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	175327	A. BUILDING _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

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F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey. The 2567 was sent electronically on 02/18/25.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		

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

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this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and

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email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 47 residents. The sample included 13 residents with two residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide written notification of the reason and location for the facility-initiated transfer for Resident (R) 44. This deficient practice placed R44 at risk of delayed care or uncommunicated care needs.

Findings Included:

- The "Medical Diagnosis" section within R44's Electronic Medical Records (EMR) included

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diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).

R44's "Admission Minimum Data Set (MDS)" completed 11/08/25 documented a Brief Interview for Mental Status (BIMS) score of ten indicating mild cognitive impairment. The MDS indicated he required substantial staff assistance with transfers, bathing, toileting, dressing, and bed mobility. The MDS indicated he used a wheelchair for mobility.

R44's "Functional Abilities Care Area Assessment (CAA)" completed 11/13/24 noted he required total assistance from two staff for his activities of daily living (ADL). The CAA instructed staff to encourage R44 to participate in his care as he was able.

R43's EMR recorded a "Discharge Assessment-Return Not Anticipated" MDS which recorded R44 discharged to the acute hospital on 11/19/24.

R44's "Care Plan" initiated 11/01/24 indicated he was at risk for a decline of his ADLs, increased falls, and nutritional impairments related to his medical diagnoses. The plan indicated he required substantial to total staff assistance for bed mobility, bathing, transfers, personal hygiene, dressing, and bathing.

R44's EMR under "Progress Notes" revealed a

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F 623	Continued From page 4 "Skilled Progress Note" completed on 11/19/24. The note revealed that R44 was sent out to an acute care facility for emergency evaluation related to low sodium levels per the physician's request. The note revealed that R44's representative was verbally notified about his hospital transport. R44's clinical record lacked evidence of written notification of the facility-initiated transfer which included the location and reason for the transfer provided to R44 or his representatives. The facility was unable to provide this documentation as requested on 02/06/25. On 02/06/25 at 01:27 AM Administrative Nurse D stated the facility only verbally notified the resident or designated representative on the transfers. She stated the facility did not provide written notification of transfers to them. The facility was unable to provide a policy related to transfers or notification requirements as requested on 02/06/25. The facility failed to provide written notification of the reason and location for the facility-initiated transfer to the hospital for R44 or his representative. This deficient practice placed R44 at risk of delayed care or uncommunicated care needs.	F 623		
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	F 657		

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the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents. The sample included 12 with 12 residents reviewed for care plan revisions. Based on observations, interviews, and record review, the facility failed to revise Resident (R)12's care plan to reflect her current transfer requirements. The facility additionally failed to revise R23's hospice care planned interventions. These deficient practices placed the residents at risk for impaired care due to uncommunicated care needs.

Findings included:

- The "Medical Diagnosis" section within R12's

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Electronic Medical Records (EMR) noted diagnoses of dysphagia (difficulty swallowing), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), cognitive-communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), major depressive disorder (major mood disorder), and a history of falls.

R12's "Quarterly Minimum Data Set (MDS)" completed 12/06/24 revealed a Brief Interview for Mental Status Score of nine indicating moderate cognitive impairment. The MDS noted she had no upper or lower extremity impairments. The MDS noted she used a wheelchair for mobility. The MDS noted she was dependent on staff assistance for bed mobility, dressing, bathing, toileting, and transfers. The MDS noted she had one non-injury fall since her last assessment.

R12's "Functional Abilities Care Area Assessment (CAA)" completed 03/20/24 indicated she required substantial assistance from staff to complete her activities of daily living (ADL). The CAA indicated a plan of care will be created to address her needs and minimize her risks.

R12's "Care Plan" initiated on 04/25/25 revealed she required assistance with her ADLs related to her impaired mobility, weakness, and difficulty walking. The plan noted she required assistance from one staff for oral care, bathing, bed mobility, dressing, and toileting (04/05/23). The plan noted she required assistance from one staff for transfers with the use of a gait belt and her walker (04/05/23). The plan noted she was at risk for falls related to her medical diagnoses. On

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10/07/24 R12's fall interventions were updated due to a non-injury fall that occurred during transfer during toileting care. The intervention instructed the use of a Hoyer lift on her for safe transfers. The facility did not resolve or cancel R12's gait belt transfer requirement.

On 02/05/25 at 07:12 AM, Staff transferred R12 from her bed to her wheelchair with the Hoyer lift. R12 was wheeled to the dining room for breakfast.

On 02/06/25 at 01:01 PM, Certified Nurse's Aide (CNA) M stated the care plan should reflect the most current and active interventions for the residents. She stated R12 was a Hoyer lift only due to her fall risk and her plan should have been updated to reflect her transfer requirements. She stated staff were to report conflicting care interventions to Administrative Nurse D.

On 02/06/25 at 01:27 PM, Administrative Nurse D stated the care plans were reviewed quarterly but could be updated with new interventions. She stated that R12 required a Hoyer lift and two staff for transfers due to her weakness and fall history.

The facility was unable to provide a policy related to care plan revisions as requested on 02/06/25.

The facility failed to revise R12's care plan to reflect her current transfer requirements. This deficient practice placed R12 at risk for impaired care due to uncommunicated care needs.
- R23's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and chronic

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kidney disease (CKD - is a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood).

The "Significant Change Minimum Data Set" (MDS) dated 10/21/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R23 required substantial to maximum staff assistance for transfers. The MDS documented R23 had received dialysis services during the observation period.

The "Quarterly MDS" dated 01/15/25 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R23 was dependent on staff assistance for transfers. The MDS documented R23 had received dialysis services during the observation period.

R23's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 10/25/24 documented she was continent of bowel and bladder.

R23's "Care Plan" dated 1/14/21 documented the staff would monitor for renal failure. The plan of care documented the staff would monitor R23's lab work and weight as ordered. The plan of care documented the dietary staff were to regulate R23's protein and potassium intake. The plan of care documented the staff would monitor for signs or symptoms of infection. The plan of care dated 07/13/22 directed the staff to monitor thrill (palpable vibration) and bruit (an audible vascular sound associated with turbulent blood flow usually heard with a stethoscope that may occasionally also be palpated as a thrill) as indicated. The plan of care directed staff to notify

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the physician if the staff were unable to feel the bruit and thrill. The plan of care dated 01/12/23 directed the staff to send a snack and/or meal to dialysis with her. The plan of care documented the staff would send a communication form with R23 on Tuesday, Thursday, and Saturday for dialysis days. The plan of care dated 01/31/23 documented a fistula (abnormal passage from an internal organ to the body surface or between two internal organs) was placed in R23's right arm. The plan of care dated 01/31/23 directed the staff not to obtain blood draws from R23's right arm. The plan of care documented the facility would transport R23 to and from the dialysis center. The plan of care dated 05/04/23 directed the staff to only obtain R23's blood pressure from her left arm. The care plan lacked revised dialysis days of Monday. Wednesday, and Friday. The care plan also lacked direction for nursing staff to monitor R23's fluid restriction.

