STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	06/16/2022

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PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

(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. The 2567 was sent electronically on 06/23/22.	F 000		
F 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of	F 576		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/23/2022

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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electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents. Based on record review and interview the facility failed to deliver mail to the facility residents on Saturdays. This placed the residents at risk for impaired psychosocial wellbeing.

Findings included:

- On 06/13/22 at 01:00 PM during the resident council meeting, the residents verbalized there was no mail delivery on Saturdays.

On 06/13/22 at 01:45 PM, Administrative Staff A stated the housekeeping staff were supposed to get the mail on the weekend, then deliver the mail to the residents. Administrative Staff A verified the mail should consistently be delivered to the residents on Saturdays; Admisnitrative Staff A verified the facility did not always deliver mail to the residents on Saturdays.

The undated facility policy "Resident Rights," documented the resident has the right to send and receive mail, and to receive letters, packages, and other materials delivered to the facility through any other means than a postal service."

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F 576	Continued From page 2 The facility failed to deliver mail to the residents in the facility on Saturdays, placing the residents at risk for impaired psychosocial wellbeing.	F 576		
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 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		

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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 29 residents. The sample included 12 residents, with one reviewed for notification of change. Based on observation, record review, and interview, the facility failed to notify the physician in a timely manner when Resident (R) 18 developed a change from her baseline/normal behaviors. This placed the resident at risk for physical decline and delayed treatment.

Findings included:

- The Electronic Medical Record (EMR) documented R18 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, mask like faces, shuffling gait, muscle rigidity and weakness). emotional disorder (chronic and often recurrent psychiatric disorders that are associated with significant impairment in quality of life, productivity, and interpersonal

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functioning), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and intellectual impairment (problems with general mental abilities that affect functioning, intellectual and functional).

The "Quarterly Minimum Data Set", dated 05/12/22, documented R18 had severely impaired cognition and was dependent upon two staff for transfers, toileting. R18 required extensive assistance of two staff for bed mobility and dressing.

The "Admission Orders," dated 04/29/22, directed staff to administer Sinemet, 10 milligrams (mg)-100 mg, 1 tablet four times a day. The order further directed staff to administer half a pill every 1.5 hours following the 07:00 AM dose and the last dose to be at 07:00 PM.

The "April 2022 Medication Administration Record (MAR)" directed staff to administer Sinemet, 10 milligrams (mg)-100 mg, 1.5 tablets every 1.5 hours following the 07:00 AM dose and the last dose to be at 07:00 PM.

Review of the MAR documented 15 times R18 received the wrong dose of medication.

The "May 2022 MAR", directed staff to administer Sinemet, 10 milligrams (mg)-100 mg, 1.5 tablets every 1.5 hours following the 07:00 AM dose and the last dose to be at 07:00 PM.

Review of the MAR documented 58 times R18 received the wrong dose of medication.

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The "Nurse's Note," dated 05/07/22 at 03:43 PM, documented R18's representative contacted the facility and reported R18 was not acting her normal self. The note further documented R18's representative asked about the resident's Sinemet dose and when staff told her the dosage, R18's representative stated the dosage was not correct. Licensed Nurse (LN) G reviewed the physician order and found the order was incorrect on the MAR. The note documented LN G then contacted the hospital and was directed to contact poison control by the physician and send the resident to the emergency department (ED).

The "Emergency Department Report," dated 05/07/22, documented R18 presented to the ED due to behavior and movement changes. The resident was supposed to get Sinemet 10/100, 0.5 mg, nine times per day and had been getting 1.5 mg, nine times per day for the last eight days. Poison control was contacted and recommended labs and an electrocardiogram (EKG -records the electrical signals from the heart]). The report documented R18's EKG was normal and her laboratory report was unremarkable; the resident was admitted for observation for dyskinesia (abnormality or impairment of voluntary movement).

On 06/15/22 at 02:15 PM, Administrative Nurse D stated she was unsure the status of the resident the day she went to the hospital. She said the LN on duty would be the best person to talk to. Administrative Nurse D further stated two nurses would double check the admission order to make sure it was correctly entered in the MAR.

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F 580	Continued From page 6 On 06/16/22 at 07:48 AM, LN G stated R18 was more anxious than usual, and would not answer staff appropriately. LN G stated she did not notify R18's physician regarding the change in R18 until R18's representative contacted her. The facility's "Doctor Notification and Necessary Assessment" policy, undated, documented to ensure that the physician was notified appropriately and proper assessment was done prior to notification to ensure adequate information was given for the physician to make an informed decision. The facility failed to notify the physician in a timely manner when LN staff identified the resident was not acting like normal. This placed the resident at risk for physical decline and delayed treatment.	F 580		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 604		

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treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents, with one reviewed for restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body). Based on observation, record review, and interview, the facility failed to provide a physician's order and an assessment for Resident (R) 30's a merry-walker (an enclosed framed wheeled walker), placing the resident at risk for complications related to physical restraints.

Findings included:

- The Electronic Medical Record (EMR) documented R30 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and

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hopelessness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 06/08/22, documented R30 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, ambulation in room and corridor, dressing, and toileting. The MDS further documented R30 had no mobility devices and no restraints.

The "Activities of Daily Living [ADLs] Care Plan," dated 03/16/22, documented R30 required assistance of two staff and gait belt to move between surfaces when not in the merry-walker. It directed staff to be cautious of how tight the straps were when R30 was in the merry-walker.

The "Fall Care Plan," dated 03/16/22, directed staff to place R30 in the merry-walker when she was restless.

R30's EMR lacked a physician order or an assessment for the merry-walker.

On 06/13/22 at 08:15 AM, observation revealed R30 in her merry-walker facing a wall in Hall 3. Her eyes were closed. Further observation revealed the merry-walker had green tarp material, held in place with Velcro, from the top to the bottom of the sides of the merry-walker. The merry-walker had a cushion attached to the inside front of the merry walker for R30 to lean against when she walked.

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On 06/13/22 at 04:25 PM, observation revealed R30 sat in her merry-walker in the living room area.

On 06/15/22 at 07:51 AM, observation revealed R30, in Hall 4, sat in the merry-walker. Her eyes were closed. Further observation revealed R30 leaned against the cushion on the front of the merry-walker and began to walk with her eyes closed. R30 stopped when the merry-walker got to the wall.

On 06/14/22 at 12:54 PM, Administrative Nurse D stated she had not obtained a doctor's order or completed an assessment for use of the merry-walker as she did not feel the merry-walker was a restraint. (Administrative Nurse D further stated the merry-walker allowed R30 to move around independently.

On 06/15/22 at 09:25 AM, Certified Nurse Aide (CNA) N stated the material on the sides of the merry-walker was put into place so R30 could not stick her feet out of the sides of the merry-walker.

On 06/15/22 at 01:00 PM, Licensed Nurse G stated the merry-walker helped the resident not to fall and verified R30 would not be able to get out of the merry-walker on her own.

On 06/16/22 at 08:12 AM, CNA M stated R30 had falls and administrative staff felt the merry-walker helped R30 not to fall; it also allowed R30 to be mobile. CNA M further stated R30 would not be able to get out of the merry walker on her own.

