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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations #163711 and #163876. The 2567 was electronically sent to the facility on 08/02/21.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The	F 577		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/02/2021

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F 577	Continued From page 1 sample included 12 residents. Based on record review and interview, the facility failed to ensure the last three years complaint survey investigation results were available for public review. Findings included: - On 07/21/21 at 11:30 AM, surveyors reviewed the "Survey Result Binder" in the plastic storage container outside the Administrators office. The facility failed to ensure complaint survey investigation from the previous three years were available for review. Continued observation revealed only one complaint survey completed the past three years was in the binder. On 07/21/21 at 12:00 PM, Administrative Staff A verified the complaint survey results were not in the survey binder, retrieved the results, and added them to the binder. Upon request, the facility did not provide a policy for posting of the survey investigation results. The facility failed to ensure the last three years complaint survey inspection results were available for public review, placing the residents, staff, and visitors at risk for receiving inaccurate survey information.	F 577		
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	F 657		

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includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 28 residents. The sample included 12 residents, with six reviewed for falls. Based on observation, record review, and interview, the facility failed to revise three of six sampled residents' fall care plans, Resident (R) 6, R11, and R15.

Findings included:

- R6's "Annual Minimum Date Set" (MDS)," dated 09/11/20, recorded the resident had long- and short-term memory loss with moderately impaired decision-making skills. The MDS recorded the resident required extensive assistance of one staff for bed mobility, dressing, eating, toileting, and personal hygiene. The MDS recorded the

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resident had upper body functional limitation in range of motion on one side, lower body functional limitation on both sides, and no falls.

The "Quarterly MDS," dated 05/21/21, recorded the same as the 09/11/20 MDS except the resident had severely impaired decision-making skills and one fall with injury.

The "Activities of Daily Living Care Plan," dated 04/19/21, directed staff to assist the resident with transfers using a sit to stand lift (mechanical lift to transfer people from a sitting to a standing position) due to dementia (progressive mental disorder characterized by failing memory, confusion), and the resident refused to participate in cares.

The revised "Fall Care Plan," dated 04/01/21, originally dated 09/28/20, directed staff to check on the resident's needs every 30-60 minutes and as needed and remind the resident to use her call light for transfers. The care plan directed staff to assist the resident with transfers due to her history of falling trying to self-transfer, poor comprehension, and poor balance. The care plan directed staff to ensure the resident wore appropriate footwear and kept the footrest on the resident's recliner down so the resident did not try to crawl out of the recliner with the footrest up.

The "Nurse's Note," dated 09/27/20 at 07:00 PM, documented staff found the resident lying on the floor on her right side, knees bent with lacerations above her right eye, under her eye, and on her right arm by her elbow. The note documented staff observed a small amount of bleeding, documented the resident was on Coumadin (prevents or reduces coagulation of blood,

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prolonging the clotting time), and applied steri-strips (wound closure tape) to the areas.

The "Incident Report," dated 09/27/20, documented staff found the resident on the floor lying on her right side, knees bent with blood on the floor under her head. Two staff assisted the resident to roll over onto her back and noticed a laceration above her right eye, applied a cold wet cloth, and pressure to the laceration. The note documented a superficial laceration under the resident's right eye with no bleeding and wound left open to air. Staff applied skin prep and steri-strips to the resident's "right arm" (no documented location), and initiated neurological checks (assess mental status, nerves motor and sensory function, pupil response, reflexes and vital signs).

The "Incident Report," dated 04/19/21, documented staff found the resident on the floor lying prone (chest down and back up) in the hallway leading to the dining room. The resident had a 0.5 centimeter (cm) by 0.2 cm cut above her left upper lip with a small amount of bleeding. Two staff used a gait belt and transferred the resident into her wheelchair. Staff propelled the resident to her room and initiated neurological checks.

The "Morse Fall Risk Assessment," dated 09/08/20 recorded a score of 75, indicating a high fall risk.

The "Fall Risk Assessment," dated 03/02/21, recorded a score of 15 (score of 7 or higher indicates a high fall risk).

