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PINE VILLAGE	86 TWENTY-SECOND AVENUE MOUNDRIDGE, KS 67107

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00181411. The 2567 was electronically sent to the facility on 09/07/06.	F 000		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 661		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/07/2023

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 72 residents. The sample included 18 residents. Based on record review and interview, the facility failed to develop a discharge summary that included a complete recapitulation (a concise summary of the resident's stay and course of treatment in the facility) of the resident's stay and post discharge plan for Resident (R) 71. This placed the resident at risk for missed care opportunities.

Findings included:

- R71's Electronic Medical Record (EMR) revealed the resident admitted to the facility on 06/05/23.

R71's "Admission Minimum Data Set" (MDS), dated 06/05/23, documented R71 required limited staff assistance with activities of daily living (ADLs) except supervision with eating. The MD'S documented the resident expected to remain in the facility.

The "Return to Community Care Area Assessment" (CAA) did not trigger.

R71's "Addendum to Baseline Care Plan," dated 06/05/23, documented an interdisciplinary evaluation to determine the support she needed to be safe and functioning at her highest level of ability while honoring her personal choices was conducted and R71's goal was to complete her rehab goals and transition to assisted living.

The "Nurse's Note," dated 06/23/23 at 02:45 PM, documented R71 was discharged from the facility to assisted living.

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F 661	Continued From page 2 Review of R72's EMR lacked a discharge summary which included a complete recapitulation of her stay. On 08/30/23 at 02:30PM, Administrative Staff A verified R71's discharge summary had an incomplete recapitulation of her stay and stated social service staff was responsible for completing the discharge summary. The facility's "Discharge/Transfer Of The Resident Policy," revised 01/19/2002, documented staff should complete a discharge summary and post discharge plan of care form which included a list of medications with instructions in simple terms, include instructions for post discharge care and explain to the resident and/or representative. and have resident and/or representative or person responsible for care sign discharge summary and post discharge care form. The facility failed to develop a discharge summary that included a complete recapitulation of R71's stay and post discharge plan. This placed the resident at risk for missed care opportunities.	F 661		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		

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accidents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 72 residents. The sample included 18 residents of which 10 were reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide a safe environment when the facility failed to assess Resident (R)16 for safe use of an electric recliner. This placed the R16 at risk for injury due to preventable accidents and hazards.

Findings included:

- R16's Electronic Medical Record (EMR) recorded cerebral vascular accident (CVA-stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain,) hemiplegia (paralysis one side of the body,) anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and essential tremors.

R16's "Quarterly Minimum Data Set" (MDS), dated 07/15/23, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R16 required extensive staff assistance with bed mobility and transfers and had two falls with minor injury.

The "Fall Care Area Assessment" (CAA), dated 04/28/23 documented staff would assure medical stability, prevent decline, expect fluctuations due to right side pain, and weakness.

The "Fall Care Plan," dated 07/31/23, recorded R16 was at risk for falls due to impaired mobility,

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weakness, poor balance, and past falls. The care plan recorded R16 failed to use the call light and wait for staff assistance with transfers and staff would perform visual checks for safety when in her room.

R16's clinical record lacked evidence the facility assessed the resident for safe use of an electric lift recliner.

The "Nurses Note," dated 03/28/23 at 04:25 PM, recorded R16 had an unwitnessed fall from her electric lift recliner and was observed in front of the recliner. R16 stated she pushed the button on the recliner "too high" and slid out of the recliner onto the floor. The resident was found sitting upright on her bottom, on the floor, in front of the recliner. She had no shoes or socks on. Her legs were in front of her. Staff educated R16 to wear nonslip footwear and wait for assistance before using the remote on the chair. No injuries were noted.

On 08/28/23 at 03:45 PM, observation revealed R16 sat in her electric lift recliner and License Nurse (LN) G administered the residents morning medication. R16 was dressed in street clothes and shoes.

On 08/30/23 at 02:30 PM Administrative Nurse D verified the resident had the electric lift recliner since admission to the facility and an electric lift chair safety assessment had not been completed on the resident's safe use of the chair. Administrative Nurse D verified the electric lift recliner assessments should be completed on admission, with a change in condition, and yearly.

The facility's "Falls Management" policy, dated

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F 689	Continued From page 5 December 2017, stated all residents would be evaluated for fall risk upon admission, increased number of falls, quarterly reviews and significant change with appropriate interventions implemented to decrease the risk of falls. The falls are reviewed by the nurse manager, Administrator and Director of Nursing. The policy documented all departments are responsible for the safety of the residents. The facility failed to assess R16 for safe use of an electric lift chair, placing the resident at risk for preventable accidents or injury.	F 689		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility had a census of 72 residents. The sample included 18 residents. Based on record review and interview, the facility failed to complete performance reviews of all nurse aides, provide regular in-service education based on the outcome of these reviews, and ensure all nurse aides received the required number of in-service training hours per year. This placed the residents at risk for inadequate care. Findings included: - The facility's employment records documented	F 730		

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the nurse aides who were employed at the facility for at least one year, review of the facility's in-service records documented one of the five Certified Nurse Aide (CNA) M lacked the required 12 hours of in-service training in the past year.

On 08/30/23 at 09:30AM, Administrative Staff A and Administrative Nurse D stated CNA M had not completed the 12 hours of required in-service training in the last year. They stated the human resource personnel was responsible to keep track of the required hours. They stated the facility had staff turn-over in that department and did not monitor the staff completion of in-service hours or ensure completion of performance reviews of the nursing staff.

