STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and complaint investigation KS00175678. The 2567 was sent electronically on 11/08/22.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/08/2022

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

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 19 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify Resident (R)29's physician of medications not administered in a timely manner. This placed the resident at risk for physical decline.

Findings included:

- R29's Electronic Medical Record (EMR) documented R29 had diagnoses of hypertension (high blood pressure), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), and pain (physical suffering or

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discomfort).

The "Quarterly Minimum Data Set" (MDS), dated 08/12/22, documented R29 had severely impaired cognition and extensive assistance of one staff for transfers, dressing, and limited assistance of one staff for ambulation, toileting, and personal hygiene. The assessment further documented R29 received diuretic (medication to promote the formation and excretion of urine) medication during the lookback period.

The "Pain Care Plan," dated 08/03/22, directed staff to administer pain medication as ordered, obtain a pain assessment every shift, and follow the pain scale to medicate as ordered.

The EMR lacked documentation of a hypertension care plan for R29, who received hypertension medication.

The "Physician's Order," dated 05/03/22, directed staff to administer gabapentin (pain medication), 100 milligram (mg), two capsules, at bedtime for neuropathic pain.

The "Medication Administration Record" (MAR), dated September 2022, documented the following days the gabapentin medication was unavailable for R29:
09/01/22-09/09/22 (nine days)

The "Physician's Order," dated 05/03/33, directed staff to administer atorvastatin (lowers cholesterol), 80 mg, by mouth, at bedtime.

The "MAR," dated September 2022, documented the following days the atorvastatin medication was unavailable for R29:

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F 580	Continued From page 3 09/08/22-08/11/22 (4 days) The "Physician's Order," dated 05/03/22, directed staff to administer spironolactone (diuretic), 12.5 mg, by mouth, daily, for edema (swelling resulting from an excessive accumulation of fluid in the body tissues). The "MAR," dated October 2022, documented the following days the spironolactone medication was unavailable for R29: 10/10/22-10/14/22 (5 days) 10/18/22-10/20/22 (3 days) The "Physician's Order," dated 05/03/22, directed staff to administer bisoprolol fumarate (blood pressure medication), 2.5 mg, dally, for hypertension. The "MAR," dated October 2022, documented the following days the bisoprolol fumarate medication was unavailable for R29: 10/4/22-10/06/22 (3 days) 10/09/22- 10/14/22 (6 days) 10/18/22-10/20/22 (3 days) The "Nurse's Note." dated 10/19/22 at 12:49 PM, documented the facility tried to contact the pharmacy two times and was told R29's insurance would not cover his medications. Staff were directed to contact the family to get the resident set up on another insurance. The note further documented the facility contacted R29's durable power of attorney (DPOA) and was told she would contact the Veteran's Administration (VA) to get his medication sent out to him and was not sure when the facility would receive the medication.	F 580		

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The "Nurse Practitioner Progress Note," dated 10/21/22 at 11:38 AM, documented she had just been notified by the facility that R29 had not received his medications because he had run out due to insurance issues; he was awaiting the medications from the VA.

On 10/26/22 at 12:00 PM, observation revealed R29 in the dining room eating his lunch.

On 11/02/22 at 10:26 AM, Licensed Nurse (LN) J stated she had contacted the pharmacy to try to get his medication ordered and was told the medication was not covered by his insurance. LN J further stated she contacted the DPOA and was told the resident could get medications through the VA and the DPOA would contact the VA to get them ordered. LN J stated, she had not been aware R29 had VA medication and would normally call the pharmacy when residents have a week and a half of medication left so that they do not run out.

On 11/2/22 at 10:57 AM, Administrative Nurse D stated staff should have contacted the physician when they realized R29 did not have his medication so that the physician could order alternate medications that R29's insurance would cover through the pharmacy. Administrative Nurse D stated they did pay for some of his medications that he received through the VA so that he would not have to continue to be without medication. Administrative Nurse D stated staff could have gotten his gabapentin from the emergency kit instead of him not receiving any medication at all.