On 07/22/21 at 01:30 PM, observation revealed

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the resident sat in a wheelchair in the commons area in front of the nurse's station with eyes closed.

On 07/28/21 at 09:00 AM, Certified Nurse Aide (CNA) M stated the resident was impulsive and tried to do things on her own even though she was unable to safely. CNA M stated staff reminded the resident to use her call light but she did not remember, so staff checked on her frequently.

On 07/28/21 at 09:45 AM, Administrative Nurse D stated the medical records lacked an investigation, implementation of new interventions, and care plan updates with each fall.

The facility's "Comprehensive- Person Centered Care Plan" policy, dated December 2012, documented the facility must update and review the care plan when there has been a significant change in the residents condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment. The policy documented assessments of the residents are ongoing and care plans are revised as information about the resident and the residents condition changes.

The facility failed to revise R6's care plan to include new fall interventions, placing the resident at risk for further injury.

- R11's "Quarterly MDS," dated 03/05/21, documented the resident had moderately

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impaired cognition and required limited assistance of one staff for transfers, unsteady balance, upper and lower functional impairment on both sides, and no falls.

The "Quarterly MDS," dated 05/28/21, documented the same as the 03/05/21 MDS except the resident had severely impaired cognition and two or more falls with injury.

The "Fall Care Area Assessment" (CAA), dated 12/11/20, documented the resident had slight limited sensory perception (the process of becoming aware of something through the senses), occasionally walked, limited mobility, and required limited staff assistance with transfers and ambulation per the resident's plan of care.

The revised "Fall Care Plan," dated 07/23/21, originally dated 02/13/21, documented the resident a high risk for falls and directed staff to ensure the resident wore appropriate footwear when ambulating, and anticipate and meet the resident's needs. The update, dated 03/14/21, directed staff to make sure the resident's window shades were down, and physical therapy to screen. The update, dated 05/29/21, directed staff to place the resident's recliner next to her bed for closer transfers. The update, dated 07/23/21, documented the resident used a chair and bed alarm, and directed staff to ensure the device was in place as needed.

The "Fall Risk Assessment," dated 03/02/21, documented the resident a high risk for falls.

The "Fall Risk Assessment," dated 05/29/21, documented the resident a high risk for falls.

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The "Fall Risk Assessment," dated 07/09/21, documented the resident a high risk for falls.

The "Fall Investigation," dated 03/09/21, documented the resident fell at 11:05 PM as she came back from the bathroom. The investigation documented the resident did not have an alarm and questioned the need for an alarm. The investigation further documented staff transferred the resident to the hospital for right hip pain. (The record lacked documentation of interventions to prevent further falls)

The "Nurse's Note," dated 03/10/21 at 03:30 AM, documented the facility spoke with hospital staff who informed the facility the resident did not have any fractures, did have significant pain, and directed facility staff to monitor the resident closely for the next few days.

The "Fall Investigation," dated 03/11/21, documented the resident fell at 03:00 PM as she was coming back from the bathroom. The investigation documented staff found the resident on the floor with her oxygen tubing coiled around an unidentified part of the residents body. The resident stated she was coming back from the bathroom, felt dizzy and fell backwards. The investigation further documented the nurse reminded the resident to use her call light and would possibly get a bed alarm. (The record lacked documentation a bed alarm was put into place)

The "Fall Investigation," dated 03/28/21, documented the resident fell at 07:05 AM going to the bathroom. The investigation documented the resident obtained a skin tear to her right and left

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elbows, and staff educated the resident to the consequences of not allowing assistance with transfers and ambulation.

The "Fall Investigation," dated 05/28/21, documented the resident fell at 10:30 PM, and staff found the resident on the floor between her bed and her recliner. The document recorded the resident was going to bed when she fell and complained of right arm pain, and staff transferred the resident to the hospital for evaluation.

The "Nurse's Note," dated 05/29/21 at 02:47 AM, documented the resident stayed at the hospital overnight for observation for pain control and did not have any fractures at this time.

