" for constipation directs staff to administer laxative (a medication tending to stimulate or facilitate evacuation of the bowels) if not bowel movement after 3 days. Docusate 100 mg two times a day as needed. If the docusate is inadequate, add Miralax 17 grams (gm) daily as needed. If still inadequate results give Milk of Magnesia (MOM) daily as needed. If still inadequate results use Mag. Citrate one bottle at a time.

On 01/18/23 at 09:05 AM, observation revealed Certified Nurse Aide (CNA) N provide peri-hygiene during brief change due to incontinence.

On 01/19/23 at 02:50 PM Licensed Nurse (LN) G reported the computer system sends an alert out for residents who have not had a bowel movement every two to three days. LN G stated she would start the facility standing order for constipation. LN also stated she would notify the physician if the resident continued without bowel movements following interventions.

On 01/23/23 at 09:20 AM Administrative Nurse D stated the bowel movement flag on the computer system for nurses and nurse aides of residents who have not had a bowel movement in 48 hours., and it was all clinical staff to monitor. Administrative Nurse D stated he was not aware of length of time no bowel movement recorded or documentation of treatment of physician

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F 757	Continued From page 61 notification. The facility failed to follow the physician "Standing Orders" for constipation, which placed R36 at risk for constipation and bowel obstruction.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		

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in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interview and record review, the facility failed to ensure an appropriate indication for Resident (R)38's, and R32's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment in reality testing)medication, failed to ensure a 14-day stop date for R17's received as needed (PRN) psychotropic (an antianxiety medication that calm and relax people with excessive restlessness) that lacked a 14 day stop date or rationale for use. This placed the affected residents at risk for unintended affects related to psychotropic drug medications.

Findings include:

- R38's Electronic Medical Record (EMR) recorded diagnoses of Alzheimer's disease

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(progressive mental deterioration characterized by confusion and memory failure.)

R 38's "Admission Minimum Data Set" (MDS), dated 11/10/22, recorded R38 had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognition impairment. The MDS recorded R38 required limited assistance of one staff for most activities of daily living (ADL). The MDS recorded R38 received an antipsychotic medication for all seven days of the look back period.

The "Psychotropic Care Area Assessment" (CAA), dated 11/17/22, recorded the resident was able to make her needs know with a diagnosis of Alzheimer's. The CAA documented the resident received Black box medications (BBW-black box warning is the strictest and most serious type of warning that the FDA gives a medication due to the serious or life-threatening side effects or risk) but lacked any other information.

The "Medication Care Plan," dated 11/17/22 recorded the resident received BBW medication and referenced the "Medication Administration Record" in the EMR.

The "Physician's Order," dated 11/22/22, directed the staff to administer Seroquel (antipsychotic) 25 milligrams (mg), at bedtime for a diagnosis of Alzheimer's.

On 1/17/22 at 04:00 PM, observation revealed R38 sat in a wheelchair at the dining room table playing bingo with other residents. Continued observation revealed Certified Nurse Aide N attempted to get the resident to use the toilet and the resident refused multiple times.

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On 01/19/23 at 09:4M, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication with a diagnosis of Alzheimer's and that was an inappropriate diagnosis for the medication. Administrative Nurse D verified the pharmacy had sent monthly reviews to the facility and December's had not been reviewed, however she would speak with the physician and get an appropriate diagnosis.

The "Antipsychotic Medication Use" policy, dated October 2021 recorded antipsychotic medication's may be considered for residents with dementia but only after medical, physical, functional, psychological, environmental cause of behavioral symptoms have been identified and addressed. Antipsychotics will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and review. Residents will only receive antipsychotic medication when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specify symptoms, and risk to the resident and others. The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. Diagnostic of a specific condition for which antipsychotic medications are necessary to treat will be based on comprehensive assessment of the resident. Antipsychotic medications shall generally be used only for the following conditions (diagnoses as documented in the record, consistent with the definitions in the "Diagnostic and Statical Manual