The facility's undated "Restraint Reduction" policy documented each resident had the right to be free from any physical or chemical restraint

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F 604	Continued From page 10 imposed for purposes of discipline or convenience of staff, and not required to treat the resident's medical symptoms. The policy further documented a physician's order was required to apply any/all restraints including indication for restraint and medical symptom to be controlled by restraint and specific shortest possible duration. The interdisciplinary team would monitor the resident while the restraint was ordered, and the resident's environment would be fully assessed for any safety hazards that may prevent the resident from being restraint free. The resident's environment would be fully assessed for any safety hazards that may prevent the resident from being restraint free. The interdisciplinary team would determine the frequency of observing and assessing the restrained resident but would never exceed 2 hours and would be removed or released at least every 2 hours. A physical restraint elimination assessment was completed at least quarterly, and more often if indicated for all resident who have any type of restraint ordered. The facility failed to assess and get a physician order for R30's merry walker which acted as a physical restraint, placing the resident at risk for injury or complications related to physical restraints.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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	F 609		

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mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 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 29 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to report an injury of unknown origin to administration staff for one sampled resident, Resident (R) 19, who had a skin tear of unknown origin on his right hand. This placed the resident at risk for further injury and unidentified abuse or mistreatment.

Findings included:

- The Electronic Medical Record (EMR) for R19 recorded diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular

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weakness of one half of the body) affecting the left non-dominant side, dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), and contracture of the left hand (abnormal permanent fixation of a joint.

The "Quarterly Minimum Data Set", dated 05/12/22, documented R19 had severely impaired cognition and was dependent upon two staff for transfers, toileting and extensive assistance of two staff for bed mobility and dressing. The MDS further documented R19 did not have any skin tears.

The "Skin Integrity Care Plan," dated 05/17/22, documented R19 was at risk for impaired skin integrity and directed staff to evaluate skin integrity monthly and as needed by a nurse.

The "Nurse's Note," dated 06/08/22 at 11:34 AM, documented a skin tear (a traumatic wound caused by mechanical forces) of unknown origin, on top of R19's right hand. The half-moon shape skin tear measured 0.5 centimeters (cm) x 3 cm. The note documented the area was cleaned, dried, triple antibiotic ointment applied and wrapped in gauze. The note further documented R19's physician was notified.

The "Physician Order," dated 06/11/22, directed staff to cleanse the skin tear to right hand with normal saline, apply triple antibiotic ointment, and cover the wound with tegaderm (a transparent medical dressing used to cover and protect wounds). The order further directed staff to change every other day until healed.

The "Nurse's Note," dated 06/16/22 at 10:00 AM,

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documented R19 had an open wound to the base of his left thumb with a small amount of yellowish-brown drainage. The note further documented R19 had an old skin tear to the right elbow that had reopened.

The "Physician Order," dated 06/16/22, directed staff to obtain a wound culture (a test to find germs that cause an infection) on the skin tear, and administer doxycycline (an antibiotic), 100 milligrams (mg), by mouth, daily for seven days.

The medical record lacked documentation how R19 received the skin tear to his right hand and lacked evidence preventive measures were evaluated and implemented.

On 06/13/22 at 10:30 AM, observation of R19 revealed a moon shaped skin tear on his right hand, without a dressing.

On 6/16/22 at 07:42 AM, observation revealed a skin tear on R19's right hand. Further observation revealed brown drainage under the transparent dressing.

On 06/15/22 at 07:47 AM, Administrative Nurse D verified an incident or investigation had not been completed for the skin tear and should have been investigated. Administrative Nurse D verified she was not aware the resident had a skin tear on his hand.

On 06/15/22 at 12:57 PM, Licensed Nurse (LN) G stated she did not know how R19 received the skin tear on his right hand and further stated R19's dressing was changed every other day.

On 06/16/22 at 08:15 AM, Certified Nurse Aide

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F 609	Continued From page 14 (CNA) M stated she was unaware how R19 had obtained the skin tear on his hand. CNA M further stated, when a resident had an injury, she would tell her charge nurse. The facility's "Skin Injury" policy, undated, documented, in support of the abuse and neglect policies, staff must be aware that any injury as a result of possible abuse or neglect must be reported immediately to the supervisor, don, and administrator. All incidents, whether considered significant or not requires completion of a facility incident report and investigation to determine causal factors for the incident and interventions implemented to prevent any further occurrences in the future. The facility's "Prevention Abuse, Neglect, and Exploitation" policy, dated 08/18/16, documented inquiries concerning Abuse, Neglect, and Exploitation reporting and investigating should be referred to the Administrator and/or Director of Nursing. The facility failed to report a skin tear of unknown origin to administration staff for cognitively impaired R19, placing him at risk for further injury and unidentified abuse or mistreatment.	F 609		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

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F 657	Continued From page 15 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to revise the care plan with interventions to prevent accidents for three sampled residents, Resident (R) 11, R18, R30 and R10, who had falls. This placed the residents at risk for further injury and skin breakdown. Findings included: - The Electronic Medical Record (EMR) documented R11 had diagnoses of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction	F 657		

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characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness, and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS) dated 04/20/22, documented R11 had severely impaired cognition, required extensive assistance of one staff for bed mobility and was independent with transfers, ambulation. The MDS further documented R11 had unsteady balance, no functional impairment, and had two or more non injury falls and one injury fall.

The "Fall Risk Assessments," dated 07/20/21, 10/22/21, 01/20/22, and 04/20/22 documented the resident a high risk for falls.

The revised "Care Plan," dated 05/04/21, originally dated 06/25/21, directed staff to put grip tape on the floor in front of the bed, slipper socks on when in bed, and put R11's laundry away. The update, dated 03/16/22, directed staff to place a scooped mattress (special mattress with raised sides). The update, dated, 05/04/22, directed staff to keep bed in lowest position.

The "Post Fall Evaluation," dated 10/20/21 at 06:02 PM, documented R11 stumbled over her own feet and fell during ambulation to the dining room. The evaluation further documented the resident received a bruise to her left hand. R11's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

The "Post Fall Evaluation," dated 03/30/22 at

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06:01 PM, documented R11 fell while ambulating in the hallway without her walker. The evaluation further documented R11 did not receive any injuries from the fall. R11's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

The "Post Fall Evaluation," dated 04/05/22 at 07:40 PM, documented R11 had a witnessed fall in the Hall 4 dining room. The evaluation further documented R11 was agitated and fell in the dining room. R11's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

The "Post Fall Evaluation," dated 04/12/22 at 03:28 PM, documented R11 fell while ambulating in the hallway without her walker. R11's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

On 06/15/22 at 08:39 AM, observation revealed R11 ambulated, with her walker, into the Hall 4 dining room. Certified Nurse Aide (CNA) O walked beside the resident. Further observation revealed R11's gait was unsteady, and CNA O assisted the resident into a chair.

On 06/16/22 at 09:00 AM, observation revealed R11 independently ambulated down Hall 4 with her walker. Further observation revealed R11's gait was steady.

On 06/15/22 at 01:16, CNA O stated R11 did not walk independently because of falls and R11 was unsteady.

On 06/16/22 at 08:23 AM, CNA M stated R11 had days she ambulated independently. CNA M said

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staff assisted the resident during the morning but R11 could ambulate alone later in the morning. CNA M further stated R11 had falls when she lost her balance or when she would forget to use her walker.

On 06/15/22 at 8:50 AM, Administrative Nurse D verified R11 had several falls and verified there were not interventions for her falls in the resident's care plan.

The facility's "Elder Directed Care Plans" policy, undated, documented the facility provided an individualized, interdisciplinary plan of care for all elders that was appropriate to the elders needs, strengths, limitations and goals based on initial, recurrent and continued needs of the elder. The care plan further documented the facility regularly reviewed and revised the plan of care, treatment and service, and the plan of care would be individualized to the needs of the elder.