R23's EMR under the "Orders" tab revealed the following physician orders:
May use dialysis dry weight to obtain weekly or monthly weight information, in the afternoon every Monday, Wednesday, or Friday for weight monitoring dated 01/12/24.

Obtain vital signs before the resident leaves and when the resident returns from dialysis on Monday, Wednesday, and Friday. Include dry weight from the dialysis center in the afternoon every Monday, Wednesday, and Friday for monitoring and in the morning every Monday, Wednesday, and Friday for monitoring dated 09/25/24.

On 02/06/25 at 09:45 AM, R23 laid on her right side asleep on her bed.

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On 12/06/25 at 12:45 PM, Certified Nurse Aide (CNA) M stated she thought R23 had dialysis on Monday, Wednesday, and Friday but was not too sure. CNA M stated that R23 was usually gone for dialysis when she arrived at work. CNA M stated she had access to a resident's care plan. CNA M stated she would refer to a resident's care plan for any care items for each resident. CNA M stated she documented R23's fluid intake under the point-of-care charting.

On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G stated everyone had access to a resident's care plan. LN G stated she had noticed that R23's care plan had the incorrect days listed for dialysis. LN G stated she was not sure who tracked or monitored R23's fluid restriction. LN G stated a nurse should be monitoring the fluid intake for R23 who received dialysis services.

On 02/06/25 at 01:26 PM, Administrative Nurse D stated she would not necessarily expect the dialysis days to be on the resident's care plan because the days for dialysis change for the holidays. Administrative Nurse D stated everyone did have access to the resident's care plan. Administrative Nurse D stated dietary monitored R23's fluid restriction. Administrative Nurse D stated the CNAs and dietary staff would document R23's fluid intake. Administrative Nurse D stated the LNs did not document fluid intake or monitor the fluid restriction for R23.

The facility's "Residents ESRD/Hemodialysis" policy last revised 09/2010 documented residents with end-stage renal disease (ESRD) would be cared for according to currently recognized standards of care. The facility would

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F 657	Continued From page 11 communicate with staff all aspects of how the resident's care would be managed, including: How the care plan would be developed and implemented, and how information would be exchanged between the facilities. The comprehensive care plan would reflect the resident's needs related to ESRD/dialysis care. The facility failed to revise R23's plan of care to include the change in dialysis days and monitoring of her fluid restriction related to CKD. These deficient practices placed R23 with unmet care needs or complications related to dialysis.	F 657		
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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 72 residents. The sample included 13 residents with one reviewed for quality of care. Based on interviews, observations, and record review, the facility failed to evaluate Resident (R)27's risks and abilities related to handling hot liquids. This deficient practice placed R27 at risk for preventable accidents and injuries. Findings included:	F 684		

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- The "Medical Diagnosis" section within R27's Electronic Medical Records (EMR) noted diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body), muscle weakness, need for assistance with personal care, cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), altered mental status, and type two diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).

R27's "Quarterly Minimum Data Set (MDS)" completed 01/09/24 revealed a Brief Interview for Mental Status Score of four indicating severe cognitive impairment. The MDS revealed no upper or lower extremity impairments and indicated she used a wheelchair for mobility. The MDS indicated she required set-up and clean-up assistance for meals. The MDS noted she was dependent on staff assistance for oral hygiene, toileting, bathing, dressing, bed mobility, and transfers. The MDS documented no swallowing disorders.

R27's "Functional Abilities Care Area Assessment (CAA)" completed 10/17/24 indicated she had left-sided hemiparesis and cognitive impairment. The CAA noted she required substantial to total staff assistance for all her activities of daily living (ADLs).

R27's "Care Plan" initiated on 12/14/23 indicated she required assistance with her ADLs related to her medical diagnoses. The plan noted she required set-up assistance with her meals (12/14/23). The plan instructed staff to monitor for

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signs of difficulty chewing or swallowing (12/14/23). The plan instructed staff to monitor her for symptoms of hydration deficits including dry lips, poor urine output, and dry gums (12/14/23). The plan noted her diet was a "No Concentrated Sweet (NCS)" diet with regular texture and thin liquids (12/14/23). The plan lacked documentation related to R16's recent coffee spill incident.

R27's EMR under "Progress Notes" revealed a "Nursing Note" completed on 12/23/24. The note indicated R27 was in the dining room as she waited for breakfast, The note revealed she spilled down the front of herself. The note indicated she was assessed with no redness, blisters, or pain. The note revealed that R27 was unable to state what happened or how she spilled her coffee.

R27's EMR revealed no documentation that indicated the facility followed up with a risk assessment to ensure R27 could safely manage hot liquids, if she required assistance, or if she required special utensils for heated drinks.

On 02/04/25 at 09:01 AM, R27 reported she had spilled coffee on herself but was not able to identify what caused the spill. She stated she sometimes struggled to hold the cups.

On 02/05/25 at 07:22 AM, R27 sat in the dining room. R16 was provided a cup of coffee. The coffee had no lid. R16 consumed her coffee without incident.

On 02/06/25 at 12:50 PM, Certified Nurse's Aide (CNA) M stated that R27 sometimes had difficulty completing her ADLs and required substantial

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staff assistance. She stated staff were expected to ensure the coffee temperatures were not too hot and provide lids for residents who had difficulty holding their drinks. She stated residents that who were at risk for spilling their drinks were provided cups with lids. She stated she sometimes provided R27 with lids for her coffee cups.

On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G stated residents that who had hot liquid spills or had difficulty holding their cups were expected to be assessed for safety and the need for special cups with lids. She stated the care plans should reflect potential risks related to residents who may have needed special utensils to prevent spills.

On 02/06/25 at 01:26 PM, Administrative Nurse D stated staff were expected to assess residents after spills to ensure no injuries occurred. She stated the kitchen also made sure the temperature of drinks was at safe levels. She was not sure if R27 had an assessment completed after her coffee spills to identify her needs with hot liquids.

The facility's policy "Quality of Care" (undated) indicated the facility was expected to provide the highest level of care while promoting a safe person-centered care environment. The policy noted staff were expected to follow all safety protocols. The policy indicated the facility was expected to prioritize individual preferences, choices, and unique needs to promote person-centered care.

The facility failed to evaluate R27's risks and abilities related to handling hot liquids. This

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F 684	Continued From page 15 deficient practice placed R27 at risk for preventable accidents and injuries.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility identified a census of 47 residents. The sample included 13 residents with three residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 38 was provided services and treatment to prevent worsening of contractures (abnormal permanent fixation of a joint or muscle) in his left hand. This deficient practice placed R38 at risk for discomfort and decreased range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension).	F 688		

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Findings included:

- R38's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), cerebrovascular accident (CVA - stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, and need for assistance with personal care.

The "Admission Minimum Data Set" (MDS) dated 06/22/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R38 had limited ROM on one side of his lower extremity. The MDS documented R38 required substantial to maximum staff assistance with dressing.

The "Quarterly MDS" dated 12/23/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R38 required partial to moderate staff assistance for dressing.