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F 758	Continued From page 65 of Mental Disorder (Current or subsequent editions): Schizophrenia Schizo-affective disorder Schizophreniform disorder Delusional disorder Mood disorder (bipolar disorder, depressions with psychotic features, and treatment refractory major depression) Psychosis in the absence of dementia Medical illness with psychotic symptoms and/or treatment -related psychosis or mania(high dose steroids) Tourette's Disorder Huntington's Disorder Hiccups Nausea and Vomiting associated with cancer or chemotherapy Diagnosis alone do not warrant the use of antipsychotic medications. Residents will not receive PRN doses of psychotic medication unless that medication is necessary to treat a specific condition that is documented in the clinical record. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. The facility failed to ensure R38 did not receive an antipsychotic medication without an appropriate diagnosis or clinical justification for its use, placing R38 at risk for adverse side effects	F 758		

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related to the use of Seroquel.

- R17's Electronic Medical Record (EMR) recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental, uncertainty and irrational fear), and depression (mood disorder characterized by persistent sadness).

R17's "Significant Change Minimum Data Set" (MDS), dated 10/25/22, documented a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. R17 required supervision with bed mobility, eating, and required limited assistance of one staff for transfers, locomotion on and off the unit, dressing, toileting, and hygiene. The MDS documented R17 received antipsychotic and antianxiety medication for all seven of the look back days.

The "Psychotic Drug Use" Care Area Assessment" (CAA), dated 11/05/22, documented R17 was able to make her needs known and received Black box medications (BBW-black box warning is the strictest and most serious type of warning that the FDA gives a medication due to the serious or life-threatening side effects or risk) but lacked any other information.

The "Medication Care Plan," dated 11/02/22 recorded the resident received BBW medication and referenced the "Medication Administration Record" in the EMR.

The "Physician's Order," dated 10/04/22, directed the staff to administer Ativan (antianxiety medication) 0.5 milligrams (mg), every four hours

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as needed for anxiety. The order lacked a stop date.

On 01/19/23 at 08:55 AM, observation revealed the resident sat at the dining room table in a wheelchair eating biscuits and gravy, hash browns, sausage and apple juice.

On 01/19/23 at 09:40M, Administrative Nurse D verified the resident received Ativan, with a physician order date of 10/14/22. Administrative Nurse D verified the facility failed to obtain the 14 days stop date or reason for continued use with the appropriate rational.

The "Antipsychotic Medication Use" policy, dated October 2021 recorded antipsychotic medication's may be considered for residents with dementia but only after medical, physical, functional, psychological, environmental cause of behavioral symptoms have been identified and addressed. Antipsychotics will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and review. Residents will only receive antipsychotic medication when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specify symptoms, and risk to the resident and others. The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. Diagnostic of a specific condition for which antipsychotic medications are necessary to treat will be based on comprehensive assessment of the resident.

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F 758	Continued From page 68 Antipsychotic medications shall generally be used only for the following conditions (diagnoses as documented in the record, consistent with the definitions in the "Diagnostic and Statical Manual of Mental Disorder (Current or subsequent editions): Schizophrenia Schizo-affective disorder Schizophreniform disorder Delusional disorder Mood disorder (bipolar disorder, depressions with psychotic features, and treatment refractory major depression) Psychosis in the absence of dementia Medical illness with psychotic symptoms and/or treatment - related psychosis or mania (high dose steroids) Tourette's Disorder Huntington's Disorder Hiccups Nausea and Vomiting associated with cancer or chemotherapy Diagnosis alone do not warrant the use of antipsychotic medications. Residents will not receive PRN doses of psychotic medication unless that medication is necessary to treat a specific condition that is documented in the clinical record. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. The facility failed to ensure R17 was free of the use of unnecessary psychotropic drugs when they failed to obtain a stop date for the use of PRN Ativan, placing R17 at risk for adverse effects from the continued use of those medications.	F 758		

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- R32's Electronic Medical Record (EMR) documented diagnoses of recurrent depression (mood disorder characterized by persistent sadness), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety disorder (a group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats).

