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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FORUM AT OVERLAND PARK	3501 W 95TH ST OVERLAND PARK, KS 66206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS 00140838, #KS 00138476, #KS 00137376, and #KS 00135340.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		

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

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facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions

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include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to ensure the right of the residents to file a grievance anonymously.

Findings included:

- Observations made during survey from 05/20/19 to 05/22/19 revealed surveyors were unable to locate a discrete location where grievances could be completed and turned in anonymously.

Review of the resident council minutes for the months of June 2018 through April 2018, did not

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include anything regarding grievances or discussions with residents regarding their right to file an anonymous grievance.

An interview on 05/21/19 at 10:50 AM with the resident council revealed the residents did not know how to obtain a grievance form without asking staff for one . Further,the residents did not know how to formally file a grievance anonymously within the facility.

An interview on 05/22/19 at 2:29 PM with activities staff Z revealed that all grievances were directed to the social worker.

On 05/22/19 at 3:55 PM social services staff X stated all grievances were directed to the him/her. He/she reported residents, family members, or staff would call or email the social worker about any grievances and he/she would complete a grievance form. When asked how a resident could file a grievance anonymously, social services staff X stated that the resident could call the ombudsman and sometimes family members would put notes in his/her mailbox. Social services staff X confirmed that all grievance forms were kept in his/her office and that there was no way for residents to anonymously obtain and file a greivance form within the facility.

The facility's complaints/grievances policy last revised on 09/01/18 documented the facility provided a copy of the complaints/grievances policy only upon request of the resident. The complaints/grievances policy did not include any information regarding a resident's right to file a grievance anonymously and did not provide any instructions on how to file a grievance anonymously within the facility.

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F 585	Continued From page 4 The facility failed to provide the means for residents to obtain and file a grievance form anonymously within the facilty.	F 585		
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 this section;	F 623		

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(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 email address and telephone number of the

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

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. The sample included 19 residents. Based on interviews, observations, and record reviews the facility failed to notify 2 of 3 (#3, #6) residents, sampled for hospitalizations, or their representatives with written reasons for the transfer. The facility also failed to notify the Office of the State Long-Term Care Ombudsman of the transfers.

Findings included:

- The Electronic Medical Record (EMR) for resident #3 documented diagnoses of muscle weakness, multiple sclerosis (MS-progressive

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disease of the nerve fibers of the brain and spinal cord), and atrial fibrillation (rapid, irregular heart beat).

The admission Minimum Data Set (MDS) dated 9/13/18 documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident required limited to extensive staff assistance with his/her Activities of Daily Living (ADLs). The resident had no falls since his/her admission.

The quarterly MDS dated 2/14/19 documented a BIMS score of 13. The resident required limited to extensive staff assistance with his/her ADLs. The resident had 2 or more non-injury falls and 2 or more minor injury falls since the last MDS entry.

The ADL Care Area Assessment dated 9/13/18 documented the resident required staff assistance with his/her ADLs due to muscle weakness, difficulty walking, unsteadiness on his/her feet and an abnormal gait. The resident had a fall risk due to these factors.

The ADL care plan revision dated 3/27/19 documented the resident required staff assistance with his/her ADLs due to muscle weakness, difficulty walking, and MS.

A progress note dated 1/12/19 documented the resident admitted to a hospital for evaluation after he/she sustained a fall.

A progress noted dated 1/16/19 documented the resident returned to the facility from the hospital.

A progress noted dated 3/23/19 documented the resident admitted to a hospital for evaluation after

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he/she sustained a fall.

A progress noted dated 3/27/19 documented the resident returned to the facility from the hospital.

On 5/22/19 at 10:28 AM the resident sat in his/her wheelchair, in his/her room. The resident stated the staff are very helpful and respectful toward him/her and have instructed him/her on fall prevention safety measures.

On 5/22/19 at 3:55 PM social services staff X stated the facility staff do not notify the Ombudsman of hospital transfers or discharges from the facility and do not provide written notification of the reason for hospitalization to the family or their representative.