The failed to revise R11's care plan with interventions to prevent further falls, placing the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) documented R18 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). emotional disorder (chronic and often recurrent psychiatric disorders that are associated with significant impairment in quality of life, productivity, and interpersonal functioning), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), diabetes mellitus (when the body cannot use glucose, not enough

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insulin made or the body cannot respond to the insulin), and intellectual impairment (problems with general mental abilities that affect functioning, intellectual and functional).

The "Admission Minimum Data Set" (MDS), dated 05/12/22, documented R18 had severely impaired cognition and required limited assistance of one staff for toileting, independent with transfers and ambulation. The MDS further documented R18 had no falls since admission.

The "Fall Risk Assessment," dated 04/29/22, documented R18 was a high risk for falls.

The "Fall Care Plan," dated 05/11/22, directed staff to determine the resident's ability to transfer. The care plan directed if a fall occurred, alert R18's provider, and obtain frequent neurological checks (a series of questions and tests to check brain, spinal cord, and nerve function).

The "Post Fall Evaluation," dated 05/14/22 at 05:24 AM, documented R18 was in her room, moving her television, and lost her balance. The evaluation further documented R18 received an abrasion to her back. R18's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

The "Post Fall Evaluation," dated 05/16/22 at 08:50 PM, documented R18 fell in her room while ambulating. The evaluation further documented R18 did not receive any injuries. R18's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

On 06/14/22 at 08:00 AM, observation revealed R18 had trouble navigating (plan or direct a route)

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her walker through her door. Further observation revealed R18 asked for assistance to get out of her door and a Certified Nurse Aide (CNA) walked with her to the dining room.

On 06/16/22 at 08:01 AM, observation revealed R18 independently ambulated, with her walker, down the hall.

On 06/15/22 at 01:00 PM, Licensed Nurse (LN) G stated she was on involved with determining any new interventions for the resident.

On 06/15/22 at 02:15 PM, Administrative Nurse D verified there was not any interventions to prevent further falls on her care plan.

The facility's "Elder Directed Care Plans" policy, undated, documented the facility provided an individualized, interdisciplinary plan of care for all elders that was appropriate to the elders needs, strengths, limitations and goals based on initial, recurrent and continued needs of the elder. The care plan further documented the facility regularly reviewed and revised the plan of care, treatment and service, and the plan of care would be individualized to the needs of the elder.

The failed to revise R18's care plan with interventions to prevent further falls, placing the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) documented R30 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and

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hopelessness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 06/08/22, documented R30 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, ambulation in room and corridor, dressing, and toileting. The MDS further documented R30 had no mobility devices and had no falls since last MDS.

The "Fall Assessment," dated 09/13/21, documented R30 a high risk for falls.

The revised "Limited Physical Mobility Care Plan," dated 03/16/22, originally dated, 12/29/21, documented R30 had a merry-walker (an enclosed framed wheeled walker) with a seat and a strap that fastened between R30's legs and a table to allow resident independence in standing, sitting, and walking. The update, dated 01/02/22, directed staff to place R30 in her merry-walker if she became restless.

The "Post Fall Evaluation," dated 11/12/21, documented the merry-walker tipped over onto its side and the resident attempted to wiggle across the floor. The evaluation further documented R30 did not receive any injury and three staff assisted the resident off of the floor with the use of a mechanical lift (a device used to transfer residents). R30's care plan lacked direction to staff on interventions to prevent falls when she was in the merry-walker.

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On 06/15/22 at 07:51 AM, observation revealed R30, in Hall 4, sat in the merry-walker with her eyes are closed. Further observation revealed R30 leaned against the cushion in front of the merry-walker, began to walk with her eyes closed. She stopped when the merry-walker got to the wall.

On 06/14/22 at 12:54 PM, Administrative Nurse D verified there was not any interventions to prevent further falls from the merry walker.

On 06/15/22 at 01:00 PM, Licensed Nurse (LN) G stated she was on involved with determining any new interventions for the resident.

On 06/16/22 at 08:12 AM, CNA M stated R30 was at the nurse's station and tipped the merry-walker over. R30 did not receive any injury, and staff used a lift to get her up off the floor. CMA M further stated she did not know of any intervention in place after the fall.

The facility's "Elder Directed Care Plans" policy, undated, documented the facility provided an individualized, interdisciplinary plan of care for all elders that was appropriate to the elders needs, strengths, limitations and goals based on initial, recurrent and continued needs of the elder. The care plan further documented the facility regularly reviewed and revised the plan of care, treatment and service, and the plan of care would be individualized to the needs of the elder.

The failed to revise R30's care plan with interventions to prevent further falls, placing the resident at risk for further falls and injury.

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- R10's "Physician Order Sheet" (POS), dated 05/10/22, documented diagnoses of dementia (group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), restlessness and agitation.

The "Admission Minimum Data Set" (MDS), dated 04/18/22, documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented R10 was independent with eating and required limited assistance of one staff for bed mobility, transfers, walking, and toileting. The MDS documented R10 had impaired balance, used a walker, had history of falls, and one non-injury fall since the prior assessment.

The "Fall Care Area Assessment" (CAA), dated 04/18/22, documented R10 had a prior fall while and home and one fall since admission.

The initial care plan lacked interventions for fall prevention until 04/19/22.

The "Fall Care Plan," dated 04/20/22, directed staff to evaluate fall risk on admission and as needed (PRN). If a fall occured, alert provider, initiate frequent neurological checks and bleeding evaluation per facility protocol. The care plan stated R10 wore short slipper socks when not wearing shoes. The 06/15/22 care plan update directed staff to apply grip strips on the floor in front of door to R10's room.

The "Fall Note," dated 04/12/2022 at 07:30 AM, documented the fall was not witnessed, occurred in the resident's room while the resident was attempting to self-toilet. Upon entering room it

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was noted that resident was laying on her back in front of the bed closest to the door, wearing slipper socks that were twisted to the side. Her walker was sitting upright by her head. Resident stated, "I wanted to go to the bathroom." Able to move all extremities. The note documented the resident was incontinent at the time of the fall. No injuries noted

The "Fall Note," dated 04/30/22 at 02:20 PM, documented R10's fall was not witnessed and occurred in her room. The resident was wearing shoes, not using her walker as instructed, and her blankets were beside her recliner. No injuries noted.

The "Fall Note," dated 05/18/2022 at 08:45 PM, documented the fall was unwitnessed in her room while she was ambulating without her walker. The resident was found sitting on floor in doorway with legs crossed and hands on knees. She stated, "I just got up to look out and see what was going on and my feet slipped out from under me. I didn't fall, I just slid down." No injuries were noted.

On 06/14/22 at 04:37 PM, observation revealed R10 sat in a recliner in her room, eyes open, feet on the floor, shoes/socks on, glasses on, and walker in reach. She stated the baby had ice cream and went to sleep. No agitation or restlessness was noted.

On 06/15/22 at 03:43 PM, Administrative Nurse D stated she and the restorative staff discuss falls in a meeting after a fall. Administrative Nurse D verified staff had not put all new interventions on the resident's care plan.

The facility's undated "Fall Follow-Up Protocol"

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F 657	Continued From page 25 documented every resident would be assessed for the causal risk factors for falling after every fall in the facility to develop interventions to prevent further falls. The fall would be documented on the care plan with interventions to prevent further falls. The facility failed to review and revise R10's care plan after each fall with resident-centered interventions aimed to prevent further falls, placing the resident at risk for further falls.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents with two reviewed for skin issues. Based on observation, interview and record review the facility failed to provide preventative interventions related to skin issues for two sampled residents, Resident (R)25 who developed a non-pressure skin issues and R19, who experienced a skin tear of unknown origin. This deficient practice placed R25 and R19 at increased risk for skin injuries. Findings included:	F 684		

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- R25's "Physician Order Sheet" (POS), dated 05/17/22, documented diagnoses of an open wound to the buttock.

