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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 10/27/22.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		

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

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(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27. The sample included 12 residents. Based on record review and interview the facility failed to notify Resident (R) 28's physician of an unintended indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) removal and a decline of condition within 24 hours of death. The placed the R28 at risk for unmet care and services.

Findings included:

-The "Medical Diagnosis" section within R28's Electronic Medical Record (EMR) included diagnoses of fracture of the right femur (thigh bone), dysphagia (swallowing difficulty), retention of urine, pain, and hypertension (elevated blood pressure).

The "Admission Minimum Data Set" (MDS),

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dated 08/21/22, documented R28 had intact cognition, no delirium (sudden severe confusion, disorientation and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality testing), or exhibited behaviors. The MDS further documented R28 required extensive assistance of two persons for activities of daily living, and had an indwelling urinary catheter. R28 had no pain treatment and had surgery requiring active skilled nursing facility care.

The "Urinary Incontinence/Indwelling Catheter Care Area Assessment," dated 09/07/22, documented R28 had moderately impaired cognition, was at risk for falls, had decreased safety awareness, and had an indwelling urinary catheter which placed R28 at risk for trauma and infection due to catheter use.

The "Care Plan" dated 09/07/22, documented R28 had an indwelling catheter due to urinary retention. The care plan further documented to monitor/record/report to medical doctor of urinary track infections, pain, burning, blood tinged urine, urine cloudiness, no output, deepening urine color, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, changes in behaviors and eating patterns.

The "Physician Order Sheet," dated 08/25/22, documented use of a urinary catheter. The order directed staff to bladder train as needed per protocol, then discontinue the catheter.

The "Physician Order," dated 09/16/22, documented R28 was overall approaching a palliative care (care designed to relieve or reduce intensity of uncomfortable symptoms with end of

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life conditions) approach and staff would do what R28 wanted in terms of eating, sleeping, and work around R28's schedule. The order further instructed staff to discontinue tamsulosin (medication used to treat enlarged prostate) but may restart if R28 had any bladder problems.

The 09/16/22 at 05:42 PM "Progress Note" recorded R28 attempted to transfer himself, was yelling, and pulled out his catheter. The note further documented the catheter was not reinserted and staff would continue to monitor and see about reinserting the next shift. The record review lacked documentation the physician was notified of the catheter removal.

The 09/21/22 at 01:45 PM "Progress Note" documented R28 complained of not feeling well. Staff changed R28's brief and noted 100 cubic centimeter (cc) or less urine output. R28 had not drank. He was assisted to bed and had a Covid-19 (an acute respiratory illness caused by a coronavirus) test with a negative result. The medical record lacked evidence the staff notified the physician of R28's condition.

The 09/26/22 "Progress Notes" documented the follow:
Aat 06:37 AM, staff assessed R28's vital signs. He had not opened his eyes; he moaned and spoke incoherently at times. His respirations were 29 breaths per minute; he took both deep and shallow breaths within the minute, and was mouth breathing.

At 10:05 AM R28 was talkative and wanting to get up for breakfast; staff tried to get him up, but R28 lost his balance and laid back into bed. The note further documented staff went to get a meal tray

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and when they returned to the room R28 was snoring.

At 01:26 PM, the note documented water was given to R28 with the head of bed elevated and he choked.

At 04:06 PM, staff updated the resident's representative on R28's condition. The representative requested morphine (a narcotic pain reliever) and atropine drops (medication used to decrease respiratory secretions), and requested staff update the representative of any changes. The note documented a fax was sent to the physician.

R28's medical record lacked evidence the choking incident was reported to the physician and the medications requested by the resident representative's requests were followed up on.

The 09/27/22 at 05:10 AM, "Progress Note" recorded R28's vital signs had ceased.

On 10/13/22 at 10:12 AM, Administrative Nurse D verified the indwelling urinary catheter was not included in R28's baseline care plan, and R28's medical record lacked physician notification of the resident pulling it out on 09/16/22, the choking episode, and the condition change within the 24 hours of death.

The facility's "Guidelines For Notifying Physician of Clinical Problems", dated 09/2017, documented guidelines are intended to ensure that medical care problems are communicated to the medical staff in a timely, efficient and effective manner, and all significant changes in the resident status are assessed and documented in

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F 580	Continued From page 5 the medical record. The charge nurse or supervisor would contact the attending physician if a clinical situation appears to require immediate discussion and management. The facility failed to notify R28's physician of an accidental removal of the indwelling catheter and the change of condition experienced 24 hours prior to the resident death, which placed R28 at risk for unmet care needs.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		

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Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

The facility had a census of 27 residents. The sample included 12 residents with two residents reviewed for abuse and four residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to report resident to resident abuse to the appropriate State Agency (SA). This placed the facility's residents at risk of ongoing abuse.

Findings included:

- The "Medical Diagnosis" section withing R15's Electronic Medical Record (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), mood disturbance, depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), need for assistance with personal cares, chronic pain and urinary incontinence.

The "Quarterly Minimum Data Set", date 08/10/22, documented R15 had severe cognitive impairment, no signs or symptoms of delirium (sudden severe confusion, disorientation and restlessness), no psychosis (any major mental disorder characterized by a gross impairment in reality testing). R15 had physical behavioral

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symptoms directed at others and rejected evaluations or cares which occurred one to three days during the look back period. The MDS further documented R15 required extensive assistance of two persons for activities of daily living. R15 was frequently incontinent of urine and bowel, and received scheduled pain and anxiety medication.

The "Annual Care Area Assessment" (CAA), dated 05/25/22, documented R15 had unspecified dementia, anxiety disorder, chronic pain, aphasia (condition with disordered or absent language function), and severe cognitive impairment. The CAA further documented R15 was at risk for communication deficits and activities of daily living function decline due to her cognitive impairment.

The "Care Plan" dated 08/25/22 documented R15 had impaired cognitive or impaired thought process related to dementia without behaviors. The care plan instructed staff to monitor/document/report any changes in decision, making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status.

The 12/22/21 at 03:00 PM "Progress Note" documented R15 struck another resident with the back of her hand because the other resident had repeatedly yelled for help. The note further documented R15 was removed from the situation and calmed down and staff kept both residents apart.

On 10/12/22 at 02:43 PM, observation revealed R15 sat in a wheelchair in the hallway.

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F 609	Continued From page 8 Housekeeper U stated R15 followed her because R15 thought they were going downtown. On 10/12/22 at 04:02 PM, Administrative Nurse D stated a report to the SA was not completed for R15's resident to resident incident because the facility's consultant stated the act needed to be malicious in nature to be reportable and R15's actions were determined nonmalicious because of R15's dementia. The facility's "Abuse and Neglect Clinical Protocol", dates 03/2018, documented the physician and staff will help to identify factors for abuse within the facility such as residents with unmanaged problematic behavior. The facility management and staff will institute measures to address the needs of resident and minimize the possibility of abuse and neglect. The management and staff, with the physician's support will address situations of suspect or identified abuse and report them in a timely manner to appropriate agencies consistent with applicable laws and regulations. The facility failed to report R15's resident to resident abuse to the SA which placed the residents at risk for ongoing abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		

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§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents. The sample included 12 residents with two residents reviewed for abuse and four residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to investigate an unwitnessed fall for cognitively impaired Resident (R) 17. This placed the resident at risk for unidentified and/or ongoing abuse or neglect.