On 07/28/21 at 09:55 AM, observation revealed Licensed Nurse (LN) G placed a gait belt around the resident's waist, assisted the resident to stand, and transferred her from her wheelchair to another wheelchair to go to an appointment. Further observation revealed LN G tried to explain what the resident needed to do to transfer safely into the other wheelchair, but the resident did not seem to understand what LN G wanted her to do. LN G continued to cue and encourage the resident to turn her body to sit in the other wheelchair and eventually LN G had to physically assist the resident to turn.

On 07/27/21 at 02:30 PM, LN G stated the resident had bed and chair alarms but could not recall how long the resident had used them. LN G further stated the resident was cognitively impaired and often forgot to call for assistance.

On 07/28/21 at 09:11 AM, Administrative Nurse D

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stated the resident was a high risk for falls, did not know when staff placed alarms on the resident, and verified she had just updated the care plan with the alarms. Administrative Nurse D verified there were not timely interventions put into place for the resident after her falls.

On 07/28/21 at 09:35 AM, Certified Nurse Aide (CNA) M stated the resident had declined in cognition and did not like to get up out of bed very often. CNA M further stated the resident had a lot of falls because she often forgot to call, got up on her own, and did not want to exercise.

The facility's "Care Plan, Comprehensive Person Centered" policy, dated December 2016, documented the assessments of residents are ongoing and care plans are revised as information about the resident and the residents condition changes. The policy documented the interdisciplinary team must review and update the care plan when there had been a significant change in the resident's condition, when the desired outcome was not met, when the resident had been readmitted to the facility from a hospital stay, and at least quarterly in conjunction with the required MDS assessment.

The facility failed to revise R11's care plan to include interventions to prevent further falls, placing the resident at risk for injury.

- R15's "Quarterly MDS," dated 09/28/20, documented the resident had moderately impaired cognition, required extensive assistance of one staff for transfers, toileting, ambulation, had upper and lower functional impairment on both sides, unsteady balance, and one fall since

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prior assessment.

The "Annual MDS," dated 06/11/21, documented the same as the 09/28/21 MDS except the resident had intact cognition, required extensive assistance of two staff for toileting, and two or more falls since the prior assessment.

The "Activities of Daily Living CAA," dated 06/11/21, documented the resident had impaired balance and required staff assistance for toileting, dressing, hygiene, transfers, and bed mobility.

The "Falls CAA," dated 06/11/21, documented the resident had impaired balance and three falls during her lookback period.

The "Fall Care Plan," dated 07/09/21, originally dated 02/21/21, directed staff to keep a pathway clutter free, encourage the resident to use the call light, and wait for assistance with all transfers. The update, dated 04/02/21, directed staff to start a toileting diary and review for a toileting program. The update, dated 07/09/21, directed staff to provide activities that promoted exercise and strength building where possible and provide 1:1 activities if bedbound.

The "Toilet Diary," dated 04/08/21, directed staff to check, ask, and or toilet hourly for 72 hours but lacked documentation a toileting diary had been completed.

The "Fall Risk Assessment," dated 12/16/20, documented the resident a high risk for falls.

The "Fall Investigation," dated 12/16/20, documented the resident stated she lost her balance, fell, and had an abrasion to her head.

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(The record lacked documentation of interventions to prevent further falls)

The "Fall Investigation," dated 04/01/21, documented the resident on the ground lying over the top of two legs of her walker. The investigation documented the resident was confused at times and had been coming back from the bathroom. The investigation further documented staff would do a 72-hour toileting diary. (The record lacked documentation a toileting diary was completed)

The "Fall Risk Assessment, "dated 04/02/21, documented the resident a high risk for falls.

The "Fall Investigation," dated 04/15/21, documented the resident on the floor in front of her family member's recliner. The investigation documented the resident stated she was going to the bathroom to wash her face and lost her balance. Staff assessed the resident and found no bruising or bumps. (The record lacked documentation of interventions to prevent further falls)

The "Fall Risk Assessment, "dated 07/08/21, documented the resident a high risk for falls.

