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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00153484, KS00152737, and KS00145177. The 2567 was sent electronically to the facility on 8/12/20.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		

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

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(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 12 residents. The sample included 12 residents. Based on interviews and record review the facility failed to provide change of condition notification to one Resident's (R83) representative when he transferred to the hospital.

Findings included:

- R83's electronic medical record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), atrial fibrillation (rapid, irregular heart beat), and acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

The "Five Day Minimum Data Set" dated 06/12/20

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documented a Brief Interview for Mental Status score of 2, which indicated severely impaired cognition.

The baseline "Care Plan" dated 06/10/20 documented R83 had short and long- term memory deficits. He required extensive staff assistance for his Activities of Daily Living and uses a wheelchair for locomotion. He was at risk for falls due to multiple medications, gait problems, impaired balance, age, and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Progress Note" dated 06/12/20 at 07:08 AM documented R83 was found on the floor in a supine (lying horizontally on the back) next to the closet with his feet facing the doorway. He was unable to tell the staff what had happened. Range of motion to legs and arms was at his normal range. He did not complain of pain at the time. His pupils were nonreactive to light, with the right eye noted to be very dry. No active bleeding was noted. He was noted to be fatigued and restless. The doctor was notified, and an order was received to send R83 to the hospital for further evaluation. The Director of Nursing was notified. R83's representative was unable to be reached. The oncoming shift was notified to attempt to reach his representative later.

The EMR lacked documentation for further attempts to contact R83's representative.

On 07/29/20 at 11:32 AM Social Service Designee X stated she provides written notification to the resident and representative regarding hospital discharges.

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F 580	Continued From page 3 On 07/30/20 at 10:48 AM Licensed Nurse (LN) G stated when she received an order to send a resident to the hospital for evaluation, she sent the resident even if she was unable to reach the resident's representative. On 07/30/20 at 12:37 PM Administrative Nurse D stated she was notified of the inability to reach R83's representative. She expected another attempt to be made later in the day and the attempt to be documented. The facility's "Responding To Medical Emergencies" policy dated 02/29/16 documented the LN notified the resident's legally responsible party to inform them of the change in condition and any subsequent physician orders. The facility failed to notify R83's representative of his fall and subsequent transfer to the hospital.	F 580		
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 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).	F 657		

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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 12 residents. The sample included 12 residents. Based on observation, interviews, and record review the facility failed to update the care plan to reflect change in code status for Resident (R) 32.

Findings included:

- The "Diagnoses" tab of R32's electronic medical record (EMR) documented diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), quadriplegia (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), and pressure ulcer of right buttock.

The "Annual Minimum Data Set" (MDS) dated 11/26/2019 revealed R32 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R32 required total dependence with two staff assistance for bed mobility, toileting, and transfers. R32 required total dependence with one staff for locomotion, dressing, eating, and personal hygiene.

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The "Quarterly MDS" dated 05/25/2020 revealed R32 had a BIMS score of 13 which indicated cognitively intact. R32 required total dependence with two staff assistance for transfers, total dependence with one staff assistance for locomotion, dressing, eating, and personal hygiene.

The "Cognitive Loss/Dementia Care Area Assessment" dated 11/26/2019 revealed R32 had some cognitive deficits which may have impaired his ability to adequately communicate his needs and wants.

The "Care Plan" revised on 12/05/2019 documented R32 was a Full Code (a technique of basic life support for the purpose of oxygenating the brain and heart until appropriate medical treatment can restore normal heart and ventilation action) and directed staff to honor R32's preference for full code.

The "Orders" tab of R32's EMR documented an order with start date 05/21/20 for DNR (Do not resuscitate [DNR]- or no code, a written legal order to withhold cardiopulmonary resuscitation, in respect of the wishes of a person in case their heart stopped or they stopped breathing).

The signed DNR form was present in R32's physical chart.

An observation on 07/30/20 at 08:48 AM revealed R32 laid in bed, activities director told R32 jokes at bedside.

On 07/30/2020 at 10:48 AM, Licensed Nurse (LN) G stated a resident's code status was in the EMR

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F 657	Continued From page 6 and in the chart. She stated if a code status was changed the Assistant Director of Nursing updated the care plan. On 07/30/2020 at 12:27 PM Administrative Nurse D stated code status was in the EMR and DNRs are in the physical chart. She stated the MDS coordinator updated the care plans. The "Individualized Care Plan" policy effective date 02/29/2016 directed facility the comprehensive care plan included any services that were not provided due to the resident's exercising of rights including the right to refuse treatment. The facility failed to update the care plan to reflect the change in code status. This placed R32 at risk for not having his wishes regarding resuscitative measures honored.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge	F 661		

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medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 12 residents. The sample included 12 residents. Based on interviews and record review the facility failed to document a recapitulation of the facility stay upon discharge from the facility for Resident (R) 35 sampled for discharge.