R38's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 05/29/24 documented he had experienced a change in functional abilities related to a recent hospitalization.

R38's "Care Plan" dated 05/16/24 documented the staff would encourage him to participate in his therapy program if applicable. The plan of care documented the staff would encourage R38 to use adaptive equipment.

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On 02/05/25 at 02:54 PM, R38 sat in his wheelchair next to his bed and watched TV. R38's left arm rested on his thigh; his left hand hung downward with fingers slightly closed. R38 stated he did not have anyone who assisted him with ROM to his left hand related to the case he did not have insurance to cover the cost of therapy.

On 12/06/25 at 12:45 PM, Certified Nurse Aide (CNA) M stated she was not sure if any staff provided ROM for R38's left side. CNA M stated she would walk R38 to the dining room.

On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G stated she was not sure if the facility had any restorative programs in place for the residents at this time.

On 02/06/25 at 01:26 PM, Administrative Nurse D stated the CNAs would provide any restorative programs for the residents. Administrative Nurse D stated the residents would be referred to therapy if they had a decline in ROM. Administrative Nurse D stated the resident would then be referred again after another decline in ROM. Administrative Nurse D stated the resident would only be placed on a restorative program if recommended by therapy.

The facility's "Resident Mobility and Range of Motion" policy revised on 07/17 documented that residents would not experience an avoidable reduction in ROM. Residents with limited ROM would receive treatment and services to increase and or prevent a further decrease in ROM. Residents with limited mobility would receive appropriate services, equipment, and assistance to maintain or improve mobility unless a reduction

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F 688	Continued From page 18 in mobility was avoidable. The care plan would include specific interventions, exercises, and therapies to maintain, and prevent avoidable decline in and or improve mobility and ROM. The facility failed to ensure R38 received services and treatment for his contractures to prevent an avoidable reduction of ROM. This deficient practice left R38 at risk for further decline and discomfort.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 72 residents, the sample included 13 with two reviewed for accidents. Based on interviews, record review, and observations, the facility failed to ensure Resident (R)16's safety related to following her care-planned fall interventions. This deficient practice placed R16 at risk for preventable falls and injuries. - The "Medical Diagnosis" section within R16's Electronic Medical Records (EMR) noted diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), dementia (a	F 689		

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progressive mental disorder characterized by failing memory and confusion), muscle weakness, and orthostatic hypotension (blood pressure dropping with change of position).

R16's "Significant Change Minimum Data Set (MDS)" completed 01/09/24 revealed a Brief Interview for Mental Status Score of four indicating severe cognitive impairment. The MDS documented no upper or lower extremity impairments and noted she used a wheelchair for mobility. The MDS indicated she was dependent on staff assistance for bed mobility, transfers, dressing, oral hygiene, and bathing. The MDS noted she had a history of falls.

R16's "Falls Care Area Assessment" completed 12/31/24 indicated she required assistance from staff related to her impaired mobility, poor cognition, and medical diagnoses. The MDS noted she was at high risk for falls related to her prescribed medications and medical diagnoses.

R16's "Care Plan" initiated on 09/12/24 indicated she required assistance with her activities of daily living (ADL). The plan indicated she required assistance from one staff for bathing, dressing, toileting, bed mobility, and transfers. The plan noted she was at risk for falls related to her medical diagnoses. The plan instructed staff to ensure her environment was clutter-free and her call light was within reach. The plan indicated she was to be transferred with one staff and a gait belt while ambulating (10/08/24). The plan documented she was to always have a Dysem (non-slip mat) in her chair (01/08/24).

R16's EMR under "Progress Notes" revealed a "Nursing Note" completed on 10/09/24. The note

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indicated she had a witnessed minor-injury fall on 10/09/24 while attempting to ambulate herself to the restroom. The note revealed she suffered a skin tear on her right hand. The note revealed staff were educated to use a gait belt and touch assistance during ambulation.

A review of the facility's "Fall Investigation #1817" completed 10/09/24 was completed. The report's root-cause section of the fall report identified staff did not utilize a gait belt or provide touch assistance while witnessing her ambulating.

On 02/05/25 at 07:56 AM, R16 sat in her recliner in her room. An inspection of her recliner revealed she had no Dycem in place.

On 02/05/25 at 02:33 PM, R16 rested in her recliner. R16 had no Dycem mat in place.

On 02/06/25 at 01:23 PM, R16 rested in her recliner. R16 had no Dycem mat in place.

On 02/06/25 at 12:50 PM, Certified Nurse's Aide (CNA) M stated R16 was a high fall risk due to her cognitive impairment and poor mobility. She stated that R16 required staff to use a gait belt and touch assistance for all transfers. She stated staff were expected to ensure R16's Dycem mat was in place before transferring her to her recliner.

On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G stated that R16's Dycem mat should be moved with her while she transferred to her recliner. She stated staff were to ensure it was in place before allowing her to sit down.

On 02/06/25 at 01:27 PM, Administrative Nurse D

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F 689	Continued From page 21 stated staff were expected to follow and ensure the care planned interventions were in place for each resident. She stated that R16's Dycem should have been in place to prevent her from slipping out of her recliner. The facility's "Fall Guidelines" revised 10/2010 documented that residents were identified for risk of falls and had interventions implemented to reduce the risk of falls. The policy noted fall risk screening would be completed on admission, quarterly for healthcare, annually for assisted living, when there was a significant change of condition, and as applicable, after a fall. The facility failed to ensure R16's safety related to following her care-planned fall interventions. This deficient practice placed R16 at risk for preventable falls and injuries.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		

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F 692	Continued From page 22 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 47 residents. The sample included 13 residents with two reviewed for nutrition. Based on observation, record review, and interviews the facility failed to identify and implement nutritional interventions related to Resident (R) 26'scontinued weight loss. This deficient practice placed R26 at risk for malnourishment-related complications. Findings included: - R26's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cognitive communication deficit, dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Annual Minimum Data Set" (MDS) dated 12/27/24 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R26 had weight loss and was not on a physician-prescribed weight loss program during the observation period. R26's "Nutritional Status Care Area Assessment" (CAA) dated 12/31/24 documented he had weight loss over the past six months.	F 692		

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R26's "Care Plan" dated 02/15/24 documented he was on a regular diet. The plan of care documented the staff would encourage adequate intake as needed. The plan of care documented the staff would monitor R26 for any difficulty with chewing, swallowing, dehydration, or signs and symptoms of aspiration. The plan of care documented the staff would notify the physician of any weight changes. The plan of care documented the staff would obtain R26's weight per facility protocol. The plan of care documented the registered dietician (RD) would consult as indicated. The plan of care documented the staff would offer snacks between meals and as needed. The plan of care dated 02/22/24 documented the staff would obtain R26's food preferences and offer alternatives as needed. The plan of care documented the staff would provide additional fluids of R26's choice. The plan of care documented the staff would provide dietary set-up assistance, encourage, and cue R26 as needed. The plan of care dated 08/12/24 documented the staff would provide a supplement per RD recommendations. The plan of care dated 10/15/24 documented the staff would offer the house supplement in the morning. The plan of care dated 12/06/24 documented the staff would offer Boost (liquid nutritional supplement) two times a day. The plan of care dated 01/24/25 documented the staff would offer Boost Fruit Breeze two times daily.