On 07/27/21 at 04:30 PM, observation revealed CNA N applied a gait belt around the resident and placed his right foot in front of the resident's feet so they would not slide forward. The resident placed her hands on her walker and stood up. CNA N held onto the resident's gait belt as she ambulated to the bathroom to wash her hands for supper. Further observation revealed the resident walked slowly to the sink, washed her hands, and asked for the wheelchair as she felt weak and

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was going to fall. Continued observation revealed a second CNA quickly got the resident's wheelchair and the resident sat down in her wheelchair.

On 07/27/21 at 02:30 PM, LN G stated the resident had dementia (progressive mental disorder characterized by failing memory, confusion), had a lot of falls, and her cognition had really declined. LN G stated the resident required one-person assistance with transfers and used a wheelchair to go long distances.

On 07/27/21 at 02:45 PM, R15 stated she needed assistance with transfers and ambulation. The resident stated she had become more unsteady, forgot to call for assistance at times, and had falls.

On 07/27/21 at 04:40 PM, CNA N stated the resident had declined in cognition and staff reminded her, but she forgot and had fallen.

On 07/28/21 at 09:11 AM, Administrative Nurse D verified she was unable to find documentation staff had completed a toileting diary and verified they had not put fall preventions into place for the resident after her falls.

The facility's "Care Plan, Comprehensive Person Centered" policy, dated December 2016, documented the assessments of residents are ongoing and care plans are revised as information about the resident and the residents condition changes. The policy documented the interdisciplinary team must review and update the care plan when there had been a significant change in the resident's condition, when the desired outcome was not met, when the resident

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F 657	Continued From page 13 had been readmitted to the facility from a hospital stay, and at least quarterly in conjunction with the required MDS assessment. The facility failed to revise R15's care plan to include interventions to prevent further falls, placing the resident at risk for injury.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 12 residents, with six reviewed for accidents. Based on observation, record review, and interview, the facility failed to prevent accidents for three of six sampled residents, Resident (R) 6, R11, and R15. Findings included: - R11's "Quarterly Minimum Data Set" (MDS), dated 03/05/21, documented the resident had moderately impaired cognition and required limited assistance of one staff for transfers, unsteady balance, upper and lower functional impairment on both sides, and no falls. The "Quarterly MDS," dated 05/28/21, documented the same as the 03/05/21 MDS	F 689		

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except the resident had severely impaired cognition and had two or more falls with injury.

The "Fall Care Area Assessment" (CAA), dated 12/11/20, documented the resident had slight limited sensory perception (the process of becoming aware of something through the senses), occasionally walked, limited mobility, and required limited staff assistance with transfers and ambulation per the resident's plan of care.

The revised "Fall Care Plan," dated 07/23/21, originally dated 02/13/21, documented the resident a high risk for falls, directed staff to ensure the resident wore appropriate footwear when ambulating, and anticipate and meet the resident's needs. The update, dated 03/14/21, directed staff to make sure the resident's shades were down and physical therapy to screen. The update, dated 05/29/21, directed staff to place the resident's recliner next to her bed for closer transfers. The update, dated 07/23/21, documented the resident used chair and bed alarms and directed staff to ensure the device was in place as needed.

The "Fall Risk Assessment," dated 03/02/21, documented the resident a high risk for falls.

The "Fall Risk Assessment," dated 05/29/21, documented the resident a high risk for falls.

The "Fall Risk Assessment," dated 07/09/21, documented the resident a high risk for falls.

The "Fall Investigation," dated 03/09/21, documented the resident fell at 11:05 PM as she came back from the bathroom. The investigation

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documented the resident did not have an alarm and questioned the need for an alarm. The investigation further documented staff transferred the resident to the hospital for right hip pain. (The record lacked documentation of interventions to prevent further falls)

The "Nurse's Note," dated 03/10/21 at 03:30 AM, documented the facility spoke with the hospital who informed the facility the resident did not have any fractures, did have significant pain, and directed facility staff to monitor the resident closely for the next few days.