Findings included:

- The "Diagnoses" tab of R35's electronic medical record (EMR) documented diagnoses of malignant neoplasm of the frontal and occipital lobes (brain cancer), hemiplegia (paralysis of one side of the body), and muscle weakness.

R35's "Admission Minimum Data Set" dated 12/10/19 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. He required limited to extensive staff assistance with his "Activities of Daily Living" (ADLs).

The "ADL Functional/Rehabilitation Potential Care Area Assessment" dated 12/10/19 documented

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R35 required staff assistance for his ADLs due to his diagnoses.

The "Care Plan" dated 12/12/19 documented R35's goal was to be discharged to home but, due to continuing decline in his condition he required a setting which was able to meet and accommodate his needs.

The "Physician's Order" tab of the EMR documented an order for discharge to a rehabilitation facility dated 01/31/20.

The nurse's "Progress Note" dated 01/31/20 documented R35 was discharged to another facility. His belongings and medications were given to his mother. He was transported by the other facility's service. Follow up instructions and education were provided to the admitting facility.

The "Transfer/Discharge Summary" tab of the EMR documented, under "Line 6," the recapitulation of stay must include diagnoses, course of illness/treatment and progress with therapy, pertinent lab, radiology, and consultation results. Facility staff documented only "follow up care to follow at facility of choice." The form lacked a full recapitulation of R35's stay..

On 07/30/20 at 10:48 AM Licensed Nurse G stated residents and their representatives were educated on the process for transferring to another facility. She documented transfers on the transfer/discharge section of the EMRs. There was a box to document which services and their condition history residents had received prior to the transfer.

On 07/30/20 at 12:37 PM Administrative Nurse D

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F 661	Continued From page 9 verified there was no recapitulation of R35's stay in the EMR. The facility's "Transfer, Discharge, & Bed-Hold Notices" policy dated 10/1/17 lacked documentation for the need for a recapitulation of the residents' stays. The facility failed to document a recapitulation of R35's facility stay after his discharge from the facility.	F 661		
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 12 residents. The sample included 12 residents. Based on record reviews, observations, and interviews the facility failed to ensure Resident (R)19 received treatment and care in accordance with professional standards of practice when the facility failed to follow a physician's order which directed staff to apply compression stocking (specially made socks which help prevent leg swelling and possible blood clots) to R19's lower extremities. Findings included:	F 684		

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- The "Diagnoses" tab of R19's electronic medical record (EMR) documented diagnoses of chronic obstructive pulmonary failure (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, hemiplegia of his left side (paralysis of one side of the body), and acute/chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

The "Admission Minimum Data Set" (MDS) dated 05/11/20 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R19 required extensive staff assistance with dressing.

The "Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" dated 05/12/20 documented R19 required maximum assistance with his ADLs.

The "Care Plan" dated 10/28/19 documented R19 required compression stockings applied in the morning and removed at bedtime. He had edema (swelling) to both legs.

The EMR documented a physician's order for bilateral leg compression stockings to be donned in the am and doffed in the PM every 12 hours for deep vein thrombosis (DVT-potentially life-threatening blood clot, usually in the legs) and edema dated 05/07/20.

The EMR also documented an order for Torsemide (medication used to remove excess fluid from the body) 20 milligrams twice daily for edema.

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R19's "Treatment Administration Record" (TAR) dated July 2020 indicated the bilateral leg compression stockings were donned at 08:00 AM and doffed at 08:00 PM. The TAR documented compression stockings were applied to R19 on 07/28/20 and 07/29/20.

On 07/28/20 at 02:05 PM R19 rested in his bed. He had no compression stockings on. There was no edema noted to his legs.

On 07/28/20 at 03:30 PM R19 rested in his bed. He had no compression stockings on. He stated the staff had not applied them today.

On 07/29/20 at 02:30 PM R19 sat in his wheelchair with his legs elevated. He had no compression stockings on. He stated sometimes the staff donned the stockings and sometimes they didn't.

On 07/30/20 at 11:55 AM R19 rested in his bed. He had no compression stockings on.