The "Quarterly Minimum Data Set" (MDS), dated 11/17/22, documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired decision making. The MDS documented R32 required supervision for eating, transfers, limited staff assistance for dressing, and extensive staff assistance for toileting, mobility, transfers. The MDS documented R32 received antipsychotic medications seven days of the lookback period.

The "Medication Care Plan," dated 11/28/22, directed staff to see the electronic "Medication Administration Record" (MAR) for the Black Box Warnings (BBW- highest warning for side effects), administer medications as ordered, and monitor for side effects and effectiveness. The care plan directed staff to obtain and monitor labwork as ordered, report results to the physician, and follow up as indicated.

The "Physician Order," dated 05/22/22, directed staff to administer Seroquel (antipsychotic), 12.5 milligrams (mg) in the afternoon for sundowning (restlessness, agitation, irritability, or confusion that can begin or worsen as daylight begins to fade).

R32's medical record lacked monitoring for target behaviors for the use of Seroquel.

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F 758	Continued From page 70 R32's EMR lacked an Abnormal Involuntary Movement Scale (AIMS) since 10/2021 (over one year ago). The "Pharmacist Review," dated 10/17/22, recommended the facility update R32's chart with a more recent AIMS (last 10/2021) and stated the need to monitor target behaviors for Seroquel. On 01/18/23 at 08:42 AM, observation revealed Certified Medication Aide (CMA) R administered medications to R32 who took the pills whole without problems. On 01/23/23 at 09:20 AM, Administrative Nurse D verified staff should have completed an AIMS quarterly, and target behaviors. Administrative Nurse D said the BBW should be placed on the care plan. The facility's "Antipsychotic Medication Use" policy, dated 10/2021, stated antipsychotic medications were subject to gradual dose reduction and re-review. Resident would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The facility failed to monitor target behaviors, including abnormal movements, for the use of Seroquel and failed to care plan BBW medications, placing R32 at risk for continued use of the antipsychotic medication without monitoring for effectiveness.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 71	F 761		

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents. Based on observation, interview, and record review the facility failed to ensure drugs were in locked storage when unattended by licensed staff. This deficient practice placed residents at risk for missing or tampered with medications.

Findings included:

- On 01/17/23 at 03:01 PM, observation revealed the facility's medication cart on the 100-hall unlocked and no nursing staff in sight. The

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F 761	Continued From page 72 drawers of medications were accessible. At 03:05 PM, Certified Medication Aide (CMA) S verified she had left the cart unlocked when she went to assist a resident in their room. On 01/19/23 at 04:10 PM, observation of the medication cart on the 100 hall revealed the cart unlocked and medication accessible with no licensed staff in sight of the cart. Administrative Staff A locked the cart as he went past. On 01/19/23 at 04:10 PM, Administrative Staff A verified staff were to lock the medication cart when leaving the area or when out of sight of the cart. The facility's "Storage of Medications" policy, dated 10/2021, documented drugs and biologicals are stored in locked compartments. The policy stated unlocked medication carts would not be left unattended. The facility failed to ensure drugs were in locked storage when unattended by licensed staff, placing the residents at risk for missing or tampered with medications.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)	F 801		

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F 801	Continued From page 73 This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.	F 801		

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F 801	Continued From page 74 (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: The facility had a census of 42 residents. Based on observation, interview, and record review the facility failed to employ a full time certified dietary manager for the 42 residents who resided in the facility and received meals from the facility kitchen. This deficient practice placed the 42 residents at risk for receiving inadequate nutrition.	F 801		

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F 801	Continued From page 75	F 801		

Findings included:

- On 01/17/23 at 08:50 AM, observation in the facility kitchen revealed damage to the ceiling covered with plastic and no staff working in the kitchen. Dietary Staff (DS) BB stated the damage was from a water pipe on 12/25/22 and the kitchen was shut down for repairs starting today. He stated the facility was buying takeout from Casey's, Firehouse Subs, IHOP, Arbys, Jimmies Eggs, Billy Sims BBQ, China One, Louie's Café, Subway and Olive Garden.

Further observation revealed the double refrigerator in the kitchen held a large opened, undated bag of hotdogs, one chunk of ham without a date. The walk-in freezer had an opened, undated bag of French fries. The last date the temperature was logged 12/26/22. This was verified by DS BB at the time of the observation.