The "Fall Investigation," dated 03/11/21, documented the resident fell at 03:00 PM as she came back from the bathroom. The investigation documented staff found the resident on the floor with her oxygen tubing coiled around an unidentified part of the residents body. The resident stated she was coming back from the bathroom, felt dizzy, and fell backwards. The investigation further documented the nurse reminded the resident to use her call light and would possibly get a bed alarm. (The record lacked documentation a bed alarm was put into place)

The "Fall Investigation," dated 03/28/21, documented the resident fell at 07:05 AM going to the bathroom. The investigation documented the resident sustained a skin tear to her right and left elbows. The investigated documented staff educated the resident to the consequences of not allowing assistance with transfers and ambulation.

The "Fall Investigation," dated 05/28/21, documented the resident fell at 10:30 PM, and

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was found on the floor between her bed and her recliner. The document recorded the resident was going to bed when she fell, complained of right arm pain, and staff transferred the resident to the hospital for evaluation.

The "Nurse's Note," dated 05/29/21 at 02:47 AM, documented the resident stayed at the hospital overnight for observation for pain control and did not have any fractures at this time.

On 07/28/21 at 09:55 AM, observation revealed Licensed Nurse (LN) G placed a gait belt around the resident's waist, assisted the resident to stand, and transferred from her wheelchair to another wheelchair to go to an appointment. Further observation revealed LN G tried to explain what the resident needed to do to transfer safely into the other wheelchair, but the resident did not seem to understand what LN G wanted her to do. LN G continued to cue and encourage the resident to turn her body to sit in the other wheelchair and eventually LN G had to physically assist the resident to turn.

On 07/27/21 at 02:30 PM, LN G stated the resident had bed and chair alarms but could not recall how long the resident had used them. LN G further stated the resident was cognitively impaired and often forgot to call for assistance.

On 07/28/21 at 09:11 AM, Administrative Nurse D stated the resident was a high risk for falls, did not know when staff placed alarms on the resident, and verified she had just updated the care plan with the alarms. Administrative Nurse D verified there were not timely interventions put into place for the resident after her falls.

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On 07/28/21 at 09:35 AM, Certified Nurse Aide (CNA) M stated the resident has declined in cognition and did not like to get up out of bed very often. CNA M further stated the resident had a lot of falls because she often forgot to call, and got up on her own, and did not want to exercise.

The facility's "Falls and Fall Risk Managing" policy, dated March 2018, documented the staff would identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling. The document stated if the resident had recurring falls despite the initial interventions, staff would implement additional or different interventions, or indicate why the current approach remained relevant. The staff would monitor and document each resident's response to interventions intended to reduce falls or the risk of falling.

The facility failed to implement timely interventions to prevent falls for cognitively impaired R11, placing the resident at risk for further falls and injury.

- R15's "Quarterly MDS," dated 09/28/20, documented the resident had moderately impaired cognition, required extensive assistance of one staff for transfers, toileting, ambulation, upper and lower functional impairment on both sides, unsteady balance, and one fall since prior assessment.

The "Annual MDS," dated 06/11/21, documented the same as the 09/28/21 MDS except the resident had intact cognition and required extensive assistance of two staff for toileting, upper and lower functional impairment on both

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sides, and had two or more falls since the prior assessment.

The "Activities of Daily Living Care Area Assessment" (CAA), dated 06/11/21, documented the resident had impaired balance and required staff assistance for toileting, dressing, hygiene, transfers, and bed mobility.

The "Falls CAA," dated 06/11/21, documented the resident had impaired balance and three falls during her lookback period.

The "Fall Care Plan," dated 07/09/21, originally dated 02/21/21, directed staff to keep a pathway clutter free, encourage the resident to use the call light, and wait for assistance with all transfers. The update, dated 04/02/21, directed staff to start a toileting diary and review for a toileting program. The update, dated 07/09/21, directed staff to provide activities that promote exercise and strength building where possible and provide 1:1 activity if bedbound.

The "Toilet Diary", dated 04/08/21, directed staff to check, ask, and or toilet hourly for 72 hours but lacked documentation a toileting diary had been completed.

The "Fall Risk Assessment," dated 12/16/20, documented the resident a high risk for falls.