The facility "Notification of Changes" policy, dated January 2022, documented the facility, consistent

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F 580	Continued From page 5 with federal and state regulations, to inform the resident, consult with the resident's physician and notify, consistent with his or her authority , the resident representative when a need to alter treatment significantly. The facility failed to notify R29's physician immediately of medications not administered in a timely manner. This placed the resident at risk for physical decline.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

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rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 19 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for hypertension (high blood pressure) medication with signs and side effects of antihypertensive medications for one sampled resident, Resident (R) 29. This placed the resident at risk for physical decline and complications related to high blood pressure.

Findings included:

- The Electronic Medical Record (EMR) documented R29 had diagnoses of hypertension (high blood pressure), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), and pain (physical suffering or

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F 656	Continued From page 7	F 656		

discomfort).

The "Quarterly Minimum Data Set" (MDS), dated 08/12/22, documented R29 had severely impaired cognition and extensive assistance of one staff for transfers, dressing, and limited assistance of one staff for ambulation, toileting, and personal hygiene. The assessment further documented R29 received diuretic (medication to promote the formation and excretion of urine) medication during the lookback period.

The EMR lacked documentation of a hypertension care plan for R29, who received hypertension medication.

The "Physician's Order," dated 05/03/22, directed staff to administer bisoprolol fumarate (blood pressure medication), 2.5 mg, dally, for hypertension.

The "MAR," dated October 2022, documented the following days the bisoprolol fumarate medication was unavailable for R29:
10/4/22-10/06/22 (3 days)
10/09/22- 10/14/22 (6 days)
10/18/22-10/20/22 (3 days)

The "Nurse's Note." dated 10/19/22 at 12:49 PM, documented the facility tried to contact the pharmacy two times and was told R29's insurance would not cover his medications. Staff were directed to contact the family to get the resident set up on another insurance. The note further documented the facility contacted R29's durable power of attorney (DPOA) and was told she would contact the Veteran's Administration (VA) to get his medication sent out to him and was not sure when the facility would receive the

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F 656	Continued From page 8 medication. The "Nurse Practitioner Progress Note," dated 10/21/22 at 11:38 AM, documented she had just been notified by the facility that R29 had not received his medications because he had run out due to insurance issues; he was awaiting the medications from the VA. On 10/26/22 at 12:00 PM, observation revealed R29 in the dining room eating his lunch. On 11/2/22 at 10:57 AM, Administrative Nurse D stated R29 should have a hypertension medication care plan with direction to staff to monitor for side effects of antihypertensive medications. On 11/2/22 at 11:17 AM, Administrative Nurse E verified she had not developed a care plan for R29's hypertension medication. The facility's "Resident Care Plans-Initial/Baseline and Comprehensive Care Plans," policy, dated February 2022, documented the facility develop and implement a baseline or a comprehensive care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care. The facility failed to develop a comprehensive care plan for R29's antihypertensive medication. This placed R29 at risk for physical decline and complications related to high blood pressure.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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§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 63 residents. The sample included 19 residents, with five reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide scheduled bathing for one sampled resident, Resident (R) 16. This placed the resident at risk for skin problems and poor hygiene.

Findings included:

- R16's "Physician's Order Sheet," dated 10/02/22, recorded diagnoses of end-stage renal disease (limited or no kidney function on a permanent basis that requires dialysis), congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissue), cerebral vascular accident (interruption in the flow of blood to cells in the brain), hemiplegia (paralysis of one side of the body) diabetes mellitus (disease in which the body does not control the amount of glucose (a type of sugar) in the blood), and refractory depression (treatment resistant mood disorder that causes significant loss of interest in daily activities).

The "Annual Minimum Data Set" (MDS), dated 10/21/22, recorded R16 had a Brief Interview for Mental Status (BIMS) score of 12 (cognitively intact) and no behaviors. The MDS recorded R16 required extensive staff assistance with transfers, dressing, personal hygiene, was incontinent of

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bowel and urine and had not received bathing during the seven-day MDS observation period.