The "Quarterly MDS, dated 05/23/22, documented a Brief Interview for Mental Status (BIMS) score of one which indicated severely impaired cognition. The MDS documented R25 required supervision for eating and extensive assistance of one staff for bed mobility, transfers, and dressing. The MDS documented R25 had an open lesion on her buttocks.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 02/20/22, documented R25 had a diagnosis of open wound to gluteal cleft (groove between the buttocks). The health care provider assessed the wound and stated that it was not a pressure ulcer.

The "Skin Care Plan," dated 09/01/21, documented the resident was able to reposition self in her recliner. R25 had a bed in her room that she chose not to sleep in. The care plan lacked further intervention to prevent skin issues.

The "Skin Care Plan," dated 06/01/22 after wound development, documented potential for pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) development. It directed staff to provide treatments as ordered and monitor for effectiveness; inform the resident/family/caregivers of any new area of skin breakdown. The care plan directed staff to monitor wound dressing with all cares to ensure it is intact and adhering, report loose dressing to the treatment nurse.

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The "Physician Note," dated 11/16/21, documented an open wound in the gluteal (buttocks) fold along the right buttock. The note documented a history of a pressure ulcer which required skin graft and skin flap repair in December 2020. The note documented the open area was near the old surgical incision. The resident complained of pain.

The "Skin Evaluation," dated 02/01/22, documented a skin issue with full thickness tissue loss. The note recorded there was odor and tunneling present and the wound was painful.

The "Progress Note," dated 03/26/22, documented R25 continued to receive antibiotics for wound infection.

The "Nursing History and Physical," dated 05/25/22, documented a non-pressure wound to the gluteal cleft, with nightly dressing changes.

On 06/15/22 at 10:20 AM, Licensed Nurse (LN) G found the wound on the resident's coccyx area had no dressing. Observation revealed a hole in the skin, approximately 0.5 cm round and unknown depth, between the anus and the coccyx. R25 complained of pain when the nurse touched her on her buttocks. R25 stated "ouch" numerous times during the wound care and attempted to stop the nurse with her hands twice. Nurse G cleaned the wound and applied the dressing.

On 06/15/22 at 10:39 AM, Administrative Nurse D verified nursing missed the weekly skin assessment the week of May 8-14 and June 5 -11 too. Administrative Nurse D verified R25's care plan lacked pressure relief interventions to protect

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R25's coccyx area.

The facility's undated "Skin Integrity" policy documented if the elder was determined to be at risk or has developed any skin integrity abnormalities, the nurse will implement action to prevent injury to the elder by maintaining and improving tissue tolerance to pressure in order to prevent injury. The nurse and the interdisciplinary team will plan and implement preventive care to avoid complications resulting from an elder's inactivity, including measures for pressure redistribution for bed and, chair, repositioning at specific, consistent and frequent intervals,

The facility failed to provide interventions to prevent the development of the skin issue, placing R25 at risk for complications related to wounds.

- The Electronic Medical Record (EMR) for R19 recorded diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body) affecting the left non-dominant side, dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), and contracture of the left hand (abnormal permanent fixation of a joint.

The "Quarterly Minimum Data Set", dated 05/12/22, documented R19 had severely impaired cognition and was dependent upon two staff for transfers, toileting and extensive assistance of two staff for bed mobility and dressing. The MDS further documented R19 did not have any skin tears.

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The "Skin Integrity Care Plan," dated 05/17/22, documented R19 was at risk for impaired skin integrity and directed staff to evaluate skin integrity monthly and as needed by a nurse.

The "Nurse's Note," dated 06/08/22 at 11:34 AM, documented a skin tear (a traumatic wound caused by mechanical forces) of unknown origin, on top of R19's right hand. The half-moon shape skin tear measured 0.5 centimeters (cm) x 3 cm. The note documented the area was cleaned, dried, triple antibiotic ointment applied and wrapped in gauze. The note further documented R19's physician was notified.

The "Physician Order," dated 06/11/22, directed staff to cleanse the skin tear to right hand with normal saline, apply triple antibiotic ointment, and cover the wound with tegaderm (a transparent medical dressing used to cover and protect wounds). The order further directed staff to change every other day until healed.

The "Nurse's Note," dated 06/16/22 at 10:00 AM, documented R19 had an open wound to the base of his left thumb with a small amount of yellowish-brown drainage. The note further documented R19 had an old skin tear to the right elbow that had reopened.

The "Physician Order," dated 06/16/22, directed staff to obtain a wound culture (a test to find germs that cause an infection) on the skin tear, and administer doxycycline (an antibiotic), 100 milligrams (mg), by mouth, daily for seven days.

The medical record lacked documentation how R19 received the skin tear to his right hand and lacked evidence preventive measures were

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evaluated and implemented.

On 06/13/22 at 10:30 AM, observation of R19 revealed a moon shaped skin tear on his right hand, without a dressing.

On 6/16/22 at 07:42 AM, observation revealed a skin tear on R19's right hand. Further observation revealed brown drainage under the transparent dressing.

On 06/15/22 at 07:47 AM, Administrative Nurse D verified an incident or investigation had not been completed for the skin tear and should have been investigated. Administrative Nurse D verified she was not aware the resident had a skin tear on his hand.

On 06/15/22 at 12:57 PM, Licensed Nurse (LN) G stated she did not know how R19 received the skin tear on his right hand and further stated R19's dressing was changed every other day.

On 06/16/22 at 08:15 AM, Certified Nurse Aide (CNA) M stated she was unaware how R19 had obtained the skin tear on his hand. CNA M further stated, when a resident had an injury, she would tell her charge nurse.

The facility's "skin injury" policy, undated, documented the facility would routinely monitor the skin condition and identify if the condition became significant and the physician notified. All injuries will be monitored routinely until resolved and staff must be aware that any injury as a result of possible abuse or neglect must be reported immediately to the supervisor, don, and administrator. The policy further documented, all incidents, whether considered significant or not

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F 684	Continued From page 31 require completion of a facility incident report and investigation to determine causal factors for the incident and interventions implemented to prevent any further occurrences in the future. The facility failed to implement interventions to prevent skin tears for R19, who obtained a skin tear of unknown origin, placing the resident at risk for further injury.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents, with nine reviewed for falls. Based on observation, record review, and interview, the facility failed to provide a safe, accident free environment when the facility failed to prevent a skin tear and loss of a toenail while getting Resident (R)19 into the facility whirlpool, failed to implement meaningful, resident centered interventions for four sampled residents, R11, R18, R30 and R10, who were at risk and had falls. The facility further failed to ensure environment was as free of hazards as possible when the facility stored chemicals in unsecured areas accessible to residents. This placed the residents at risk for falls, and accident related injury .	F 689		

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Findings included:

- The Electronic Medical Record (EMR) for R19 recorded diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body) affecting the left non-dominant side, dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), contracture of the left hand (abnormal permanent fixation of a joint, and cerebrovascular accident (CVA-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).

The "Quarterly Minimum Data Set", dated 05/12/22, documented R19 had severely impaired cognition and was dependent upon two staff for transfers, toileting and extensive assistance of two staff for bed mobility and dressing. The MDS further documented R19 did not have any skin tears.

The "Skin Integrity Care Plan," dated 05/17/22, documented R19 was at risk for impaired skin integrity and directed staff to evaluate skin integrity monthly and as needed by a nurse.