Review of R26's EMR under the "Weights/Vital Signs" tab reviewed from 06/01/24 through 01/01/25 revealed a weight loss of 26.4 pounds.

R26's EMR under the "Orders" tab revealed the following physician orders:

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Regular diet, regular texture, and thin consistency for liquids dated 03/28/24.

Boost two times a day for supplement 90 milliliters (ml) supplement ordered 12/06/24 and discontinued on 01/23/25.

Boost Fruit Breeze two times a day for supplement 90ml chart amount consumed supplement dated 01/23/25.

Review of R26's EMR under the "Progress Notes" tab revealed a "Nutrition Note" dated 04/17/24 at 03:55 PM documented the Rd reviewed R26's readmission orders. No recommendations were noted.

A "Nutrition Note" dated 12/06/24 documented RD reviewed R26 clinical record related to weight loss. R26's current weight was 192 lbs. which was a weight loss of seven pounds in 30 days and a weight loss of 13 lbs. in 90 days. Documented R26 remained on a regular diet. R26 received 90ml of house supplement in the morning. R26's clinical record reviewed, and house supplement was discontinued and recommended Boost twice a day.

On 02/05/25 at 08:11 AM, R26 ambulated with his walker from the dining to his room. R26 sat in his recliner next to his bed and watched TV.

On 12/06/25 at 12:45 PM, Certified Nurse Aide (CNA) M stated she was not aware of any weight loss related to R26. CNA M stated she was not aware of any interventions for R26 to enhance his meals or snacks.

On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G

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F 692	Continued From page 25 stated she was not aware of any weight loss for R26. On 02/06/25 at 01:26 PM, Administrative Nurse D stated she expected dietary to communicate any weight loss to the nursing department related to R26. The facility's "Weight Assessment and Intervention" policy revised on 09/08 documented that the multidisciplinary (IDT) team would strive to prevent, monitor, and intervene for undesirable weight loss for residents. The Dietitian would review the "Weights Record" to follow individual weight trends over time. Negative trends would be evaluated by the IDT. The physician and the IDT team would identify conditions and medications that would be causing weight loss or increasing the risk of weight loss. The facility failed to identify an ongoing weight loss and implement nutritional interventions related to R26's weight loss. This also placed R26 at risk for malnourishment-related complications.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 47 residents. The sample included 13 residents with one resident reviewed for hemodialysis (a procedure	F 698		

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using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 23 had a physician order for hemodialysis that included an indication. The facility also failed to follow a physician's order for fluid restriction for R23. These deficient practices placed her at risk of adverse outcomes and physical complications related to dialysis.

Findings included:

- R23's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and chronic kidney disease (CKD - is a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood).

The "Significant Change Minimum Data Set" (MDS) dated 10/21/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R23 required substantial to maximum staff assistance for transfers. The MDS documented R23 had received dialysis services during the observation period.

The "Quarterly MDS" dated 01/15/25 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R23 was dependent on staff assistance for transfers. The MDS documented R23 had received dialysis services during the observation period.

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R23's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 10/25/24 documented she was continent of bowel and bladder.

R23's "Care Plan" dated 1/14/21 documented the staff would monitor for renal failure. The plan of care documented the staff would monitor R23's lab work and weight as ordered. The plan of care documented the dietary staff were to regulate R23's protein and potassium intake. The plan of care documented the staff would monitor for signs or symptoms of infection. The plan of care dated 07/13/22 directed the staff to monitor thrill (palpable vibration) and bruit (an audible vascular sound associated with turbulent blood flow usually heard with a stethoscope that may occasionally also be palpated as a thrill) as indicated. The plan of care directed staff to notify the physician if the staff were unable to feel the bruit and thrill. The plan of care dated 01/12/23 directed the staff to send a snack and/or meal to dialysis with her. The plan of care documented the staff would send a communication form with R23 on Tuesday, Thursday, and Saturday for dialysis days. The plan of care dated 01/31/23 documented a fistula (abnormal passage from an internal organ to the body surface or between two internal organs) was placed in R23's right arm. The plan of care dated 01/31/23 directed the staff not to obtain blood draws from R23's right arm. The plan of care documented the facility would transport R23 to and from the dialysis center. The plan of care dated 05/04/23 directed the staff to only obtain R23's blood pressure from her left arm.

R23's EMR under the "Orders" tab revealed the following physician orders:

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Assess thrill and bruit, every shift for dialysis. Check for patency by auscultation and palpating the shunt site. Feel for the thrill, palpate the shunt with your fingers. Hear a bruit with your stethoscope, put the scope on the shunt, and listen for the whoosh, whoosh sound dated 04/21/23.

Fluid restriction 40 ounces (oz) or less over 24 hours which is 1200 milliliters (ml) or less: 250ml with meals. Nursing in room-day/evening/night-100ml and med pass 50ml, every day and night shift related to CKD dated 01/03/24.

May use dialysis dry weight to obtain weekly or monthly weight information, in the afternoon every Monday, Wednesday, or Friday for weight monitoring dated 01/12/24.

Obtain vital signs before the resident leaves and when the resident returns from dialysis on Monday, Wednesday, and Friday. Include dry weight from the dialysis center in the afternoon every Monday, Wednesday, and Friday for monitoring and in the morning every Monday, Wednesday, and Friday for monitoring dated 09/25/24.

Dialysis access site monitoring: Assess the left arm shunt site each shift for signs and symptoms of infection such as redness, tenderness, warmth, and/or swelling at the site. If any of these conditions are present notify the medical provider dated 10/01/24.

Review of R23's clinical record lacked a physician order for dialysis. R23's clinical record lacked

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documentation of her fluid restriction was monitored for fluid overload or dehydration.

On 02/06/25 at 09:45 AM, R23 laid on her right side asleep on her bed.

On 12/06/25 at 12:45 PM, Certified Nurse Aide (CNA) M stated she thought R23 had dialysis on Monday, Wednesday, and Friday but was not too sure. CNA M stated that R23 was usually gone for dialysis when she arrived at work. CNA M stated she had access to a resident's care plan. CNA M stated she would refer to a resident's care plan for any care items for each resident.

On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G stated R23 should have a physician order for dialysis which included the indication for dialysis. LN G stated she was not sure who tracked or monitored R23's fluid restriction. LN G stated a nurse should be monitoring the fluid intake for R23 who received dialysis services.

On 02/06/25 at 01:26 PM, Administrative Nurse D stated she would expect there to be an order for R23's dialysis. Administrative Nurse D stated dietary monitored R23's fluid restriction. Administrative Nurse D stated the CNAs and dietary staff would document R23's fluid intake. Administrative Nurse D stated the LNs did not document fluid intake or monitor the fluid restriction for R23.