The refrigerator temperature in the dining room was 40 and the temperature log stopped at 12/6/22. This was verified by DS BB at the time of the observation.

On 01/19/23 at 08:12 AM, DS BB verified the facility had ladles in the kitchen but were using the serving spoons instead. He stated "we are giving them plenty of food" even though not measured. At 08:26 AM, DS BB handled toast with gloved hands to butter then place on plates.

On 01/17/23 at 08:50 AM, DS BB verified he was the food service manager but was not certified, and in fact, had just started classes.

On 01/19/23 at 10:00 AM, DS BB stated the

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F 801	Continued From page 76 registered dietician came to the facility every other Friday. He stated he had submitted to her the catering schedule and where the foods were to be obtained. On 01/23/23 at 05:15 PM, DS BB verified the registered dietician had not been to the facility for at least two months. Upon request the facility did not provide a Dietary Manager policy. The facility's "Dietician" policy, dated 20/2021, stated a qualified dietician would help oversee food and nutrition services provided to the residents. The facility's food services manager would receive frequently scheduled consultations. The facility's dietician was responsible for developing and implementing person centered education programs involving food and nutrition services for all facility staff, overseeing the food preparation, service and storage. The facility failed to employ a full time certified dietary manager for the 42 residents who resided in the facility and received meals from the facility kitchen, placing the residents at risk for receiving inadequate nutrition.	F 801		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable,	F 804		

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F 804	Continued From page 77	F 804		

attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents. Based on observation, interview, and record review the facility failed to ensure foods remained at a safe, hot, holding temperature during the meal service. This deficient practice placed the 42 residents who received meals from the facility at risk for food borne illness.

Findings included:

- On 01/19/23 at 07:57 AM, Dietary Staff (DS) CC obtained breakfast food temperatures from ready to eat food brought to the facility from an outside source. DS CC stated when they brought the food in, it probably cooled.
Temperatures included:
White gravy : 145 degrees Fahrenheit (F)
bacon: 131degrees F
sausage: 130 degrees F
fried potatoes: 128 degrees F
scrambled eggs: 130 degrees F

The temperature log indicated temperatures should be 140-165 degrees F.

On 01/19/23, further observation at 08:00 AM, staff discovered the steam table outlet was not working and changed to another electrical outlet.
At 08:38 AM, food temperatures were:
Eggs: 120 degrees F
Bacon: 140 degrees F
Potatoes: 120 degrees F
Gravy: 90 degrees F

On 01/19/23 at 08:45 AM, DS BB stated as long

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F 804	Continued From page 78 as the food had not been out two hours it was ok. Staff warm up plates/food as requested. The facility's "Food preparation and Service" policy, dated 10/2021, stated food and nutrition services employees prepare and serve foo in a manner that complies with safe food handling practices. The policy stated previously cooked food would be reheated to 165 degrees for at least 15 seconds. Proper hot and cold temperatures are to be maintained during food service. The facility failed to maintain food temperatures at a minimum of 135 degrees during the meals service, placing residents at risk for unpalatable food or food borne illness.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		

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F 812	Continued From page 79	F 812		

standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents. Based on observation, interview, and record review the facility failed to store, prepare, and serve food to the residents of the facility in a safe, sanitary manner. This deficient practice placed the 42 residents of the facility who received their meals form the kitchen at risk for food borne illnesses.

Findings included:

- On 01/17/23 at 08:50 AM, observation in the facility kitchen revealed damage to the ceiling covered with plastic and no staff working in the kitchen. Dietary Staff (DS) BB stated the damage was from a water pipe on 12/25/22 and the kitchen was shut down for repairs starting that day.

Further observation revealed the double refrigerator in the kitchen held a large opened, undated bag of hotdogs, one chunk of ham without a date. The walk-in freezer had an opened, undated bag of French fries. The last date staff logged the temperature was 12/26/22. The refrigerator temperature in the dining room was 40 and the temperature log stopped at 12/6/22.