The facility's 30-day Notice of Discharge and the 30-day Notice of Transfer policies dated 9/1/18 lacked documentation regarding Ombudsman notification or written notification to the family required for discharges from the facility.

The facility failed to provide written notification of the reason for the discharge to the resident or his/her representative and failed to notify the Ombudsman of the discharge for resident #3 when he/she required hospitalization on 1/12/19 and 3/23/19.

- The Electronic Medical Record (EMR) for resident #6 documented diagnoses of pneumonitis (inflammation of the lung tissue), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and congestive heart failure (CHF-a condition with low

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heart output and the body becomes congested with fluid).

The admission Minimum Data Set (MDS) dated 9/26/18 documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident required supervision to extensive staff assistance with his/her Activities of Daily Living (ADLs).

The quarterly MDS dated 3/27/19 documented a BIMS score of 13. The resident required supervision to extensive staff assistance with his/her ADLs.

The ADL Care Area Assessment dated 9/26/18 documented the resident required staff assistance due to a decreased range of motion to his/her upper extremities.

The care plan dated 1/18/19 documented the facility staff monitored and reported changes of signs and symptoms that indicated a worsening of the resident's condition.

A progress note dated 1/12/19 documented the resident admitted to the hospital due to coughing, wheezing, diarrhea, and vomiting.

A progress note dated 1/17/19 documented the resident readmitted to the facility.

A progress note dated 4/27/19 documented the resident transferred to the hospital due to a change of condition i.e.: coughing, twitching, disorientation, and talking to him/herself.

A progress note dated 5/2/19 documented the resident readmitted to the facility.

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F 623	Continued From page 10 On 5/21/19 at 12:15 PM the resident sat at the dining table, eating his/her lunch. On 5/22/19 at 3:55 PM social services staff X stated the facility staff do not notify the Ombudsman of hospital transfers or discharges from the facility and do not provide written notification of the reason for hospitalization to the family or their representative. The facility's 30-day Notice of Discharge and the 30-day Notice of Transfer policies dated 9/1/18 lacked documentation regarding Ombudsman notification or written notification to the family required for discharges from the facility. The facility failed to provide written notification of the reason for the discharge to the resident or his/her representative and failed to notify the Ombudsman of the discharge for resident #6 when he/she required hospitalization on 1/12/19 and 4/27/19.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		

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or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to develop and implement a comprehensive care plan to include health care conditions/diagnoses and interventions to help prevent hospitalizations for resident #6 and failed to develop and implement a comprehensive care plan to include the ongoing health issues with the

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toes and toenail infections for resident #2

- The EMR (electronic medical record) for resident #6 included a diagnosis of chronic obstructive pulmonary disease or COPD (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dysphagia (difficulty swallowing), respiratory failure (failure of the respiratory system), parkinsonism (a progressive neurological disorder characterized by resting tremor, rolling of the fingers, mass-like faces, shuffling gait, muscle rigidity, and weakness),
Pneumonitis (inflammation of the lungs) due to inhalation of food and vomit, congestive heart failure or CHF (a condition with low heart output and the body becomes congested with fluid), and cognitive communication deficit, difficulty walking, osteoarthritis (a disease of the joints), muscle weakness and the need for assistance with personal care.

The Admission Minimum Data Set (MDS) dated 09/26/18 for resident #6 documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident had difficulty swallowing and was on a mechanically altered diet. The resident required the extensive assistance of one staff member for activities of daily living (ADLs), had range of motion impairment in both arms, and required the use of a walker or wheelchair for locomotion. Active diagnoses included CHF, A-fib or other dysrhythmias, HTN, thyroid disorder, and Parkinson's Disease.

Review of the Care Area Assessment (CAA) dated 09/26/18 for activities of daily living (ADL)

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function documented that resident #6 required limited to extensive assistance due to the resident's Parkinson's diagnosis.

Review of the care plan between 09/20/18 and 05/01/19 for resident #6 lacked significant health conditions/diagnoses and interventions to prevent hospitalizations.

Review of the admission progress note dated 09/20/18 at 14:36 documented admitting diagnoses of dysphagia (difficulty swallowing), weakness, heart failure and arthritis.