The facility's "Residents ESRD/Hemodialysis" policy last revised 09/2010 documented residents with end-stage renal disease (ESRD) would be cared for according to currently recognized standards of care. The facility would communicate with staff all aspects of how the

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F 698	Continued From page 30 resident's care would be managed, including: How the care plan would be developed and implemented, and how information would be exchanged between the facilities. The comprehensive care plan would reflect the resident's needs related to ESRD/dialysis care. The facility failed to monitor R23's fluid restriction and ensure she had a physician for dialysis. These deficient practices placed R23 at risk of potential adverse outcomes and physical complications related to dialysis.	F 698		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §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 identified a census of 47. The sample included 13 residents with four residents reviewed for dementia care. Based on observation, record review, and interviews, the facility failed to ensure staff provided the necessary person-centered activities and interventions to address R13's dementia (a progressive mental disorder characterized by failing memory, and confusion) diagnosis which included the need for close supervision to prevent the resident from wandering and falls. This deficient practice placed R13 at risk of ineffective treatment and decreased quality of care. Findings included:	F 744		

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- R13's Electronic Medical Record (EMR) documented diagnoses of dementia, heart failure (a condition where the heart is unable to pump blood effectively), hypertension (HTN - elevated blood pressure), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).

R13's "Significant Change Minimum Data Set (MDS)" dated 09/27/24 documented she had both long and short-term memory problems. R13 had moderately impaired cognitive skills for daily decision-making. R13 displayed signs of delirium (sudden severe confusion, disorientation, and restlessness) with inattention, disorganized thinking, and altered level of consciousness that fluctuated. R13 displayed the behavior of wandering. R13 had trouble concentrating during the look-back period. R13 required maximal assistance from staff with her activities of daily living (ADL) and functional abilities. R13 used a wheelchair to assist with mobility. R13 had a fall with injury since the prior assessment.

R13's "Quarterly MDS" dated 01/07/25 documented a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R13 displayed signs of delirium with inattention and disorganized thinking. R13 required maximal assistance to total dependence on staff for her ADLs and function abilities. R13 had a fall with a major injury since the prior assessment.

R13's "Cognition Care Area Assessment (CAA)" dated 09/30/24 documented she had been positive for the coronavirus (COVID - highly contagious respiratory virus). She needed consistent redirection as she would not remain in

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her room. R13 was very confused, argumentative with the staff, and sometimes refused care.

R13's Care Plan last revised on 01/20/25 directed staff that she was able to make her own decisions on what activities she would like to participate in. Staff were directed to encourage R13 to participate in activities if needed. Staff were to engage R13 in activities of interest. Staff were to monitor R13 for patterns that would cause her to display exit-seeking. Staff were directed to cue, re-orient, and supervise the resident as needed. Staff were to ensure call light and items (items not specific) were within reach. Staff were directed to keep R13's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion. Staff were directed to provide R13 with items of her interest (coloring, balls of yarn, sit with her), and a place where the activity can be enjoyed, for close visual observation by staff, a preferred leisure activity of the resident to reduce wandering. Staff were directed that R13 required staff assistance of one with a gait belt for toileting and transfers. Staff were to educate R13 on the use of her call light and ensure the call light was within reach. Staff were directed to ensure a clutter-free environment for R13 with adequate lighting and personal items within reach. R13's care plan lacked person-centered staff direction for a resident with dementia on what activities R13 preferred or attended.

A review of R13's "Event Calendar Report" for November 2024, December 2024, and January 2025 documented her main activity attendance was independent activities from 06:00 AM to 07:00 AM. R13 did not participate in group exercises provided daily.

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On 02/04/25 at 10:36 AM, R13 sat in her wheelchair in the main television area of the memory unit. R13 had a cervical collar (a brace used to support and protect your neck and spinal cord) on and her head was leaning forward toward her chest.

On 02/05/25 at 08:30 AM, R13 sat in her wheelchair at the dining table feeding herself at times. R13 had her cervical collar on and would rest leaning her head forward.

On 02/05/25 at 02:15 PM, R13 sat in her wheelchair in the television area with other residents watching tv. One staff member was present on the memory care unit but was providing care to another resident and was not present with the residents in the room.

On 02/05/25 at 09:02 AM, Certified Medication Aide (CMA) R stated she worked on the memory care unit quite a bit. CMA R stated most of the time she was the only staff on the unit so in the morning she was responsible for getting all the residents changed, dressed, and brought out for breakfast in the morning. CMA R stated there were a few residents who would attend activities off of the unit but R13 did not. CMA R stated with her being the only staff on the unit she was not able to provide activities often to the residents. CMA R stated on some days during the week another staff would come to assist her in the afternoons so she could bathe the residents.

On 02/06/25 at 01:21 PM, Activity Z stated that she was the activity person and was part-time. Activity Z stated the facility did have monthly activity calendars. Activity Z stated she would

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come back to the memory unit and do a balloon toss or simple crafts with the residents.

On 02/06/25 at 01:26 AM, Administrative Nurse D stated that the activity director did do a lot with the residents on the memory unit when she could. Administrative Nurse D stated another aide would come to the unit a couple of days of the week for several hours to assist the CMA when she needed to give residents baths or do activities when able to. Administrative Nurse D stated the facility's Facebook page had many pictures of activities that the facility did and many of the pictures were from activities done on the memory unit.

The "Dementia" policy last revised in April 2013 documented that individuals with dementia who had end-stage, or terminal status would have appropriate management including pertinent limitations on life-sustaining medical treatments. The physician would help staff adjust the interventions and overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, and changes in the resident or family wishes.

The "Activity Programs" policy last revised in June 2018, documented the activities program was provided to support the well-being of the residents and to encourage both independence and community interaction. Activities offered were based on the comprehensive resident-centered assessment and the preferences of each resident. The activities program was ongoing and included facility-organized group activities, independent individual activities, and assisted individual activities. Activities were not necessarily

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F 744	Continued From page 35 limited to formal activities being provided by activities staff. Other facility staff, volunteers, visitors, residents, and family members may also provide the activities. Individualized and group activities were provided that: reflect the schedules, choices, and rights of the residents; reflect the cultural and religious interests, hobbies, life experiences, and personal preferences of the residents. Residents were encouraged, but not required, to participate in scheduled activities. The facility failed to ensure staff provided the necessary person-centered activities and interventions to address R13's dementia diagnosis which included the need for close supervision to prevent the resident from wandering and falls. This placed R13 at risk for This deficient practiced placed R13 at risk for risk ineffective treatment and decreased quality of care.	F 744		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		

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F 755	Continued From page 36 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility identified a census of 47 residents. The sample included 13 residents with one medication room and four medication carts. Based on observation, record review, and interviews, the facility failed to ensure controlled substances were accounted for and reconciled between shifts. This placed the residents at risk for misappropriation and/or diversion of controlled substances. Findings included: - On 02/04/24 at 07:20 AM, a review of the December 2024, January, and February 2025 "Narcotic Count Sheet" on the 100, 200, 300, and 500 halls and the over stock narcotics, revealed a missing signature either for the on-coming nurse or the off-going nurse for the morning shift on 01/30, 01/31, 02/01, 02/02, and 02/03.	F 755		

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On 02/04/24 at 07:20 AM, a review of the December 2024, January, and February 2025 "Narcotic Hand Count Sheet" on the 100, 200, 300, and 500 halls and the overstock narcotics revealed a missing signature either for the on-coming nurse signature or the off-going nurse for the evening shift on 01/26, 01/29, 02/01, and 02/03.