The "Activities of Daily Living (ADLS) Care Plan," dated 10/21/22, R16 was at risk for skin breakdown due to bowel and urine incontinence and required extensive staff assistance with personal hygiene and bathing. The "ADL Care Plan" recorded the resident often refused his scheduled showers and directed staff to offer R16 a sponge bath when he refused showers.

The facility's undated "Bathing schedule," directed staff to shower R16 on Monday and Thursday nights every week.

The "September Bathing Report," recorded R16 received bathing on the following days:
09/09/22 (8-day interval)
09/29/22 (19-day interval)

The "October Bathing Report," recorded R16 received bathing on the following days:
10/04/22

On/11/02/22, R16 currently had a 29-day interval without bathing.

On 10/26/22 at 11:09 AM, observation revealed R16 resting in bed, with the head of the bed slightly elevated. Continued observation revealed dried food on R16's beard and mouth, his long-sleeved t-shirt and pants were soiled with food stains, socks appeared soiled and stiff, and the resident's fingernails were untrimmed and dirty.

On 10/27/22 at 02:47 PM, observation revealed R16 sat in a wheelchair in his room. Continued

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F 677	Continued From page 11 observation revealed R16's shirt and pants soiled with food stains (same soiled pants as the previous day), fingernails dirty, untrimmed and the resident had an unpleasant odor. On 11/01/22 at 03:10 PM, Certified Nurse Aide (CNA) M stated staff record bathing on the computer and a bath sheet, and staff should provide scheduled bathing for the resident. On 11/01/22 at 10:32 AM, Licensed Nurse (LN) G stated R16 required limited staff assistance with bathing, frequently refused bathing and staff should provide R16's scheduled bathing or document the reason for refusal. On 11/2/22 at 09:10 AM, Administrative Nurse D stated R16 had behaviors and frequently rejected cares and bathing. Administrative Nurse D stated staff should provide R16's scheduled bathing or document the reason for the refusal. The facility's "Bath/Shower Policy," dated May 2021, directed staff to provide resident bathing as scheduled and document appropriate information in the medical record. The facility failed to provide scheduled bathing for R16, placing the resident at risk for skin problems and poor hygiene.	F 677		
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	F 689		

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§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sampled included 19 residents, with seven reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide a safe environment and failed to implement resident centered interventions for one sampled resident, Resident (R) 46. This placed the resident at risk for further falls and injury.

Findings included:

- R46's Electronic Medical Record (EMR) for R46 documented diagnoses of dementia with behavioral disorder (progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), diabetes mellitus type two (when the body cannot use glucose, not enough insulin made or the body cannot respond to insulin), and chronic kidney disease (when a disease or condition impairs kidney function, causing kidney damage to worsen over several months or years).

The "Quarterly Minimum Data Set" (MDS), dated 03/02/22, documented R46 and severely impaired cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, personal hygiene, and toileting. The MDS further documented R46 had two or more non injury falls, no functional impairment, and unsteady balance.

R46's "Annual MDS," dated 09/13/22, documented R46 had long and short term

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memory problems and required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. The MDS further documented R46 had no falls, no functional impairment, and unsteady balance.

The "Fall Risk Assessments," dated 05/18/22, 05/20/22, 08/20/22, 08/26/22, 09/12/22, 09/16/22, and 09/28/22, documented a high risk for falls.

The "Fall Care Plan," dated 08/03/22 directed staff to assist R46 with morning routine as she allowed, place non-skid strips along the bed. The update, dated 09/15/22, directed staff to place a perimeter overlay to mattress to clearly define edges of bed. The update, dated 09/26/22, directed staff to encourage R46 to be up in the daytime by providing activities of interest. The update, dated 09/28/22, directed staff to re-secure perimeter overlay to mattress to ensure it does not slip off.

The "Nurse's Note," dated 05/20/22 at 05:37 AM, documented R46 was found on the the floor in the kitchen area with her back towards her wheelchair, and her feet out in front of her. The note further documented R46 did not have any injuries. The EMR lacked evidence of a resident centered intervention was put into place to prevent further falls.