On 07/30/20 at 10:30 AM Certified Nurse Aide (CNA) M stated the CNAs apply the residents' compression stockings most of the time.

On 07/30/20 at 12:19 PM Licensed Nurse (LN) G stated the CNAs don the residents' compression stockings and the nurses record the procedure. LN G stated she assessed the resident to make sure the stockings had been donned prior to recording on the TAR.

On 07/30/20 at 12:37 PM Administrative Nurse D stated the CNAs are responsible for the donning of compression stockings. The procedure was

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F 684	Continued From page 12 recorded by the nurses in the TAR. She expected the procedure to be done as it was documented. The facility lacked a policy for following physician orders and documentation on the TAR. The facility failed to ensure staff applied R19's compression stockings as directed by the physician's order. This failure had the potential of increased leg edema and possible DVT formation, which could result in unnecessary complications and hospitalization.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 12 residents. The sample included 12 residents with one resident reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, interviews, and	F 686		

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record reviews, the facility failed to follow wound care orders for Resident (R) 32 as ordered by the wound care center provider for a stage four (wound that extends below the subcutaneous [beneath the skin] fat into deep tissues like muscles, tendons, and ligaments) pressure ulcer on the resident's right buttocks/ischium (part of the hip bone).

Findings included:

- The "Diagnoses" tab of R32's electronic medical record (EMR) documented diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), quadriplegia (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), and pressure ulcer of right buttock stage four.

The "Annual Minimum Data Set" (MDS) assessment dated 11/26/2019 revealed R32 did not have a pressure ulcer at the time of the assessment but was at risk for development of a pressure ulcer.

The "Quarterly MDS" assessment dated 05/25/2020 revealed R32 had a stage four unhealed pressure ulcer.

The "Pressure Ulcer/Injury Care Area Assessment" (CAA) dated 11/26/2019 revealed R32 was at increased potential for pressure ulcer/injury related to immobility, presence of catheter (soft hollow tube, which is passed into the bladder to drain urine), incontinence of bowel (inability to control bowel movements) and dependence on others for repositioning.

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The "Care Plan" dated 07/27/2020 documented the resident had a stage four pressure wound to right ischium and directed facility to administer medications and treatments as ordered and monitor for effectiveness.

The "Orders" tab of the EMR documented an order with a start date of 07/27/20 to crust peri-wound (tissue surrounding a wound) with stoma powder (nonmedicated powder that is designed to absorb moisture from raw and broken skin) and skin prep (a solution when applied that forms a protective waterproof barrier on the skin) with every wound-vac (method of decreasing air pressure around a wound to assist the healing) dressing change every Monday, Wednesday, and Friday for wound care.

Wound care center orders from 07/22/20 provider visit directed staff to crust peri-wound with stoma powder and skin prep with each dressing change.

An observation on 07/27/2020 at 02:53 PM revealed Licensed Nurse (LN) G failed to crust peri-wound with stoma powder and skin prep as ordered with wound-vac dressing change.

An observation on 07/29/2020 at 04:01 PM revealed LN G failed to crust peri-wound with stoma powder and skin prep as ordered with wound-vac dressing change.

On 07/29/2020 at 03:58 PM LN G stated there was a new order for stoma powder but that it was for R32's peri-area rash. She stated R32 did not have any other wounds.

On 07/30/2020 at 09:10 AM Administrative Nurse E stated the nurses review new orders from the

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F 686	Continued From page 15 wound clinic and that she reviewed the orders on weekly wound assessments. She stated she had not seen the most recent order from R32's last wound clinic visit. On 07/30/2020 at 10:48 AM LN G stated when the resident came back from the wound clinic, the nurse put new orders in the computer, notified the wound nurse of the new order, and gave a copy to the facility provider. On 07/30/2020 at 12:27 PM Administrative Nurse D stated the charge nurse verified any new orders from the wound clinic and the wound nurse made sure it was in place. On R32's new order for stoma powder peri-wound, she expected staff to put it around the outside of the wound. The facility failed to provide a policy for wound care and wound care orders. The facility failed to follow wound care orders from wound care clinic for R32's stage four pressure ulcer which had the potential for a prolonged healing process and possible complications.	F 686		
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.	F 689		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 12 residents. The sample included 12 residents with three residents sampled for accidents. Based on observations, interviews, and record reviews the facility failed to ensure staff implemented interventions to prevent injury from falls when staff failed to provide a floor mat as indicated in R2's plan of care. This deficient practice placed R2 at risk for injury due to falls and/or accidents.