On 02/04/24 at 01:00 PM, Licensed Nurse (LN) G stated each nurse or Certified Medication Aide (CMA) was to count with the on-coming and off-going nurse daily. She stated nursing staff were not supposed to leave the facility until the narcotic count was correct.

On 02/06/24 at 01:26 PM, Administrative Nurse D said she expected anyone on the medication carts to count with the oncoming nurse each shift.

The facility's "Controlled Substances" policy revised 04/19 documented the facility complies with all laws, regulations, and other requirements, related to handling, storage, disposal, and documentation of controlled medication. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Any discrepancies in the controlled substance count should be documented and reported to the director of nursing services immediately.

The facility failed to ensure an accurate reconciliation of controlled medications was completed. This deficient practice placed residents at risk of medication misappropriation and diversion.

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take

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when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

The facility reported a census of 72 residents. The sample included 13 residents with six reviewed for unnecessary medications. Based on record review, observations, and interviews, the facility failed to ensure the Consulting Pharmacist (CP) identified and made recommendations related to Resident (R) 12's Midodrine (medication used to raise low blood pressure) medication. This placed R12 at risk for unnecessary medications and potential side effects.

Findings included:

- The "Medical Diagnosis" section within R16's Electronic Medical Records (EMR) noted diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, and orthostatic hypotension (blood pressure dropping with change of position).

R16's "Significant Change Minimum Data Set (MDS)" completed 01/09/24 revealed a Brief Interview for Mental Status Score of four indicating severe cognitive impairment. The MDS documented no upper or lower extremity impairments and noted she used a wheelchair for mobility. The MDS indicated she was dependent on staff assistance for bed mobility, transfers, dressing, oral hygiene, and bathing. The MDS noted she had orthostatic hypotension.

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R16's "Functional Abilities Care Area Assessment" completed on 12/31/24 indicated she required assistance from staff related to her impaired mobility, poor cognition, and medical diagnoses. The MDS noted she was at a high risk for falls related to her prescribed medications.

R16's "Care Plan" initiated 09/12/24 indicated she was at risk for cardio/circulatory complications related to her orthostatic hypotension. The plan instructed staff to monitor for signs and symptoms related to cardiac stress, complete vitals as ordered, and administer her medications as ordered.

R16's EMR under "Physician's Orders" revealed a discontinued order for staff to administer ten milligrams (mg) of Midodrine by mouth three times a day for orthostatic hypotension. The order was started on 09/12/24 and discontinued on 12/12/24. No blood pressure monitoring parameters were listed in the orders.

R16's EMR under "Physician's Orders" revealed an active order (started 12/14/24) for staff to administer five milligrams of Midodrine by mouth two times a day for low blood pressure. No blood pressure monitoring parameters were listed in the orders.

R16's EMR under "Medication Administration Record (MAR)" revealed her afternoon Midodrine medication was administered on 12/06/24. The MAR revealed her systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was 177 millimeters of mercury (mmHg) over her Diastolic

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blood pressure (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) of 72mmHg at (177/72 mmHg).

R16's MAR revealed her evening dose of Midodrine was given on 01/10/25. The MAR revealed her blood pressure was 142/85 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/17/25. The MAR revealed her blood pressure was 140/71 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/19/25. The MAR revealed her blood pressure was 146/76 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/20/25. The MAR revealed her blood pressure was 142/73 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/26/25. The MAR revealed her blood pressure was 143/74 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/30/25. The MAR revealed her blood pressure was 154/76 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/31/25. The MAR revealed her blood pressure was 156/69 mmHg at the time the medication was given.

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R16's MAR revealed her evening dose of Midodrine was given on 02/01/25. The MAR revealed her blood pressure was 145/80 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 02/02/25. The MAR revealed her blood pressure was 158/63 mmHg at the time the medication was given.

A review of the facility's "Monthly Medication Review" from 01/01/2024 through 02/01/2025 revealed no pharmacy notes or recommendations related to R16's Midodrine medication.

On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G stated midodrine medication should be held if the resident blood pressure was higher than the ordered amount or the risk of causing hypertension (high blood pressure). She stated the order should have included parameters and staff should have verified the medication with the physician. She stated the parameters for midodrine were usually to hold for SBC above 120mmHg. She was not sure if the pharmacy monitored the parameters for Midodrine.

On 02/06/25 at 01:26 PM, Administrative Nurse D stated staff should hold the medication and notify the prescriber if they feel the medication was given outside the parameters or potential adverse effects. She stated the pharmacy reviews all resident's medication and sends the reports back to the facility. She stated she was not informed that R16's medication was being given with high blood pressure.

The facility was unable to provide a policy related

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F 756	Continued From page 43 to monthly pharmacy reviews as requested on 02/06/25. The facility failed to ensure the CP identified and made recommendations related to R12's Midodrine medication. This placed R12 at risk for unnecessary medications and potential side effects.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents. The sample included 13 residents, with six reviewed for unnecessary medications. Based on	F 757		

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record review, observations, and interviews, the facility failed to ensure safe medication administration for Resident (R)12's Midodrine (medication used to raise low blood pressure) medication. This placed R12 at risk for unnecessary medications and potential side effects.

Findings included:

- The "Medical Diagnosis" section within R16's Electronic Medical Records (EMR) noted diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, and orthostatic hypotension (blood pressure dropping with change of position).

R16's "Significant Change Minimum Data Set (MDS)" completed 01/09/24 revealed a Brief Interview for Mental Status Score of four, indicating severe cognitive impairment. The MDS documented no upper or lower extremity impairments and noted she used a wheelchair for mobility. The MDS indicated she was dependent on staff assistance for bed mobility, transfers, dressing, oral hygiene, and bathing. The MDS noted she had orthostatic hypotension.

R16's "Functional Abilities Care Area Assessment," completed on 12/31/24, indicated she required assistance from staff related to her impaired mobility, poor cognition, and medical diagnoses. The MDS noted she was at a high risk for falls related to her prescribed medications.

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R16's "Care Plan," initiated 09/12/24, indicated she was at risk for cardio/circulatory complications related to her orthostatic hypotension. The plan instructed staff to monitor for signs and symptoms related to cardiac stress, complete vitals as ordered, and administer her medications as ordered.

R16's EMR under "Physician's Orders" revealed a discontinued order for staff to administer ten milligrams (mg) of Midodrine by mouth three times a day for orthostatic hypotension. The order was started on 09/12/24 and discontinued on 12/12/24. No blood pressure monitoring parameters were listed in the orders.