The "Fall Committee Note" dated 09/29/22 at 09:04 PM, documented R46 had a non injury fall that occurred on 09/28/22 at 06:00 AM. The note further documented R46 was on the floor next to her bed. The note directed staff to ensure R46's perimeter overlay was secured to the bed frame to prevent rolling out of bed.

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On 11/01/22 at 10:45 AM, observation revealed R46 sat in her wheelchair and Certified Nurse Aide (CNA) N placed a gait belt around her waist. Further observation revealed CNA N and CNA O held on to the gait belt of the resident, stood, and transferred her to her bed. Continued observation revealed R46 had a perimeter overlay on her bed and it was securely strapped to the bed frame; there was a fall mat beside the bed.

On 11/01/22 at 10:45 AM, CNA O stated she was unaware of any recent falls for the resident, but she had only been with the facility for a month. CNA O further stated R46's bed was to be lowered to the floor and a fall matt was placed beside the bed to help prevent falls.

On 11/02/22 at 10:26 AM, Licensed Nurse J stated R46 had a perimeter mattress on her bed to help the resident know where the edges of the bed were and staff bring her out by the nurse's station during the day when she was awake to monitor her.

On 11/02/22 at 11:06 AM, Administrative Nurse D stated the mattress should be strapped to the bed frame so the mattress did not move and cause R46 to fall out of bed. Administrative Nurse D verified there was not a fall intervention for the 5/20/22 fall.

The facility "Falls" policy, dated December 2021, documented the residents are assessed and evaluated to identify risks for injury due to falls. The residents receive necessary treatment and monitoring after a fall and interventions are implemented to minimize risks for injury die to falls. The policy documented the care plan was updated to minimize risks for injury die to falls

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F 689	Continued From page 15 and the team would place a note in the computer with verification of interventions or new interventions. The facility failed to ensure R46's perimeter overlay was securely strapped to the bed frame which caused R46 to fall out of bed and further failed to implement new fall interventions for cognitively impaired R46 after a fall in 05/2022. This placed the resident at risk for further falls and injury.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 63 residents. The	F 692		

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sample included 19 residents. Based on observation, record review, and interview the facility failed to accurately monitor the fluid intake for a 2000 milliliter (ml) per day fluid restriction for one sampled resident, Resident (R) 16. This placed the resident at risk for dehydration.

Findings included:

- R16's "Physician's Order Sheet," dated 10/02/22, recorded diagnoses of end-stage renal disease (limited or no kidney function on a permanent basis that requires dialysis), congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissue), cerebral vascular accident (interruption in the flow of blood to cells in the brain), hemiplegia (paralysis of one side of the body) diabetes mellitus (disease in which the body does not control the amount of glucose (a type of sugar) in the blood), and refractory depression (treatment resistant mood disorder that causes significant loss of interest in daily activities).

The "Annual Minimum Data Set" (MDS), dated 10/21/22, recorded R16 had a Brief Interview for Mental Status (BIMS) score of 12 (cognitively intact) and no behaviors. The MDS recorded R16 required extensive staff assistance with transfers, staff supervision with eating and received dialysis (process to remove excess water, solutes and toxins from the blood in people whose kidneys no longer function appropriately).

The "Dialysis Care Plan," dated 10/21/22, recorded R16 was on a physician ordered 2000 ml per day fluid restriction and directed nursing staff to provide 1280 ml of fluids per day and