Findings Included:

- The Electronic Medical Record (EMR) documented R17 had diagnoses of dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion caused by decreased blood flow to the brain), hypertension (high blood pressure), diabetes mellitus type 2 (when the body's ability to produce or respond to the hormone insulin is impaired), and overactive bladder (a problem with bladder function that causes the sudden need to urinate).

R17's "Quarterly Minimum Data Set" (MDS),

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dated 08/26/22, documented R17 had severely impaired cognition and required limited assistance of one staff for bed mobility, transfers, and toileting. The MDS further documented R17 had unsteady balance, no functional impairment, and had two falls since prior assessment.

The "Fall Risk Assessments" dated 8/23/22, 6/2/22, 5/21/22, and 02/21/22 documented R17 was a high risk for falls.

The "Fall Care Plan," dated 09/19/22, directed staff to encourage the resident to use her call light for assistance. The care plan recorded R17 could ambulate independently with her walker and required cues and direction. The care plan lacked further interventions to prevent falls.

The "Incident Report," dated 05/03/22, documented R17 was found on her knees next to her bed and the resident could not say what happened. The document further stated she was assisted up and put back to bed by two staff; she did not complain of pain. The document lacked an investigation or root cause analysis regarding the fall.

Review of the EMR lacked documentation regarding the fall.

On 10/11/22 at 10:00 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around R17's waist and assisted the resident to stand up. R17's gait was slow, unsteady, and she walked hunched over with her walker to the bathroom.

On 10/13/22 10:44 AM, Administrative Nurse D verified an investigation into the fall was not

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F 610	Continued From page 11 completed because an agency nurse was on duty at the time of the fall. Administrated Nurse D further stated an investigation and root cause analysis should have been completed after the fall. The facility "Fall and Fall Risk, Managing" policy, dated 03/18/22, documented staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The policy further documented staff would monitor and document each resident's response to interventions intended to reduce falling or the risks of falls. If interventions were successful in preventing falling, staff would continue the interventions or reconsider whether those measures were still needed if the problem that the intervention has resolved. The facility failed to investigate an unwitnessed fall for cognitively impaired R17, placing the resident at risk for further injury and unidentified abuse or mistreatment.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		

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(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 section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for one sample resident, Resident (R) 3, who had a diagnosis of severe thrombocytopenia (deficiency of platelets in the blood causing bleeding into the tissues, bruising, and slow blood

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clotting after injury). This placed the resident at risk of complications related to bleeding or bruising.

Findings included:

- The Electronic Medical Record (EMR) recorded R3 had diagnoses of dementia without behavioral disturbances (a progressive mental disorder characterized by failing memory and confusion caused by decreased blood flow to the brain), weakness (lacking strength), thrombocytopenia, and hypertension (high blood pressure).

R3's "Significant Change Minimum Data Set" (MDS) dated 09/27/22, documented R3 had severely impaired cognition and required supervision of one staff for bed mobility. transfers, ambulation, dressing and toileting. The assessment further documented R3 had unsteady balance had two or more falls and did not take an anticoagulant (having the effect of retarding or inhibiting the coagulation of the blood) medication.

R3's EMR lacked documentation of a thrombocytopenia care plan, with interventions to prevent bleeding and bruising.

The "Nurse's Note," dated 09/13/22, documented R3 had multiple bruises to his arms, face, inside his mouth, and tongue and requested to discontinue his blood thinner and order blood work.

The "Physician Progress Note," dated 09/14/22, documented R3 was bruising easier and had bruises all over his arms, face, back of his neck, in his mouth and on the right cheek. The note

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further documented R3's blood work showed a platelet count of 4000 and R3 was on Eliquis (an anticoagulant medication), had no fever, no evidence of infection, and no blood in his stool, urine, or vomiting. The documentation noted a diagnosis of acute isolated severe thrombocytopenia with bruising and bleeding and recorded the physician would discuss with R3's family to recommend inpatient transfer for acute treatment and workup of acute thrombocytopenia.

The "Physician Order," dated 09/14/22, directed staff to administer dexamethasone (an anti-inflammatory medication), 40 milligrams (mg), daily for four days.

The "Physician Progress Note," dated 09/21/22, documented R3 had diffuse bruising over his arms with some improvement. The note further documented the physician was working with the pharmacy to get immunoglobulin infusion (IVIG-a therapy treatment for patients with antibody deficiencies) ordered for R3 at 85 grams (gm) daily for two doses and then recheck his platelets in several days after.

The "Physician Progress Note, dated 10/05/22, documented R3's platelet count had improved to 30,000 with oral steroids and two doses of IVIG. The note further documented R3 had a repeat platelet count scheduled two weeks from the last check and the physiciane would see R3 on the next routine visit and as needed to follow if to see if R3 needed more platelets.

On 10/10/22 at 02:30 PM, observation revealed R3 had diffuse bruising to both arms and face.

On 10/12/22 at 09:47 AM, Certified Nurse Aide M

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F 656	Continued From page 15 stated she would tell her charge nurse if the resident had more bruising. On 10/12/22 at 02:17 PM, Licensed Nurse (LN) G stated R3's anticoagulant was discontinued when R3 started to have diffuse bruising; R3 received an infusion to help with the clotting. On 10/13/22 at 10:45 AM, Administrative Nurse D stated a care plan should have been implemented with direction to staff on what to watch for with the resident's bruising. The facility's "Care Plans, Comprehensive Person-Centered" policy, dated March 2022, documented a comprehensive person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident, The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The facility failed to develop a comprehensive care plan for R3 after he was diagnosed with thrombocytopenia. This placed the resident at risk for complications related to bleeding and bruising.	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--	F 657		

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F 657	Continued From page 16 (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 27 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to update care plan with interventions for Resident (R)15, R7and R23. This deficient practice placed the residents at risk for unmet care needs. Findings included: -The "Medical Diagnosis" section within R15's Electronic Medical Record (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), mood disturbance, depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness,	F 657		

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worthlessness, emptiness and hopelessness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), need for assistance with personal cares, chronic pain and urinary incontinence.

The "Quarterly Minimum Data Set", date 08/10/22, documented R15 have severe cognitive impairment, no signs or symptoms of delirium (sudden severe confusion, disorientation and restlessness), no psychosis (any major mental disorder characterized by a gross impairment in reality testing), had physical behavioral symptoms directed at others and rejected evaluations or cares which occurred one to three days during a look back period. The MDS further documented R15 required extensive assistance of two persons for activities of daily living, was frequently incontinent of urine and bowel, and received scheduled pain and anxiety medication.

The "Annual Care Area Assessment" (CAA), dated 05/25/22, documented R15 had unspecified dementia, anxiety disorder, chronic pain, aphasia (condition with disordered or absent language function), severe cognitive impairment. The CAA further documented R15 was at risk for communication deficits and activities daily living function decline due to her cognitive impairment.

The "Care Plan", dated 08/25/22, documented R15 had impaired cognitive or impaired thought process related to dementia without behaviors. The care plan instructed staff to monitor/document/report any changes in decision, making ability, memory, recall and

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general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status.

