

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175441	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER VILLAGE SHALOM INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5500 WEST 123RD ST OVERLAND PARK, KS 66209		
(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	F 000			
F 550 SS=D	The following citations represent the findings of a Health Resurvey and Complaint #KS00180119.. The 2567 was sent electronically on 10/30/23. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/30/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents with one reviewed for dignity. Based on observation, record review, and interview, The facility failed to promote dignity for Resident (R) 39 during medication administration, and R22 during noon meal service. This placed the resident's at risk for undignified care and services. Findings included: - R39's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) aphasia (condition with disordered or absent language function), and adult failure to thrive (includes not doing well, feeling poorly, weight loss, poor self-care that could be seen in elderly individuals). The "Quarterly Minimum Data Set" (MDS), dated 08/25/23, documented R39 had a Brief Interview for Mental Status (BIMs) score of 99 and had moderately impaired cognition. R39 was dependent upon two staff for bed mobility, transfers, and dressing. R39 was dependent upon one staff for eating, toileting, and personal hygiene. The assessment further documented	F 550			

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F 550	Continued From page 2 R39 received nutrition daily through a feeding tube (tube for introducing high calorie fluids into the stomach). R39's "Care Plan," dated 08/30/23, directed staff to administer medications as ordered, and provide tube feedings as ordered. On 10/17/23 at 08:00 AM, observation revealed Licensed Nurse (LN) I went into R39's room to administer morning medications and did not knock on the door prior to entering. LN I did not shut the curtains or shut the door to R39's room. LN I lifted up R39's night gown, which left the resident's legs, incontinence brief, and stomach exposed. LN I checked placement of R39's feeding tube and began to administer medications. Further observation revealed three staff members came to R39's room and talked with LN I during the administration. On 10/17/23 at 08:15 AM, LN I stated he should have shut the door and curtains prior to administering the resident her medications via the tube. On 10/18/23 at 10:46 AM, Administrative Nurse D stated LN I should have shut R39's door and curtains before he started the medication administration per tube. The facility's "Dignity" policy, dated 01/20/22, documented the facility would promote care for residents of the facility in a manner ad in an environment that maintained and enhanced each elder's dignity and respect in full recognition of the elder's individuality. The facility failed to promote care for R39 in a	F 550			

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F 550	Continued From page 3 dignified manner during medication administration through her feeding tube. This placed the resident at risk for undignified care and services. - On 10/16/23 at 12:00 PM, during the noon meal service, observation revealed R22 sat at a bedside table against the wall alone. Further observation revealed R22 asked Certified Nurse Aide (CNA) M if she was going to get a lunch tray. CNA M stated, "They are working on it." Continued observation revealed at 12:15 PM, R22 asked if she was going to get any lunch and a CNA stated, "They are still working on it." Observation revealed at 12:40 PM, as all the other resident's had received their meals, R22 asked again if she was going to eat lunch that day, and a CNA stated, "Would you like some potato chip while you wait?" Further observation revealed at 1:00 PM, R22 still had not received her meal. On 10/16/23 at 1:05 PM, Dietary Staff BB stated R22 received a kosher meal (a cultural dietary framework for food preparation, processing, and consumption) and the dietary aide forgot to grab it when the aide got the food from the kitchen. On 10/19/23 at 01:00 PM, Dietary Consultant HH stated the staff member who was in charge of the kosher kitchen was off on that day and staff should have remembered to get R22's tray from that kitchen. The facility's "Dignity" policy, dated 01/20/22, documented the facility would promote care for residents of the facility in a manner ad in an environment that maintained and enhanced each elder's dignity and respect in full recognition of	F 550			

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F 550	Continued From page 4 the elder's individuality.	F 550			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565			

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F 565	Continued From page 5 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to act upon the concerns of the resident council group concerning issues of care and life in the facility. This placed the residents at risk of decreased quality of care and services. Findings included: - The monthly Resident Council meetings recorded the following: In September 2023, the residents voiced concerns over staffing and the desire for more consistent staff. Other concerns included the residents did not always get a menu in advance, and the kitchen ran out of orange juice and cranberry juice. - In August 2023, the residents voiced concerns again over staffing and the desire for more consistent staff. Further concerns again included residents did not always get a menu in advance and did not get the food they ordered. - In July 2023, the residents voiced concerns over staffing again, and the desire for more consistent staff. Further concerns included late meals, and unavailable food items with no alternatives. - In June 2023, the council concerns remained over the lack of staffing and the desire for more	F 565			

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F 565	Continued From page 6 consistent staff. Further concerns included the hamburgers and hot dogs were burnt, the chicken was overcooked, and the facility continued to run out of staples like juices and brown sugar. No May 2023 meeting was noted. In April 2024, the council concerns remained over the lack of staffing and the desire for more consistent staff. In March 2023, the council voiced concerns over staff were always on their cell phones. Additional concerns included breakfast and lunch were not always on time. In February 2023, the residents voiced concerns about the nursing staff were always on cell phones. Additional concerns included the call light response time needed work. In January 2023, the council voiced concerns over staffing and having to wait for staff. Call light response time remained a concern as well. No December 2023 meeting was noted. In November 2024, the residents voiced concerns over staffing and the desire for more consistent staff and the need for more staff. Additional concerns included nursing staff were on cell phones, and the eggs were rubbery. Residents wanted more fruit. In October 2014, the residents voiced concern over staffing. Additional concerns included the Salisbury chopped steak was tough and the hamburgers were burnt and lacked flavor.	F 565			

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F 565	Continued From page 7 On 10/19/23 at 02:00 PM Administrative Staff A verified awareness of the resident council's continued concerns from month to month and stated staffing was on ongoing issue. Administrative Staff A stated the facility had a new management company for dining to help with the food concerns and understood the ongoing issues. The facility "Resident Council" policy, dated 11/23/15, documented each resident would be encouraged to organize, meet, participate in Resident Council and a designated staff would provide assistance and respond to written request that result from the group meetings, and shall listen to the views and act upon the recommendations and grievances of such groups concerning proposed policy and operational decisions affecting resident care and life in the facility. The facility failed to act promptly upon the concerns of the resident council groups concerning issues of care and life in the facility, which placed the residents who resided in the facility at risk for decreased quality of life.	F 565			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609			

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F 609	Continued From page 8 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to report to the State Agency (SA) an unwitnessed fall that resulted in a fracture for Resident (R)50, who was unable to state what happened. This placed the resident at risk for unidentified and ongoing abuse or neglect. Findings Included: - R50's Electronic Medical Record (EMR) documented diagnoses of repeated falls, confusional arousal (when a sleeping person appears to wake up, but their behavior is unusual or strange), muscle spasms, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot	F 609			

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F 609	Continued From page 9 respond to the insulin). The "Admission Minimum Data Set" (MDS) dated, 05/06/23, documented R50 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition and required extensive assistance of one staff for bed mobility, transfers, ambulation; and supervision and one staff assistance for personal hygiene. The MDS further documented R50 had unsteady balance, lower impairment functional impairment on both sides, and had no falls. The "Quarterly MDS," dated 07/27/23, documented R50 had a BIMS score of 13, which indicated intact cognition and required extensive assistance of one staff for bed mobility, toileting, dressing, personal hygiene. R50 did not ambulate. The assessment further documented R50 had unsteady balance, lower functional impairment on both sides, and had no falls. The "Fall Risk Assessments," dated 05/02/23, 05/08/23, 06/18/23, 07/21/23, 08/29/23, 09/07/23, and 10/03/23, documented R50 was at risk for falls. The "Care Plan," dated 10/03/23, initiated on 06/26/23, directed staff to keep his walker within arm's reach, cue and assist to the bathroom after all meals, remind him to call for assistance, and place a sign on his wall to remind him to call for assistance. The update, dated, 07/27/23, directed staff to switch out his call light necklace to his wrist, so he could locate it better. The update, dated 08/29/23, directed staff to ensure his bed was at the standard height. The update, dated 09/03/23, directed staff to ensure R50 wore nonskid socks. The update, dated 09/07/23,	F 609			

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F 609	Continued From page 10 directed staff to ensure resident wore nonskid socks and place anti-slip traction to tape on the floor to the right and left of the bed. The update, dated 09/30/23, directed staff to rearrange R50's room to improve safety and do hourly checks as R50 was cognitively impaired and confused. The update, dated 10/03/23, directed staff to ensure the light in his room was adequate, family members educated to call for assistance with R50 required assistance, remind R50 to call for assistance, educated R50 on the bed controls and how to use them, educated R50 to call for assistance when he wants to get out of bed, and remind R50 to wear nonskid socks. The "Fall Investigation," dated 09/30/23 at 10:30 PM, documented R50 was on the floor in his room. R50 stated he did not know what happened. The note recorded R50 was last toileted around 09:15 PM. The investigation further documented R50 had a laceration above his left eye which measured 0.1 centimeter (cm) by 0.2 cm, and some bruises on the right ribs. R50 complained of pain all over and went to the emergency room for evaluation. The investigation documented R50 sustained a fractured nasal bone, a fracture of the lumbar transverse process (type of spinal fracture), and a facial laceration. The "Nurse's Note," dated 10/03/23 at 06:44 PM, documented R50 had bruises to his face and arms, and education was provided on fall prevention and education on how to use the call light system, to demonstrate back to staff, and he was unable to use the call light system. R50's clinical record lacked evidence the unwitnessed fall was reported to the SA, as required, within the required timeframes.	F 609			

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F 609	Continued From page 11 On 10/17/23 at 09:30 AM, observation revealed Certified Nurse Aide (CNA) M pushed R50's wheelchair into the bathroom, instructed him to use the wheelchair arms to push up, stand, and grab onto the grab bars by the toilet. Further observation revealed, CNA M did not use a gait belt and R50 was very unsteady and could not follow her instructions. CNA M instructed him to turn to the left, he would turn to the right, and after multiple times cuing, he was able to turn to the left as instructed so she could assist him with toileting. On 10/19/23 at 10:46 AM, Administrative Nurse D stated she did not report the fall to the SA because there were two staff members on shift, so she did not feel there was abuse involved. The facility's "Abuse, Neglect, and Exploitation" policy, dated 01/03/22, documented all residents would be treated with respect, kindness, and dignity they deserve, and the facility would ensure steps were followed in identifying both residents and staff who might have the potential to be abusive as well as what to do in case of a suspected incident of physical, emotional or social abuse, neglectful treatment, or misappropriated of resident personal property. The facility failed to report to the SA an unwitnessed fall with significant injury for R50, who was unable to state what happened. This deficient practice placed him at risk for further injury and unidentified abuse or mistreatment.	F 609			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677			