R16's EMR under "Physician's Orders" revealed an active order (started 12/14/24) for staff to administer five milligrams of Midodrine by mouth two times a day for low blood pressure. No blood pressure monitoring parameters were listed in the orders.

R16's EMR under "Medication Administration Record (MAR)" revealed her afternoon Midodrine medication was administered on 12/06/24. The MAR revealed her systolic blood pressure (SBP - relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was 177 millimeters of mercury (mmHg) over her Diastolic blood pressure (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) of 72mmHg at (177/72 mmHg).

R16's MAR revealed her evening dose of Midodrine was given on 01/10/25. The MAR revealed her blood pressure was 142/85 mmHg

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at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/17/25. The MAR revealed her blood pressure was 140/71 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/19/25. The MAR revealed her blood pressure was 146/76 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/20/25. The MAR revealed her blood pressure was 142/73 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/26/25. The MAR revealed her blood pressure was 143/74 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/30/25. The MAR revealed her blood pressure was 154/76 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 01/31/25. The MAR revealed her blood pressure was 156/69 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 02/01/25. The MAR revealed her blood pressure was 145/80 mmHg at the time the medication was given.

R16's MAR revealed her evening dose of Midodrine was given on 02/02/25. The MAR

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F 757	Continued From page 47 revealed her blood pressure was 158/63 mmHg at the time the medication was given. On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G stated midodrine medication should be held if the resident blood pressure was higher than the ordered amount or the risk of causing hypertension (high blood pressure). She stated the order should have included parameters and staff should have verified the medication with the physician. She stated the parameters for midodrine were usually to hold for SBC above 120mmHg. On 02/06/25 at 01:26 PM, Administrative Nurse D stated staff should hold the medication and notify the prescriber if they feel the medication was given outside the parameters or potential adverse effects. The facility's "Medication and Treatment Orders" policy revised 07/2016 indicated medications were administered based upon the practitioner's order and intended use. The policy noted that licensed staff will administer medication using safe administration guidelines and practices ensuring the correct dose, medication, time, route, and strength. The policy indicated the prescriber might be contacted for medication concerns. The facility failed to ensure safe medication administration for R12's Midodrine medication. This placed R12 at risk for unnecessary medications and potential side effects.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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F 758	Continued From page 48 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented 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	F 758		

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rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 47 residents. The sample included 13 residents with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure an appropriate indication or a documented physician rationale for antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, and a gradual dose reduction was not attempted for Resident (R) 26. The facility also failed to ensure R1 had physician rationale for continued use of as-needed psychotropic (alters mood or thought) medications for an extended period beyond 14 days. These deficient practices placed the residents at risk for adverse medication effects and unnecessary medications.

Findings included:

- R26's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cognitive communication deficit, dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

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The "Annual Minimum Data Set" (MDS) dated 12/27/24 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R26 had received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and an antianxiety (a class of medications that calm and relax people) medication during the observation period. The MDS documented no gradual dose reduction (GDR) was completed and there was no physician documentation that GDR was clinically contraindicated for R26.

R26's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 12/31/24 documented he received antianxiety medication and antidepressant (a class of medications used to treat mood disorders) medication.

R26's "Care Plan" dated 02/15/24 documented the staff would administer his medication as ordered. The plan of care documented the staff would monitor for possible dose reduction.

R26's EMR under the "Orders" tab revealed the following physician orders:
Olanzapine (antipsychotic) oral tablet five milligrams (mg) give one tablet by mouth two times a day related to violent behaviors dated 11/29/24.

On 02/05/25 at 08:11 AM, R26 ambulated with his walker from the dining to his room. R26 sat in his recliner next to his bed and watched TV.

On 02/06/25 at 01:05 PM, Licensed Nurse (LN) G stated the director of nursing would ensure the

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correct indication was listed for any antipsychotic medication. LN G stated she added the diagnosis given by the physician writing the order.

On 02/06/25 at 01:26 PM, Administrative Nurse D stated she had noticed the physician had not documented a rationale for no GDR or an approved indication for his antipsychotic medication for R26's psychotropic medications. Administrative Nurse D stated the facility was going to reach out to the physician for documentation for the rationale.

The facility's "Medication and Treatment Orders" policy last revised 07/16 documented that orders for medications and treatments would be consistent with principles of safe effective order writing. Medications would be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in the state. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist monthly.

The facility failed to ensure an appropriate indication or a documented physician rationale for R26's Olanzapine medication and a physician rationale for no GDR on all of his psychotropic medication. This placed R26 at risk for unnecessary psychotropic medications and related complications.
- R1's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (a major mood disorder that causes persistent feelings of sadness) and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods).

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R1's "Annual Minimum Data Set (MDS)" dated 07/25/24 documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required partial assistance when bathing. R1 used a wheelchair and a walker to assist with mobility. R1 received an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), and an anticoagulant (a class of medications used to prevent the blood from clotting) on a scheduled basis.

R1's "Psychotropic Drug Use Care Area Assessment (CAA)" dated 07/29/24 documented she currently had orders for Prozac (an antidepressant medication) daily, trazodone (an antidepressant medication) for depression, and Buspar (an antianxiety medication). Staff were to encourage expressions of feelings and provide reassurance and validation of feelings as needed. Nursing was to monitor for potential side effects of her medications and notify the physician of any concerns with the medications or mood state.

R1's Care Plan last revised on 12/20/24 directed staff to administer medications as ordered. The care plan directed staff the Psychotropic Review Committee would meet for gradual dose reduction, risk versus benefit, and review medications.

R1's "Orders" tab of the EMR documented an order dated 02/01/24 for Ativan (an antianxiety medication) 0.5 milligrams (mg) by mouth every six hours as needed for anxiety.

The Consultant Pharmacist's monthly Medication

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Regimen Review (MRR) on 02/04/25 documented a recommendation for a rationale for the continued use of the as-needed (prnPRN) Ativan. The physician's response dated and noted on 02/04/25 documented to continue the order for two months for anxiety. The physician's response lacked a reason and or rationale for the continued use.

On 02/05/25 at 12:15 PM, R1 sat in her wheelchair and propelled herself down the hallway from the dining room.

On 02/06/25 at 01:26 PM Administrative Nurse D stated she would receive the monthly pharmacy reviews and forward them to the physicians for them to sign. Administrative Nurse D stated she would then send the nursing recommendations to the nurse and then she would document the physician's responses and send the papers on to medical records to be scanned in. Administrative Nurse D stated she had not realized the physician had not documented a rationale for the continued use of R1's Ativan.

The facility's "Medication and Treatment Orders" policy last revised 07/16 documented that orders for medications and treatments would be consistent with principles of safe effective order writing. Medications would be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in the state. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist monthly.