The facility's "Required Training for Staff and Volunteers" dated 05/01/2021, documented the facility would ensure staff and volunteers are provided with training and continuing education related to the rights of persons served. The facility had developed, implemented, and maintained an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with defined and expected roles. The facility determines the amount and type of training necessary based on the "Facility Assessment Training topics for all staff. All direct care staff are required to attend twelve (12) hours of continuing education annually including but not limited to:
Dementia.
Infection control, blood borne pathogens and Antibiotic Stewardship.
HIPAA and confidentiality.
Resident rights and facility responsibilities.
Prevention of abuse, neglect exploitation and

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F 730	Continued From page 7 mistreatment of residents. Corporate compliance and ethics. Emergency preparedness. Quality Assurance /Performance Improvement (OAPI). Safety and Hazard training program. The Human Resources department would verify credentials and document verification at the time of employment and when credentials are renewed or updated. The facility Director of Nursing defines the competencies required of the staff providing care, treatment and services related to techniques, procedures and technology. The facility failed to ensure nurse aides employed at least one year completed 12 hours of required in-service education, placing the residents who resided in the facility at risk for receiving inadequate care.	F 730		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		

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psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 72 residents. The sample included 18 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure an appropriate indication for use, or a documented physician rationale

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which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R)19, who had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). This placed the resident at risk for unnecessary psychotropic (alters mood or thought) medications and related side effects.

Findings included:

- R19's Electronic Medical Record (EMR) documented she had a diagnoses of dementia, paranoid personality disorder, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), visual (experienced through vision) and auditory (experienced through hearing) hallucinations (sensing things while awake that appear to be real, but the mind created) , and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue).

R19's "Quarterly Minimum Data Set" (MDS), dated 07/29/23, documented R19 had a Brief Interview for Mental Status (BIMS) score of five, which indicated severe impaired cognition. The MDS documented the R19 required supervision with activities of daily living (ADLs). The MDS documented R19 received an antipsychotic and antidepressant (class of medications used to treat

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mood disorders and relieve symptoms of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medication every day during the lookback period.

R19"s "Psychotropic Medication Care Plan," dated 07/26/23, instructed staff to observe, document, and report to physician if R19 showed signs or symptoms of drug related complications; notify social service staff if noting signs or symptoms of depressed mood or cognitive decline. The care plan instructed staff to address R19's mood, affect, and anxiety concerns with the interdisciplinary team (IDT) in weekly meetings, and monitor R19 for exacerbation of delusions and hallucinations. The care plan instructed staff to administer to R19 Seroquel (antipsychotic medication), 25 milligram (mg) every evening for hallucinations.

The "Physician Order," dated 10/04/22, instructed staff to administer Seroquel, 25 mg tablet, every evening for hallucinations.

The "Monthly Pharmacy Regimen Review" documented the following:
On 12/2/22 the pharmacist recommended the physician place an acceptable diagnosis for R19's Seroquel, and listed the acceptable diagnoses as schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder), or Tourette's syndrome (involves uncontrollable repetitive movements or unwanted sounds (tics), such as

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repeatedly blinking the eyes, shrugging shoulders, or blurting out offensive words) and requested the physician pick one of them. The physician responded the resident had hallucinations but did not address placing the acceptable indication for use or the required documentation for the Seroquel.

On 01/05/23 the pharmacist documented Seroquel 25 mg with a diagnoses of hallucinations was not an acceptable diagnosis and recommended the physician change to one of the appropriate diagnoses (schizophrenia, Huntington disease, or Tourette's syndrome). The physician responded R19 was receiving it for hallucinations and had not tolerated a reduction in the past.

On 02/21/23 the pharmacist requested a gradual does reduction (GDR) for R19's Seroquel and requested an approved diagnosis for it. The physician responded no change in the dose, and noted the resident suffered from delusions and paranoia, and stopping the medicine would not be in her best interest but failed to address the request for changing the Seroquel diagnosis.

On 03/19/23 the pharmacist requested the physician place an approved diagnosis for R19's Seroquel (schizophrenia, Huntington disease, or Tourette's). The physician responded R19 had failed a dose reduction of the medication in the past but did not address changing the Seroquel diagnosis.

On 04/02/23 the pharmacist requested the physician indicate which diagnosis should be marked to the Seroquel order, as use of antipsychotics were discouraged. The pharmacist

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requested the physician choose a diagnosis from the list which included schizophrenia, Tourette's syndrome, Huntington disease, major depressive disorder, bipolar disorder, delusional disorder or Parkinson's disease psychosis. The physician checked delusional disorder due to medical condition.

On 05/10/23, 06/03/23 and 07/04/23, the pharmacist did not address the inappropriate diagnoses for R19's Seroquel.

R19's clinical record lacked a physician-signed rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic.

On 08/29/23 at 12:00 PM, R19 sat in a chair at the dining room table and visited politely with other residents at the table.

On 08/31/23 at 09:49 AM, Administrative Nurse D verified the physician had not placed an approved diagnosis for R19's Seroquel and stated staff should have followed up on the pharmacist recommendation and obtained an appropriate diagnosis.

The facility's "Antipsychotic Medication Policy," revised 12/15/21, documented all physician orders for antipsychotic medications would be clear and accurate and would include a diagnosis, condition, or indication for use.

The facility failed to ensure an appropriate indication for use, or or the required documentation, for the continued of Seroquel for R19, who had dementia.This placed the resident

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F 758	Continued From page 13 at risk for unnecessary psychotropic medications.	F 758		