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F 677	Continued From page 12 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents with six residents reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to provide necessary services to maintain good personal hygiene, including bathing, for Resident (R)61. This placed the resident at risk for poor personal hygiene and infection. Findings included: - R61's Electronic Medical Record (EMR) recorded diagnoses of cerebral vascular accident (CVA-stroke- sudden death of brain cells due to impaired lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis one side of the body), and weakness. R61's "Quarterly Minimum Data Set" (MDS), dated 08/16/23, recorded R61 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. The MDS recorded R61 required extensive assistance of one staff for most ADL and bathing. The MDS recorded bathing did not occur in the seven day look back period. R61's "Care Plan," dated 08/21/23, indicated R61 required one to two staff assistance with ADL care. The care plan recorded the resident preferred showers on Monday and Thursday	F 677			

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F 677	Continued From page 13 evenings. R61's bathing list and skin documentation documented the residents bath were scheduled twice a week on Sundays and Tuesdays. The July 2023 bathing report documented the resident received a bath on the following days: 07/03/23 07/05/23 07/07/23 0710/23 07/12/23 07/17/23 07/19/23 The August 2023 bathing report documented the resident received a shower on the following days: 08/02/23 (11 days with no shower) 08/07/23 08/09/23 08/15/23 08/17/23 08/22/23 The September 2023 bathing report documented the resident received a shower on the following days: 09/04/23 (12 days with no shower) 09/11/23 09/18/23 09/25/23 The October 2023 bathing report documented the resident received a shower on the following days: 10/02/23 (six days with no shower) 10/09/23 10/16/23			F 677			

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F 677	Continued From page 14 On 10/16/23 at 12:30 PM, observation revealed R61 sat in a wheelchair at the dining room table. Continued observation revealed the resident was dressed in street clothes and the resident's hair was uncombed. On 10/19/23 at 09:00 AM, Administrative Nurse D verified the residents had scheduled bath/shower days and the aides documented in the EMR. Administrative Nurse D said the facility did not have any additional shower sheets. Administrative Nurse D verified the resident was scheduled to have a shower on Sunday and Tuesday evenings and verified the resident's EMR noted the dates she received a shower and verified the resident had not received bathing twice weekly. Administrative Nurse D stated she felt like the residents received their assigned shower/baths, but the staff failed to record the baths/showers in the EMR. Upon request the facility did not provide an activity of daily living/bathing policy. The facility failed to provide the necessary care and bathing services for R61, placing the resident at risk for poor hygiene.	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684			

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F 684	Continued From page 15 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents with one reviewed for non-pressure skin injuries. Based on observation, record review, and interview, the facility failed to follow up on Resident (R) 23's impaired skin with interventions to prevent further injuries and failed to document the treatment that was administered for a skin tear of unknown origin on the resident's left lower leg. This placed the resident at risk for further skin injuries and related complications. Findings Included: - R23's Electronic Medical Record (EMR) documented diagnoses of reduced mobility, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), polyneuropathy (simultaneous malfunction of peripheral nerves throughout the body), and hypertension (high blood pressure). The "Quarterly Minimum Data Set" (MDS), dated 08/02/23, documented R23 had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R23 required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The assessment further documented she received ointment other than to her feet. R23's "Care Plan," dated 08/09/23 directed staff to inspect her skin when dressing, bathing, and toileting for open areas or discoloration, and report it to the nurse. The plan directed staff to	F 684			

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F 684	Continued From page 16 provide nutrition intervention per recommendation of the dietician, and weekly skin assessment by a licensed staff. On 10/17/23 at 08:55 AM, observation of R23's left lower leg revealed two Steri-strips (wound closure tape) over a small, scabbed area. License Nurse (LN) H stated she did not know R23 had a skin tear. LN H took Skin-prep (liquid skin protectant) and rubbed it on top of the wound. LN H removed the Steri-strips and said she would look for documentation regarding the area. On 10/17/23 at 09:00 AM, R23's EMR lacked evidence of documentation of R23's wound including the causative factor, the treatment applied, or physician notification. A "Nurse's Note," dated 10/17/23 and entered at 03:55 PM, documented R23 presented that day with a small scab to left lower extremity with Steri-strips attached. The Steri-strips were removed, and there was a small scab which measured 0.3 centimeters (cm) in length. Skin-prep was applied, and staff notified the physician and family. The note documented staff would apply Tubi-grips (elasticated tubular bandage designed to provide tissue support in treating strains, sprains, soft tissue injuries, general edema and tissue protection) to R23's lower extremities to be removed at bedtime. On 10/19/23 at 10:46 AM, Administrative Nurse D stated, all skin injuries should be reported to administrative staff and physician for investigation and follow-up. The facility's "Wound Management Policy and	F 684			

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F 684	Continued From page 17 Procedure," dated 09/12/23, documented any resident with a wound received treatment and services consistent with the resident's goals of treatment and promote healing and prevention of infection. The facility failed to follow up on R23's impaired skin with interventions to prevent further injuries and failed to document the treatment that was administered on the resident's left lower leg. This placed the resident at risk for further skin injuries and related complications.	F 684			
F 686 SS=G	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 had a census of 66 residents. The sample included 18 residents, with six reviewed for 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). Based on observation, record review, and interview, the	F 686			

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F 686	Continued From page 18 facility failed to implement preventative measure to prevent facility acquired pressure ulcers for three sampled residents. As a result, Resident (R) 26 developed facility acquired deep tissue injuries (DTI-localized areas of tissue damage of necrosis that develop because of pressure) to his right heel and his right and left outer malleolus (a bony projection on either side of the ankle), a Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer on his left heel, and a Stage 1 (pressure wound which appears reddened, does not blanch, and may be painful but is not open) on his left buttocks (the fleshy round parts that form the lower rear area). The facility further failed to prevent and adequately monitor and treat facility acquired pressure injuries for R17 and R3. This deficient practice also placed the residents at risk for further skin breakdown, pain, and infections. Findings included: - R26's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), hereditary ataxia (motor incoordination resulting from dysfunction of the cerebellum and its connections), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues). The "Admission Minimum Data Set) (MDS), dated 05/25/23, documented R26 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R26 was	F 686			

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F 686	Continued From page 19 dependent upon two staff for transfers, toileting, and required extensive assistance of two staff for bed mobility, and dressing. The MDS further documented R26 was at risk for pressure ulcers, had a pressure relieving device for his bed and chair, and had no skin breakdown. The "Quarterly MDS," dated 08/09/23, documented R26 had a BIMS score of 11 which indicated moderately impaired cognition. R26 was dependent upon two staff for transfers, dressing, toileting, and required extensive assistance of two staff for bed mobility. The MDS further documented R26 was at risk for pressure ulcers, had a pressure relieving device for his bed and chair, and had no skin breakdown. The "Braden Scale Assessment," (a formal assessment for predicting pressure ulcer risk), dated 05/23/23, 06/12/23, 08/04/23, 08/08/23, and 08/15/23, documented R26 was at risk for pressure ulcers. R26's "Care Plan," initiated on 08/15/23 documented R26 was at risk for pressure ulcers and directed staff to complete a Braden scale assessment quarterly and as needed with condition change, inspect the skin when dressing, bathing, and toileting, and keep R26's skin clean and dry using a protective skin barrier cream with each brief change. The plan directed staff to use a pressure relieving air mattress and chair cushion and reposition him every 2-3 hours while in bed and when sitting up as needed. The update, dated 08/29/23, documented R26 had a blister on his left heel and right heel, and directed staff to place heel protectors on the resident when in bed. An intervention dated 09/20/23 documented R26 had a Stage 2 pressure ulcer to	F 686			

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F 686	Continued From page 20 his left heel and a DTI to his right heel, treatment orders were in place, and he was seen by a wound doctor. It directed staff to place the heel protectors on every morning after R26 was transferred with the mechanical lift and administer Prostat (a supplement) twice a day to aid in wound healing. An update, dated 10/06/23, documented R26 had a new pressure area to his left malleolus and the certified nurse aides were instructed not to put booties on tight and to leave the strap loose. The "Nurse's Note," dated 08/28/23 at 03:42 PM, documented R26 had a fluid filled blister to his left heel which measured 2.0 centimeters (cm) by 2.0 cm and was most likely caused by friction. The nursing staff would apply Skin-prep (liquid skin protectant) daily, cover with a bordered gauze dressing, and discuss heel protectors when in bed. The "Nurse's Note," dated 08/29/23, documented the hospice aide found a fluid filled blister to R26's right heel which was like the left heel which measured 2.5 cm by 2.0 cm, most likely caused by friction. The note documented nursing staff would apply Skin-prep daily and cover with a bordered gauze dressing; staff would see if hospice would provide another pair of heel protectors for when R26 was in both bed and wheelchair. The "Skin Assessment," dated 09/01/23, documented R26 had a facility acquired Stage 2 fluid filled blister on his left heel which measured 3.8 cm by 3.6 cm by 0.1 cm. The staff applied Skin-prep and covered the area with a bordered gauze.	F 686			