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F 692	Continued From page 17 dietary staff provide 720 ml of fluids per day. The September 2022 Medication Administration Record (MAR) recorded R16 received an average of 658 ml of fluids per day. The October 2022 MAR recorded R16 received an average of 731 ml of fluids per day. R16's clinical record lacked further documentation regarding daily fluid intake and/or intake provided by dietary. On 10/27/22 at 07:55 AM, observation revealed R16 sat in a wheelchair at the dining table. R16 ate/drank independently. On 11/01/22 at 10:19 AM, Licensed Nurse (LN) G stated R16 was on a daily fluid restriction due to dialysis and nursing staff recorded the fluids the resident consumed each shift on the MAR. On 11/02/22 at 09:20 AM, Administrative Nurse D stated R16 was on a physician ordered fluid restriction due to dialysis; staff should accurately monitor the resident's fluid intake and document the fluid intake on the MAR each shift. The facility's "Fluid Restriction Policy," dated February 2022, directed staff to distribute fluids as scheduled, ensure adequate fluids were consumed and accurately record the resident's fluid intake on the medical record. The facility failed to accurately monitor R16's daily fluid intake for a 2000 ml per day fluid restriction, placing the resident at risk for dehydration.	F 692		
F 697 SS=D	Pain Management	F 697		

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F 697	Continued From page 18 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 63 residents. The sample included 19 residents with three reviewed for pain. Based on observation, record review, and interview, the facility failed to provide pain medication for one sampled resident, Resident (R) 172. This placed R172 at risk for further pain and discomfort. Findings included: - R172's Electronic Medical Record (EMR) documented R172 was admitted on 10/21/22 at 04:21 PM with diagnoses of closed fracture of the head of the right femur (broken bone), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), hypertension (high blood pressure), posttraumatic stress disorder (psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), and diabetes mellitus type 2 (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 10/28/22, was in progress. The "Pain Care Plan," dated 10/23/22, directed	F 697		

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staff to administer analgesia (pain) medication as ordered, administer one half-hour before treatments or care, follow pain scale to medicate as ordered, and R172 was able to call for pain medication. The care plan further directed staff to assess R172's pain every shift and report any change related to pain or discomfort.

The "Physician's Order," dated 10/21/22, directed staff to administer hydrocodone (medication for moderate to severe pain), 5/325 milligram (mg), by mouth, every four hours, as needed, for pain.

The "Admission Pain Assessment," dated 10/21/22, documented R172 had pain at that time rated a six on the scale of one to ten (zero represented no pain and 10, the worst pain imaginable), and he had almost constant pain that worsened with physical activity.

The "Medication Administration Record" (MAR) for October 2022, documented R172 did not receive pain medication until 10/22/22 at 12:25 PM. (20 hours after admission)

The "Nurse's Note," dated 10/22/22 at 12:25 PM, documented the nurse obtained a code from the pharmacy for the as needed hydrocodone medication and R172 voiced pain rated a nine out of ten that migrated down his right hip.

On 10/27/22 at 02:45 PM, observation revealed R172 on his back in bed.

On 10/27/22 at 02:45 PM, R172 stated he did not receive pain medication until the second day he was in the facility because the nurse stated she needed to get an authorization code to get his medication. R172 further stated he had a lot of

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pain.

On 10/27/22 at 03:00 PM, Certified Medication Aide (CMA) S stated R172 did not receive his pain medication on the day he was admitted to the facility because they did not have a code to get the medication out of the emergency kit.

On 10/27/22 at 03:21 PM, Licensed Nurse (LN) I stated she was not working when R172 was admitted to the facility. LN I worked with R172 the next day and saw he did not have his pain medication. LN I further stated she had tried several times that morning to contact the pharmacy and did not receive a response. LN I stated she contacted the Nurse Practitioner to get pain medication for R172 and he received his hydrocodone around noon.

On 11/2/22 at 10:28 AM, LN J stated the facility usually received new admission paperwork a couple hours before they come to the facility and if the new resident had pain medication orders, she would contact the physician to sign off on the order so that the resident would have their pain medication when they arrive at the facility. LN J further stated the facility emergency kit had hydrocodone pain medication if a resident needed it.

On 11/2/22 at 10:57 AM, Administrative Nurse D stated nursing staff should have contacted the physician the day of admission to sign off on the hydrocodone medication for R172.