Review of the health status noted dated 1/12/2019 at 1:38 PM documented the resident was sent to the hospital for acute respiratory distress, diarrhea, vomiting, and confusion.

Review of a transfer/discharge note dated 02/08/19 documented resident #6 was transferred/discharged to the hospital for aspiration pneumonia due to swallowing issues related to Parkinson's .

Review of the health status note dated 02/13/19 at 12:36 PM documented the resident returned from the hospital with diagnoses with severe sepsis due to pneumonia, aspiration pneumonia, acute hypoxemia respiratory failure, acute exacerbation of COPD and CHF.

Review of a transfer/discharge noted dated 04/27/19 documented resident #6 transferred/discharged to the hospital for COPD exacerbation.

Review of the admission progress noted on 5/2/2019 at 4:30 PM documented the resident

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returned to the facility from the hospital at 4:30 PM with diagnoses of acute COPD exacerbation, acute respiratory failure with hypoxia, elevated troponin, and CHF.

An observation on 05/21/19 at 12:15 PM revealed resident #6 sitting at a dining table with two other individuals waiting for lunch. The resident was sociable with others, appeared well-groomed and was wearing house shoes.

An interview on 05/22/19 at 2:52 PM with direct care staff O stated that he/she referred to the care plan or other direct care staff to learn about the care a resident required.

An interview on 05/22/19 at 3:11 PM with administrative nursing staff D stated the baseline care plan was completed by whoever did the admission and that floor nurses, the DON, or the MDS coordinator revised the care plans. Administrative nursing staff D stated that if a resident transferred to the hospital, the care plan might be generalized for COPD or CHF with reasons for going to the hospital, such as aspiration pneumonia.

An interview on 05/22/19 at 01:52 PM with licensed nursing staff G stated that if a resident went to the hospital he/she would put that on the care plan with relevant interventions for that health condition/illness.

The facility's care plan and communication policy last revised on 09/01/18 documented the nurse updated the plan of care as the resident's needs changed and that the interdisciplinary team met weekly. Ongoing and quarterly review of the plan of care would occur at care plan meetings. The

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policy documented that a resident's plan of care was oriented towards preventing avoidable declines and managing risk factors to the extent possible and should include the healthcare information necessary to properly care for each resident such as safety concerns and areas of risk, skin issues, and acute medical conditions. The comprehensive care plan was used to furnish services to the resident which intended to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being.

The facility failed to develop and implement a comprehensive care plan to include health care conditions/diagnosis and interventions to prevent hospitalizations for resident #6.

- The EMR (electronic medical record) for resident #2 included a diagnosis of difficulty walking (09/18/17), muscle weakness (07/08/17) and polyosteroarthritis (joint pain and stiffness) (11/27/18).

The Annual Minimum Data Set (MDS) dated 11/09/18 for resident #2 documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident reported the presence of pain and experienced pain frequently. The resident required the extensive assistance of one staff member for activities of daily living (ADLs) and required the use of a walker or wheelchair for locomotion.

The Quarterly MDS dated 02/09/19 for resident #2 documented an infection of the foot.

Review of the Care Area Assessment (CAA)

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dated 11/09/18 for cognitive loss/dementia documented a cognitive deficit for resident #2 that resulted in confusion. The CAA for visual function documented the resident was at risk for the inability to participate with ADLs. The CAA for ADL Function documented that resident #2 required assisted with managing his/her personal hygiene and ADLs.

Review of the care plan for resident #2, last revised on 05/10/19, lacked a care plan for the resident's ongoing problems with his/her toenails, interventions, and the need for the resident to be seen by a podiatrist.

Review of the skin assessment dated 04/20/19 documented resident #2 verbalized to staff that his/her right and left toes hurt even after seeing the podiatrist. The resident told staff that he/she felt like he/she needed to see the podiatrist again.

Review of the health status note dated 06/01/18 at 4:46 AM documented that resident #2 received Cephalexin (antibiotic) for a left great toenail infection. The resident rated the toe pain 8/10 and was given pain medication.

Review of a health status note dated 06/04/18 at 3:04 PM documented the resident was seen by the podiatrist and had no new orders.