The "Fall Investigation," dated 12/16/20, documented the resident stated she lost her balance, fell, and had an abrasion to her head. (The record lacked documentation of interventions to prevent further falls)

The "Fall Investigation," dated 04/01/21,

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documented the resident on the ground lying over the top of two legs of her walker. The investigation documented the resident was confused at times and had been coming back from the bathroom. The investigation further documented staff would do a 72-hour toileting diary. (The record lacked documentation a toileting diary was completed)

The "Fall Risk Assessment, "dated 04/02/21, documented the resident a high risk for falls.

The "Fall Investigation," dated 04/15/21, documented the resident was on the floor in front of her husband's recliner. The investigation documented the resident stated she was going to the bathroom to wash her face and lost her balance. Staff assessed the resident and found no bruising or bumps. (The record lacked documentation of interventions to prevent further falls)

The "Fall Risk Assessment, "dated 07/08/21, documented the resident a high risk for falls.

On 07/27/21 at 04:30 PM, observation revealed CNA N applied a gait belt around the resident and placed his right foot in front of the resident's feet, so they would not slide forward. The resident placed her hands on her walker and stood up. CNA N held onto the resident's gait belt as she ambulated to the bathroom to wash her hands for supper. Further observation revealed the resident walked slowly to the sink, washed her hands and asked for the wheelchair as she felt weak and was going to fall. Continued observation revealed a second CNA quickly got the resident's wheelchair and the resident sat down in her wheelchair.

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On 07/27/21 at 02:30 PM, LN G stated the resident had dementia, fell a lot, and her cognition had declined. LN G stated the resident required one-person assistance with transfers and used a wheelchair to go long distances.

On 07/27/21 at 02:45 PM, R15 stated she needed assistance with transfers and ambulation. The resident stated she has become more unsteady and forgot to call for assistance at times and had falls.

On 07/27/21 at 04:40 PM, CNA N stated the resident had been declining in cognition and staff reminded her, but she forgot and had fallen.

On 07/28/21 at 09:11 AM, Administrative Nurse D verified she was unable to find documentation staff had completed a toileting diary and verified they had not put fall preventions into place for the resident after her falls.

The facility's "Falls and Fall Risk Managing" policy, dated March 2018, documented the staff would identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling. The document stated if the resident had recurring falls despite the initial interventions, staff would implement additional or different interventions, or indicate why the current approach remained relevant. The staff would monitor and document each resident's response to interventions intended to reduce falls or the risk of falling.

The facility failed to implement interventions to prevent falls for R15, placing the resident at risk for further falls and injury.

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- R6's "Annual Minimum Date Set" (MDS)," dated 09/11/20, recorded the resident had long and short-term memory loss with moderately impaired decision-making skills. The MDS recorded the resident required extensive assistance of one staff for bed mobility, dressing, eating, toileting, and personal hygiene. The MDS recorded the resident had upper functional limitation in range of motion on one side, lower functional limitation on both sides, and no falls.

The "Quarterly MDS," dated 05/21/21, recorded the same as the 09/11/20 MDS except the resident had severely impaired decision-making skills and one fall with injury.

The "Activities of Daily Living Care Plan," dated 04/19/21, directed staff to assist the resident with transfers using a sit to stand lift (mechanical lift to transfer people from a sitting to a standing position), due to dementia (progressive mental disorder characterized by failing memory, confusion) and the resident refused to participate in cares.

The revised "Fall Care Plan," dated 04/01/21, originally dated 09/28/20, directed staff to check on the resident's needs every 30-60 minutes and as needed, and remind the resident to use her call light for transfers. The care plan directed staff to assist the resident with transfers due to her history of falling trying to self-transfer, poor comprehension, and poor balance. The care plan directed staff to ensure the resident wore appropriate footwear and keep the footrest on the resident's recliner down so the resident did not try to crawl out of the recliner with the footrest up.

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The "Nurses Note," dated 09/27/20 at 07:00 PM, documented staff found the resident lying on the floor on her right side, knees bent with lacerations above her right eye, under her eye, and on her right arm by her elbow. The note documented staff observed a small amount of bleeding, documented the resident was on Coumadin (a blood thinner medication), and applied steri-strips (wound closure tape) to the areas.