The 12/10/21 at 01:24 PM "Progress Note" documented R15 had rammed her wheelchair into residents, staff, and furniture. The note documented one on one supervision to prevent injuries to others. The care plan lacked intervention update.

The 12/22/21 at 03:00 PM "Progress Note" documented R15 had struck another resident with the back of her hand because the other resident had been repeatedly yelling for help. The note further documented R15 was removed from the situation and calmed down and kept both residents apart. The care plan lacked intervention.

The 02/06/22 at 03:17 PM "Progress Note" documented R15 had angry behavior and tried to enter multiple resident rooms throughout the day. She continually stood up from wheelchair, yelled at staff and residents. The note further documented staff attempted to entertain R15 but she would run into them with the walker. The care plan lacked intervention to address this behavior.

The 04/15/22 at 12:15 PM "Progress Note" documented R15 behavior was angry and aggressive,and yelling. She went into other residents' rooms and took plate at noon and dumped it. The care plan lacked interventions to address this behavior.

The 04/22/22 at 09:06 AM "Progress Note" documented R15 threw a glass of water in the dining room and had been removed from the

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table. The care lacked intervention to address this behavior.

The 04/30/22 at 05:17 PM "Progress Note" documented R15 had angry behavior in the dining room and wheeled herself around the dining room. The note further documented dietary staff asked R15 if she wanted something to drink besides water and R15 stated she did not want water. R15 then picked up her water glass and threw water into the face of another resident sat next to her. R15 was removed from the dining room. The care plan lacked intervention to address this behavior.

On 10/12/22 at 02:43 PM, observation revealed R15 in a wheelchair in the hallway. Housekeeper U stated R15 had been following her because R15 thought they were going downtown. R15 was alert and independently mobile in her wheelchair.

On 10/13/22 at 03:01 PM, Certified Medication Aide (CMA) R stated if residents had behaviors, the staff tried to see what was wrong. Staff checked with the resident to see if the resident wase hungry, thirsty, needed to go to the bathroom or had pain. CMA R was not sure what was on the care plan specifically for R15.

On 10/13/22 at 10:21 AM, Administrative Nurse D verified the care plan lacked interventions to address R15's ongoing behaviors and lacked non-pharmacological interventions.

The facility's "Behavioral Assessment, Intervention and Monitoring" policy, dated 03/2019, documented the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and

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potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented if necessary, to protect the resident and others from harm. The care plans the rationale for the intervention and approaches.

The facility failed to revise R15s care plan to address verbal and physical behaviors which placed the resident at risk of continued behaviors.

The "Medical Diagnosis" section within Resident (R)7s Electronic Medical Record (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, hallucinations (sensing things while awake that appear to be real, but the mind created), history of falls, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), pain, insomnia (inability to sleep), retention of urine and restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

The "Admission Minimum Data Set", dated 07/25/22, documented R7 had severe cognitive impairment, had no delirium (sudden severe confusion, disorientation and restlessness), hallucinations, or psychosis (any major mental disorder characterized by a gross impairment in reality testing). R7 had verbal behavioral symptoms directed toward others and significantly disrupted care and or living environment one to three days during the look back period. The MDS further documented R7 required limited to extensive assistance of one

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staff for activities of daily living (ADL's), was not steady and only able to stabilize with staff assistance, had falls after admission with one injury, received scheduled pain, antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications.

The "Dementia/Cognitive Loss Care Area Assessment" (CAA), dated 07/27/22, documented R7 had dementia, hallucinations, depression, history of falls, anxiety, severe cognitive impairment, and had behaviors of yelling/screaming two days of the look back period. The CAA further documented R7 was at risk for behaviors, falls and ADL decline.

The "Care Plan", initiated 07/18/22, documented R7 was at high risk for falls related to dementia. Interventions directed staff to place the call light within reach and encourage use for assistance as needed. R7 needed prompt response to all request for help. The care plan documented R7 had an actual fall with no injury, the interventions directed staff to provide activities that promote strength building where possible, provide one to one activity, and consult physical therapy for strength and mobility.

The "Fall/Incident Progress Notes" documented: On 07/22/22 at 07:29 PM, R7 stated he fell in his bathroom earlier yesterday. The records lacked intervention update to care plan and investigation. On 08/02/22 at 02:50 PM, the care plan review made changes R7 was now independent with front wheeled walker throughout the facility. The care plan lacked this intervention.

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On 09/23/22 at 02:06 PM, staff heard yelling, and found R7 lying on the bathroom floor. R7 reported he got dizzy while looking down. The care plan review document no changes.
On 09/23/22 at 07:45 PM, R7 was found on the floor of his bathroom, no apparent injuries, Ativan reschedule for a different time. The care plan lacked this intervention.
On 09/24/22 at 09:45 AM, staff heard R7 yelling from his room. R7 found sitting on the floor in front of his recliner. R7 reported trying to reach for something on his side table, stood up and lost his balance, went to sit down and slid off the chair to the floor. Intervention to move the side table closer to recliner for ease of retrieving items. The care plan lacked this intervention.
On 09/25/22 at 02:20 AM, R7 found on the floor of his bedroom. R7 stated he was coming back from the bathroom and got dizzy. R7 was re-educated on importance of calling for help before he ambulated. The care plan lacked interventions to prevent further falls.
On 09/25/22 at 01:15 PM, R7 found in bathroom, had incontinent bowel movement on toilet and floor. R7 attempted to clean self and had baby powder on his buttocks, jeans and floor. Staff aided clean up. R7 became belligerent, conducted 30 minutes checks and changed timing of antianxiety medication. Baby powder was removed as it is a serious fall hazard. These interventions where not reflected in the care plan.
On 09/30/22 at 09:10AM, R7 found on the floor neat the closet in his room. R7 reported going to breakfast, but he had already had breakfast. R7 had also been incontinent and staff aided with product change and clothing change. The care plan lacked intervention to prevent further falls.
On 10/2/22 at 07:45 AM, documented staff was assisted to the dining room for breakfast, R7

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attempted to get out of chair unassisted and fell backwards, R7 had remained on 30-minute checks, and re-educated to wait for assistance. The care plan lacked intervention to prevent further falls.
On 10/08/22 at 08:55 AM, documented staff heard R7 yelling, was found on floor by recliner. R7 stated the "floor slipped", the assisted to the bathroom. The not further documented R7 had dementia and would try 30-minute checks throughout the day, and R7 had not tolerated alarms as the alarms upset him and increased his anxiety level. The care plan lacked these interventions.

On 10/11/22 at 12:18 PM observation revealed R7 returning from lunch, independently with a front wheeled walker, and goes into his bathroom. Staff reminded R7 that staff needed to keep eyes on him because of falls.

On 10/12/22 at 08:19 AM, Licensed Nurse (LN) G, stated when a resident has fallen the nurses assesses the resident for injury, a fall packet is initiated and documented in the progress notes. Staff are to have a huddle meeting afterwards to determine cause of falls. LN G stated the nurses and Director of Nursing were responsible to update the care plan with interventions to prevent further falls.

On 10/13/22 at 12:06 PM, Administrative Nurse D, stated after a fall the facility had a process that included a fall assessment, and a fall investigation should be completed, and a care plan updated with interventions to prevent further falls. Administrative Nurse D verified R7's care plan lacked interventions following falls.