On 01/17/23 at 08:50 AM, observation revealed a dishwasher in the facility kitchen hooked up to Prestige Premier rinse and sanitizer, but no temperature or sanitation log could be found.

On 01/19/23 at 07:57 AM, observation revealed DS CC obtained breakfast food temperatures using the same thermometer without cleaning

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F 812	Continued From page 80	F 812		

between four different foods. When DS CC plated food for the residents he handled the bacon, sausages and biscuits with the same gloves hands, not tongs.

On 01/19/23 at 08:26 AM, DS BB handled toast with gloved hands to butter then place on plates.

On 01/19/23 at 10:00 AM, DS BB verified staff should not use hands to handle food items when plating meals, the thermometer should be cleaned after each food item, and dated food when opened. DS BB also verified staff should obtain and document the cold storage temperatures and dishwashing temperatures and sanitation.

The facility's "Food Receiving and Storage" policy, dated 10/2021, stated all foods stored in the refrigerator or freezer would be covered, labeled, and dated. Functioning of the refrigeration and food temperatures would be monitored at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state specific requirements. Opened containers must be dated and sealed.

The facility's "Food preparation and Service" policy, dated 10/2021, stated gloves are worn when handling food directly and changed between tasks. Disposable gloves are single use items and to be discarded after each use.

The facility's "Dishwashing Machine Use" policy, dated 10/2021, stated dishwashing machine that use hot water to sanitize must maintain hot water at 165 F. Dishwashing machine used with chemical sanitation must have a minimum

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F 812	Continued From page 81 concentration of 50-100 parts per million (ppm) chlorine or 150-200 ppm quaternary ammonium. The operator would check temperatures with each cycle and record the results in a facility log. The facility failed to store, prepare, and serve food to the residents of the facility in a safe, sanitary manner, placing the 42 residents of the facility who received their meals form the kitchen at risk for food borne illnesses.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of	F 849		

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the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing;

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counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to

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assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the

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facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 42 residents. The sample included 12 residents with two reviewed for hospice. Based on observation, interviews, and record review, the facility failed to ensure collaboration with the hospice provider to establish a plan for Resident (R)194's care and included shared information regarding R194's care needs, medication and equipment provided by hospice as well as the frequency of nursing visits and nursing care provided by hospice. This placed R194 at risk for uncommunciated or unmet care needs related to end of life cares.

Findings included :

- R194's Electronic Medical Record (EMR) recorded diagnoses of respiratory failure and dementia (progressive mental disorder characterized by failing memory and confusion).

The "Admission Minimum Data Set" (MDS), dated 01/11/23, documented R194 had severe cognitive impairment, required limited to extensive assistance with activities of daily living (ADL), and had medically complex conditions.

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The MDS further documented R194 had condition or chronic disease that may result in a life expectancy of less than six months.

The "Advance Directive/End of Life Care Plan," dated 01/09/22, documented R194 chose to participate in hospice and was enrolled in hospice on 12/30/22. The care plan lacked information related to the coordination of care and services from the facility and hospice provider.

The "History and Physical (H&P)" dated 01/09/23, documented R194 had been hospitalized for acute respiratory failure and found to have bilateral pleural effusion underwent treatment and was sent to the nursing home on hospice.

The "Progress Note", dated 01/16/23 at 09:43, documented the Durable Power of Attorney (DPOA), requested a care plan meeting at a specific date and time so the hospice could attend also.

On 01/18/23 at 10:33 AM, observation revealed R194 laid in bed with her breakfast meal on the overbed table, uneaten, the resident's upper dentures laying in the bed next to her right shoulder, the call light under her head pillow, not in reach, and the oxygen nasal cannula not in her nose.

On 01/18/23 at 10:33 AM, Licensed Nurse (LN) G, verified R194 did not have her dentures in and sometimes takes then out, the call light was not within reach, and the oxygen cannula was not in her nose. LN G said R194 needed assistance with eating and drinking. LN G verified R194's food was not at a safe temperature to eat and assisted the resident to drink. LN G also verified

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R194 was on hospice services and the hospice information was kept in a book at the nurse's station. LN G stated she would have to refer to the hospice book to verify care and services from hospice.