The facility's "Pain Assessment and Management" policy, dated March 2022, documented the pain management program was based on a facility wide commitment to

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F 697	Continued From page 21 appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. The policy further documented nonpharmacological interventions may be appropriate alone or in conjunction with medications. The facility failed to provide pain medication for R172 who had pain upon admission. This placed the resident at risk for further pain and discomfort.	F 697		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		

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§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 19 residents, with one reviewed for tube feeding. Based on observation, record review, and interview, the facility to ensure licensed nursing staff possessed the necessary knowledge and skills when staff administered Resident (R) 41's medication by mouth though the order read, and the licensed nurse was aware, the medications were ordered via percutaneous endoscopic gastrostomy (PEG) feeding tube (a feeding tube placed through the skin and stomach wall to allow nutrition, fluids and/or medication to be put directly into the stomach bypassing the mouth) by the physician. This deficient practice placed the resident at risk for aspiration.

Findings included:

- R41's Electronic Medical Record (EMR) documented R41 had diagnoses of dysphagia (swallowing difficulty), aphasia (condition with disordered or absent language function), hypertension (high blood pressure) and hemiplegia (paralysis of one side of the body).

The Quarterly Minimum Data Set" (MDS), dated 09/01/22, documented R41 had severely impaired cognition, dependent on two staff for transfers and extensive assistance of one staff for

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dressing, personal hygiene, and eating. The MDS further documented R41 had no choking or swallowing difficulty with medications, and received 51% or more of daily intake via feeding tube, and received speech therapy services.

The "Care Plan," dated 09/03/22, directed staff to elevate the head of the bed and maintain it at least 30-45 degrees at all times. The care plan further directed staffto administer medications as ordered and monitor for side effects and effectiveness.

The "Physician's Order," dated 08/11/22, directed staff to administer ferrous sulfate (medication to treat iron deficiency), 325 milligram (mg), administer via peg tub, daily for supplementation.

The "Physician's Order," dated 08/18/22, directed staff to administer folic acid (a vitamin), 1 mg, administer via peg tub, daily for supplementation.

On 10/27/22 at 08:10 AM, observation revealed Licensed Nurse (LN) I crushed and mixed R41's ferrous sulfate and folic acid medication with applesauce. Further observation revealed R41 sat in bed with the head of his bed elevated. LN I administered his medication by mouth.

On 10/27/22 at 08:10 AM, LN I stated R41 was able to eat meals in his room and if he ate less than 50% of his meal, he received nutrition through his feeding tube. LN I further stated R41's orders were recently changed and he would be receiving more nutrition through his feeding tube. LN I stated the orders for R41's medications were incorrect and she said she could administer R41's medications by mouth. LN I stated she gave all of R41's early morning

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F 726	Continued From page 24 medication by mouth and went on to say she would ask for clarification of the orders. On 11/02/22 at 11:00 AM, Administrative Nurse D stated R41's orders were correct, and staff should administer his medication via peg tube. Administrative Nurse D stated LN I passed her skills fair competencies which included medication administration via feeding tube in March. She stated LN I should have administered R41's medication as ordered. The facility "Medication Administration Via Feeding Tube" policy, dated January 2022, documented a physician's order was required for the administration of any medication via feeding tube. The policy further documented liquid dosage forms should be ordered if available and tablets that must be crushed prior to administration via feeding tube required a specific order. The facility follow the general procedures for the administration of medication for the eight rights of medication administration. The facility to ensure licensed nursing staff possessed the necessary knowledge and skills when staff administered R41's medication by mouth though the order read, and the licensed nurse was aware, the medications were ordered via feeding tube. This deficient practice placed the resident at risk for aspiration.	F 726		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		

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§483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to ensure a reconciliation of controlled medications at the end of daily work shifts. The facility further failed to ensure Resident (R)29's medications were available for administration as ordered by the physician. This placed residents at risk for misappropriation of medications by staff and ineffective medication

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regimen.

Findings included:

- On 10/26/22 at 08:50 AM, observation of the southwest-hall medication cart lacked evidence staff performed a reconciliation of controlled substances and signed the " Controlled Medication Count Sheet" at shift change 14 times from 10/01/22 to 10/26/22.