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The facility's "Managing Falls and Fall Risk" policy, dated 03/2018, documented based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors or falls for each resident at risk or with a history of a fall. If falling recurs despite initial interventions staff will implement additional or different interventions or indicate why the current approach remains relevant. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current intervention.

The facility failed to update R7's care plan with fall interventions which placed the resident at risk for continued falls and behaviors.

- The Electronic Medical Record (EMR) documented R23 had diagnoses of constipation, atrial fibrillation (irregular heart rate), pain (a unpleasant sensory and emotional experience associated with actual or potential tissue damage), and weakness (lacking strength).

R23's "Quarterly Minimum Data Set" (MDS), dated 09/09/22, documented R23 had intact cognition and required extensive assistance of one staff for bed mobility, transfers, ambulation, and toileting. The MDS further documented R23 had unsteady balance, lower impairment on both sides and had no falls,

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The "Fall Risk Assessments," dated 09/07/22, 06/07/22, 05/19/22, and 03/08/22 documented R17 was a high risk for falls.

The "Fall Care Plan," dated 09/27/22, documented R23 a high risk for falls and directed staff to keep her call light within reach and provide a safe environment. The care plan lacked further interventions to prevent falls.

The "Fall Investigation," dated 05/19/22, documented R23 was on the floor by her bathroom door. The investigation documented a Certified Nurse Aide (CNA) had just taken her to the bathroom and had left the resident at her sink to wash her hands when the resident lost her balance and fell. The investigation documented staff should stay with the resident.

On 10/11/22 at 10:45 AM, observation revealed CNA O placed a gait belt around the resident's waist, had R23 scoot to the front of her recliner, and assisted the resident to stand up. R23's gait was slow as she has one leg shorter than the other, and CBA O held onto her gait belt all the way into the bathroom.

On 10/11/22 at 10:40 AM, CNA O stated R23 had a fall around her sink and stated the resident could not stand unassisted at the sink because she would fall. CNA O further stated she did not know what interventions were put into place after the fall.

On 10/12/22 at 02:30 PM, Licensed Nurse (LN) G stated staff are not to leave the resident unattended while she was at the sink because she was a high fall risk.

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F 657	Continued From page 26 On 10/13/22 at 10:45 AM, Administrative Nurse D stated the CNA was not supposed to leave the resident unattended and verified the care plan should be updated with the interventions. The facility's "Care Plan, Comprehensive, Person-Centered" policy, dated March 2022, documented the interdisciplinary team reviewed and updated 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 from a hospital stay, and at least quarterly in conjunction with the required quarterly MDS assessment. The facility failed to revise R23's care plan with person- centered interventions to prevent falls, placing the resident at risk for further falls and injury.	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	F 660		

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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 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

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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 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 had a census of 27 residents. The sample included 12 residents, with one reviewed for discharge. Based on interview and record review, the facility failed to develop a discharge plan for one sampled resident, Resident (R) 27, who admitted to the facility for skilled therapy. This placed the resident at risk for unidentified discharge goals and impaired discharge planning.

Findings included:

- The Electronic Medical Record (EMR) documented R27 had diagnoses of weakness (lacking strength) and sacrum fracture (a break in the large triangular bone that forms the last part of the vertebral column).

The "Admission Minimum Data Set" (MDS), dated 07/13/22, documented R27 had intact

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cognition and required extensive assistance of one staff for bed mobility, transfers, ambulation, and toileting. The MDS further documented R27 expected to be discharged to the community but no discharge planning had occurred.

The EMR lacked documentation a discharge plan had been developed upon admission to the facility.

The "Nurse's Note," dated 07/07/22 at 04:49 PM, documented R27 was admitted to the facility with a closed sacral fracture and was a high fall risk. The note further stated R27 planned to discharge to home after therapy.

On 10/12/22 at 2:30 PM, Licensed Nurse (LN) G stated she did the admission paperwork but was not involved in the discharge plan process.

On 10/13/22 at 10:44 AM, Administrative Nurse D verified there was not a discharge plan developed when the resident was admitted to the facility.

The facility's "Discharge Summary and Plan" policy dated December 2016, documented the post discharge plan would be developed by the care planning interdisciplinary team with the assistance of the resident and his or her family and would include where the individual planned to reside, arrangements that had been made for follow-up care and services, and a description of the resident's stated discharge goals.

The facility failed to develop a discharge plan for R27, who planned to go back to the community after therapy, placing the resident at risk for unidentified discharge goals and impaired discharge planning.

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F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced	F 676		

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by:
The facility had a census of 27 residents. The sample included 12 residents, with two reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide consistent bathing services for Resident (R) 3 who required staff assistance with bathing. This placed the residents at risk for complications related to poor hygiene.

Findings Included:

- The Electronic Medical Record (EMR) recorded R3 had diagnoses of dementia without behavioral disturbances (a progressive mental disorder characterized by failing memory and confusion caused by decreased blood flow to the brain), weakness (lacking strength), thryombocytopenia (deficiency of platelets in the blood causing bleeding into the tissues, bruising, and slow blood clotting after injury), and hypertension (high blood pressure).

R3's "Quarterly Minimum Data Set" (MDS), dated 07/01/22, documented R3 had moderately impaired cognition and was independent with all ADL's. The MDS further documented bathing did not occur during the look back period.

The "ADL Care Plan," dated 07/19/22, directed staff to check R3's nail length, trim and clean them on bath days and as necessary. The care plan documented R3 was able to perform tasks in the shower independently with supervision on Saturday evening and as needed.

The "September and October 2022 Bathing Record" documented R3 requested showers on Saturdays evenings and documented the resident

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had not received a shower during the following days:
09/11/22-09/26/22 (16 days)
09/28/22-10/07/22 (10 days)

The EMR documented R3 refused his shower on 09/17/22.

On 10/11/22 at 09:45 AM, observation revealed R3's hair was uncombed, and his fingernails were long and had brown substance underneath them.

On 10/12/22 at 02:17 PM, Licensed Nurse (LN) G stated R3 used to be independent in the shower but now required supervision. LN G further stated R3 often refused showers and staff tried to get the resident to take a shower on Saturday so he was clean for church on Sundays.

On 10/13/22 at 09:47 AM, Certified Nurse Aide (CNA) M stated R3 had a history of refusing his showers and when he refused, staff went during the day or the next day to get him to take a shower.

On 10/13/22 at 10:45 AM, Administrative Nurse D stated if a resident refused, staff should chart it in the EMR and continue to encourage the resident to take a shower.

The "Bath, Shower/Tub" policy, dated February 2018, documented the facility promoted cleanliness to provide comfort to the resident and to observe the condition of the resident's skin. The policy further documented, if the resident refused, staff notify the supervisor of the refusal and report of there information in accordance with facility policy and professional standards of care.

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F 676	Continued From page 33 The facility failed to provide consistent bathing opportunities for R3, placing the resident at risk for complications related to poor hygiene.	F 676		
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 had a census of 27 residents. The sample included 12 residents, with two reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide consistent bathing services for Resident (R)17. This placed the resident at risk for complications related to poor hygiene. Findings included: - The Electronic Medical Record (EMR) documented R17 had diagnoses of dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion caused by decreased blood flow to the brain), hypertension (high blood pressure), diabetes mellitus type 2 (when the body's ability to produce or respond to the hormone insulin is impaired), and overactive bladder (a problem with bladder function that causes the sudden need to urinate). R17's "Quarterly Minimum Data Set" (MDS), dated 08/26/22, documented R17 had severely impaired cognition and limited assistance of one	F 677		

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staff for bed mobility, transfers, toileting, and personal hygiene. The MDS further documented R17 was dependent upon one staff member for bathing.