Review of the medication administration note dated 06/08/18 at 12:17 PM documented an order to apply Bacitracin ointment (topical antibiotic) 500 units/gram to the left great toe topically two times a day for infection.

Review of the administration note dated 07/13/18 at 5:23 AM documented that resident #2 reported

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that all of his/her toes hurt and believed he/she needed to have his/her toenails cut. It was noted that some of the toenails were a light green color with possible fungus. The resident stated he/she had been waiting to be seen by the podiatrist, but had not been seen yet.

A health status noted dated 01/29/19 at 11:22 AM documented resident #2's right great toe was red and swollen with a small scratch near the toenail. The resident stated it was painful and requested to see the podiatrist. The physician was notified and would assess resident's toe later in the day.

Review of the health status note dated 01/29/19 at 10:34 PM documented an order for resident #2 to take Augmentin(antibiotic) 875mg by mouth two times per day for 10 days for cellulitis (skin infection) of the right great toe.

A health status note dated on 03/19/19 at 2:14 PM documented resident #2 complained of bilateral great toe pain, the toes were red and slightly swollen. The physician ordered for the resident to see the podiatrist again and provided an order for Keflex (antibiotic) 500mg four times per day for 10 days.

An observation on 05/22/19 at 08:57 AM revealed resident #2 sitting alone at dining table waiting for breakfast, alert, well-groomed, wearing non-skid socks, had two glasses of juice, a bowl of fruit, and a cinnamon roll. The resident rubbed the top of her right foot and said that is was hurting.

An observation on 05/22/19 at 03:16 PM of resident #2's toes revealed the toenails were thick, yellow, and the skin on the left and right great toes were pink in comparison to the other

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toes.

An interview on 05/20/19 at 12:28 PM with resident #2 stated that his/her toenails hurt and needed to be cut. The resident stated he/she had been begging for help for the past couple of months to get his/her toenails cut, but nobody gave answers or would cut his/her toenails.

An interview on 05/22/19 at 02:52 PM with direct care staff O stated he/she referred to the care plan or talk with other direct care staff to learn about a resident's care requirements.

An interview on 05/22/19 at 3:16 PM with licensed nursing staff G stated that if a resident had problems with toenail infections that the resident's care plan should have something about toenails or infections. The nurse stated that the list of residents to be seen by the podiatrist came from social services staff X, and licensed nurses could add residents to the list to be seen.

An interview on 05/22/19 at 03:55 PM with social services staff X stated that he/she received a list of residents to be seen from the podiatrist and added to the list if needed. Resident #2 was seen by the podiatrist 8/2018, 10/2018, 3/2019, and was to be seen in June 2019. The podiatrist visited once every 60 days.

An interview on 05/22/19 at 3:11 PM with administrative nursing staff D stated that resident #2 had gout, complained of foot pain, and the resident had antibiotics for his/her toenails. Administrative nursing staff D stated the care plan did not include anything specific regarding the resident's toenails.

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F 656	Continued From page 19 The facility's care plan development and communication policy last revised on 09/01/18 documented the nurse updated the plan of care as the resident's needs changed and that the interdisciplinary team met weekly. Ongoing and quarterly review of the plan of care would occur at care plan meetings. The policy documented that a resident's plan of care was oriented towards preventing avoidable declines and managing risk factors to the extent possible and should include the healthcare information necessary to properly care for each resident such as safety concerns and areas of risk, skin issues, and acute medical conditions. The comprehensive care plan was used to furnish services to the resident which intended to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility failed to develop and implement a comprehensive care plan for the ongoing issues related to resident #2's toenails, infections, the need to be seen by a podiatrist and relevant interventions.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		

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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 identified a census of 32. The sample included 19 residents. Based on record review, observations, and interviews, the facility failed to review and revise the care plan related to falls for 1 resident (#15) and failed to update the care plan related to advanced directives and preferences for 1 resident. (#6).

Finding include:

- Resident #15's electronic medical record (EMR) revealed diagnoses of hypertension (elevated blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia (progressive mental disorder characterized by failing memory, confusion).