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F 686	Continued From page 21 The "Skin Assessment," dated 09/11/23, documented R26 had a Stage 2 pressure injury to his left heel which measured 2.8 cm by 3.2 cm by 0.1 cm. The staff applied Skin-prep and covered the area with a bordered gauze. The "Physician Order," dated 09/14/23, directed staff to cleanse the open left heel wound with wound cleanser and apply Aquacel ag (an antimicrobial dressing), cover with a ABD pad (large pad to absorb drainage), and change daily. The "Physician Order," dated 09/15/23, directed staff to cleanse the left wound with wound cleanser, Skin-prep the edges of the wound, and cover with a bordered dressing. The "Skin Assessment," dated 09/18/23 documented R26 had a Stage 2 pressure injury to his left heel which measured 3.0 cm by 3.3 cm by 0.2 cm. The "Skin Assessment," dated 09/18/23, documented R26 had a deep tissue injury to his right heel which measured 2.0 cm by 3.1 cm. The staff applied Skin-prep and a dry dressing. The "Weekly Skin Assessment," dated 09/25/23, documented R26's left heel measure 2.0 cm by 3.3 cm by 0.1 cm, and staff to applied Skin-prep the edges of the wound and cover with a dry dressing. The "Skin Assessment," dated 10/02/23, documented R26's left heel measured 2.0 cm by 3.1 cm by 0.1 cm. The staff applied Skin-prep to the edges of the wound and covered with a dry dressing.	F 686			

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F 686	Continued From page 22 The "Skin Assessment," dated 10/02/23, documented R26's right heel had a deep tissue injury which measured 1.9 cm by 2.8 cm and staff were to apply Skin-prep and a dry dressing. The "Nurse's Note," dated 10/06/23, documented the physician removed the blister to R26's left heel and directed staff to apply Xeroform (a non-adherent primary dressing that maintains a moist wound environment) to the left heel wound, cover with a bordered gauze dressing, and change the dressing daily. The note further directed staff to stop Skin-prep to the right heel and just cover the area with bordered gauze, and change the dressing on Monday, Wednesday, and Fridays. The note further documented R26 developed a dark purple area to his left outer malleolus due to his heel protectors being too tight. Staff were Skin-prep the area and cover with a silicone dressing to be changed on Monday, Wednesday, and Fridays, and educate staff not to put the heel protectors on tight. The "Skin Assessment," dated 10/09/23, documented R26 had a deep tissue injury to his left outer malleolus, which measured 1.1 cm by 1.3 cm, and staff applied Skin-prep to the area. The "Nurse's Note," dated 10/17/23, documented a new order from the physician for zinc ointment, twice a day, to be applied to R26's coccyx (small triangular bone at the base of the spine) and buttocks, for breakdown prevention. The "Skin Assessment," date 10/18/23, documented staff found a new dark purple area to R26's right outer malleolus. The staff applied Skin-prep and covered the area with a foam dressing.	F 686			

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F 686	Continued From page 23 On 10/17/23 at 11:21 AM, observation during personal cares revealed R26 had an area on his left buttock that was approximately 5 cm by 2 cm, light pink and a small, darkened area near the center of the wound. On 10/17/23 at 02:15 PM, observation revealed Licensed Nurse (LN) H washed her hands, donned clean gloves, removed the soiled dressing from R26's left outer malleolus. LN H said the wound was caused by a heel protector strap that was put on too tight. The area was approximately the size of a quarter and had a scab on it. Further observation revealed LN H changed gloves, cleansed the wound with wound cleanser, placed Xeroform on the wound, and covered it with a dry dressing. On 10/18/23 at 07:15 AM, LN H washed her hand, donned clean gloves, removed the soiled dressing from the left inner heel. The area was approximately the size of a quarter, had a scab over the wound. LN H cleansed the area with wound cleanser and placed Xeroform on the wound and covered it with a dry dressing. Continued observation revealed LN H took R26's right sock off and removed the soiled dressing off of his right heel. The area was approximately the size of a quarter and had a scab over top of it. Observation revealed a dark purple area over the right outer malleolus, and LN H stated she did not know the resident had the dark purple area. LN H cleansed the right heel ulcer with wound cleanser and placed a dry dressing over it. LN H wiped the right outer malleolus with wound cleanser, applied Skin-prep, and placed a dry dressing over it. On 10/19/23 at 09:00 AM, observation revealed	F 686			

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F 686	Continued From page 24 R26 sat in his wheelchair. He wore bilateral heel protectors, but his right malleolus was resting on the foot pedal out of his heel protector. On 10/17/23 at 11:21 AM, CNA M stated the area on R26's buttock had not been there the day before and said she had never seen any type of dressing on it. CNA M stated R26 would tell staff when he wanted to lay down and had already been up in the wheelchair since 06:30 AM, without repositioning. On 10/17/23 at 11:30 AM, LN H stated the area on R26's buttock was scar tissue and when the CNAs provide personal cares, they rubbed the area too hard. LN H said that caused the top layer of the scar tissue to rub off. LN H stated staff were not putting any dressings on the scarring in order to prevent breakdown. LN H stated she would talk with hospice to ask for a Roho cushion (pressure relief cushion made of soft, flexible air cells) for R26's wheelchair. On 10/18/23 at 07:15 AM, LN H stated the pressure areas on R26's heels were from friction and verified R26 was not wearing heel protectors prior to the breakdown. LN H stated R26 had ataxia and would cause him to have spasms and his legs would move a lot, like frog legs. LN H stated she felt that the heel protectors did not stay in place due to the resident's movement of his legs, and that was how the right malleolus broke down. LN H stated R26 slept with socks on at night, so the CNAs would not have seen the new area on his right malleolus. On 10/19/23 at 10:46 AM, Administrative Nurse D stated there should have been interventions in place to prevent the breakdown on R26's feet.	F 686			

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F 686	Continued From page 25 Administrative Nurse D said R26 should be laid down more often to prevent further breakdown. The facility's "Wound Management Policy and Procedure," dated 09/12/23, documented the facility was committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers, unless the individuals clinical condition demonstrates they are unavoidable. The facility failed to implement interventions to prevent pressure ulcers for R26, and failed to ensure cares were delivered in a manner to prevent injury or wound worsening which resulted in a facility acquired DTI, a Stage 2 and Stage 1 pressure ulcers. This also placed the resident at risk for further breakdown. - R17 's Electronic Medical Record (EMR) listed diagnoses of osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk,) edema (swelling resulting from an excessive accumulation of fluid in the body tissue,) and heart failure. R17's "Annual Minimum Data Set" (MDS), dated 08/23/23, recorded the resident had a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired cognition. The MDS documented R17 required extensive assistance of two staff with bed mobility and transfers. The MDS further documented the resident had one unstageable (depth of the wound is unknown due to the wound bed is covered by a thick layer of other tissue and pus) pressure ulcer that was not	F 686			

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F 686	Continued From page 26 present on admission. The "Pressure Ulcer Care Area Assessment" (CAA), dated 08/28/23, documented the resident required extensive assistance and had bowel and bladder incontinence that placed her at risk for impaired skin integrity. The CAA documented staff provide incontinent care as needed, skin inspection, and the use of a pressure reducing mattress. R17's "Care Plan," dated 8/28/23, documented staff would apply moisture barrier cream with each brief change and provide a pressure relieving chair cushion. The plan directed staff to reposition the resident from side to side every two hours when in bed and shift weight from side to side every two hours when sitting in the chair. The "Braden Scale Assessment" for predicting pressure ulcer risk, dated 08/23/23 documented a score of 13.0, which indicated a high risk. The "Physician Order," dated 08/28/23 ordered the staff to obtain weekly skin assessments by a licensed nurse. The "Tissue Analytics Wound Evaluation," dated 10/17/23, documented the date of onset was 10/17/23 and the wound was identified as an unstageable pressure ulcer, facility acquired, to the right buttocks. The wound measured 1.0 cm x 1.05 cm by 0.1 cm depth. The current treatment was listed as wound cleanser, Skin-Prep and a foam dressing three times a week and as needed. The evaluation documented the wound as "New." The evaluation lacked any further description of the wound.	F 686			

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F 686	Continued From page 27 The "Tissue Analytics Wound Evaluation," dated 10/19/23, documented R17 had one open area on her right gluteal (buttock) area, measuring 1.0 cm by 1.5 cm by 0.10 cm. The area was listed as an unstageable pressure ulcer, facility acquired. The "Physician Order," dated 09/13/22, documented staff would place the resident on an up/down schedule, three times a day the resident may be up for an hour with meals and may attend activities and at other times must be lying on a low air loss mattress. The "Physician Order," dated 10/06/23, documented for staff to apply Desitin (a barrier ointment relieves irritated skin and protects skin and helps seal out wetness) daily defense 13% cream, two grams, topically two times a day, for wound prevention to the bottom and any reddened areas. On 10/17/23 at 08:50 AM, R17 laid in bed on her back. Licensed Nurse (LN) K, and Certified Nurse Aide (CNA) P positioned R17 on her left side. LN K cleansed the open area on R71's right buttock with wound cleanser. The wound appeared as a one-inch reddened round area with approximately three-quarters of an inch open. LN K applied Desitin cream to the buttocks and open area. Continued observation revealed the area was red and open and the Desitin would not cover the area. LN K stated she would contact the physician for a new wound treatment order due to the Desitin not covering or protecting the open area. On 10/19/23 at 09:00 AM, Administrative Nurse E verified R71 developed a facility acquired pressure ulcer on her right buttock. Administrative	F 686			

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F 686	Continued From page 28 Nurse E reported the resident recently had a decline in condition and had increased loose stools which may have contributed to the open areas. The "Wound Management, " policy dated 09/12/23, documented the facility was committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers, unless the individuals clinical condition demonstrates they are unavoidable. Ant resident with a wound receives treatment and services consistent with the resident's goals of treatment. The goal as one of promoting healing and preventing infections unless a resident's preferences and medically condition necessities palliative care as the primary focus. The facility failed to monitor the effectiveness of interventions to prevent the worsening of an unstageable facility acquired pressure ulcer for R17, placing the resident at risk for further skin breakdown. - R3's Electronic Medical Record (EMR) listed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion,) tremors (involuntary, quivering movement,) spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities,) and aphasia (condition with disordered or absent language function.) R3's "Quarterly Minimum Data Set" (MDS), dated 08/23/23, recorded the resident had severely	F 686			