Upon request from Administrative Nurse D on 01/19/23 and 01/23/22 the facility could not provide hospice orders, or a plan of care for R194.

The facility's "Hospice Program" policy dated 10/2021, documented hospice services are available to residents at the end of life. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care for residents needs. Coordination care plans for resident receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. The coordination care plan will reflect the resident's goals and wishes, as stated in his or her advanced directives and during ongoing communication with the resident or representative including palliative goals and objectives, palliative interventions and medical treatment and diagnostic test. The coordination care plan shall be revised and updated as necessary to reflect the resident current status including but not limited to diagnosis, problem list, symptoms management, bowel and bladder care, nutrition and hydration need, oral health, spiritual activity and psychosocial needs and mobility and positioning.

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F 849	Continued From page 88 The facility failed to collaborate with hospice for the care and services provided to R194 which placed the resident at risk for unmet care needs.	F 849		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: The facility had a census of 42 residents. Based on record review and interview, the facility failed to ensure the staff person designated as the Infection Preventionist, who was responsible for the facility's Infection Prevention and Control Program, completed the specialized training in infection prevention and control. This placed the residents at risk for lack of identification and treatment of infections. Findings included:	F 882		

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F 882	Continued From page 89 - On 01/19/23 at 01:20 PM, Administrative Nurse E stated she was responsible for the Infection Prevention and Control Program and lacked certification as an Infection Preventionist. Administrative Nurse E stated she had completed most of or all the training modules but had not taken the test or received the certification. The "Surveillance for Infections" policy, dated October 2021 documented the Infection Preventionist will conduct ongoing surveillance for Healthcare- Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission -based precautions and other preventative measures. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpretation surveillance data. The Infection Control Committee and/or Quality Assurance and Performance Improvement (QAPI) Committee may be involved in interpretation of the data. The facility failed to ensure the person designated as the Infection Preventionist completed the required certification, placing the residents at risk for lack of identification and treatment of infections.	F 882		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883		

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F 883	Continued From page 90 receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		

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(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents. The sample included 12 residents of which five were reviewed for immunization status. Based on record review and interview, the facility failed to offer and provide and/or obtain informed refusals for influenza and pneumococcal vaccinations and failed to offer and provide the residents and/or their representative the current years "Vaccine Information Statement" (VIS-information sheets produced by the CDC [Centers for Disease Control and Prevention] that explained both the benefits and risk of vaccine to vaccine recipients for Resident (R)5, R10, R17, R29 and R35. This placed the affected residents at increased risk for illness and infection.

Findings included:

- R5's clinical record lacked evidence the current year "Vaccine Information Statement" form was provided to the resident and/or resident's representative, or an informed refusal was obtained.

R10's clinical record lacked evidence the current year "Vaccine Information Statement" form was provided to the resident and/or resident's representative or an informed refusal was obtained.

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R17's clinical record lacked evidence the current year "Vaccine Information Statement" form was provided to the resident and/or resident's representative or an informed refusal was obtained.

R29's clinical record lacked evidence the current year "Vaccine Information Statement" form was provided to the resident and/or resident's representative or an informed refusal was obtained.

R35's clinical record lacked evidence the current year "Vaccine Information Statement" form was provided to the resident and/or resident's representative or an informed refusal was obtained.

On 01/19/23 at 12:15 PM Administrative Nurse F verified the residents were offered the yearly influenza vaccine, but the facility failed to provide the current year CDC "VIS" and failed to obtain a yearly signed consent from the resident and/or their representative.

The facility's "Vaccination of Residents" policy dated October 2021, documented residents would be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated. The policy documented prior to receiving the vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations Current vaccine information statements are located at the CDC website for educational materials) Provision of such education shall be documented in the

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F 883	Continued From page 93 resident's medical record. The facility failed to offer and provide and/or obtain informed refusals for influenza and pneumococcal vaccinations for R5, R10, R17, 29 and R35 and failed to provide the current year VIS. This placed the affected residents increased risk for illness and infection.	F 883		