The "Incident Report," dated 09/27/20, documented staff found the resident on the floor lying on her right side, knees bent with blood on the floor under her head. Two staff assisted the resident to roll over onto her back and noticed a laceration above her right eye, applied a cold wet cloth and pressure to the laceration. The note documented a superficial laceration under the resident's right eye with no bleeding and left open to air. Staff applied steri-strips, skin prep and steri-strips to the resident's "right arm" (no documented location), and initiated neurological checks (assess mental status, nerves motor and sensory function, pupil response, reflexes and vital signs).

The "Incident Report," dated 04/19/21, documented staff found the resident on the floor lying prone (chest down and back up) in the hallway leading to the dining room. The resident had a 0.5 centimeter (cm) by 0.2 cm cut above left upper lip with a small amount of bleeding. Two staff transferred the resident using a gait belt into her wheelchair. Staff propelled the resident to her room and initiated neurological checks.

The "Morse Fall Risk Assessment," dated 09/08/20 recorded a score of 75, indicating a high

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fall risk.

The "Fall Risk Assessment," dated 03/02/21, recorded a score of 15 (a score of 7 or higher indicates a high fall risk).

On 07/22/21 at 01:30 PM, observation revealed the resident sat in a wheelchair in the commons area in front of the nurse's station with eyes closed.

On 07/28/21 at 09:00 AM, Certified Nurse Aide (CNA) M stated, the resident was impulsive, and tried to do things on her own even though she was unable to safely. C.NA M stated staff reminded the resident to use her call light, but she did not remember, so staff checked on her frequently.

On 07/28/21 at 09:45 AM, Administrative Nurse D stated the medical records lacked an investigation implementation of new interventions with each fall.

The facility's "Fall Prevention and Management" policy, dated March 2018, recorded a fall refers to any unintentional coming to rest on the ground, floor or other lower level, but not the result of an overwhelming external force. The policy documented the staff, with the input of the attending physician, will implement resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. The policy recorded if falling reoccurs despite initial interventions, staff will implement additional of different interventions, or indicate why the current approach remains relevant. The policy recorded if the resident continues to fall, staff will re-evaluate the situation

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F 689	Continued From page 24 and whether it is appropriate to continue or change current interventions. As, needed, the attending physician would help staff reconsider possible causes that may not previously have been identified. The staff would monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. The facility failed to provide adequate supervision and interventions to prevent falls for cognitively impaired R6, who had multiple falls with injury, placing the resident at risk for further falls.	F 689		
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	F 758		

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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 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 28 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, record review, and interview, the facility failed to ensure an appropriate diagnosis for one of the five sampled residents, Resident (R) 24's antipsychotic (medication used to treat any major mental disorder characterized by a gross impairment in reality testing) medication Zyprexa.

Findings included:

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- R24's "Physician Order Sheet" (POS), dated 07/14/21 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance and anxiety (intense, excessive, and persistent worry and fear about everyday situations) disorder.

R24's "Quarterly Minimum Data Set" (MDS) , dated 07/02/21, recorded the resident had severely impaired cognition and no behaviors. The MDS recorded the resident required extensive assistance of one to two staff for transfers. The MDS documented the resident received an antipsychotic medication seven days during the lookback period.

R24's "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 11/16/20, recorded the resident had a diagnosis of dementia with severe cognitive impairment, and inattention and disorganized thinking.

R24's "Care Plan," dated 07/12/21, directed staff to monitor the resident for possible signs and symptoms of agitation, unsteadiness, poor appetite, depression, and confusion regarding the use of Zyprexa, and report to the physician.

R24's "Abnormal Involuntary Movement Scale (AIMS) Assessment," (assessment for detection of involuntary movements related to use of antipsychotic medications) dated 05/16/21, recorded a score of 0 (a score of two or higher indicates the resident has involuntary movements).