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F 686	Continued From page 29 impaired cognition. The MDS documented R3 required extensive assistance of two staff with bed mobility and transfers. The MDS further documented the resident had two unstageable (depth of the wound is unknown due to the wound bed is covered by a thick layer of other tissue and pus) pressure ulcers, not present on admission. R3's " Care Plan," dated 08/28/23, documented the resident had limited physical mobility due to general weakness and cognitive decline. The care plan documented the resident required extensive assist of one to two staff for bed mobility and required total dependence of two staff for transfers with a Hoyer lift (total body mechanical lift). The "Braden Scale Assessment" for predicting pressure ulcer risk, dated 08/01/23 documented a score of 15.0, which indicated a mild risk. The "Physician Order," dated 07/21/23 directed staff to apply Skin-prep twice daily to the residents left lateral foot and left great toe. The "Physician Verbal Order," on 10/04/23 directed the nurse to cleanse the left heel wound with wound cleanser and apply Skin-prep to the peri wound intact skin before dressing three times a week. The resident's family was notified of the new skin injury. The "Wound Evaluation," dated 10/06/23 (two days after the physician gave a verbal order for the wound) documented R3 had one open area on her left heel, measuring 1.9 centimeters (cm) by 2.4 cm by 0.3 cm depth. The evaluation documented the wound as a new Stage 3 (full thickness pressure injury extending through the	F 686			

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F 686	Continued From page 30 skin into the tissue below) pressure wound, which was facility acquired. R3 had an additional open area on her left great toe, measuring 0.7 cm by 0.5 cm by 0.2 cm. The evaluation documented the wound was a new, unstageable pressure ulcer, also facility acquired. The facility lacked any more "Wound Evaluation" measurements after 10/06/23 until exit date 10/19/23. On 10/17/23 at 08:10 AM, observation revealed Licensed Nurse (LN) K, and Certified Nurse Aide (CNA) P positioned R3 on her right side. LN K removed the old dressing on R3's left heel, cleansed the left heel open area with wound cleanser, applied Skin-prep, then placed a Polymen (non-adhesive dressing that will cleanse, fill, absorb and moisten wounds throughout the healing process) film island dressing over the open area. Continued observation revealed LN K removed the old dressing from R3's left great medial toe, cleansed with wound cleanser, applied Skin-prep, and then applied a Mepilex (absorbent, bordered foam dressing) dressing over the wound. The resident had pressure relieving boots. On 10/17/23 at 10:00 AM LN K verified the resident had recently developed the open area on her left great toe and staff thought it was caused from the Podous boot (lightweight plastic shell with a liner to help treat and prevent lower extremity disorders. LN K stated the left heel wound was from the heel opening on the Podous boot. On 10/19/23 at 09:20 AM, Administrative Nurse D verified the resident developed the facility	F 686			

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F 686	Continued From page 31 acquired Stage 3 pressure ulcer on her left heel and a facility acquired unstageable pressure ulcer on the left medial great toe. Administrative Nurse D verified the resident did have Podous boots, and the areas developed from the use of the boot. The "Wound Management, " policy dated 09/12/23, documented the facility was committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers, unless the individuals clinical condition demonstrates they are unavoidable. Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. The goal as one of promoting healing and preventing infections unless a resident's preferences and medically condition necessities palliative care as the primary focus. The facility failed to prevent the development of a Stage 3 facility acquired left heel pressure ulcer, and an unstageable facility acquired, left great toe pressure ulcer for R3 and failed to monitor to promote healing placing the resident at risk for further skin breakdown.	F 686			
F 689 SS=G	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	F 689			

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F 689	Continued From page 32 accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents, with five reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide supervision for one sampled resident, Resident (R) 31, who fell in the facility courtyard and fractured (broken) her right arm and right middle finger. The facility further failed to ensure a safe environment for R50, who fell in his room and fractured his nasal bone, fractured his lumbar transverse process (the bony projection on either side of your spine), sustained a laceration (cut) to his left eye, and bruising to his right side. These failures placed the residents at risk for further falls and related injury. Findings included: - The Electronic Medical Record (EMR) for R31 documented diagnoses of malignancy neoplasm of the colon (colon cancer), confusional arousal (when a sleeping person appears to wake up, but their behavior is unusual or strange), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Significant Change Minimum Data Set" (MDS), dated 07/27/23, documented R31 had a Brief Mental Status Score (BIMs) of 14, which indicated intact cognition. The MDS further documented R31 required extensive assistance of one staff for toileting and limited assistance of one staff for bed mobility, ambulation, dressing, and personal hygiene. The assessment documented R31 had unsteady balance, upper functional impairment on one side, and had no	F 689			

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F 689	Continued From page 33 falls. R31's "Fall Risk Assessments," dated 10/31/22, 11/12/22, 02/14/23, 04/27/23, 07/31/23, 08/03/23, and 09/22/23, documented R31 was at risk for falls. R31's "Care Plan," dated 08/03/23, initiated on 11/12/22, directed staff to educated R31 on the use of the call light system, assess for appropriate assistive device for mobility and transfers on admission, quarterly, and as needed. The update, dated, 08/03/23, directed staff to keep personal items within reach, ensure her call light was within reach, assist R31 to put her shoes on properly. The update, dated 09/22/23, directed staff to assign a staff member to monitor and assist residents while outside and coming in and out of the patio door. The "Fall Investigation," dated 09/22/23, documented, on 09/22/23 at 01:10 PM, R31's friend was coming in from the courtyard and R31 sat in a chair in the dining room, near the door to the courtyard. R31 got up when her friend was at the courtyard door to open it for her, and at the same time her friend moved, when she had previously had a hand on the door, the door opened more quickly than anticipated, and R31 tripped over the threshold going outside. The investigation documented R31 landed face first on the concrete, with her head landing in the mulch of the landscaping, hurting her middle finger and right wrist. The investigation documented R31 was sent to the Emergency Room for evaluation, and it was determined she had a fracture to her right middle finger and a fractured right wrist. The intervention for the fall documented team members would be assigned	F 689			

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F 689	Continued From page 34 to the residents when they are going outside so the staff would be there to safely assist them in and out. The "Nurse's Note," dated 09/25/23 at 02:40 PM, documented R31 returned from the hospital with her right arm in a splint and wrapped with an ace wrap, her fingers warm to the touch with mild swelling. On 10/17/23 at 11:42 AM, observation revealed R31 independently ambulated with a walker in the dining room. On 10/17/23 at 09:30 AM Certified Nurse Aide (CNA) M stated R31 was independent with transfers and ambulation and had some recent falls which resulted in a fracture of her arm. On 10/19/23 at 10:16 AM, Licensed Nurse (LN) H stated staff were not going outside with residents until R31 had her fall with a fracture. LN H stated staff now were assigned to make sure if a resident went outside, staff would be aware and could help residents go in and out of the doors. LN H stated she was not really sure what happened with R31 because she was helping other residents. She stated her understanding was that the resident who was outside with R31 took a tissue box and put it in the doorway so the door would not shut and somehow when R31 tried to help the other resident come inside, R31 lost her balance and fell in the courtyard. On 10/18/23 at 10:46 AM, Administrative Nurse D stated R31's daughter took R31 and another resident outside in the courtyard; when she brought R31 back inside, she took a tissue box and propped the door open so the other resident	F 689			

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F 689	Continued From page 35 could come inside when she was ready. Administrative Nurse D further stated when R31 was at a dining room table, she saw her friend having trouble getting the door open, so she got up and pushed on the door while the other resident was pulled on the door, and R31 lost her balance and fell. Administrative Nurse D stated that even though R31's daughter placed the tissue box in the door, it was the nursing staff responsibility to make sure the residents were safe outside and could safely get back inside. On 10/18/23 at 04:00 PM, Administrative Staff A stated all families had door cards so they could get in and out of the facility when there was not a receptionist at the front door. Administrative Staff A said R31's daughter used her card to open the courtyard door and did not notify staff that she left the other resident outside, the family member also propped the courtyard door open. The facility's "Fall Management" policy, dated 01/20/22, documented, residents are assessed for risk for falls by a licensed nurse and interventions are placed in the plan of care, and staff would ensure resident's rooms are free from hazards that could cause a fall. The policy documented staff would attempt to identify the cause of the fall and documented in nursing notes and seek to identify all that contributed to the fall. The facility failed to provide adequate supervision to prevent accidents and hazards for R31 who attempted to assist another resident inside from the courtyard and had a fall which resulted in a fractured right arm and middle finger. This placed the resident at risk for further falls and pain.	F 689			

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F 689	Continued From page 36 - R50's Electronic Medical Record (EMR) documented diagnoses of repeated falls, confusional arousal (when a sleeping person appears to wake up, but their behavior is unusual or strange), muscle spasms, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Admission Minimum Data Set" (MDS) dated, 05/06/23, documented R50 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition and required extensive assistance of one staff for bed mobility, transfers, ambulation; and supervision and one staff assistance for personal hygiene. The MDS further documented R50 had unsteady balance, lower impairment functional impairment on both sides, and had no falls. The "Quarterly MDS," dated 07/27/23, documented R50 had a BIMS score of 13, which indicated intact cognition and required extensive assistance of one staff for bed mobility, toileting, dressing, personal hygiene. R50 did not ambulate. The assessment further documented R50 had unsteady balance, lower functional impairment on both sides, and had no falls. The "Fall Risk Assessments," dated 05/02/23, 05/08/23, 06/18/23, 07/21/23, 08/29/23, 09/07/23, and 10/03/23, documented R50 was at risk for falls. The "Care Plan," dated 10/03/23, initiated on 06/26/23, directed staff to keep his walker within arm's reach, cue and assist to the bathroom after all meals, remind him to call for assistance, and	F 689			

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F 689	Continued From page 37 place a sign on his wall to remind him to call for assistance. The update, dated, 07/27/23, directed staff to switch out his call light necklace to his wrist, so he could locate it better. The update, dated 08/29/23, directed staff to ensure his bed was at the standard height. The update, dated 09/03/23, directed staff to ensure R50 wore nonskid socks. The update, dated 09/07/23, directed staff to ensure resident wore nonskid socks and place anti-slip traction to tape on the floor to the right and left of the bed. The update, dated 09/30/23, directed staff to rearrange R50's room to improve safety and do hourly checks as R50 was cognitively impaired and confused. The update, dated 10/03/23, directed staff to ensure the light in his room was adequate, family members educated to call for assistance with R50 required assistance, remind R50 to call for assistance, educated R50 on the bed controls and how to use them, educated R50 to call for assistance when he wants to get out of bed, and remind R50 to wear nonskid socks. The "Fall Investigation," dated 06/17/23 at 10:50 PM, documented staff found R50 between the bed and the recliner. R50 had raised the bed too high, tried to get into the bed and fell. The "Fall Investigation," dated 07/22/23 at 03:00 AM, documented R50 was on the floor beside the foot of the bed, naked and had a dry incontinence brief lying beside him. The investigation further documented R50 had periods of confusion and was known to disrobe and rummage through his belongings, and directed staff to monitor R50 during rounds for evidence he was restless. The "Fall Investigation," dated 07/28/23 at 11:45 PM, documented R50 was on the floor and	F 689			