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The significant change Minimum Data Set (MDS) dated 1/16/19 documented the resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS recorded the resident required extensive assistance of two staff persons for bed mobility, transfers, dressing, and personal hygiene. The MDS documented one fall with no major injury and not steady during surface to surface transfers, without assistance.

The quarterly MDS dated 4/16/19 documented a BIMS of 10 which indicated moderate cognitive impairment, recorded that resident required extensive assistance of two staff persons for bed mobility, toilet use, transfers and extensive assistance of one staff person for dressing. The MDS documented one fall with no major injury, unsteady moving from seated to standing position, moving on and off the toilet and surface to surface transfers without assistance.

The Care Area Assessment (CAA) dated 1/16/19 for falls documented that he/she was at risk for falls due to muscle weakness, difficulty with walking, dementia and hemiplegia (paralysis of one side of the body) with hemiparesis (muscular weakness of one half of the body). The fall assessment dated 1/4/19 revealed a score of 65, which indicated high risk for falls.

The care plan revised on 6/13/17 directed staff that resident #15 was at a high risk for falls. An intervention dated 8/23/18 indicated the resident required assistance with bedtime activities of daily living (ADLs) and directed staff to transfer him/her to bed by 9:00 P.M. The intervention dated 8/29/19 directed staff to continue to offer and anticipate his/her needs for assistance. The care

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plan lacked interventions related to falls that occurred on 6/9/18, 7/10/18, 12/31/18, and 3/24/19.

The progress notes dated 6/10/19 documented a non-injury fall. The progress note dated 7/10/18 documented a non-injury fall. The progress note dated 8/22/18 documented a non-injury fall. The progress note dated 8/29/18 documented a non-injury fall. The progress note dated 12/31/18 documented a fall with an abrasion on left side of his/her forehead. The progress note dated 3/24/19 documented a non-injury fall.

On 5/22/19 resident #15 at 7:04 A.M. sat upright on the side of his/her bed calling out for staff to come and talk to him/her.

On 5/22/19 at 1:52 P.M. licensed staff G stated that nursing staff revised and updated the care plans after each fall.

On 5/22/19 at 2:44 P.M. direct care staff N stated that he/she knew how to care for the residents from the Kardex in point click care system on the KIOSK (a small, stand-alone device providing information for staff on a computer screen and was often used for entering services provided) and assignment sheet.

On 5/22/19 at 3:11 P.M. licensed administrative staff D stated fall interventions should be care planned after each fall and reinforce previous care planned interventions.

The facility care plan development and communication policy with a revision date of 9/1/18 documented the licensed nurse updated the care plan with a relevant information as the

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resident needs changed. The care plan would be reviewed quarterly and ongoing.

The facility failed to revise the care plan with effective interventions aimed to prevent falls for resident #15.

- The electronic medical record for resident #6 included diagnoses of difficulty walking, osteoarthritis (a disease of the joints), muscle weakness and the need for assistance with personal care.

The Admission Minimum Data Set (MDS) dated 09/26/19 for resident #6 documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident required the extensive assistance of one staff member for activities of daily living (ADLs), had range of motion impairment in both arms, and required the use of a walker or wheelchair for locomotion.

Review of the Care Area Assessment (CAA) dated 09/26/18 for pressure ulcers documented that weekly skin assessments were done by the nursing staff, and a pressure reduction mattress and wheelchair cushion were in place.

Review of the care plan for resident #6, last revised on 05/12/19, lacked revision to include the resident's preference to wear shoes or the refusal to leave shoes off, despite physician orders to leave shoes off to enable wound healing. The care plan documented that resident #6 was a Full Code (resuscitate). The care plan was not revised to reflect the resident's accurate code status when it changed to DNR (do not resuscitate) per physician's order on 05/14/19.

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Review of the physician's order dated 05/05/19 ordered for resident #6 to leave shoes off and to wear nonskid socks.

An observation on 05/22/19 at 11:55 AM revealed licensed nursing staff G put a sock and house shoe on resident's right foot after changing the dressing on the right heel pressure ulcer. Licensed nursing staff G did not encourage the resident to leave the shoes off.