On 10/26/22 at 09:12 AM, observation of the northwest-hall medication cart lacked evidence staff performed a reconciliation of controlled substances and signed the "Controlled Medication Count Sheet" at shift change 25 times from 10/01/22 to 10/26/22.

On 10/26/22 at 08:50 AM, Licensed Nurse (LN) K stated two nurses should count the narcotic medications every shift and sign the "Controlled Medication Count Sheet" to verify an accurate narcotic medication count.

On 10/26/22 at 09:12 AM, Certified Medication Aide (CMA) R stated two nurses should count the narcotic medications every shift and sign the "Controlled Medication Count Sheet" to verify an accurate narcotic medication count.

On 11/02/22 at 09:20 AM, Administrative Nurse D stated two nurses should count the narcotic medications every shift and sign the "Controlled Medication Count Sheet" to verify an accurate narcotic medication count.

The facility's "Controlled Medication Policy," dated December 2019, directed staff to follow safeguards/guidelines to prevent loss or diversion

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of narcotic medications. The "Controlled Medication Policy" directed the on-coming and off-going charge nurses count narcotic medications and sign the "Controlled Medication Count Sheet" to confirm an accurate controlled substance count.

The facility failed to ensure a reconciliation of controlled medications at the end of daily work shifts, placing residents at risk for misappropriation of medications by staff.
- R29's Electronic Medical Record (EMR) documented R29 had diagnoses of hypertension (high blood pressure), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), and pain (physical suffering or discomfort).

The "Quarterly Minimum Data Set" (MDS), dated 08/12/22, documented R29 had severely impaired cognition and extensive assistance of one staff for transfers, dressing, and limited assistance of one staff for ambulation, toileting, and personal hygiene. The assessment further documented R29 received diuretic (medication to promote the formation and excretion of urine) medication during the lookback period.

The "Pain Care Plan," dated 08/03/22, directed staff to administer pain medication as ordered, obtain a pain assessment every shift, and follow the pain scale to medicate as ordered.

The EMR lacked documentation of a hypertension care plan for R29, who received hypertension medication.

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The "Physician's Order," dated 05/03/22, directed staff to administer gabapentin (pain medication), 100 milligram (mg), two capsules, at bedtime for neuropathic pain.

The "Medication Administration Record" (MAR), dated September 2022, documented the following days the gabapentin medication was unavailable for R29:
09/01/22-09/09/22 (nine days)

The "Physician's Order," dated 05/03/33, directed staff to administer atorvastatin (lowers cholesterol), 80 mg, by mouth, at bedtime.

The "MAR," dated September 2022, documented the following days the atorvastatin medication was unavailable for R29:
09/08/22-08/11/22 (4 days)

The "Physician's Order," dated 05/03/22, directed staff to administer spironolactone (diuretic), 12.5 mg, by mouth, daily, for edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The "MAR," dated October 2022, documented the following days the spironolactone medication was unavailable for R29:
10/10/22-10/14/22 (5 days)
10/18/22-10/20/22 (3 days)

The "Physician's Order," dated 05/03/22, directed staff to administer bisoprolol fumarate (blood pressure medication), 2.5 mg, dally, for hypertension.

The "MAR," dated October 2022, documented the

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following days the bisoprolol fumarate medication was unavailable for R29:
10/4/22-10/06/22 (3 days)
10/09/22- 10/14/22 (6 days)
10/18/22-10/20/22 (3 days)

The "Nurse's Note." dated 10/19/22 at 12:49 PM, documented the facility tried to contact the pharmacy two times and was told R29's insurance would not cover his medications. Staff were directedto contact the family to get the resident set up on another insurance. The note further documented the facility contacted R29's durable power of attorney (DPOA) and was told she would contact the Veteran's Administration (VA) to get his medication sent out to him and was not sure when the facility would receive the medication.

The "Nurse Practitioner Progress Note," dated 10/21/22 at 11:38 AM, documented she had just been notified by the facility that R29 had not received his medications because he had run out due to insurance issues; hewas awaiting the medications from the VA.

On 10/26/22 at 12:00 PM, observation revealed R29 in the dining room eating his lunch.