The "ADL Care Plan," dated 09/19/22, documented R17 was dependent upon staff for bathing twice a week on Tuesday and Friday evening and as necessary. The care plan further documented R17 required extensive assistance of one staff for personal hygiene.

The "June, July, and August 2022 Bathing Record" documented R17 requested showers on Tuesday and Friday evenings and documented the resident had not received a shower during the following days:
06/13/22-07/21/22 (39 days)
07/23/22-08/01/22 (10 days)

The EMR documented R17 refused her shower on 06/24 and 07/19/22.

The "September and October 2022 Bathing Record" documented R17 requested showers on Tuesday and Friday evenings and documented the resident had not received a shower during the following days:
09/21/22-10/03/22 (13 days)

The EMR documented R17 refused her shower on 09/23/22 and 09/27/22.

On 10/11/22 at 10:00 AM, observation revealed R17's hair was uncombed, and her fingernails had a brown substance underneath them.

On 10/11/22 at 10:00 AM, Certified Nurse Aide (CNA) N stated R17 was able to brush her own

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F 677	Continued From page 35 hair with supervision but was unsure if the resident refused her baths. CNA N further stated if it was a resident's bath day, it was written on the CNA sheet and after the shower was given, staff charted the bath in the EMR. 10/12/22 at 02:30 PM, Licensed Nurse G stated R17 refused her baths often and if her fingernails were dirty, the bath aide was supposed to clean them during baths. On 10/13/22 10:44 AM, Administrative Nurse D stated R17 refused her baths often and staff should continue to offer her showers. The "Bath, Shower/Tub" policy, dated February 2018, documented the facility promoted cleanliness to provide comfort to the resident and to observe the condition of the resident's skin. The policy further documented, if the resident refused, staff notify the supervisor of the refusal and report of there information in accordance with facility policy and professional standards of care. The facility failed to provide consistent bathing for R17, placing the resident at risk for complications related to 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 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	F 684		

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care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents. The sample included 12 residents with one reviewed for constipation. Based on observation, record review, and interview, the facility failed to identify and provide interventions for lack of bowel movements for Resident (R) 23 who had a history of constipation (difficulty in emptying the bowels). This placed the resident at risk for impaction (a mass of dry, hard stool that cannot pass out of the colon or rectum).

Findings included:

- The Electronic Medical Record (EMR) documented R23 had diagnoses of constipation, atrial fibrillation (irregular heart rate), pain (a unpleasant sensory and emotional experience associated with actual or potential tissue damage), and weakness (lacking strength).

R23's "Quarterly Minimum Data Set" (MDS), dated 09/09/22, documented R23 had intact cognition and required extensive assistance of one staff for bed mobility, transfers, ambulation, and toileting. The MDS further documented R23 was frequently incontinent of bowel.

The "Care Plan," dated 09/27/22, documented R23 had bowel incontinence related to weakness and directed staff to provide pericare after each incontinent episode. The care plan lacked interventions to prevent constipation.

R23's "Admission Assessment," dated 03/08/22, documented the resident was alert with moderately impaired cognition. R23 had a history

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of constipation and had bowel incontinence.

The "Physician Order," dated 03/22/22, directed staff to administer Milk of Magnesia (a laxative used to treat constipation), 30 milliliters (ml), every 24 hours, as needed for constipation.

The "Physicians Order," dated 03/09/22, directed staff to administer Miralax (a laxative to treat constipation), 17 grams (gm), every 24 hours, as needed for constipation.

The "Bowel Monitoring Record," dated July 2022, documented R23 did not have a bowel movement for the following days:
07/05/22 - 07/8/22 (4 consecutive days)
07/16/22-07/20/22 (4 consecutive days)
07/22/22-07/25/22 (4 consecutive days)

The "Treatment Administration Record," dated July 2022, lacked documentation interventions were provided during the lack of bowel elimination on the above dates.

The "Bowel Monitoring Record," dated September 2022, documented R23 did not have a bowel movement for the following days:
09/20/22-09/24/22 (4 consecutive days)

The "Treatment Administration Record," dated September 2022, lacked documentation interventions were provided during the lack of bowel elimination on the above dates.

The "Bowel Movement Record," dated October 2022, documented R23 did not have a bowel movement for the following days:
10/08/22-10/11/22 (4 consecutive days)

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F 684	Continued From page 38 The "Treatment Administration Record," dated October 2022, lacked documentation interventions were provided during the lack of bowel elimination on the above dates. On 10/10/22 at 02:45 PM, observation revealed R23 sat in her recliner watching television. On 10/11/22 at 10:45 AM, Certified Nurse Aide (CNA) O stated R23 had problems with constipation and staff administered as needed medication for her constipation. CNA O further stated if a resident did not have a bowel movement for two days, their name was put on a list and the nurse administered the as needed medication. On 10/12/22 at 02:17 AM, Licensed Nurse (LN) G stated if a resident did not have a bowel movement for two days, their name was flagged, and the resident was administered a laxative. LN G said if the laxative was not effective, staff also offered prune juice or repeated the laxative. On 10/13/22 at 10:44 AM, Administrative Nurse D stated if the resident refused any of the as needed laxatives, staff should document the refusal and continue to offer. Upon request, a bowel movement protocol was not provided by the facility. The facility failed to identify the lack of bowel elimination and provide interventions for R26, who had a history of constipation, placing the resident at risk for impaction.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§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 27 residents. The sample included 12 residents, with four reviewed for falls. Based on observation, record review, and interview, the facility failed to implement meaningful, resident centered interventions to prevent falls for Resident (R) 17, and R23. This placed the residents at increased risk for falls and fall related injury.

Findings included:

- The Electronic Medical Record (EMR) documented R17 had diagnoses of dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion caused by decreased blood flow to the brain), hypertension (high blood pressure), diabetes mellitus type 2 (when the body's ability to produce or respond to the hormone insulin is impaired), and overactive bladder (a problem with bladder function that causes the sudden need to urinate).

R17's "Quarterly Minimum Data Set" (MDS), dated 08/26/22, documented R17 had severely impaired cognition and limited assistance of one staff for bed mobility, transfers, and toileting. The MDS further documented R17 had unsteady

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balance, no functional impairment, and had two falls since prior assessment.

The "Fall Risk Assessments," dated 8/23/22, 6/2/22, 5/21/22, and 02/21/22 documented R17 was a high risk for falls.

The "Fall Care Plan," dated 09/19/22, directed staff to encourage the resident to use her call light for assistance. It recorded R17 could ambulate independently with her walker and required cues and direction. The care plan lacked further interventions to prevent further falls.

The "Incident Report," dated 05/03/22, documented R17 was found on her knees next to her bed and the resident could not say what happened. The document further stated she was assisted up and put back to bed by two staff and did not complain of pain. The document lacked an investigation or root cause analysis regarding the fall.

Review of the EMR lacked documentation regarding the fall.