An observation on 05/22/19 at 03:10 PM revealed resident sat in his/her wheelchair with both feet on the floor, wearing house shoes and socks. Did not observe staff encourage the resident to leave his/her shoes off.

An interview on 05/20/19 at 03:06 PM with direct care staff M stated he/she knew a resident's code status by looking at the color of the resident's name label located outside of the resident's room, which was either white or yellow - a white label meant do not resuscitate and a yellow label meant that the resident needed to be resuscitated. As an example, direct care staff M pointed at the yellow name label outside of the room and explained that resident's label was yellow, which meant to resuscitate.

An interview on 05/22/19 at 2:59 PM with direct care staff M stated that he/she would notify the nurse regarding abnormal skin issues and learned about how to care for residents from the nurse.

An interview on 05/22/19 at 2:52 PM with direct care staff O stated that he/she would refer to the care plan or other direct care staff to learn about

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the care a resident required.

An interview on 05/22/19 at 1:52 PM with licensed nursing staff G stated that he/she would put pressure ulcers on the care plan for residents who had pressure ulcers and include interventions on how to care for the pressure ulcers. Licensed nursing staff G stated that when a resident's code status changed from what was in the care plan he/she immediately notified the director of nursing (DON) and the MDS coordinator via email and revised the care plan.

An interview on 05/22/19 at 3:16 PM with licensed nursing staff G stated that resident #6 admitted with the pressure ulcer in September of 2018. The nurse admitted he/she knew the resident was not supposed to wear shoes, but since admission on 09/20/18, the resident had insisted on wearing shoes while up in the wheelchair.

An interview on 05/20/19 at 3:28 PM with social services staff X stated that resident's code statuses were reviewed at every care plan meeting and that resident #6 was a full code and confirmed there was no signed DNR in the EMR.

An interview on 05/20/19 at 04:28 PM with administrative nursing staff D revealed a DNR that was signed on 05/02/19 for resident #6 and signed by the physician on 05/14/19 that was not scanned into the chart for resident #6.

An interview on 05/22/19 at 3:11 PM with administrative nursing staff D stated that nurses, the DON, or the MDS coordinator revised the care plans. Administrative nursing staff D stated that care plans were revised shortly after a physician's order when a resident's code status

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F 657	Continued From page 26 changed. The facility's care plan and communication policy last revised on 09/01/18 documented the nurse updated the plan of care as the resident's needs changed and that the interdisciplinary team met weekly. Ongoing and quarterly review of the plan of care would occur at care plan meetings. The facility failed to ensure the timely revision of a person-centered, comprehensive care plan for the code status and preferences of Resident #6.	F 657		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to ensure that resident #2 received proper treatment and care to maintain good foot health. Findings included:	F 687		

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- The EMR (electronic medical record) for resident #2 included diagnoses of difficulty walking (09/18/17), muscle weakness (07/08/17) and polyosteroarthrist (joint pain and stiffness) (11/27/18).

The Annual Minimum Data Set (MDS) dated 11/09/18 for resident #2 documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident required extensive assistance of one staff member for activities of daily living (ADLs) and used a walker or wheelchair for locomotion.

Review of the Care Area Assessment (CAA) dated 11/09/18 for cognitive loss/dementia documented a cognitive deficit for resident #2 that resulted in confusion. The CAA for visual function documented the resident was at risk for the inability to participate with ADLs. The CAA for ADL Function documented that resident #2 required assisted with managing his/her personal hygiene and ADLs.

Review of the care plan for resident #2, last revised on 05/10/19, lacked a care plan for the resident's ongoing problems with his/her toenails, interventions, and the need for the resident to be seen by a podiatrist.

Review of the skin assessment dated 04/20/18 documented resident #2 verbalized to staff that his/her right and left toes hurt even after seeing the podiatrist. The resident told staff that he/she felt like he/she needed to see the podiatrist again.

Review of the health status note dated 06/01/18 at 4:46 AM documented that resident #2 received Cephalexin (antibiotic) for a left great toenail

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infection. The resident rated the toe pain 8/10 and was given pain medication.