The "Risk for Unilateral Neglect Cerebrovascular Accident (CVA)," dated 05/17/22, directed staff to ensure a safe environment, and evaluate R19's awareness of affected side.

The "Nurse's Note," dated 05/16/22 at 07:16 AM, documented R19's left pinky toenail got caught in the whirlpool (a therapeutic bath in which all or part of the body is exposed to forceful whirling

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currents of hot water) and came off. The note further documented there was a moderate amount of blood, and a pressure dressing (a bandage that is designed to apply pressure to a area of the body) was applied to stop the bleeding. The note documented R19 received a skin tear (a traumatic wound caused by mechanical forces) to his left upper arm which measured 7.2-centimeter (cm) x 4.5 cm, with most of the skin gone. It had a moderate amount of blood, and a pressure dressing was applied.

The "Physician Order," dated 05/16/22, directed staff to apply pressure dressing to left pinky toes for 24 hours, then cleanse the wound with normal saline (used to cleanse wounds), apply triple antibiotic ointment (TAO) and cover with a band aide daily until healed. The order further directed staff to apply a pressure dressing to R19's left upper arm for 24 hours, cleanse with normal saline, apply tao, cover with a nonstick pad, and wrap with coban (a self-adherent compression bandage used for protection), daily, until healed.

Review of the EMR lacked documentation an investigation or skin assessment was completed for the resident's injuries.

On 06/16/22 at 07:42 AM, observation revealed the skin tear to R19's upper left arm was open to air and was almost healed.

On 06/15/22 at 07:47 AM, Administrative Nurse D verified an investigation was completed for any residents' injuries and stated one should have been completed for R19's injuries

On 06/15/22 at 12:57 PM, Licensed Nurse (LN) G stated R19 received a skin tear when staff were

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had gotten out of the whirlpool . LN G further stated she thought his pinky toe got caught in the whirlpool door because R19 cannot move his left side. LN G verified an investigation was not completed for the injuries.

On 06/16/22 at 08:15 AM, Certified Nurse Aide (CNA) M stated she did not know how the resident received the skin tear to his left arm. CNA M said R19 cannot use his left side.

The facility's "Skin Injury" policy, undated, documented the facility would routinely monitor the skin condition and identify if the condition became significant and the physician notified. All injuries will be monitored routinely until resolved and staff must be aware that any injury as a result of possible abuse or neglect must be reported immediately to the supervisor, don, and administrator. The policy further documented, all incidents, whether considered significant or not, require completion of a facility incident report and investigation to determine causal factors for the incident and interventions implemented to prevent any further occurrences in the future.

The facility failed to implement interventions to prevent further skin tears and injuries to toes for R19, who had hemiplegia to his left side, placing the resident at risk for further injury.

- The Electronic Medical Record (EMR) documented R11 had diagnoses of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional

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state characterized by exaggerated feelings of sadness, worthlessness and emptiness, and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS) dated 04/20/22, documented R11 had severely impaired cognition, required extensive assistance of one staff for bed mobility and was independent with transfers, ambulation. The MDS further documented R11 had unsteady balance, no functional impairment, and had two or more non injury falls and one injury fall.

The "Fall Risk Assessments," dated 07/20/21, 10/22/21, 01/20/22, and 04/20/22 documented the resident a high risk for falls.

The revised "Care Plan," dated 05/04/21, originally dated 06/25/21, directed staff to put grip taped placed on the floor in front of the bed, slipper socks on when in bed, and put R11's laundry away. The update, dated 03/16/22, directed staff to place a scooped mattress (special mattress with raised sides). The update, dated, 05/04/22, directed staff to keep bed in lowest position.

The "Post Fall Evaluation," dated 10/20/21 at 06:02 PM, documented R11 stumbled over her own feet and fell during ambulation to the dining room. The evaluation further documented the resident received a bruise to her left hand. R11's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

The "Post Fall Evaluation," dated 03/30/22 at 06:01 PM, documented R11 fell while ambulating

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in the hallway without her walker. The evaluation further documented R11 did not receive any injuries from the fall. R11's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

The "Post Fall Evaluation," dated 04/05/22 at 07:40 PM, documented R11 had a witnessed fall in the Hall 4 dining room. The evaluation further documented R11 was agitated and fell in the dining room. R11's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

The "Post Fall Evaluation," dated 04/12/22 at 03:28 PM, documented R11 fell while ambulating in the hallway without her walker. R11's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

On 06/15/22 at 08:39 AM, observation revealed R11 ambulated, with her walker, into the Hall 4 dining room. Certified Nurse Aide (CNA) O walked beside the resident. Further observation revealed R11's gait was unsteady, and CNA O assisted the resident into a chair.

On 06/16/22 at 09:00 AM, observation revealed R11 independently ambulated down Hall 4 with her walker. Further observation revealed R11's gait was steady.

On 06/15/22 at 01:16, CNA O stated R11 did not walk independently because of falls and R11 was unsteady.
On 06/16/22 at 08:23 AM, CNA M stated R11 had days she ambulated independently. CNA M said staff assisted the resident during the morning but R11 could ambulate alone later in the morning.

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CNA M further stated R11 had falls when she lost her balance or when she would forget to use her walker.

On 06/15/22 at 8:50 AM, Administrative Nurse D verified R11 had several falls and verified there were not interventions for her falls in the resident's care plan

The facility's "Fall Follow Up Protocol" undated policy documented each resident who resided at the facility would be provided services and care that ensured that the resident's environment remained as free from accident hazards as was possible and each resident received adequate supervision and assuasive devices to prevent accidents. Every resident would be assessed for the causal risk factors for falling at the time of admission, upon return from a health care facility and after every fall in the facility. Each resident of this facility who experienced a fall would be treated and assessed to adequately treat any current injuries, whether physical or psychosocial, and comprehensively assessed to determine causal effects of the fall to develop interventions to prevent further falls. The fall was documented on the care plan with interventions to prevent further falls based on the determined causal factors.

The facility failed to implement meaningful, resident centered interventions for cognitively impaired R11, who had multiple falls, placing the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) documented R18 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the

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fingers, masklike faces, shuffling gait, muscle rigidity and weakness). emotional disorder (chronic and often recurrent psychiatric disorders that are associated with significant impairment in quality of life, productivity, and interpersonal functioning), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and intellectual impairment (problems with general mental abilities that affect functioning, intellectual and functional).

The "Admission Minimum Data Set" (MDS), dated 05/12/22, documented R18 had severely impaired cognition and required limited assistance of one staff for toileting, independent with transfers and ambulation. The MDS further documented R18 had no falls since admission.

The "Fall Risk Assessment," dated 04/29/22, documented R18 was a high risk for falls.

The "Fall Care Plan," dated 05/11/22, directed staff to determine the resident's ability to transfer. The care plan directed if a fall occurred, alert R18's provider, and obtain frequent neurological checks (a series of questions and tests to check brain, spinal cord, and nerve function).

The "Post Fall Evaluation," dated 05/14/22 at 05:24 AM, documented R18 was in her room, moving her television, and lost her balance. The evaluation further documented R18 received an abrasion to her back. R18's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

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The "Post Fall Evaluation," dated 05/16/22 at 08:50 PM, documented R18 fell in her room while ambulating. The evaluation further documented R18 did not receive any injuries. R18's clinical record lacked evidence of a resident centered intervention put into place to prevent further falls.

On 06/14/22 at 08:00 AM, observation revealed R18 had trouble navigating (plan or direct a route) her walker through her door. Further observation revealed R18 asked for assistance to get out of her door and a Certified Nurse Aide (CNA) walked with her to the dining room.