The "Fall Investigation," dated 06/01/22, documented R17 attempted to self transfer and lost her balance and fell to the floor. R17 was assisted up and placed into bed by two staff members. The investigation directed staff to check on the resident every 30 minutes and to leave her door open.
The EMR lacked evidence the intervention of 30 minute checks was implemented.

The "Fall Investigation," dated 07/31/22, documented R17 was found on the floor with one pant leg down around her ankle and the other

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pant leg was off. The resident was incontinent and had tried to change her pants. The investigation lacked interventions to prevent further falls.

On 10/11/22 at 10:00 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around R17's waist and assisted the resident to stand up. R17's gait was slow, unsteady, and she walked hunched over with her walker to the bathroom.

On 10/11/22 at 10:00 AM, CNA N stated R17 was able to walk independently with her walker; staff tried to walk with her but she would get out of bed on her own and walk down the hall. CNA N further stated she was unsure of any falls for R17 or any interventions to prevent falls.

On 10/12/22 at 02:30 PM, Licensed Nurse (LN) G stated R17 could walk independently. LN G acknowledged R17 had falls but was unaware of any new interventions related to R17's falls.

On 10/13/22 10:44 AM, Administrative Nurse D verified an investigation into the fall on 05/03/22 was not completed because an agency nurse was on duty at the time of the fall. Administrated Nurse D further stated an investigation and root cause analysis should have been completed after the falls and the care plan should be updated to show interventions were implemented to prevent falls.

The facility "Fall and Fall Risk, Managing" policy, dated 03/18/22, documented staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications

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from falling. The policy further documented staff would monitor and document each resident's response to interventions intended to reduce falling or the risks of falls. If interventions were successful in preventing falling, staff would continue the interventions or reconsider whether those measures were still needed if the problem that the intervention has resolved.

The facility failed to implement meaningful, person-centered falls for cognitively impaired R17, who had multiple falls, placing the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) documented R23 had diagnoses of constipation, atrial fibrillation (irregular heart rate), pain (a unpleasant sensory and emotional experience associated with actual or potential tissue damage), and weakness (lacking strength).

R23's "Quarterly Minimum Data Set" (MDS), dated 09/09/22, documented R23 had intact cognition and required extensive assistance of one staff for bed mobility, transfers, ambulation, and toileting. The MDS further documented R23 had unsteady balance, lower impairment on both sides and had no falls,

The "Fall Risk Assessments," dated 09/07/22, 06/07/22, 05/19/22, and 03/08/22 documented R23 was a high risk for falls.

The "Fall Care Plan," dated 09/27/22, documented R23 a high risk for falls and directed staff to keep her call light within reach, and provide a safe environment.

The "Fall Investigation," dated 05/19/22,

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documented R23 was on the floor by her bathroom door. The investigation documented a Certified Nurse Aide (CNA) had just taken her to the bathroom and had left the resident at her sink to wash her hands when the resident lost her balance and fell. The investigation documented staff should stay with the resident. The clinical record lacked evidence this intervention was added tot he plan of care.

On 10/11/22 at 10:45 AM, observation revealed CNA O placed a gaitbelt around the resident's waist, had R23 scoot to the front of her recliner , and assisted the resident to stand up. R23's gait was slow as she has one leg shorter than the other, and CBA O held onto her gait belt all the way into the bathroom.

On 10/11/22 at 10:40 AM, CNA O stated R23 had a fall around her sink and stated the resident could not stand unassisted at the sink because she would fall. CNA O further stated she did not know what interventions were put into place after the fall.

On 10/12/22 at 02:30 PM, Licensed Nurse (LN) G stated staff are not to leave the resident unattended while she was at the sink because she was a high fall risk.

On 10/13/22 at 10:45 AM, Administrative Nurse D stated the CNA was not supposed to leave the resident unattended and verified no interventions were implemented after the fall.

The facility "Fall and Fall Risk, Managing" policy, dated 03/18/22, documented staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident

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F 689	Continued From page 44 from falling and try to minimize complications from falling. The policy further documented staff would monitor and document each resident's response to interventions intended to reduce falling or the risks of falls. If interventions were successful in preventing falling, staff would continue the interventions or reconsider whether those measures were still needed if the problem that the intervention has resolved. The facility failed to implement the intervention identified to prevent falls for R23, who had a fall, placing the resident at risk for further falls and injury.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		

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and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents. The sample included 12 residents with two reviewed for urinary catheter (tube inserted into bladder to drain urine into a collection bag). Based on observation, record review, and interview the facility failed to provide appropriate treatment and services to prevent urinary tract infections, when staff failed to ensure R22's, who had a history of urinary tract infections (UTIs- infection of any part of the urinary system), urinary catheter bag remained off contaminated surfaces. This placed R22 at increased risk for recurring UTI and related complications.

Findings included:

- R22's Electronic Medical Record (EMR) documented R22 had diagnosis of UTI.

R22's "Quarterly Minimum Data Set," (MDS), dated 09/09/22, documented R22 required extensive staff to supervision assistance with activities of daily living (ADLs). R22 had an indwelling urinary catheter, and was frequently

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incontinent of bowel.

R22's "ADLs Care Plan," revised on 08/25/22, documented R22 required extensive staff assistance to supervision with ADLs.

R22's "Indwelling Catheter Care Plan," revised on 08/25/22, documented the resident had a urinary catheter and instructed staff to check tubing for kinks when R22 was up each shift, monitor for signs and symptoms of discomfort on urination and frequency, and monitor/document for pain/discomfort due to catheter.

R22's EMR documented he had a UTI on 04/14/22 and 06/10/22.

On 10/11/22 at 12:41 PM, observation revealed Certified Nurse Aide (CNA) O assisted R22 to the bathroom and had him sit on the toilet. Observation revealed CNA O placed gloves on, removed R22's incontinent brief, took the urinary catheter drainage bag out of a privacy bag, placed it on the floor, without a barrier underneath it, took R22's left shoe off and left leg out of the pant leg. Observation revealed CNA O removed and discarded gloves, placed new gloves on, and proceeded to place a new incontinent brief over the shoe of R22's right prothesis, and the inside of the incontinent brief touched the bottom of R22's right shoe. Observation revealed CNA O picked the urinary catheter drainage bag off the floor, strung it through the incontinent brief and pant leg.

On 10/13/22 at 10:20 AM, Administrative Nurse D stated R22's catheter tubing, drainage bag, and incontinent brief should not touch the floor, and the incontinent brief should not touch the bottom

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F 690	Continued From page 47 of his shoes when staff provided incontinent cares. The facility's "Urinary Catheter Care Policy," revised 08/2022, documented the purpose of the procedure was to prevent urinary catheter associated complications, including urinary tract infections. Use aseptic technique when handling or manipulating the drainage system. Use aseptic technique when handling or manipulating the drainage system. Be sure the catheter tubing and drainage bag are kept off the floor. The facility failed to provide appropriate treatment and services to prevent urinary tract infections when staff failed to ensure R22's urinary catheter remained off contaminated surfaces. This placed the resident at increased risk for UTI.	F 690		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		

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assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27. The sample included 12 residents. Based on record review and interview the facility failed to ensure staff possessed the skills and knowledge necessary to accurately assess and respond to changes in Resident (R) 28's condition which included physician involvement and notification. The placed the R28 at risk for unmet care and services.