Review of a health status note dated 06/04/18 at 3:04 PM documented the resident was seen by the podiatrist and had no new orders.

Review of the administration note dated 06/08/18 at 12:17 PM documented an order to apply Bacitracin ointment (topical antibiotic) 500 units/gram to the left great toe topically two times a day for infection.

Review of the administration note dated 07/13/18 at 5:23 AM documented resident #2 reported that all of his/her toes hurt and believed he/she needed to have his/her toenails cut. It was noted that some of the toenails were a light green color with possible fungus. The resident stated he/she had been waiting to be seen by the podiatrist, butpodiatrist but had not been seen yet.

A health status noted dated 01/29/19 at 11:22 AM documented resident #2's right great toe was red and swollen with a small scratch near the toenail. The resident stated it was painful and requested to see the podiatrist. The physician was notified and would assess resident's toe later in the day.

Review of the health status note dated 01/29/19 at 10:34 PM documented an order for resident #2 to take Augmentin(antibiotic) 875mg by mouth two times per day for 10 days for cellulitis (skin infection) of the right great toe.

A health status note dated on 03/19/19 at 2:14 PM documented resident #2 complained of bilateral great toe pain, the toes were red and slightly swollen. The physician ordered for the

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resident to see the podiatrist again and provided an order for Keflex (antibiotic) 500mg four times per day for 10 days.

An observation on 05/21/19 at 12:21 PM revealed resident #2 resting in his/her bedroom in the recliner with both feet elevated, a blanket on, door open, and his/her walker next to chair.

An observation on 05/22/19 at 08:57 AM revealed resident #2 sat alone at a dining table waiting for breakfast, alert, well-groomed, wearing non-skid socks, had two glasses of juice, a bowl of fruit, and a cinnamon roll. The resident rubbed the top of his/her right foot and said it hurt.

An observation on 05/22/19 at 03:16 PM of resident #2's toes revealed the toenails were thick, yellow, and the skin on the left and right great toes were pink in comparison to the other toes.

An interview on 05/20/19 at 12:28 PM with resident #2 stated that his/her toenails hurt and needed to be cut. The resident stated he/she had been begging for help for the past couple of months to get his/her toenails cut, but nobody gave answers or would cut his/her toenails.

An interview on 05/22/19 at 02:52 PM with direct care staff O stated he/she referred to the care plan or talk with other direct care staff to learn about a resident's care requirements.

An interview on 05/22/19 at 3:16 PM with licensed nursing staff G stated that if a resident had problems with toenail infections that the resident's care plan should have something about toenails or infections. The nurse stated that the list of

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F 687	Continued From page 30 residents to be seen by the podiatrist was received from social services staff X, and licensed nurses could add residents to the list to be seen. An interview on 05/22/19 at 03:55 PM with social services staff X stated that he/she received a list of residents to be seen from the podiatrist and added to the list if needed. Resident #2 was seen by the podiatrist 8/2018, 10/2018, and 3/2019. Resident #2 was not seen by a podiatrist for a span of 4 months between October 2018 and March of 2019. An interview on 05/22/19 at 3:11 PM with administrative nursing staff D stated that resident #2 had gout, complained of foot pain, and the resident has had antibiotics for his/her toenails. Administrative nursing staff D stated the care plan did not include anything specific regarding the resident's toenails. The facility failed to ensure that resident #2 received proper treatment and care to maintain good foot health.	F 687		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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F 758	Continued From page 31 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 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 32 residents.	F 758		

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The sample included 19 residents. Based on interviews, observations, and record review the facility failed to follow physician's recommendations for a discontinuation of an antianxiety medication. (#13)

Findings included:

- The Electronic Medical Record (EMR), for resident #13 listed diagnoses of cognitive communication deficit and major depressive disorder (major mood disorder).

The admission Minimum Data Set (MDS) dated 04/23/19, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. He/she required limited to extensive staff assistance for Activities of Daily Living (ADLs). He/she received an antipsychotic (medication used to treat mental disorders) 7 of 7 days, an antianxiety (class of medications that calm and relax people with excessive nervousness or tension) 3 of 7 days, antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) 7 of 7 days.