On 06/16/22 at 08:01 AM, observation revealed R18 independently ambulated, with her walker, down the hall.

On 06/15/22 at 01:00 PM, Licensed Nurse (LN) G stated when R18's gait and balance were off, she would fall.

On 06/15/22 at 02:15 PM, Administrative Nurse D verified there was not any interventions to prevent further falls on her care plan.

On 06/16/22 at 08:26 AM, CNA M stated R18 was independent with ambulation and did not know anything about her falls. CNA M further stated she was not involved with determining interventions to prevent further falls.

The facility's "Fall Follow Up Protocol" undated policy documented each resident who resided at the facility would be provided services and care that ensured that the resident's environment remained as free from accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent

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accidents. Every resident would be assessed for the causal risk factors for falling at the time of admission, upon return from a health care facility and after every fall in the facility. Each resident of this facility who experienced a fall would be treated and assessed to adequately treat any current injuries, whether physical or psychosocial, and comprehensively assessed to determine causal effects of the fall to develop interventions to prevent further falls. The fall was documented on the care plan with interventions to prevent further falls based on the determined causal factors.

The facility failed to implement meaningful, resident centered interventions for cognitively impaired R18, who had falls, placing the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) documented R30 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 06/08/22, documented R30 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, ambulation in room and corridor, dressing, and

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toileting. The MDS further documented R30 had no mobility devices and had no falls since last MDS.

The "Fall Assessment," dated 09/13/21, documented R30 a high risk for falls.

The revised "Limited Physical Mobility Care Plan," dated 03/16/22, originally dated, 12/29/21, documented R30 had a merry-walker (an enclosed framed wheeled walker) with a seat and a strap that fastened between R30's legs and a table to allow resident independence in standing, sitting, and walking. The update, dated 01/02/22, directed staff to place R30 in her merry walker if she became restless.

The "Post Fall Evaluation," dated 11/12/21, documented the merry walker tipped over onto its side and the resident attempted to wiggle across the floor. The evaluation further documented R30 did not receive any injury and three staff assisted the resident off of the floor with the use of a mechanical lift (a device used to transfer residents). R30's care plan lacked direction to staff on interventions to prevent falls when she was in the merry-walker.

On 06/15/22 at 07:51 AM, observation revealed R30, in Hall 4, sat in the merry walker with her eyes are closed. Further observation revealed R30 leaned against the cushion in front of the merry walker, began to walk with her eyes closed. She stopped when the merry walker got to the wall.

On 06/14/22 at 12:54 PM, Administrative Nurse D verified R30 had a fall while in the merry walker. She stated she wanted the resident to be able to

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be in the walker when R30 was anxious so that the resident could move around independently.

On 06/15/22 at 01:00 PM, Licensed Nurse G stated R30 did have a fall while in the merry-walker, but the merry-walker allowed the resident to be more independent.

On 06/16/22 at 08:12 AM, CNA M stated R30 was at the nurse's station and tipped the merry walker over. R30 did not receive any injury, and staff used a lift to get her up off the floor. CMA M further stated she did not know of any intervention in place after the fall.

The facility's "Fall Follow Up Protocol" undated policy documented each resident who resided at the facility would be provided services and care that ensured that the resident's environment remained as free from accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents. Every resident would be assessed for the causal risk factors for falling at the time of admission, upon return from a health care facility and after every fall in the facility. Each resident of this facility who experienced a fall would be treated and assessed to adequately treat any current injuries, whether physical or psychosocial, and comprehensively assessed to determine causal effects of the fall to develop interventions to prevent further falls. The fall was documented on the care plan with interventions to prevent further falls based on the determined causal factors.

The facility failed to implement a meaningful, resident centered intervention for cognitively impaired R30, who had a fall while in her merry

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walker, placing the resident at risk for further falls and injury.
- R10's "Physician Order Sheet" (POS), dated 05/10/22, documented diagnoses of dementia (group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), restlessness and agitation.

The "Admission Minimum Data Set" (MDS), dated 04/18/22, documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented R10 was independent with eating and required limited assistance of one staff for bed mobility, transfers, walking, and toileting. The MDS documented R10 had impaired balance, used a walker, had history of falls, and one non-injury fall since the prior assessment.

The "Fall Care Area Assessment" (CAA), dated 04/18/22, documented R10 had a prior fall while and home and one fall since admission.

The initial care plan lacked interventions for fall prevention until 04/19/22.

The "Fall Care Plan," dated 04/20/22, directed staff to evaluate fall risk on admission and as needed (PRN). If fall occurs, alert provider, initiate frequent neurological checks and bleeding evaluation per facility protocol. The care plan stated R10 wore short slipper socks when not wearing shoes. The 06/15/22 care plan update directed staff to apply Grip strips on the floor in front of door to R10's room.

The "Fall Note," dated 04/12/2022 at 07:30 AM, documented the fall was not witnessed, occurred in the resident's room while the resident was

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attempting to self-toilet. Upon entering room it was noted that resident was laying on her back in front of the bed closest to the door, wearing slipper socks that were twisted to the side. Her walker was sitting upright by her head. Resident stated, "I wanted to go to the bathroom." Able to move all extremities. The note documented the resident incontinent at the time of the fall. No injuries noted

The "Fall Note," dated 04/30/22 at 02:20 PM, documented R10's fall was not witnessed and occurred in her room. The resident was wearing shoes, not using her walker as instructed, and her blankets were beside her recliner. No injuries noted.

The "Fall Note," dated 05/18/2022 at 08:45 PM, documented the fall was unwitnessed in her room while she was ambulating without her walker. The resident was found sitting on floor in doorway with legs crossed and hands on knees. She stated, "I just got up to look out and see what was going on and my feet slipped out from under me. I didn't fall, I just slid down." No injuries noted.

On 06/14/22 at 04:37 PM, observation revealed R10 sat in a recliner in her room, eyes open, feet on the floor, shoes/socks on, glasses on, and walker in reach. She stated the baby had ice cream and went to sleep. No agitation or restlessness noted.

On 06/15/22 at 03:43 PM, Administrative Nurse D stated she and the restorative staff discuss falls in a meeting after a fall. Administrative Nurse D verified staff had not put all new interventions on the resident's care plan.

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The facility's undated "Fall Follow-Up Protocol" documented every resident would be assessed for the causal risk factors for falling after every fall in the facility to develop interventions to prevent further falls. The fall would be documented on the care plan with interventions to prevent further falls.

The facility failed to identify and implement resident-centered interventions aimed to prevent further falls after three falls in the facility, placing the resident at risk for further falls.

- On 06/13/22 at 09:10 AM, during the initial tour, observation revealed an unlocked bathroom door on the 300 hall. The following items were observed in the cabinet under the sink:
1 15 ounce (oz) aerosol can of Brody Disinfectant spray, with the warning label "keep out of reach of children", hazardous to humans and domestic animals.
1 6.7 oz container of Mystic Woods automatic spray refill with the warning label "keep out of reach of children" and avoid contact with eyes.

Continued observation revealed an unlocked soiled utility room door on the 300 hall.

The following items were observed in a cabinet under the sink in the unlocked soiled utility room:
1 22 oz spray can of Resolve carpet cleaner with the warning "Keep out of Reach of Children", may cause eye irritation, hazardous chemical.
1 128 oz T Cleaner -Neutral all-purpose cleaner "Keep out of reach of children."

On 06/14/22 at 10:40 AM, Administrative Nurse E verified the chemicals and products with the warning labels should be locked up and or out of

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F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents with two reviewed for pain. Based on observation, interview and record review the facility failed to provide interventions during wound care to manage Resident (R) 25's distress and pain. This placed	F 697		

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the resident at risk for prolonged and unnecessary pain or distress.