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F 689	Continued From page 38 directed staff to change his call light necklace to his wrist so he could locate it better. The "Fall Investigation," dated 08/20/23 at 08:07 PM, documented R50 was in his room on his hands and knees, he had attempted to transfer himself from his wheelchair to his bed and had adjusted the height of the bed and it was too high for him to transfer. The investigation documented the control to his bed was moved as he was unable to demonstrate his ability to utilize the controls appropriately and orange tape was in place to clearly indicated the appropriate height of the bed to aide in a safe transfer. The "Fall Investigation." dated 08/29/23 at 03:50 AM, documented R50 was found on his floor, naked with a dry incontinence brief beside him, he stated he slipped while he tried to get into bed. The investigation further documented the bed was at standard height at 11:50 PM, and at the time of his fall, the bed was in a low position. The investigation documented staff were educated on why the bed was at standard position at night. The "Nurse's Note," dated 09/28/23 at 10:07 PM, documented on 09/27/23 and 9/28/23, R50 was very restless and tried to stand several times without locking his wheelchair, and tried to pull down his pants several times. R50 stated he did not know what he wanted, would be calm for short periods of time, then became restless again, and required one on one (1:1) with the nurse. The "Fall Investigation," dated 09/30/23 at 10:30 PM, documented R50 was on the floor in his room, he stated he did not know what happened and had been toileted around 09:15 PM. The	F 689			

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F 689	Continued From page 39 investigation further documented R50 had a laceration above his left eye which measured 0.1 centimeter (cm) by 0.2 cm, and some bruises on the right ribs. R50 complained of pain all over and went to the Emergency Room for evaluation. The investigation documented R50 sustained a fractured nasal bone, and a fracture of the lumbar transverse process, and a facial laceration. The "Nurse's Note," dated 10/03/23 at 06:44 PM, documented R50 had bruises to his face and arms, and education was provided on fall prevention and education on how to use the call light system, to demonstrate back to staff, and he was unable to use the call light system. On 10/17/23 at 09:30 AM, observation revealed Certified Nurse Aide (CNA) M pushed R50's wheelchair into the bathroom, instructed him to use the wheelchair arms to push up, stand, and grab onto the grab bars by the toilet. Further observation revealed, CNA M did not use a gait belt and R50 was very unsteady and could not follow her instructions. CNA M instructed him to turn to the left, he would turn to the right, and after multiple times cuing, he was able to turn to the left as instructed so she could assist him with toileting. On 10/17/23 at 09:30 AM, CNA M stated, she did not use a gait belt on R50 because he was a standby assist so she did not need to. CNA M stated R50 did have a lot of falls and were instructed to make sure his bed was the standard height, nonskid strips beside his bed, try to assist him with toileting every two hours, and get him up first in the morning. On 10/19/23 at 10:00 AM, Licensed Nurse (LN) H	F 689			

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F 689	Continued From page 40 stated R50 was getting better, he had been confused for a while, was impulsive, and liked to get up on his own. On 10/19/23 at 10:46 AM, Administrative Nurse D stated staff were to use a gait belt with R50 as he was a fall risk and was impulsive. Administrative Nurse D further stated she felt the fall with the fractures was because R50 had a lot of clutter in his room and he fell over it. The facility's "Fall Management" policy, dated 01/20/22, documented residents are assessed for risk for falls by a licensed nurse and interventions are placed in the plan of care. The staff would ensure resident's rooms are free from hazards that could cause a fall. The policy documented staff would attempt to identify the cause of the fall and documented in nursing notes and seek to identify all that contributed to the fall. The facility failed to ensure that interventions in place to prevent falls were adequately implemented by staff consistently to prevent falls for R50, who had a fall with major injury. This placed the resident at risk for further falls and related complications.	F 689			
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756			

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F 756	Continued From page 41 §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 had a census of 66 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R)13's medications which lacked indications for use and the inappropriate indication for the use of an antipsychotic (class of medications used to treat	F 756			

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F 756	Continued From page 42 major mental conditions which cause a break from reality) for R13, R2, R53, and R23. The facility further failed to ensure the CP identified and reported the lack of a stop date for R13 and R57s' as needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed the residents at risk for unnecessary medications and related side effects. Findings Included: - R13's Electronic Medical Record (EMR) recorded diagnoses of a fracture around internal prostheses (artificial body part) left hip, abnormality of gait and mobility, need for assistance with personal cares, dementia (progressive mental disorder characterized by failing memory, confusion) , cardiomegaly (heart disease), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), sleep disorder and encounter for attention to colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). The "Significant Change Minimum Data Set" (MDS), dated 09/19/23, documented R13 had severe cognitive impairment as assessed by staff, inattention and altered level of consciousness behaviors, which fluctuated, and had verbal behavioral symptoms directed toward others which occurred one to three days of the observation period. R13 required extensive assistance of two staff for activities of daily living , was always incontinent of urine and had an ostomy present. The MDS further documented R13 received an antipsychotic, antianxiety, antidepressant (class of medications used to treat	F 756			

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F 756	Continued From page 43 mood disorders), and opioid (a type of medication used to treat pain) on a routine basis. The MDS recorded no gradual dose reduction was attempted for the antipsychotic, and the physician had not documented it as contraindicated. The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 09/22/23, documented R13 had a significant decline and was placed on hospice (end of life) services. R13 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) and was currently prescribed psychotropic (alters mood or thought) medication to help her with signs and symptoms of dementia. The CAA further documented R13 took lorazepam (antianxiety medication) and quetiapine (antipsychotic medication) both scheduled with additional lorazepam ordered as needed, and noted the medications had a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) increasing the risk of adverse consequences. R13's "Care Plan," dated 09/08/23, documented R13 took quetiapine and sertraline (antidepressant) to manage anxiety and sleep disorder. The care plan directed staff to observe and document any signs or symptoms of drug related complications to the physician, and document behavioral episodes daily on the behavior tracking form. The "Physician Orders", dated 09/09/23, directed staff to administer the following medications which lacked an indication for use: Sertraline 25 mg daily. Quetiapine 50 mg daily in the evening.	F 756			

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F 756	Continued From page 44 Multivitamin with iron daily. Melatonin (used to aid sleep) 3 mg daily at bedtime. Losartan (used to treat high blood pressure) 50 mg twice daily. Folic Acid (nutritional supplement) 800 mg daily. Docusate Sodium (stool softener) 100 mg daily. Aspirin 81 mg daily. The "Physician Order," dated 09/11/23, directed staff to administer lorazepam 0.5 mg as needed every six hours for agitation/restlessness/anxiety. This order lacked a stop date or specified duration and was administered 10/02/23, 10/12/23, 10/13/23, 10/14/23, and 10/16/23. The "Pharmacist Review," dated 10/09/23, documented the CP had no recommendations. R13's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing antipsychotic use. On 10/17/23 at 11:35 AM observation revealed R13 sat in her Broda (specialty chair with the ability to tilt and recline) chair, dressed, and groomed for the day. Certified Medication Aide (CMA) R administered R13's medications. CMA R verified quetiapine and sertraline lacked a diagnosis/indication for use. CMA R reported R13's sertraline and quetiapine were for behaviors. On 10/18/23 at 03:27 PM, Licensed Nurse (LN) G stated the as needed lorazepam should have an automatic stop date of 14 days, and the computer system did not flag the order to be renewed.	F 756			

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F 756	Continued From page 45 On 10/19/23 at 12:50 PM, Administrative Nurse D verified the quetiapine lacked an appropriate indication for the use of the medication and the as needed lorazepam should have had a stop date of 14 days following the original order. Administrative Nurse D verified the CP had not identified and alerted the facility of the irregularities. The facility's "Psychotropic Medication Use" policy, dated 02/07/22, documented any resident admitted with an as needed psychotropic medication will have a 14-day stop date. The facility's "Consultant Pharmacist" policy, dated 02/04/22, documented the consultant pharmacist agrees to render the required service in accordance with state and federal laws, regulation, and guideline; facility policies and procedures; community standards of practice; and guidelines: facility policies and procedure; community standards of practice; and professional standards of practice. The facility failed to ensure the CP identified and reported R13's lack of indication for use of medication and the lack of an appropriate indication for use of antipsychotic medication and the lack of a 14-day stop date or specified duration for PRN antianxiety medication. This placed the resident at risk for inappropriate use of medications. - R53's Electronic Medical Record (EMR), documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), posttraumatic stress disorder (PTSD- mental disorder characterized by an acute	F 756			

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F 756	Continued From page 46 emotional response to a traumatic event or situation involving severe environmental stress) victim of crime and terrorism, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The "Quarterly Minimum Data Set" (MDS), dated 07/27/23, documented R53 had a BIMS score of 03, which indicated severe cognitive impairment, required limited assistance of one staff for activities of daily living, and was occasionally incontinent of urine and bowel. The MDS further documented R53 took an antipsychotic medication and an antidepressant medication (class of medications used to treat mood disorders) on a routine basis. The resident had a gradual dose reduction attempt and a reduction had not been documented by a physician as clinically contraindicated. The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 03/08/23, documented the pharmacist monitored R53's medications regularly and made recommendations as needed. The gradual dose reduction for the use of an antipsychotic was refused by the family as they felt R53 was stable. R53's "Care Plan", dated 08/01/23, documented R53 had a mood state problem related to her diagnosis of dementia and PTSD as evidenced by depressed mood indicators. The care plan directed staff to report any changes in mood to physician, promote a homelike environment, when possible, use familiar objects from home,	F 756			