Findings included:

-The "Medical Diagnosis" section within R28's Electronic Medical Record (EMR) included diagnoses of fracture of the right femur (thigh bone), dysphagia (swallowing difficulty), retention of urine, pain, and hypertension (elevated blood pressure).

The "Admission Minimum Data Set" (MDS), dated 08/21/22, documented R28 had intact cognition, no delirium (sudden severe confusion, disorientation and restlessness), psychosis (any major mental disorder characterized by a gross

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impairment in reality testing), or exhibited behaviors. The MDS further documented R28 required extensive assistance of two persons for activities of daily living, and had an indwelling urinary catheter (tube inserted into the bladder to drain urine). R28 had no pain treatment and had surgery requiring active skilled nursing facility care.

The "Urinary Incontinence/Indwelling Catheter Care Area Assessment," dated 09/07/22, documented R28 had moderately impaired cognition, was at risk for falls, had decreased safety awareness, and had an indwelling urinary catheter which placed R28 at risk for trauma and infection due to catheter use.

The "Care Plan" dated 09/07/22, documented R28 had an indwelling catheter due to urinary retention. The care plan further documented to monitor/record/report to medical doctor of urinary track infections, pain, burning, blood tinged urine, urine cloudiness, no output, deepening urine color, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, changes in behaviors and eating patterns.

The "Physician Order Sheet", dated 08/25/22, documented use of a urinary catheter. The order directed staff to bladder train as needed per protocol, then discontinue the catheter.

The "Physician Order", dated 09/16/22, documented R28 was overall approaching a palliative care (care designed to relieve or reduce intensity of uncomfortable symptoms with end of life conditions) approach and would do what R28 wanted in terms of eating, sleeping, and work around R28's schedule. The order further

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instructed staff to discontinue tamsulosin (medication used to treat enlarged prostate) but may restart if R28 had any bladder problems.

The 09/21/22 at 01:45 PM, "Progress Note" documented R28 complained of not feeling well. Staff changed R28's brief and noted 100 cubic centimeter (cc) or less urine output. R28 had not drank. He was assisted to bed and had a Covid-19 (an acute respiratory illness caused by a coronavirus) test with a negative result. The medical record lacked evidence the staff notified the physician of R28's condition.

The 09/26/22 "Progress Notes" documented: At 06:37 AM, staff assessed R28's vital signs. He had not opened his eyes; he moaned and spoke incoherently at times. His respiration were 29 breaths per minute; he took both deep and shallow breaths within the minute and was mouth breathing.

At 10:05 AM, R28 was talkative and wanting to get up for breakfast, staff tried to get him up, but R28 lost his balance and laid back into bed. The note further documented staff went to get a meal tray and when they returned to the room R28 was snoring.

At 01:26 PM, the note documented water was given to R28 with the head of bed elevated and he choked.

At 04:06 PM, staff updated the resident's representative on R28's condition. The representative requested morphine (a narcotic pain reliever) and atropine drops (medication used to decrease respiratory secretions), and requested staff update the representative of any

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changes. The note documented a fax was sent to the physician.

R28's medical record lacked evidence the choking incident was reported to the physician and lacked evidence of staff follow up on the request for medications in respone to R28's conditiona nd his representative's request.

The 09/27/22 at 05:10 AM, "Progress Note" recorded R28's vital signs had ceased.

On 10/13/22 at 10:12 AM, Administrative Nurse D verified the indwelling urinary catheter was not included in R28's baseline care plan, and R28's medical record lacked physician notification of the resident pulling it out on 09/16/22, the choking episode, and the condition change within the 24 hours of death.

The facility's "Guidelines For Notifying Physician of Clinical Problems", dated 09/2017, documented guidelines are intended to ensure that medical care problems are communicated to the medical staff in a timely, efficient and effective manner, and all significant changes in the resident status are assessed and documented in the medical record. The charge nurse or supervisor would contact the attending physician if a clinical situation appears to require immediate discussion and management.

The facility failed to ensure staff possessed the skills and knowledge necessary to accurately assess and respond to changes in Resident (R) 28's condition which included physician involvement and notification This placed the R28 at risk for unmet or delayed care and services.

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F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		

§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 27 residents. The sample included twelve residents with two reviewed for behaviors. Based on observation, interview, and record review, the facility failed to provide dementia (progressive mental disorder characterized by failing memory, confusion) care and services to maintain the highest practicable level of wellbeing for Resident (R)15. This placed the resident at risk decreased quality of life.

Findings included:

-The "Medical Diagnosis" section within R15's Electronic Medical Record (EMR) included diagnoses of dementia, mood disturbance, depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), need for assistance with personal cares, chronic pain and urinary incontinence.

The "Quarterly Minimum Data Set", date 08/10/22, documented R15 had severe cognitive

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impairment, no signs or symptoms of delirium (sudden severe confusion, disorientation and restlessness), no psychosis (any major mental disorder characterized by a gross impairment in reality testing). R15 had physical behavioral symptoms directed at others and rejected evaluations or cares which occurred one to three days during the look back period. The MDS further documented R15 required extensive assistance of two persons for activities of daily living, was frequently incontinent of urine and bowel, and received scheduled pain and anxiety medication.

The "Annual Care Area Assessment" (CAA), dated 05/25/22, documented R15 had unspecified dementia, anxiety disorder, chronic pain, aphasia (condition with disordered or absent language function), and severe cognitive impairment. The CAA further documented R15 was at risk for communication deficits and had an activities daily living function decline due to her cognitive impairment.

The "Care Plan", dated 08/25/22, documented R15 had impaired cognitive or impaired thought process related to dementia without behaviors. The care plan instructed staff to monitor/document/report any changes in decision, making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status.

The 12/10/21 at 01:24 PM "Progress Note", documented R15 rammed her wheelchair into residents, staff, and furniture. The note documented one on one supervision to prevent injuries to others.

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The 12/22/21 at 03:00 PM "Progress Note" documented R15 struck another resident with the back of her hand because the other resident had been repeatedly yelling for help. The note further documented R15 was removed from the situation and calmed down and kept both residents apart.

The 02/06/22 at 03:17 PM "Progress Note" documented R15 had angry behavior throughout the day and tried to enter multiple resident rooms. She continually stood up from wheelchair, yelled at staff and residents. The note further documented staff attempted to entertain R15 but R15 would run into them with the walker.

The 04/15/22 at 12:15 PM "Progress Note", documented R15 behavior was angry and aggressive, was yelling, and going into another residents' rooms. R15 took a plate at noon and dumped it in her lap.

The 04/22/22 at 09:06 AM "Progress Note" documented R15 threw a glass of water in the dining room. Staff removed R15 from the table.

The 04/30/22 at 05:17 PM "Progress Note", documented R15 had angry behavior in the dining room and wheeled herself around the dining room. The note further documented dietary staff asked R15 if she wanted something to drink besides water and R15 stated she did not want water. R15 then picked up her water glass and threw the water into the face of another resident who was sitting next to her. Staff removed R15 from the dining room.

The clinical record lacked evidence staff evaluated for causal factors or triggers and

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lacked interventions for prevention of further behaviors and/or redirection when behaviors occur.