Findings included:

- R2's electronic medical record (EMR) documented diagnoses of muscle weakness, difficulty walking, cognitive communication deficit, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The 09/18/19 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely impaired cognition. She required extensive staff assistance with her "Activities of Daily Living" (ADLs). She was incontinent of bowel and bladder. She had no falls since her admission.

The "Quarterly MDS" dated 06/16/20 documented a BIMS score of one, which indicated severely impaired cognition. She required extensive to total assistance with her ADLS. She had no falls since the prior assessment.

The 09/19/19 "Falls Care Area Assessment"

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documented R2 had increased potential for falls related to her gait and balance deficits and cognitive impairment with poor safety awareness.

The resident's "Care Plan" dated 12/04/19 documented R2 was at risk for falls related to Alzheimer's diagnosis and poor safety awareness. She was provided with fall mats at her bedside, when she was in bed, to reduce the risk for injury from falls.

A "Progress Note" dated 12/3/19 documented R2 was found lying on the floor, face down with the left side of her face touching the floor. She sustained a small abrasion to her right pointer finger, both knees were reddened, her right big toe was bleeding, her left eyebrow was swollen, and her left upper cheek was red and tender to touch. She was sent to the hospital for further evaluation.

On 07/29/20 at 01:21 PM R2 was resting in bed with her eyes closed. One side of her bed was against the wall. The bed was in a low position. There was no floor mat noted beside the bed. A small stool with rollers on it was next to the bed.

On 07/29/20 at 03:25 PM R2 was resting in bed. The bed was in the low position. There was no floor mat beside the bed. The small stool with rollers on it was about 3 feet from the bed.

On 07/30/20 at 10:30 AM Certified Nurse Aide (CNA) M stated staff knew when residents were a fall risk from staff report and observations of the residents' movements. CNA M stated R2 required her bed to be in a low position and a floor mat placed beside her bed to help prevent injury from falls.

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F 689	Continued From page 18 On 07/30/20 at 10:48 AM Licensed Nurse G stated an immediate intervention was started by the nurse on duty after a resident fall. The comprehensive care plan was then revised by the administrative staff. On 07/30/20 at 12:37 PM Administrative Nurse D stated falls are investigated to analyze the root cause of the fall and care plan interventions are implemented. She expected the floor mat to be placed by R2's bedside when the resident was in bed. The undated "Fall Management Program v 1.0" documented the fall investigation ensured the residents' comprehensive care plans were adjusted as needed. The facility's "Individualized Care Plan" policy dated 11/1/17 documented the residents' comprehensive care plans were revised with significant changes in the residents' conditions. The facility failed to ensure a floor mat was placed beside R2's bed, while she rested in bed. This deficient practice failed to ensure her environment was free from accident hazards, as directed by her comprehensive care plan. This had the potential for unnecessary injuries associated with a fall.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 693		

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enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 12. The sample included 12 residents with one resident reviewed for feeding tube (tube for introducing high calorie fluids into the stomach). The facility failed to provide appropriate care and services to prevent complications of enteral feedings when staff failed to date and time the feeding tube administration tubing and feeding formula bag for Resident (R) 32.

Findings included:

- The "Diagnoses" tab of the electronic medical record (EMR) documented diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), adult gastrostomy

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status (surgical creation of an artificial opening into the stomach thru the abdominal wall), and dysphagia (difficulty swallowing).

The "Annual Minimum Data Set" (MDS) dated 11/26/2019 revealed R32 did not have a feeding tube at the time of the assessment.

The "Quarterly MDS" dated 05/25/2020 revealed R32 had a feeding tube and received 51% or more of total calories through feeding tube.

The "Nutritional Status Care Area Assessment" (CAA) dated 11/26/2019 indicated R32 required assistance with meals.

The "Care Plan" initiated 05/21/2020, revision on 06/15/2020 documented R32 required tube feedings related to multiple sclerosis. He was dependent with tube feedings and water flushes ordered by the physician.

The "Orders" tab of the EMR documented an order with a start date of 07/09/2020 for enteral feeding (tube feedings) of Fibersource (feeding tube formula) HN (high nutrition) at 60 milliliters (mL) per hour every shift.

An observation on 07/27/2020 at 09:11 AM revealed R32's feeding tube administration tubing and feeding formula bag was not dated/timed.

An observation on 07/30/20 at 08:30 AM revealed the feeding tube administration tubing and feeding formula bag was not dated/timed, R32 was receiving feeding formula through administration tubing at 60 mL per hour.