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F 756	Continued From page 47 encourage continued visits with family and maintain a clam, non-threatening manner while working with the resident. The "Physician Order", dated 02/07/20, documented to administer Seroquel (antipsychotic) 12.5 milligrams (mg) daily for dementia without behavior disturbance/paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) behaviors. The "Consultant Pharmacist Reports," dated 02/13/23 through 10/09/23, documented a medication review was completed with no recommendations made. R53's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing antipsychotic use On 10/17/23 at 10:05 AM, observation revealed R53 approached the medication cart singing, then reported needing to use the bathroom and staff assisted R53 to her room. On 10/19/23 at 12:50 PM, Administrative Nurse D Verified the resident's Seroquel lacked an appropriate indication for the use of the medication. The facility's "Consultant Pharmacist" policy, dated 02/04/22, documented the consultant pharmacist agreed to render the required service in accordance with state and federal laws, regulation, and guideline; facility policies and procedures; community standards of practice:	F 756			

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F 756	Continued From page 48 and guidelines: facility policies and procedure; community standards of practice; and professional standards of practice. The Consultant Pharmacist failed to identify and report to the Director of Nursing, medical director, and physician, R53s' inappropriate indication for the use of an antipsychotic medication. This placed the resident at risk for inappropriate use of medications. - R2's Electronic Medical Record (EMR), documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), hypertension (elevated blood pressure), acute embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the blood stream) of lower extremity, muscle weakness and gastro esophageal reflux (GERD-backflow of stomach contents to the esophagus), and constipation (difficulty passing stools). The "Significant Change Minimum Data Set" (MDS), dated 08/18/23, documented R2 had moderately impaired cognition as assessed by staff, required extensive assistance of two staff for activities of daily living, had functional range of motion impairment to one side of lower extremity, and was always incontinent of urine and bowel. The MDS further documented R2 received scheduled pain and antipsychotic medications, and a gradual dose reduction was contraindicated on 06/18/23. The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 01/05/23, documented R2's use of an antipsychotic, which	F 756			

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F 756	Continued From page 49 placed the resident at risk for problems and side effects. The CAA noted the resident had not demonstrated side effects or adverse consequences to the use of medication. The Consultant Pharmacist conducted a review of the resident's medication and made recommendations. R2's "Care Plan", dated 08/21/23, documented R2 took an antipsychotic (quetiapine) due to periods of increased agitation/anxiety/restlessness. The care plan directed staff to observe and document any signs/symptoms of drug related complications to the resident's physician as needed and document behavioral episodes daily on the behavior tracking form. The "Physician Order", dated 09/28/23, directed staff to administer quetiapine (antipsychotic) 25 milligrams (mg) daily for Alzheimer's disease. The "Pharmacist Consultant Note", dated 10/09/23, documented a medication review was completed with no recommendations. R2's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing antipsychotic use On 10/17/23 at 10:08 AM, observation revealed Certified Medication Aide (CMA) R administering R2's medications. CMA R explained to the resident what she was doing and R2 questioned the medications, CMA R offered to get a list of medications and the indication for use, R2's declined the offer and took the medications.	F 756			

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F 756	Continued From page 50 On 10/19/23 at 12:50 PM, Administrative Nurse D verified the quetiapine lacked appropriate diagnosis of the use and confirmed the CP had no identified and reported the irregularity. The facility's "Consultant Pharmacist" policy, dated 02/04/22, documented the consultant pharmacist agrees to render the required service in accordance with state and federal laws, regulation, and guideline; facility policies and procedures; community standards of practice; and guidelines: facility policies and procedure; community standards of practice; and professional standards of practice. The CP failed to identify and report to the Director of Nursing, medical director, and physician, R2's inappropriate indication for the use of an antipsychotic medication. This placed the resident at risk for inappropriate use of medications. - R57's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental, uncertainty and irrational fear), and dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion). R57's "Quarterly Change Minimum Data Set" (MDS), dated 09/27/23, documented the resident had severely impaired cognition. R57 required extensive assistance with bed mobility, transfer, dressing, toilet use, and locomotion on and off the unit and hygiene. The MDS lacked documentation R57 received an antianxiety medication during the look back days. The "Cognitive Loss Care Area Assessment"	F 756			

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F 756	Continued From page 51 (CAA), dated 05/09/23, documented R57 had memory problems due to dementia and the disease process, and impaired decision-making skills. R57's "Care Plan," dated 07/24/23, directed staff to anticipate the residents care needs prior to the resident becoming overly stressed, break tasks down into simple steps, and proceed one at a time. The "Physician's Order," dated 08/03/23, directed the staff to administer Ativan (antianxiety) 0.5 milligrams (mg), every four hours as needed for anxiety and restlessness. The order lacked a stop date. Review of additional information the facility provided on 10/19/23 to the surveyors after exit from the facility regarding a pharmacist request on 08/17/23 for continued use of the PRN Ativan to extend beyond the 14 days, the physician would ensure proper documentation existed in the resident's medical record and indicate the duration for the PRN order. On 08/31/23 (28 days after the initial order) the physician documented the resident required the medication for symptom management of end-of-life care, but still did not include a specified duration. Review of additional information the facility provided on 10/19/23 to the surveyors after exit from the facility regarding a pharmacist request on 09/28/23 for continued use of the PRN Ativan to extend beyond the 14 days, the physician would ensure proper documentation existed in the resident's medical record and indicate the duration for the PRN order. On 09/28/23 (28 days after the last documented request) the physician	F 756			

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F 756	Continued From page 52 documented the resident required Ativan for agitation and anxiety near end-of-life care but still did not include a specified duration. The resident's medical record lacked a stop date recorded for the PRN Ativan in the resident's physician orders and/or on the Medication Administration Record. Review of the "Medication Administration Record" in the EMR revealed the resident last received the Ativan 0.5mg on 10/18/23 for anxiety. R57's EMR documented a diagnosis of restlessness for continued use of the Ativan. On 10/18/23 at 12:30 PM, observation revealed the resident sat in a wheelchair at the dining room table with staff assisting him to eat lunch. On 10/19/23 at 08:45 AM, Administrative Nurse D verified the resident received Ativan, with a physician order date of 08/03/23. Administrative Nurse D verified the facility failed to obtain the 14 days stop date or reason for continued use with the appropriate rationale. Administrative Nurse D verified the consultant Pharmacist recommended a 14 day stop for the resident's use of as needed Ativan, but the facility failed to obtain an order for the request. The "Psychotropic Medications" policy, dated 02/07/22, documented the resident's need for psychotropic medication would be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose can be lowered or discontinued. Both physician and nursing staff would evaluate the effectiveness of PRN orders for psychotropic	F 756			

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F 756	Continued From page 53 drugs to manage behavior. PRN orders for psychotropic drugs are limited to 14 days. Prior to the end of the 14-day period, the ordering practitioner would assess the resident's response to the PRN medication and would document a thoughtful risk benefit rational statement for continued use of the medication. The "Consultant Pharmacist" policy, dated 02/02/23, documented regular and reliable consultant pharmacist services are provided to the elders. The facility maintains a written agreement with the consultant pharmacist, signed by the Administrator and the consultant pharmacist or a representative from the providing pharmacy. The consultant pharmacist agrees to render the require services in accordance with local, state and federal laws, regulations, and guidelines; facility policies and procedures; community standard of practice; and professional standards of practice. The consultant pharmacist would submit a written report of findings and recommendations resulting from the review of medication therapy documentation as described above. The facility's CP notified the Director of Nursing, medical director, and the physician the needed stop date for R14's PRN psychotropic medication, however the facility failed to obtain a timely physician order to discontinue or renew the medication which placed the resident at risk for unnecessary psychotropic medications and adverse medication side effects. - R23's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety	F 756			

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F 756	Continued From page 54 (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion). The "Quarterly Minimum Data Set" (MDS), dated 08/02/23, documented R23 had a Brief Interview for Mental Status (BIMs) score of three which indicated severely impaired cognition. R23 required extensive assistance with bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further documented R23 received antipsychotic medication daily and had no behaviors. R23's "Care Plan," dated 08/15/23, initiated of 08/09/23, documented R23 received antipsychotic medication for anxiety and directed staff to documented behavioral episodes daily, complete an "Abnormal Involuntary Movement Scale (AIMS)" on admission then quarterly, and as needed. The plan directed staff to discuss reduction in dosing when target behaviors were absent and follow the CP recommendations. The "Physician's Order," dated 08/05/22, directed staff to administer Seroquel (an antipsychotic medication), 12.5 milligrams (mg), one tablet, by mouth, daily for agitation, restlessness, and mood disorder. The "Physician's Order," dated 08/05/22, directed staff to administer Seroquel, 50 mg, one tablet, by mouth, daily for agitation restlessness, and mood disorder.	F 756			

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F 756	Continued From page 55 R23's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing Seroquel use. Review of the "Medication Regimen Review" for 10/18/22, 11/15/22, 12/16/22, 01/30/23, 02/13/23, 03/14/23, 05/04/23, 05/15/23, 06/15/24, 07/19/23, 08/17/23, 09/12/23, and 10/09/23 failed to address the inappropriate diagnoses of Seroquel. On 10/17/23 at 08:30 AM, observation revealed R23 sat in her wheelchair, in the dining room, eating breakfast. On 10/17/23 at 02:00 PM, Licensed Nurse (LN) H stated R23 received Seroquel for a long time; LN H thought it was administered for R23's agitation and said R23 did not have any behaviors. On 10/1/23 at 10:46 AM, Administrative Nurse D verified there was not an appropriate indication for use of Seroquel and the CP had not identified and reported the irregularity. The "Consultant Pharmacist" policy, dated 02/02/23, documented regular and reliable consultant pharmacist services are provided to the elders. The facility maintains a written agreement with the consultant pharmacist, signed by the Administrator and the consultant pharmacist or a representative from the providing pharmacy. The consultant pharmacist agrees to render the require services in accordance with local, state and federal laws, regulations, and guidelines; facility policies and procedures; community standard of practice; and professional standards of practice. The consultant pharmacist	F 756			