The "Physician Order," dated 01/15/20, directed staff to administer the resident Zyprexa for a

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	175347	A. BUILDING _____ B. WING _____	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 758	Continued From page 27	F 758		

diagnosis of dementia without behavioral disturbance.

The "Pharmacy Consult" review, dated 06/30/21, documented the diagnosis of dementia as an inappropriate diagnosis for the use of Zyprexa.

On 07/21/21 at 03:30 PM, observation revealed the resident sat up in her recliner and read the newspaper with no behaviors noted.

On 07/28/21 at 10:05 AM, Administrative Nurse D verified dementia was not an appropriate diagnosis for a resident who received Zyprexa.

The facility's "Antipsychotic Medication Use" policy, dated December 2016, documented antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional, psychiatrics, social and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period and are subject to gradual dose reduction. Antipsychotic medication shall generally be used for the following conditions/diagnosis as documented in the record, consistent with the definitions(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent additions): Schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) , Schizo-affective disorder, delusional disorder, mood disorders, psychosis (any major mental disorder characterized by a gross impairment in reality testing) in the absence of dementia, medical illness with psychotic

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F 758	Continued From page 28 symptoms and/or treatment related psychosis or mania, Tourette's disorder (nervous system disorder involving repetitive movements or unwanted sounds), Huntington's (hereditary, neurodegenerative illness with physical, cognitive and emotional symptoms), hiccups, nausea and vomiting associated with cancer or chemotherapy The facility failed to ensure an appropriate diagnosis for the use of R24's Zyprexa, placing the resident at risk for adverse side effects.	F 758		
F 812 SS=E	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 standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. Based on observation and interview, the facility failed to store food in a safe and sanitary manner for the	F 812		

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28 residents that resided in the facility and received meals from the kitchen.

Findings Included:

- On 07/21/21 at 08:40 AM, observation during initial kitchen tour revealed the commercial double door refrigerator contained the following items:
five hamburger patties in a plastic bag with no date opened
one plastic bag with two hard boiled eggs with no date when the eggs were boiled
one half full opened package of approximately 100 pieces Hormel fully cooked bacon with no date opened.

On 07/21/21 at 09:00 AM, observation of the upright freezer revealed the following opened, frost covered, and undated items:
four bags of French toast with 30 pieces in each bag
eight waffles
20 hushpuppies
four bags of cinnamon raisin biscuits with approximately 30 biscuits in each bag
20 sausage patties
four slices of rye bread
four bags containing one chicken strip with 12 French fries in a bag
four triangular hash brown patties in one bag.
Continued observation revealed the freezer shelves covered with approximately one-inch thick frost ice buildup.

On 07/21/21 at 10:30 PM, observation during initial kitchen tour revealed one - 4 foot (ft) by 2 ft overhead florescent light fixture, located directly above the food preparation area, with black and

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brown gray lint on the top and sides of the light cover. Continued observation revealed eight overhead florescent lights 4 ft by 2 ft, located in the food preparation area with gray lint covering the top perimeter of the lights. Continued observation of the stove hood had gray lint covering the top of the hood.

On 07/28/21 at 09:30 AM, Dietary Staff (DS) BB verified the refrigerator contained food that was not dated when opened, the freezer had ice on the shelves with food not dated, and frost covered the food in the freezer that need to be discarded.

On 07/28/21 at 10:40 AM, DS BB verified the kitchen staff did not clean the light fixtures and assumed the maintenance staff cleaned the overhead florescent light fixtures. DS BB verified the dirty stove hood and stated dietary staff would clean the top of the stove hood.

The facility's "Food Receiving and Storage" policy, dated October 2017, documented the foods shall be received and stored in a manner that complies with safe food handling practices. All food stored in the refrigerator or freezer will be covered, labeled, and dated with "use by" date. The policy documented the freezer must keep frozen foods frozen solid with the wrappers of frozen foods intact until thawing.

Upon request, the facility did not provide a policy for cleaning or preventative maintenance.

The facility failed store food in a safe and sanitary manner for the 28 residents that resided in the facility and received meals from the facility kitchen, placing the residents at risk for foodborne illness.

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