On 11/02/22 at 10:26 AM, Licensed Nurse (LN) J stated she had contacted the pharmacy to try to get his medication ordered and was told the medication was not covered by his insurance. LN J further stated she contacted the DPOA and was told the resident could get medications through the VA and the DPOA would contact the VA to get them ordered. LN J stated, she had not been aware R29 had VA medication and would normally call the pharmacy when residents have

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F 755	Continued From page 30 a week and a half of medication left so that they do not run out. On 11/2/22 at 10:57 AM, Administrative Nurse D stated staff should have contacted the physician when they realized R29 did not have his medication so that the physician could order alternate medications that R29's insurance would cover through the pharmacy. Administrative Nurse D stated they did pay for some of his medications that he received through the VA so that he would not have to continue to be without medication. Administrative Nurse D stated staff could have gotten his gabapentin from the emergency kit instead of him not receiving any medication at all. The facility "Obtaining and refilling medications" policy undated, documented the facility obtained medications from new physicians orders and refilled the medications needed in a timely manner. The policy further documented it was the responsibility of each staff member who passed medications to ensure each resident had a adequate amount of every prescribed medication at all times. The facility failed to ensure R29's medications were available for administration, placing the resident at risk for decline due to not receiving his physician ordered medications.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		

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appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents and five medication carts. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to label and store drugs and biologicals for two of five medication carts. This placed the affected residents at risk for ineffective medication regimens.

Findings included:

- On 10/26/22 at 08:15 AM, during initial tour of facility, observation revealed the Hall 100 nurse's medication cart had an insulin (medication used to regulate blood sugar) pen which lacked a date when opened for use for Resident (R) 20. Licensed Nurse (LN) H stated the insulin should

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F 761	Continued From page 32 have open date. On 10/26/22 at 01:23 PM observation reveal the Hall 100 medication cart was unlocked and unattended by staff. Observation further revealed cognitively impaired, independently mobile R8 in a wheelchair in the vicinity of the unlocked medication cart. Certified Medication Aide (CMA) R verified the medication cart was left unlocked. On 11/02/22 at 12:40 PM Administrative Nurse D verified insulin pens should be labeled with an opened date and medication carts were to be locked when not in use or unattended. The facility's "Medication Administration/Medication Labels" policy, dated 03/2022, documented medications are labeled in accordance with facility requirements and state and federal laws. Insulin after being open for the first use, will have the date the medication was opened labeled on the pen, box or vial. Upon request the facility did not provide a policy for securing/locking medication carts. The facility failed to label insulin pen when opened and failed to ensure an unsupervised medication cart was locked, which placed residents at risk to receive ineffective medication and provided unsafe access to medications.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to transport clean clothing in a sanitary manner and failed to adequately disinfect a glucometer (blood sugar reading machine). This placed the residents at risk for infectious disease processes.

Findings included:

- On 10/26/22 at 12:37 PM observation revealed Laundry Aide U delivered clean residents' personal clothes to hall 100 without a cover or barrier. Laundry Aide U stated she was not told the clean laundry should be covered.

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F 880	Continued From page 35 On 11/02/22 at 11:51 AM observation revealed Licensed Nurse (LN) H cleaned glucometer after use using disinfecting wipes. The container of wipes had an expiration date of 04/2021. LN H verified expiration date of 04/2021 and verified the wipes should not be used. On 11/02/22 at 12:39 PM Administrative Nurse D stated she thought she had removed all expired cleansing wipes. She further stated staff should utilize cleansing products which were not expired. The facility's "Infection Control Policy/Procedure: Laundry", dated 09/2021, documented the policy of this facility that careful precautionary procedures must be followed by laundry personnel to prevent the spread of infectious disease to other staff members, residents, and visitors. Upon request the facility did not provide a policy regarding the use of disinfecting wipes. The facility failed to deliver transport residents' personal laundry in a sanitary manner throughout the hall and failed to cleanse multi-use medical equipment adequately which placed the residents at risk for infectious disease processes.	F 880		