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F 756	Continued From page 56 would submit a written report of findings and recommendations resulting from the review of medication therapy documentation as described above. The CP failed to report to the Director of Nursing or physician the lack of an appropriate indication for R23's Seroquel, placing the resident at risk for adverse side effects.	F 756			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758			

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F 758	Continued From page 57 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure indications for medication use for Resident (R)13's including an appropriate indication or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the use of an antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) for R13, R2, R53, and R23, and failed to ensure a stop date for R13 and R57's for as needed (PRN) antianxiety (class of medications that calm and relax people) medication as required. This placed the residents at risk for adverse side effects related to	F 758			

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F 758	Continued From page 58 psychotropic (altering mood and mind) medication use. Findings Included: - R13's Electronic Medical Record (EMR) recorded diagnoses of a fracture around internal prostheses (artificial body part) left hip, abnormality of gait and mobility, need for assistance with personal cares, dementia (progressive mental disorder characterized by failing memory, confusion) , cardiomegaly (heart disease), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), sleep disorder and encounter for attention to colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). The "Significant Change Minimum Data Set" (MDS), dated 09/19/23, documented R13 had severe cognitive impairment as assessed by staff, inattention and altered level of consciousness behaviors, which fluctuated, and had verbal behavioral symptoms directed toward others which occurred one to three days of the observation period. R13 required extensive assistance of two staff for activities of daily living, was always incontinent of urine and had an ostomy present. The MDS further documented R13 received an antipsychotic, antianxiety, antidepressant (class of medications used to treat mood disorders), and opioid (a type of medication used to treat pain) on a routine basis. The MDS recorded no gradual dose reduction was attempted for the antipsychotic, and the physician had not documented it as contraindicated. The "Psychotropic Drug Use Care Area	F 758			

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F 758	Continued From page 59 Assessment" (CAA), dated 09/22/23, documented R13 had a significant decline and was placed on hospice (end of life) services. R13 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) and was currently prescribed psychotropic (alters mood or thought) medication to help her with signs and symptoms of dementia. The CAA further documented R13 took lorazepam (antianxiety medication) and quetiapine (antipsychotic medication) both scheduled with additional lorazepam ordered as needed, and noted the medications had a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) increasing the risk of adverse consequences. R13's "Care Plan," dated 09/08/23, documented R13 took quetiapine and sertraline (antidepressant) to manage anxiety and sleep disorder. The care plan directed staff to observe and document any signs or symptoms of drug related complications to the physician, and document behavioral episodes daily on the behavior tracking form. The "Physician Orders", dated 09/09/23, directed staff to administer the following medications which lacked an indication for use: Sertraline 25 mg daily. Quetiapine 50 mg daily in the evening. Melatonin (used to aid sleep) 3 mg daily at bedtime. The "Physician Order," dated 09/11/23, directed staff to administer lorazepam 0.5 mg as needed every six hours for agitation/restlessness/anxiety. This order lacked a stop date or specified	F 758			

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F 758	Continued From page 60 duration and was administered 10/02/23, 10/12/23, 10/13/23, 10/14/23, and 10/16/23. R13's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing antipsychotic use. On 10/17/23 at 11:35 AM observation revealed R13 sat in her Broda (specialty chair with the ability to tilt and recline) chair, dressed, and groomed for the day. Certified Medication Aide (CMA) R administered R13's medications. CMA R verified quetiapine and sertraline lacked a diagnosis/indication for use. CMA R reported R13's sertraline and quetiapine were for behaviors. On 10/18/23 at 03:27 PM, Licensed Nurse (LN) G stated the as needed lorazepam should have an automatic stop date of 14 days, and the computer system did not flag the order to be renewed. On 10/19/23 at 12:50 PM, Administrative Nurse D verified the quetiapine lacked an appropriate indication for the use of the medication and the as needed lorazepam should have had a stop date of 14 days following the original order. The facility's "Psychotropic Medication Use" policy, dated 02/07/23, documented the physician's order for psychotropic drug will include both a qualifying diagnosis, list of specific target behaviors which the staff will monitor during the drug administration. The policy documented any resident admitted with an as needed psychotropic medication will have a 14-day stop date.	F 758			

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NAME OF PROVIDER OR SUPPLIER VILLAGE SHALOM INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5500 WEST 123RD ST OVERLAND PARK, KS 66209		
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F 758	Continued From page 61 The facility failed to ensure appropriate indication for psychotropic medications ordered, and failed to ensure an appropriate indication for use, or the required physician documentation for the use on an antipsychotic. The facility further failed to ensure PRN psychotropic medications had a stop date. This placed R13 at risk for adverse side effects related to psychotropic medication. - R53's Electronic Medical Record (EMR), documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), posttraumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) victim of crime and terrorism, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The "Quarterly Minimum Data Set" (MDS), dated 07/27/23, documented R53 had a BIMS score of 03, which indicated severe cognitive impairment, required limited assistance of one staff for activities of daily living, and was occasionally incontinent of urine and bowel. The MDS further documented R53 took an antipsychotic medication and an antidepressant medication (class of medications used to treat mood disorders) on a routine basis. The resident had a gradual dose reduction attempt and a reduction had not been documented by a physician as clinically contraindicated.	F 758			

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F 758	Continued From page 62 The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 03/08/23, documented the pharmacist monitored R53's medications regularly and made recommendations as needed. The gradual dose reduction for the use of an antipsychotic was refused by the family as they felt R53 was stable. R53's "Care Plan", dated 08/01/23, documented R53 had a mood state problem related to her diagnosis of dementia and PTSD as evidenced by depressed mood indicators. The care plan directed staff to report any changes in mood to physician, promote a homelike environment, when possible, use familiar objects from home, encourage continued visits with family and maintain a calm, non-threatening manner while working with the resident. The "Physician Order", dated 02/07/20, documented to administer Seroquel (antipsychotic) 12.5 milligrams (mg) daily for dementia without behavior disturbance/paranoiaic (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) behaviors. R53's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing antipsychotic use. On 10/17/23 at 10:05 AM, observation revealed R53 approached the medication cart singing, then reported needing to use the bathroom and staff assisted R53 to her room. On 10/19/23 at 12:50 PM, Administrative Nurse D	F 758			

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F 758	Continued From page 63 Verified the resident's Seroquel lacked an appropriate indication for the use of the medication. The facility's "Psychotropic Medication Use" policy, dated 02/07/23, documented the physician's order for psychotropic drug will include both a qualifying diagnosis, list of specific target behaviors which the staff will monitor during the drug administration. The facility failed to ensure an appropriate indication or the required physician documentation for the use of R53's antipsychotic placing the resident at risk for unnecessary adverse side effects. - R2's Electronic Medical Record (EMR), documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), hypertension (elevated blood pressure), acute embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the blood stream) of lower extremity, muscle weakness and gastro esophageal reflux (GERD-backflow of stomach contents to the esophagus), and constipation (difficulty passing stools). The "Significant Change Minimum Data Set" (MDS), dated 08/18/23, documented R2 had moderately impaired cognition as assessed by staff, required extensive assistance of two staff for activities of daily living, had functional range of motion impairment to one side of lower extremity, and was always incontinent of urine and bowel. The MDS further documented R2 received scheduled pain and antipsychotic medications,	F 758			

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F 758	Continued From page 64 and a gradual dose reduction was contraindicated on 06/18/23. The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 01/05/23, documented R2's use of an antipsychotic, which placed the resident at risk for problems and side effects. The CAA noted the resident had not demonstrated side effects or adverse consequences to the use of medication. The Consultant Pharmacist conducted a review of the resident's medication and made recommendations. R2's "Care Plan", dated 08/21/23, documented R2 took an antipsychotic (quetiapine) due to periods of increased agitation/anxiety/restlessness. The care plan directed staff to observe and document any signs/symptoms of drug related complications to the resident's physician as needed and document behavioral episodes daily on the behavior tracking form. The "Physician Order", dated 09/28/23, directed staff to administer quetiapine (antipsychotic) 25 milligrams (mg) daily for Alzheimer's disease. R2's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing antipsychotic use. On 10/17/23 at 10:08 AM, observation revealed Certified Medication Aide (CMA) R administering R2's medications. CMA R explained to the resident what she was doing and R2 questioned the medications, CMA R offered to get a list of	F 758			

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F 758	Continued From page 65 medications and the indication for use, R2's declined the offer and took the medications. On 10/19/23 at 12:50 PM, Administrative Nurse D verified the quetiapine lacked appropriate diagnosis of the use and confirmed the CP had no identified and reported the irregularity. The facility's "Psychotropic Medication Use" policy, dated 02/07/23, documented the physician's order for psychotropic drug will include both a qualifying diagnosis, list of specific target behaviors which the staff will monitor during the drug administration. The facility failed to ensure an appropriate indication or the required physician documentation for the use of R2's antipsychotic placing the resident at risk for unnecessary adverse side effects. - R57's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental, uncertainty and irrational fear), and dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion). R57's "Quarterly Change Minimum Data Set" (MDS), dated 09/27/23, documented the resident had severely impaired cognition. R57 required extensive assistance with bed mobility, transfer, dressing, toilet use, and locomotion on and off the unit and hygiene. The MDS lacked documentation R57 received an antianxiety medication during the look back days. The "Cognitive Loss Care Area Assessment"	F 758			

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F 758	Continued From page 66 (CAA), dated 05/09/23, documented R57 had memory problems due to dementia and the disease process, and impaired decision-making skills. R57's "Care Plan," dated 07/24/23, directed staff to anticipate the residents care needs prior to the resident becoming overly stressed, break tasks down into simple steps, and proceed one at a time. The "Physician's Order," dated 08/03/23, directed the staff to administer Ativan (antianxiety) 0.5 milligrams (mg), every four hours as needed for anxiety and restlessness. The order lacked a stop date. Review of the "Medication Administration Record" in the EMR revealed the resident last received the Ativan 0.5mg on 10/18/23 for anxiety. Review of additional information the facility provided on 10/19/23 to the surveyors after exit from the facility regarding a pharmacist request on 08/17/23 for continued use of the PRN Ativan to extend beyond the 14 days, the physician would ensure proper documentation existed in the resident's medical record and indicate the duration for the PRN order. On 08/31/23 (28 days after the initial order) the physician documented the resident required the medication for symptom management of end-of-life care, but still did not include a specified duration. Review of additional information the facility provided on 10/19/23 to the surveyors after exit from the facility regarding a pharmacist request on 09/28/23 for continued use of the PRN Ativan to extend beyond the 14 days, the physician	F 758			