On 10/12/22 at 02:43 PM, observation revealed R15 in a wheelchair in the hallway. Housekeeper U stated R15 had been following her, because R15 thought they were going downtown. R15 is alert and independently mobile in her wheelchair.

On 10/13/22 at 03:01 PM, Certified Nurse Aide (CNA) O stated residents who have behaviors the staff try to see what is wrong, they check with the resident to see if they are hungry, thirsty, need to go to the bathroom or might have pain.

On 10/12/22 at 11:06 AM, Social Service Designee (SSD) X mental health service needs were done through a telehealth system. SSD X reported the resident's medication was reviewed and talk therapy conducted every two weeks.

On 10/13/22 at 10:21 AM, Administrative Nurse D verified the care plan lacked interventions to address R15's ongoing behaviors and lack of non-pharmacological interventions should have also been in place. Administrative Nurse D verified R15 had not had mental health services for ongoing behaviors.

The facility's "Behavioral Assessment, Intervention and Monitoring" policy, dated 03/2019, documented the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented if necessary, to protect the resident and others from harm. The care plans the

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F 744	Continued From page 56 rationale for the intervention and approaches. The facility failed to provide person-centered dementia care and services to maintain the highest practicable level of wellbeing for R15. This placed the resident at risk for decreased quality of life.	F 744		
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	F 758		

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F 758	Continued From page 57 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 Electronic Medical Record (EMR) documented R17 had diagnoses of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure), diabetes mellitus type 2 (diabetes mellitus type 2 (when the body's ability to produce or respond to the hormone insulin is impaired), and overactive bladder (a problem with bladder function that causes the sudden need to urinate). The "Quarterly Minimum Data Set" (MDS), dated 08/26/22, documented R17 had severely impaired cognition and required limited assistance of one staff for bed mobility, transfers, toileting and personal hygiene. The MDS further documented R17 had physical behavior one to three days per week and received an antipsychotic (a class of medication used to	F 758		

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manage delusions, hallucinations and paranoia) medication seven days during the look back period.

R17's "Care Plan," dated 09/19/22, documented R17 received psychotropic (medications which alter mood or thought) medications related to dementia with behaviors, had a black box warning medication, and directed staff to monitor for side effects and effectiveness, consult with pharmacy to consider dosage reduction as appropriate.

The "Physician Order," dated 04/21/22, directed staff to administer risperidone (an antipsychotic medication), 0.25 milligrams (mg) three times a day, for dementia with behavioral disturbance.

On 10/11/22 at 08:20 AM an observation reveled Certified Medication Aide (CMA) M crushed and mixed R17's medication in pudding and administered it to R17 without difficulty.

On 10/11/22 at 10:00 AM, Certified Nurse Aide (CNA) N stated R17 did not have behaviors when she cared for the resident and stated they have a good relationship.

On 10/13/22 at 10:45 AM, Administrative Nurse D verified dementia was not an appropriate diagnosis for the risperidone medication,

The facility's "Psychotropic Medication Use" policy, dated July 2022, documented residents who have not used psychotropic medications are not prescribed or given these medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record.

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The facility failed to ensure an appropriate diagnosis for the use of R17's risperidone. placing the resident at risk for adverse side effects related to antipsychotic medication use.

The facility had a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure Resident (R)7's as needed Ativan (an antianxiety medication) had a stop date and Seroquel (antipsychotic medication used to treat psychosis and other mental emotional conditions) had an approved diagnosis as required, and further failed to ensure R17 had an approved diagnosis for the use of risperidone (antipsychotic). This practice placed R7 and R17 at risk for adverse side effects related to psychotropic (altering mood or mind) medication use.

Findings included:

-The "Medical Diagnosis" section within Resident (R)7s Electronic Medical Record (EMR) included diagnoses of dementia without behavioral disturbance, hallucinations (sensing things while awake that appear to be real, but the mind created), history of falls, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), pain, insomnia (inability to sleep), retention of urine and restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

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The "Admission Minimum Data Set", dated 07/25/22, documented R7 had severe cognitive impairment, had no delirium (sudden severe confusion, disorientation and restlessness), hallucinations, or psychosis (any major mental disorder characterized by a gross impairment in reality testing). R7 had verbal behavioral symptoms directed toward others and significantly disrupted care and or living environment one to three days during a look back period. The MDS further documented R7 required limited to extensive assistance of one staff for activities of daily living (ADL's), was not steady and only able to stabilize with staff assistance, had falls after admission with one injury, received scheduled pain, antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications.

The "Dementia/Cognitive Loss Care Area Assessment" (CAA), dated 07/27/22, documented R7 had dementia, hallucinations, depression, history of falls, anxiety, severe cognitive impairment, and had behaviors of yelling/screaming two days. The CAA further documented R7 was at risk for behaviors, falls and ADL decline.

The "Care Plan" initiated on 07/27/22, documented R7 had potential for physical and verbal aggression with episodes of hollering. The intervention directed staff to administer medications as ordered, monitor/document for side effects and effectiveness, explain all procedures to the resident starting and allow time to adjust to changes.

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The "Physician Orders" dated 07/19/22, directed staff to administer:
Seroquel 25 mg for hallucinations.

The "Physician Orders" dated 09/24/22, directed staff to administer:
Lorazepam 0.5 mg every 6 hours as needed for increased anxiety and dementia with behavioral disturbance.

On 10/11/22 at 12:18 PM, observation revealed R7 independently returned to his room after the midday meal. He walked with a walker, greeted staff in the hallway, entered his room, stopped in the bathroom, then sat in the recliner. R7 requested his door be left open to the hallway. Shortly thereafter R7 hollered at anyone passing his room door for someone to come and turn the television on.

On 10/13/22 at 12:03 PM, Administrative Nurse D, verified R7 had an Ativan as needed order without a stop date and received Seroquel with an unapproved diagnosis of hallucinations.

The facility's "Psychotropic Medication Use" policy, dated July 2022, documented residents who have not used psychotropic medications are not prescribed or given these medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record.

The facility failed to ensure R7's as needed Ativan had a stop date and Seroquel had an approved diagnosis as required. This practice placed R7 at risk for adverse side effects related antipsychotic medication use.

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F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: The facility had a census of 27 residents. The sample included 12 residents. Based on record review and interview the facility failed to maintain an ongoing infection surveillance program which included antibiotic stewardship. This placed the 27 residents who resided in the facility at increased risk for receiving an infection and/or negative effects of antibiotic use. Findings included: - On 10/13/22 at 10:11 PM, Administrative Nurse D verified the facility infection prevention program lacked an antibiotic stewardship element and stated she had not implemented one. The facility's "Antibiotic Stewardship Policy," revised 12/2016, documented antibiotics would be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. When a nurse called a physician/prescriber to communicate suspected infections and had the following information available: signs and symptoms, when first onset of symptoms were first observed, resident hydration status, current medications list, allergy	F 881		

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F 881	Continued From page 63 information, infection type, any orders for warfarin (medication used to thin blood), last creatinine clearance (a test that helps determine whether the kidneys are functioning normally) if available and time of last antibiotic dose. When antibiotics were prescribed to a resident over the phone the primary care practitioner would assess the resident within 72 hours of the telephone order. The facility failed to maintain an ongoing infection surveillance program which included antibiotic stewardship. This placed the 27 residents who resided in the facility at risk for receiving an infection.	F 881		