Findings included:

- R25's "Physician Order Sheet" (POS), dated 05/17/22, documented diagnoses of open wound of buttock, and dementia (the loss of cognitive functioning).

The "Quarterly MDS, dated 05/23/22, documented a Brief Interview for Mental Status (BIMS) score of one which indicated severely impaired cognition. The MDS documented R25 required supervision for eating and extensive assistance of one staff for bed mobility, transfers, and dressing. The MDS documented R25 had an open lesion on her buttocks, received scheduled pain medication, had vocal complaints of pain daily, and received opioid medication seven days of the look back period.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 02/20/22, documented R25 had a diagnosis of open wound to gluteal cleft.(area between the buttocks) The health care provider assessed the wound and stated that it is not a pressure ulcer.

The "Skin Care Plan," dated 09/01/21, documented the resident was able to reposition self in her recliner. R25 had a bed in her room that she chose not to sleep in. The "Skin Care Plan," dated 06/01/22, documented potential for pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) development. It directed staff to provide treatments as ordered and monitor for effectiveness; inform the

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resident/family/caregivers of any new area of skin breakdown. The care plan directed staff to monitor wound dressing with all cares to ensure it is intact and adhering, report loose dressing to the treatment nurse.

The "Pain Care Plan," dated 06/01/22, directed staff to administer pain medications per order, and if non-medication interventions were ineffective, evaluate for non-verbal indicators of pain. Monitor for factors that precipitate or aggravate pain. Apply hot or cold packs for comfort.

The "Physician Note," dated 11/16/21, documented an open wound in the gluteal (buttocks) fold along the right buttock. The note documented a history of a pressure ulcer which required skin graft and skin flap repair in December 2020. The note documented the open area was near the old surgical incision. The resident complained of pain.

The "Progress Note," dated 12/7/21 at 11:08 PM, documented R25 was agitated and combative with cares when the staff member attempted to reapply the dressing to R25's coccyx. R25 hit the staff member multiple times with a newspaper and then threw water on the staff. Staff were unable to encourage the resident to allow dressing placement.

The "Skin Evaluation," dated 02/01/22, documented a skin issue with full thickness tissue loss. The note recorded there was odor and tunneling present and the wound was painful.

The "Progress Note," dated 03/09/22 at 02:30 AM, documented staff noted R25 had discomfort

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during the packing of the wound.

The "Progress Note," dated 03/19/22 at 09:49 AM, documented R25 used protective body movements, reported pain occurred multiple times a day, and the wound to her coccyx was a pain level of five (0-10 scale with zero as no pain and ten at the worst pain imaginable).

The "Progress Note," dated 03/26/22, documented R25 continued to receive antibiotics for wound infection. The note documented the wound dressing came off, and noted the resident had pain with dressing change with the resident stating "ouch" multiple times.

The "Progress Note," dated 03/27/22 at 02:04 AM, documented R25 had moderate discomfort noted with dressing placement.

The "Progress Note," dated 03/30/22 at 02:31 AM, documented R25 complained of pain with the dressing change.

The "Progress Note," dated 03/31/22 at 11:15 AM, documented R25 stated "ouch" during the dressing change.

The "Skin Evaluations," dated 05/16/22 and 05/23/22, documented R25 had an open lesion of the buttocks and constant pain.

The "Nursing History and Physical," dated 05/25/22, documented a non-pressure wound to the gluteal cleft, with nightly dressing changes. The note recorded R25 had facial grimacing with peri care to the buttocks.

The "Pain Assessment," dated 05/28/22 at 10:16

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PM, documented vocal complaints of pain daily; non-medication interventions did not provide relief. The note recorded scheduled medication were provided and R25 stated "ouch" with peri care to buttocks.

The EMR recorded a "Physician's order" for Norco (narcotic pain medication), 5/325 milligrams (mg), three times per day, started 03/16/22.

The "Physician Standing Orders," dated 01/10/22, ordered Tylenol 650 mg, every four hours as needed (PRN).

Review of March, April, May, and June 2022 "Medication Administration Record" (MAR) revealed the PRN Tylenol had not been administered since 03/13/22.

On 06/15/22 at 10:20 AM, Licensed Nurse (LN) G found the wound on the resident's coccyx area had no dressing. Observation revealed a hole in the skin, approximately 0.5 cm round and unknown depth, between the anus and the coccyx. R25 complained of pain when the nurse touched her on her buttocks. R25 stated "ouch" numerous times during the wound care and attempted to stop the nurse with her hands twice. Nurse G cleaned the wound and applied the dressing. LN G did not offer pain medication.

On 06/14/22 at 07:50 AM, LNG stated the resident did not like the wound dressing change as it was painful to her. The dressing changes were scheduled for night shift.

On 06/15/22 at 10:39 AM, Administrative Nurse D agreed nurses should notify the provider of

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F 697	Continued From page 51 unrelieved pain during wound care and request pain intervention orders. On 06/15/22 at 03:52 PM, Certified Nurse Aide (CNA) P stated when staff changed R25's brief, the resident became agitated and stated "it hurts." On 06/16/22 at 04:30 PM, Consultant GG verified she expected nursing staff to administer pain medication prior to wound care and to notify her if the resident's complaints of pain during the wound care continued. The facility's undated "Pain policy and Procedure" documented at any point that pain is communicated either verbally or non-verbally treatment will be rendered in the form of medication or non-medication intervention. This will be documented on the PRN Pain Assessment form or in the nurse's notes if non-medical intervention is used. Pain medication may be prescribed for the resident from our standing orders. if pain persists or is not controlled, the physician will be notified for further orders or assessment. The facility failed to provide pain interventions during wound care to manage R25's distress and pain. This placed the resident at risk for prolonged and unnecessary pain or distress	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure	F 700		

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correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents with one reviewed for side rails. Based on observation, interview, and record review the facility failed to assess Resident (R) 17's bed side rails for safety, This deficient practice placed R17 at risk for entrapment or injury.

Findings included:

- R17 was admitted to the facility 04/28/22 for skilled care related to muscle weakness.

The "Admission Minimum Data Set" (MDS), dated 05/11/22, documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R17 required assistance of two staff for bed mobility, transfers, toileting, and dressing. The MDS documented

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R17 had a fall prior to admission, no falls since admission, and no restraints were used.

The "ADL Care Area Assessment" (CAA), dated 05/11/22, documented R17 needed staff assistance to get in and out of bed and was independent in rolling left and right once in bed.

The "Care Plan," dated 04/28/22, lacked side rail information.

R17's medical record lacked a side rail safety assessment.

The "Lift/Transfer Evaluation," dated 05/24/22, documented R17's right side was stronger, she did not have upper extremity strength, and was partially able to assist with repositioning in bed.

On 06/13/22 at 09:46 AM, observation revealed a side rail on each side of R17's bed with large openings of 12 x 12 inches. R17 stated she brought them to the facility from home because she wanted her own side rails. R17 stated she cannot sit up in bed or get out of bed on her own.

On 06/15/22 at 03:52 PM, Certified Nurse Aide (CNA) P stated the resident used the side rails on her bed during transfers.

On 06/13/22 at 03:20 PM, Administrative Nurse D verified staff should have assessed R17's bed side rails for safety and gaps.