On 07/30/2020 at 10:48 AM Licensed Nurse (LN)

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F 693	Continued From page 21 G stated the tube feeding bags and tubing are changed on night shift and are dated. On 07/30/2020 at 12:27 PM Administrative Nurse D stated she expected staff to change tube feeding bags every 24 hours and to date/initial the tubing and bag. The procedural guideline "Care of Gastrostomy or Jejunostomy (surgical creation of an opening through the skin at the front of the abdomen and the wall of the jejunum [part of the small intestine]) Tube" dated 2014 did not address dating the feeding administration tubing or formula bag. The facility failed to date and time feeding tube administration tubing and feeding formula bag for R32 which had the potential for administration of unsafe equipment and unwarranted physical complications.	F 693		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 12 residents. The sample included 12 residents. Based on observations, interviews, and record reviews, the facility failed to assess Resident (R) 32's pain before, during, and after wound dressing change.	F 697		

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F 697	Continued From page 22 Findings included: - The "Diagnoses" tab of R32's electronic medical record (EMR) documented diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), quadriplegia (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), and pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of right buttock/ischium (part of the hip bone) stage four. The 'Annual Minimum Data Set' (MDS) assessment dated 11/26/2019 revealed R32 complained of pain rarely during the assessment period and did receive PRN (as needed) pain medication. The "Quarterly MDS" assessment dated 05/25/2020 revealed R32 denied the presence of pain and did not receive PRN pain medication during the assessment period. The "Cognitive Loss/Dementia Care Area Assessment" dated 11/26/2019 revealed R32 had some cognitive deficits which may have impaired his ability to adequately communicate his needs and wants. The "Care Plan" dated 12/06/2020 documented the resident had a stage four pressure wound to right ischium and directed facility to assess and treat pain before, during, and after wound care treatment. On the "Orders" tab of the EMR, there was no	F 697		

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F 697	Continued From page 23 order for pain assessment scheduled in the "Medication Administration Record" (MAR). An observation on 07/27/2020 at 03:12 PM revealed Licensed Nurse (LN) G did not assess pain before, during, or after dressing change. An observation on 07/29/2020 at 04:09 PM revealed LN G did not assess pain before, during, and after wound dressing change. An interview on 07/27/20 at 09:11 AM R32 stated the wound on his buttocks became uncomfortable when he sat in the wheelchair too long and he did not receive pain medication for it. An interview on 07/30/2020 at 12:27 PM Administrative Nurse D stated every resident was assessed for pain every shift and pain was documented on the MAR. An interview on 07/30/2020 at 12:41 PM LN H stated that residents were assessed for pain every shift and the pain assessment was on the MAR. The undated "Pain Management Program" directed that a pain assessment included current level of pain and pain management. The facility failed to assess pain before, during, or after wound dressing change for R32 which placed R32 at risk for increased pain, physical and psychosocial complications.	F 697		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		

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§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 when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 12 residents.

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The sample included 12 residents. Five residents were sampled for unnecessary medication review. Based on observations, record reviews, and interviews the facility failed to ensure the Consultant Pharmacist (CP) identified and reported a blood pressure medication was given outside of the Primary Care Provider's (PCP) ordered parameters for Resident (R) 14.

Findings included:

- The "Diagnoses" tab of R14's electronic medical record (EMR) documented diagnoses of atrial fibrillation (rapid irregular heartbeat) and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).

The "Admission Minimum Data Set" (MDS) dated 08/14/19 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. She required extensive to total staff assistance with her "Activities of Daily Living" (ADLs).

The "Quarterly MDS" dated 05/13/20 documented a BIMS score of seven, which indicated severely impaired cognition. She required extensive to total staff assistance with her ADLs.

The 08/14/19 "ADL Functional/Rehab Potential Care Area Assessment" documented R14 required extensive assistance with self-care due to hemiparesis (paralysis of one side of the body).

The "Care Plan" dated 08/22/19 documented R14 had altered cardiovascular status due to her CHF and atrial fibrillation. The facility administered her medications.

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The "Physician's Order" tab of R14's EMR documented an order for Carvedilol (medication used to treat hypertension- (elevated blood pressure) and CHF) 3.125 milligrams twice daily for hypertension. Hold if the systolic blood pressure (the pressure in arteries during the contraction of the heart) was under 85 millimeters of mercury (mmHg) or the heart rate was under 60 and notify the Cardiovascular Physician dated 12/7/19.