The Psychotropic (medication which can alter mood or thoughts) Drug Use Care Area Assessment CAA) dated 04/23/19 documented he/she received psychotropic medications related to mental illness. He/she was compliant with the regimen.

The Care Plan for psychotropic medications for depressive disorder dated 04/23/19 documented he/she received psychotropic medications and was at risk for complications including sedation, suicidal thoughts, and behaviors.

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On 05/10/19 the Pharmacy Review recommended that Alprazolam 0.25 milligrams (mg) 1 tablet via G-tube every 8 hours as needed (PRN) for anxiety ordered on 05/09/19 for resident #13 be discontinued.

On 05/13/19 the facility received the 05/10/19 Pharmacy Review signed by the physician agreed to the recommendation of discontinuing the medication.

Review of the Medication Administration Record (MAR) on 05/20/19-05/22/19 revealed that Alprazolam 0.25mg PRN was still active and had not been discontinued.

On 05/21/19 9:32 PM resident #13 was laying in his bed and was pleasant and conversant.

On 05/22/19 at 1:52 PM the administrative nursing staff D stated that medication reviews are sent to them, then they put them in the physician's box and then review it with the physician. Once the physician signed the medication review, the nurse or director of nursing (DON) signs it and should enter it into MAR.

On 05/22/19 at 5:15 PM the administrative nursing staff D stated that the medication should have been removed from the MAR by the nursing staff after they received the pharmacy recommendation signed by the physician.

Review of the facility's Medication Management policy effective dated 04/01/19 stated upon receipt of a physician's order to discontinue a medication, the Director of Resident Care (DRC),

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F 758	Continued From page 34 or licensed designee, will: Transcribe order onto the resident's MAR; Document the information in the resident record; Notify the issuing pharmacy; Remove the discontinued from the medication storage cart/cabinet and store in the designated secure area for drugs awaiting return/destruction. The facility failed to discontinue the PRN antianxiety medication for resident #13 as recommended by the consultant pharmacist and agrred upon by the physician.	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	F 761		

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be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents and identified 2 medication carts and 3 treatment carts. Based on observations and interviews, the facility failed to date opened insulin pens (medications used to treat diabetes mellitus-when the body cannot use glucose note enough insulin made or the body cannot respond to the insulin) and failed to lock the cart for 1 (#2) of 2 treatments carts in the west hall.

Findings included:

- During the initial tour 5/20/19 at 8:15 AM an observation revealed opened and undated Lantus and Humalog insulin pens in treatment cart #2.

During an observation on 5/22/19 at 8:10 AM revealed an unlocked and unattended treatment cart (#2).

During an observation on 5/22/19 at 8:26 AM revealed an unlocked and unattended treatment cart (#2).

During an observation on 5/22/19 at 8:40 AM revealed an unlocked and unattended treatment cart (#2). The treatment cart contained 3 insulin pens, 24 different medication cards, 1 bottle of aspirin, 1 bottle of Vitamin D3, a tube of Biofreeze (medication used for pain relief), and 2 bottles of fungus powder.

On 5/22/19 at 8:18 AM licensed staff nurse I stated treatments carts are locked when unattended.

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According to https://www.lantus.com the Lantus pens which are in use should be disposed of 28 days after opening.

According to https://www.humalog.com the Humalog pens which are in use should be disposed of 28 days after opening.

On 5/22/19 at 8:18 AM licensed staff I stated treatment carts are locked when unattended.

On 5/22/19 at 8:30 AM corporate staff GG stated treatment carts are locked when unattended.

On 5/23/19 at 11:48 AM administrative nursing staff D stated he/she expected the nursing staff to date the insulin pens after opening.

The facility's Medication Management Guidelines dated 9/1/18 documented no discontinued, outdated or deteriorated medications are retained for use and all medication carts are always under visual control of the nurse at all times when in use.

The facility failed to date opened insulin pens, which could cause a possible adverse reaction including reduced therapeutic benefit to the resident receiving the medication and failed to lock treatment cart #2.