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F 758	Continued From page 67 would ensure proper documentation existed in the resident's medical record and indicate the duration for the PRN order. On 09/28/23 (28 days after the last documented request) the physician documented the resident required Ativan for agitation and anxiety near end-of-life care but still did not include a specified duration. Review of the "Medication Administration Record" in the EMR revealed the resident last received the Ativan 0.5mg on 10/18/23 for anxiety. On 10/18/23 at 12:30 PM, observation revealed the resident sat in a wheelchair at the dining room table with staff assisting him to eat lunch. On 10/19/23 at 08:45 AM, Administrative Nurse D verified the resident received Ativan, with a physician order date of 08/03/23. Administrative Nurse D verified the facility failed to obtain the 14 days stop date or reason for continued use with the appropriate rationale. Administrative Nurse D verified the consultant Pharmacist recommended a 14 day stop for the resident's use of as needed Ativan, but the facility failed to obtain an order for the request. The "Psychotropic Medications" policy, dated 02/07/22, documented the resident 's need for psychotropic medication would be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose can be lowered or discontinued. Both physician and nursing staff would evaluate the effectiveness of PRN orders for psychotropic drugs to manage behavior. PRN orders for psychotropic drugs are limited to 14 days. Prior to the end of the 14-day period, the ordering practitioner would assess the resident 's	F 758			

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F 758	Continued From page 68 response to the PRN medication and would document a thoughtful risk benefit rational statement for continued use of the medication. The facility failed to ensure R57 was free of the use of unnecessary psychotropic drugs when they failed to obtain a stop date for the use of PRN Ativan, placing R57 at risk for adverse effects from the continued use of those medications. - R23's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion). The "Quarterly Minimum Data Set" (MDS), dated 08/02/23, documented R23 had a Brief Interview for Mental Status (BIMs) score of three which indicated severely impaired cognition. R23 required extensive assistance with bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further documented R23 received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) medication daily and had no behaviors. R23's "Care Plan," dated 08/15/23, initiated of 08/09/23, documented R23 received antipsychotic medication for anxiety and directed staff to documented behavioral episodes daily,	F 758			

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F 758	Continued From page 69 complete an "Abnormal Involuntary Movement Scale (AIMS)" on admission then quarterly, and as needed. The plan directed staff to discuss reduction in dosing when target behaviors were absent, and follow the Pharmacy Consultant recommendations. The "Physician's Order," dated 08/05/22, directed staff to administer Seroquel (an antipsychotic medication), 12.5 milligrams (mg), one tablet, by mouth, daily for agitation, restlessness, and mood disorder. The "Physician's Order," dated 08/05/22, directed staff to administer Seroquel, 50 mg, one tablet, by mouth, daily for agitation restlessness, and mood disorder. R23's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for ongoing Seroquel use. On 10/17/23 at 08:30 AM, observation revealed R23 sat in her wheelchair, in the dining room, eating breakfast. On 10/17/23 at 02:00 PM, Licensed Nurse (LN) H stated R23 received Seroquel for a long time; LN H thought it was administered for R23's agitation and said R23 did not have any behaviors. On 10/1/23 at 10:46 AM, Administrative Nurse D verified there was not an appropriate indication for use of Seroquel. The "Consultant Pharmacist" policy, dated	F 758			

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F 758	Continued From page 70 02/02/23, documented regular and reliable consultant pharmacist services are provided to the elders. The facility maintains a written agreement with the consultant pharmacist, signed by the Administrator and the consultant pharmacist or a representative from the providing pharmacy. The consultant pharmacist agrees to render the require services in accordance with local, state and federal laws, regulations, and guidelines; facility policies and procedures; community standard of practice; and professional standards of practice. The consultant pharmacist would submit a written report of findings and recommendations resulting from the review of medication therapy documentation as described above. The facility failed to ensure an appropriate indication or the required physician documentation for the use of R23's Seroquel, placing the resident at risk for unnecessary adverse side effects.	F 758			
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who,	F 851			

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F 851	Continued From page 71 through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by	F 851			

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F 851	Continued From page 72 CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. Based on interview and record review, the facility failed to submit accurate staffing information through Payroll Based Journaling (PBJ) to the Centers for Medicare and Medicaid Services (CMS). This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - Review of the facility's submission of payroll data to CMS revealed no data had been submitted as required by CMS for Fiscal Year (FY) 2022 Quarter 4. On 10/19/23 at 11:41 AM, Administrative Staff A provided email information related to the PBJ submission for quarter 4 that the information was submitted with errors. Administrative Staff A stated the facility tried to resubmit the information but since it was past the submission deadline, it was not possible to resubmit the correct information. The facility's "Mandatory Submission of Staffing Information" policy, dated 11/22/22, documented the facility Administrator was responsible to ensure the person assigned to submission and the person to complete the task in the absence of the primary submitter are appropriately trained	F 851			

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F 851	Continued From page 73 and demonstrate competency in the submission process including but not limited to: complete data for the entire reporting period including hours paid for all required staff each day, provision of accurate data, provision of data by the required deadline, and submission of the required staffing information based on payroll data in a uniform format. The facility failed to submit accurate PBJ information to CMS for FY 2022 Quarter 4. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.	F 851			
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The	F 882			

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F 882	Continued From page 74 sample included 18 residents. Based on interview and record review, the facility failed to ensure the staff person designated as the Infection Preventionist (IP) possessed the qualifying education, training, experience as well as certification required to fulfill the role, placing the residents at risk of unidentified and untreated infections. Findings included: - On the survey form "Department Heads" filled out by the facility, the facility identified the IP as Certified Medication Aide (CMA) R. On 10/18/23 at 11:08 AM, Certified Medication Aide (CMA) R identified self as the facility IP. CMA R provided a transcript of "Nursing Home Infection Preventionist Training Course" (Web-Based) completion of two continuing education units (CEU) dated 05/17/23. Participating via phone, Consultant GG stated she was the consultant which worked mostly off site, and made occasional onsite visits to support CMA R in the role of IP. On 10/19/23 at 11:33 AM, the facility provided Licensed Nurse (LN) J's proof of completion of the "Nursing Home Infection Preventionist Training Course" (Web-Based). LN J reported working two days a week with one day designated as the wound nurse and one day working with CMA R for infection control. LN J was also responsible for the facility's immunizations. The facility's "Infection Preventionist" policy, dated 10/18/22, documented the qualifications and position requirement must possess current, unencumbered, active licensure in an applied	F 882			

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F 882	Continued From page 75 clinical science including but not limited to: Nursing, Medical Technology, Microbiology, Epidemiology, or other related field or other appropriate educational degree. The policy further documented IP must work in the facility for substantial time to complete with Infection Prevention duties. The facility failed to ensure CMA R, the staff person designated as the IP, had the qualifying education, training, experience and certification required to fulfill the role, placing the residents at risk of unidentified and untreated infection.	F 882			
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883			

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F 883	Continued From page 76 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents with five residents reviewed for pneumococcal (a disease that refers to a range of illness that affects various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to obtain	F 883			

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F 883	Continued From page 77 pneumococcal history and administer the vaccine for four out of five reviewed for pneumococcal immunization status. Findings included: - Resident (R)44's clinical record revealed on 09/28/23 the resident's representative gave verbal consent for the administration of a pneumococcal vaccination. On 10/11/23 staff received an order to administer the vaccination. On 10/11/23 the medical record documented the vaccine was not covered by insurance related to R44 being on hospice services. As of 10/19/23, no further follow up completed for the administration of a pneumococcal vaccine. - R36's clinical record revealed on 09/22/23 the resident's representative signed for the administration of a pneumococcal vaccination. On 10/11/23 staff received an order to administer the vaccination. As of 10/19/23 R36 had not received a pneumococcal vaccination. - R53's clinical record revealed on 11/12/20 and 09/22/23 the resident's representative gave verbal consent for the administration of a pneumococcal vaccination. On 10/11/23 staff received an order to administer the vaccination. As of 10/19/23 R53 had not received a pneumococcal vaccination. - R2's clinical record revealed on 10/01/23 the resident's representative gave verbal consent for the administration of a pneumococcal vaccination. As of 10/19/23 R2 had not received a pneumococcal vaccination. On 10/18/23 at 03:06 PM Certified Medication	F 883			

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F 883	Continued From page 78 Aide (CMA) R, the facility's designated Infection Preventionist (IP) stated the facility obtained consent for the pneumococcal vaccination in September and October 2023. CMA R verified the vaccines had not been administered. The facility's "Immunization Policy", dated 10/02/23, documented recognizing the major impact and mortality of the influenza and/or pneumonia disease on residents of nursing homes: and the effectiveness of vaccines in reducing healthcare cost and preventing illness, hospitalization, and death, this facility has adopted the following policy statement. All resident, staff, and volunteers of this facility will be offered the influenza vaccine annually, unless there is a documented contraindication or if the resident or their representative refuses the vaccine after the appropriate education related to the risk of the conditions and the risk of failure to receive the vaccine. These vaccines will be administered by appropriate qualified personnel who are following facility procedures, without the need for an individual physician evaluation or order other than the signed standing orders. Each person offered the vaccine) s) will be provided information from the Centers for Disease Control and Federal Drug Administration regarding benefits and risks of the vaccine. All admissions throughout the year will be offered the pneumovax injection as recommended by Centers for Disease Control (CDC) and desired by the resident and approved by the primary care physician after investigation/inquiry related to current immunization status. Each resident's, staff's, and volunteer's immunization status will be determined, if possible, prior to vaccination, and will be documented in the resident's clinical record in the "Immunization Record." Vaccination	F 883			

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F 883	Continued From page 79 refusal and reasons why will be documented by the facility in addition to education related to risk of refusing immunization. The facility failed to ensure R44, R36, R53, and R2 received the pneumococcal vaccination as consented by the resident's representatives, placing the residents at risk to acquire, spread and experience complications related to pneumococcal disease.	F 883			