The "Medication Administration Record" (MAR) reviewed from February 2020 through 07/27/20 indicated the Carvedilol was given when systolic blood pressure readings were below 85 mmHg seven of 58 times in February, one of 62 times in March, one of 60 times in April, one of 62 times in May, one of 60 times in June, and three of 54 times in July.

The monthly Medication Regimen Review (MRR) from August 2019 to June 2020 lacked evidence the CP notified the facility of Carvedilol given outside of ordered parameters for R14.

On 07/28/20 at 02:22 PM R14 colored a picture, as she laid in bed.

On 07/30/20 at 10:48 AM Licensed Nurse G stated she held the medication, notified the physician, and documented the information in the progress notes when a resident's blood pressure was below physician ordered parameters.

On 07/30/20 at 12:27 PM Administrative Nurse D stated she expected the nursing staff to notify the physician if a blood pressure was outside of the ordered parameters.

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(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 756	Continued From page 27 On 08/03/20 at 08:08 AM Administrative Nurse D stated she expected the nursing staff to hold a blood pressure medication when a blood pressure was low. 08/03/20 at 12:52 PM Consultant GG stated she looked at antihypertensives to see if the medication had parameters and if the medications were given within parameters. She stated if she saw any that were given outside parameters, she let the facility know. She stated she noticed several administrations for carvedilol for R14 were given outside parameters and noted that on the July MRR. The "Medication Regimen Review" Policy dated 12/01/2007 directed Consultant Pharmacist will conduct MMRs if required under a Pharmacy Consultant Agreement. The facility failed to ensure the CP identified R14's blood pressure medication was given when her blood pressures were outside of physician ordered parameters. This deficient practice had the potential of unnecessary medication use and unwarranted 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	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	07/30/2020

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F 757	Continued From page 28	F 757		

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 12 residents. The sample included 12 residents. Five residents were sampled for unnecessary medication review. Based on observations, record reviews, and interviews the facility failed to hold antihypertensive (medication used to treat high blood pressure) medication for Resident (R) 14, when her blood pressures were outside standing order parameters.

Findings included:

- The "Diagnoses" tab of R14's electronic medical record (EMR) documented diagnoses of atrial fibrillation (rapid irregular heartbeat) and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).

The "Admission Minimum Data Set" (MDS) dated 08/14/19 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. She required extensive to total staff

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F 757	Continued From page 29	F 757		

assistance with her "Activities of Daily Living" (ADLs).

The "Quarterly MDS" dated 05/13/20 documented a BIMS score of seven, which indicated severely impaired cognition. She required extensive to total staff assistance with her ADLs.

The 08/14/19 "ADL Functional/Rehab Potential Care Area Assessment" documented R14 required extensive assistance with self-care due to hemiparesis (paralysis of one side of the body).

The "Care Plan" dated 08/22/19 documented R14 had altered cardiovascular status due to her CHF and atrial fibrillation. The facility administered her medications.

The "Physician's Order" tab of R14's EMR documented an order for Carvedilol (medication used to treat hypertension- (elevated blood pressure) and CHF) 3.125 milligrams twice daily for hypertension. Hold if the systolic blood pressure (the pressure in arteries during the contraction of the heart) was under 85 millimeters of mercury (mmHg) or the heart rate was under 60 and notify the Cardiovascular Physician dated 12/7/19.

The "Medication Administration Record" (MAR) reviewed from February 2020 through 07/27/20 indicated the Carvedilol was given when systolic blood pressure readings were below 85 mmHg seven of 58 times in February, one of 62 times in March, one of 60 times in April, one of 62 times in May, one of 60 times in June, and three of 54 times in July.

On 07/28/20 at 02:22 PM R14 colored a picture,

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as she laid in bed.

On 07/30/20 at 10:48 AM Licensed Nurse G stated she held the medication, notified the physician, and documented the information in the progress notes when a resident's blood pressure was below physician ordered parameters.

On 07/30/20 at 12:27 PM Administrative Nurse D stated she expected the nursing staff to notify the physician if a blood pressure was outside of the ordered parameters.

On 08/03/20 at 08:08 AM Administrative Nurse D stated she expected the nursing staff to hold a blood pressure medication when a blood pressure was low.

The facility failed to provide a policy on administration of antihypertensive medications and their parameters.

The facility failed to hold R14's antihypertensive medication when her blood pressures were outside of physician ordered parameters. This deficient practice had the potential of unnecessary medication use and unwarranted side effects.