The facility failed to ensure the physician provided an appropriate rationale for the continued use of

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F 758	Continued From page 54 PRN Ativan for R1. This deficient practice placed the R1 at risk for unnecessary medication administration and related complications.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents. Based on observations, record reviews, and interviews, the facility failed to ensure safe medication storage of one of its four medication carts. This deficient practice placed the resident	F 761		

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F 761	Continued From page 55 at risk for diversion and ineffective medication regimen. Findings Included: - On 02/04/25 at 07:01 AM, an inspection of the 100 Hall revealed an unsecured treatment cart outside of Resident (R) 21's. R21's door was closed. No staff were present in the hallway to monitor the cart. An inspection of the cart revealed medications and wound care supplies for R21 in the top drawer. On 02/04/25 at 07:05 AM, Administration Nurse E walked down the hall and verified that the cart was left unlocked. She stated staff were expected to lock the cart. Administrative Nurse E secured the cart. On 02/06/25 at 01:07 PM, LN I stated the medication carts were to be locked when not in use. On 02/06/25 at 01:28 PM, Administrative Nurse D stated staff were expected to lock the cart during medication passes and treatment when entering the resident's rooms. The facility's "Storage of Medications" revised 11/2020 indicated drugs and biologicals were expected to be always stored in a locked compartment or area. The facility failed to ensure safe medication storage of one of four medication carts. This deficient practice placed the residents at risk for diversion and ineffective medication regimen.	F 761		
F 838 SS=F	Facility Assessment	F 838		

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F 838	Continued From page 56 CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that	F 838		

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may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility's resources, including but not limited to the following:
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;
(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment, the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the

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governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:
§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.

§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.

§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.

§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident

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care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 72 residents. The sample included 13 residents. Based on observations, interviews, and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 72 residents residing in the facility.

Findings Included:

- On 02/05/25, Administrative Nurse D provided a "Facility Assessment" updated 08/08/24. A review of the facility assessment revealed the following:

The facility assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The facility assessment lacked staffing levels required for each shift, to include, evenings and weekends. The facility assessment indicated the facility would develop a comprehensive staffing plan utilizing the staffing model.

The facility assessment lacked informed contingency plans for events that did not require activation of the facility's emergency plan but had the potential to impact resident care. The facility assessment noted the facility would determine the resources necessary to care for residents successfully throughout the day, night, weekends,

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F 838	Continued From page 60 and emergencies. The facility assessment failed to identify the means of input gathered from the residents and their representatives when formulating the assessment data. On 02/05/25 at 01:27 PM, Administrative Nurse D stated the facility assessment was revised annually. She stated staffing requirements were determined by the acuity of the facility and each unit's needs. She stated she met with the facility's leadership team to review the facility assessment annually. The facility's policy, "Facility Assessment," revised 10/2018, indicated the facility assessment was conducted yearly to determine and update the facility's capacity to meet the needs of the residents. The policy indicated the assessment would identify the specific nursing and staffing requirements, nursing services, treatment options, and emergency management. The facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 72 residents residing in the facility.	F 838		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 62 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 47 residents. The facility identified three residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure used face masks were stored or disposed of in a sanitary manner, the facility further failed to ensure all oxygen cannulas were stored in a sanitary manner and further failed to ensure a Legionella disease (Legionella is a bacterium which can cause pneumonia in vulnerable populations) program specific to the facility was put in place. These deficient practices placed the residents at risk for infectious diseases.	F 880		

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Findings included:

- On 02/04/25 at 10:57 AM, R36's nasal cannula was thrown over her wheelchair, and the nasal cannula was not stored in a sanitary manner.

On 02/05/25 at 12:02 PM, the nasal cannula was thrown over a blue oxygen canister in the dining room, the nasal cannula was not stored in a sanitary manner.

The facility lacked documentation of the implementation of a water system program for waterborne contamination, specifically for legionella diseases.

On 02/05/25 at 12:55 PM, Administrative Staff A stated the facility was unable to provide any additional information specific to the facility for legionella.

On 02/06/25 at 10:27 AM a used blue mask with makeup on the inside of the mask was laid on the personal protective (PPE) cart, the cart sat outside of the room of a resident with COVID-19 (highly contagious respiratory virus).

On 02/06/25 at 12:49 PM, Certified Nurse's Aide (CNA) M stated all respiratory equipment not in use should be stored in a plastic bag with the resident's name written on the bag. CNA M stated face masks should be thrown away or stored in a plastic bag.

On 02/06/25 at 01:00 PM, Licensed Nurse (LN) G stated all nasal cannulas should be stored in a plastic, drawstring bag, with the resident's name written on the bag. LN G stated mask should be

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F 880	Continued From page 64 thrown away when the staff are finished with the mask. LN G stated she did not know about the Legionella program. On 02/06/25 at 01:26 PM, Administrative Nurse D stated all respiratory equipment, including nasal cannulas not in use, should be stored in a plastic bag. Administrative Nurse D stated she was unsure what the legionella program was. She stated all used masks should be thrown in the trash; masks should never be left on a cart. The facility's "Personal Protective Equipment" revised 10/18 documented personal protective equipment appropriate to specific task requirements was always available. The facility's "Legionella Water Management Program" revised 09/22 documented the facility was committed to the prevention, detection, and control of waterborne contaminations including legionella. The purpose of the water management program was to identify areas in the water system where legionella bacteria can grow and spread and to reduce the risk of legionnaire's disease. The facility failed to ensure used face masks were stored or disposed of in a sanitary manner, the facility further failed to ensure all oxygen cannulas were stored in a sanitary manner and further failed to ensure a Legionella disease program specific to the facility was implemented. These deficient practices placed the residents at risk for infectious diseases.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		

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F 883	Continued From page 65 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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F 883	Continued From page 66 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: The facility identified a census of 47 residents. The sample included 13 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to offer or obtain informed declinations or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20 - vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for Resident (R) 1, R12, R27, and R28. This placed the residents at increased risk for complications related to pneumonia. Findings included: - Review of R1's clinical record revealed the PCV13 was administered on 10/06/17 and the Pneumococcal Polysaccharide Vaccine (PPSV23) was administered on 10/12/18. R1's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication.	F 883		

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Review of R12's clinical record revealed the PCV13 was administered on 12/28/16 and the PPSV23 was administered on 03/29/21. R12's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication.

Review of R27's clinical record revealed the PPSV23 was administered on 03/29/21. R27's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication.

Review of R28's clinical record revealed the PCV13 was administered on 07/19/16 and the PPSV23 was administered on 02/21/23. R28's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication.

On 02/05/25 at 03:14 PM, Administrative Nurse E, the facility Infection Preventionist, stated she was responsible for tracking the resident's immunization status. Administrative Nurse E stated she had overlooked R1, R12, R27, and R28's PCV20 immunization status.

The facility's "Pneumococcal Vaccine" policy last revised 08/2016 documented all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, would be offered the vaccine series within thirty (30) days of admission to the facility

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WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 68 unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status would be conducted within five working days of the resident's admission if not conducted prior to admission. The facility failed to offer and administer PCV20 or obtain informed declinations for R1, R12, R27, and R28, who were eligible to receive the vaccination. This placed R1, R12, R27, and R28 at increased risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease.	F 883		