The facility's undated "Use of Side Rails" policy documented the facility's regular maintenance program will include regular inspections of all bed systems including rails, of each bed to ensure a safe environment. The facility will also ensure

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F 700	Continued From page 54 individual side rail assessments and evaluations are performed on a regular basis. The policy stated side rails would only be applied per manufacturer's instructions, using all cautions noted by the manufacturer and supplier. The policy documented gap measurements would be performed prior to implementation and at least quarterly to ensure safety from potential entrapment following FDA guidelines for acceptable gaps as follows: recommendations for any open space between the perimeters of the rail or between the rail and mattress should be less than 4 and 3/4 inches. The policy documented all side rails and mobility enhancers would be checked by maintenance at least monthly and documented on maintenance logs. The facility failed to assess R17's bed side rails for safety, placing the resident at risk for entrapment or injury.	F 700		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		

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F 756	Continued From page 55 (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 29 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to respond to the consultant pharmacist (CP) notification of the inappropriate diagnosis for antipsychotic medications (type of psychiatric medication which are available on prescription to treat psychosis and are licensed to treat certain types of mental illness) for two of five residents reviewed, Resident (R)5 and R10. This deficient practice placed R10 and R5 at risk for continued use of antipsychotic medications without an appropriate diagnosis.	F 756		

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F 756	Continued From page 56	F 756		

Findings included:

- R5's "Physician Order Sheet" (POS), dated 05/10/22, documented diagnoses of anxiety disorder (persistent feeling of anxiety or dread), vascular dementia (dementia caused by an impaired supply of blood to the brain), and recurrent major depression (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).

The "Quarterly Minimum Data Set" (MDS), dated 03/29/22, documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS documented R5 was independent with eating, required staff assistance for all other activities of daily living and received antipsychotic medication seven days of the lookback period.

The "Medication Care Plan," dated 05/14/22, documented R5 had a behavior problem of excessive crying and her depression was exacerbated by reminiscing of history of abuse done to her. When the resident was crying, staff were to just sit and listen to resident and allow her to vent and validate her feeling. The care plan directed staff to monitor the amount of times R5 had excessive crying, and difficulty sleeping. The care plan documented the consult pharmacist to review medications, staff were to review pharmacy consult recommendations and follow up as indicated.

The "Physician Order," dated 12/09/21, directed staff to administer Abilify (antipsychotic), 5 milligrams (mg) at bedtime for depression and anxiety.

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Pharmacist reviews from 01/04/22 through 03/07/22, documented no concerns with R5's medications. The 04/11/22 (four months after the start of the antipsychotic) pharmacist consultant requested an appropriate diagnosis and gradual dose reduction (GDR) for Abilify. The physician replied antipsychotics should have GDRs attempted, please have R5 see a psychiatric consult.

The "Psychiatric Nurse Practitioner Notes," dated 05/05/22 and 06/07/22, documented the resident received Abilify and ordered staff to continue the medication without changing the diagnosis.

On 06/14/22 at 08:00 AM, observation revealed Certified Medication aide (CMA) R administered ten medications to R5 in her room.

On 06/15/22 at 09:40 AM, Administrative Nurse D verified Abilify lacked an appropriate diagnosis and verified the Pharmacist consultant had not recommended change to appropriate diagnosis until April 2022 (4 months after start).

The facility's 10/04/2016 policy for "Pharmacist Consultant Policy and Procedure" documented recommendations for providers will be taken to the resident's primary care provider for physician review and if no response within 10 days, nurse management will follow up with a phone call or fax to the physician and documented date and time. Upon receipt of the primary care provider's orders nurse management will note and implement any changes and if no changes ordered, will note the risk versus benefit in the nurse's notes. If no risk versus benefit statement is provided, the pharmacist recommendation will be returned to the provider with a request for the

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F 756	Continued From page 58	F 756		

risk versus benefit statement.

The 10/04/2016 policy for "Proper Diagnosis for Antipsychotic Medications" documented upon finding improper diagnosis for antipsychotic medications, nurse management will notify the prescribing physician in writing and advise of acceptable diagnoses of Huntington's, Tourette's, or schizophrenia for antipsychotic medications per CMS. If no new order or acceptable diagnosis is received, nurse management will follow up with the pharmacist consultant at the next monthly in-house visit.

The facility failed to act upon the CP's notification of the inappropriate diagnosis for the antipsychotic medication Abilify, placing R5 at risk of inappropriate use of the antipsychotic.

- R10's "Physician Order Sheet" (POS), dated 05/10/22, documented diagnoses of dementia with behavioral disturbance (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), restlessness and agitation.

The "Admission Minimum Data Set" (MDS), dated 04/18/22, documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented no mood or behavior issues. R10 was independent with eating and required limited assistance of one staff for all other activities of daily living (ADL). The MDS documented R10 had impaired balance, used a walker, had history of falls, and one non-injury fall since prior assessment. The MDS documented R10 received antipsychotic medication seven days of

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F 756	Continued From page 59	F 756		

the lookback period.

The "Psychotropic Drug Use," Care Area Assessment (CAA), dated 04/20/22, documented behaviors were noted while R10 was in the hospital and R10 has had no behaviors since admission to the facility. R10 was admitted with an order for Zyprexa (antipsychotic medication).

The "Medication Care Plan," dated 04/20/22, documented the consultant pharmacist was to review medications. The resident will have fewer episodes of yelling weekly due to use of Zyprexa.

The "Physician Order," dated 04/11/22, directed staff to administer Zyprexa 5 milligrams (mg) (1/2 tab) at bedtime for restlessness and agitation.

The "Pharmacist Consult Review," dated 05/04/22, recommended an appropriate diagnosis for Zyprexa. The physician replied the resident needed an appointment with the psychiatric nurse practitioner, please schedule.

On 06/13/22 at 09:20 AM, observation revealed Certified Medication Aide (CMA) R administered medications to R10 who took the pills whole with bites of pudding. R10 did not speak during the observation and no agitation was noted.

On 06/15/22 at 02:36 PM, Administrative Nurse D verified the diagnosis for Zyprexa was not correct per regulations and the pharmacist had noted that 05/04/22. She stated the physician ordered a psychiatric consult to obtain the correct diagnosis, but the resident had not seen the psychiatric practitioner yet.

The facility's undated policy for "Physician Orders

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F 756	Continued From page 60 for Medications and Treatments" documented orders for medication will include clinical rationale or diagnosis for the order. The facility's 10/04/2016 policy for "Pharmacist Consultant Policy and Procedure" documented recommendations for providers will be taken to the resident's primary care provider for physician review and if no response within 10 days, nurse management will follow up with a phone call or fax to the physician and documented date and time. Upon receipt of the primary care provider's orders nurse management will note and implement any changes and if no changes ordered, will note the risk versus benefit in the nurse's notes. If no risk versus benefit statement is provided, the pharmacist recommendation will be returned to the provider with a request for the risk versus benefit statement. The 10/04/2016 policy for "Proper Diagnosis for Antipsychotic Medications" documented upon finding improper diagnosis for antipsychotic medications, nurse management will notify the prescribing physician in writing and advise of acceptable diagnoses of Huntington's, Tourette's, or schizophrenia for antipsychotic medications per CMS. If no new order or acceptable diagnosis is received, nurse management will follow up with the pharmacist consultant at the next monthly in house visit. The facility failed to respond to the CP's notification of the inappropriate diagnosis for the antipsychotic medication Zyprexa, placing R10 at risk of inappropriate use of the antipsychotic.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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F 758	Continued From page 61 §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; §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	F 758		

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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 29 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, interview, and record review two of five residents reviewed, Resident (R)5 and R10 had an inappropriate diagnosis for antipsychotic medications (type of psychiatric medication which are available on prescription to treat psychosis and are licensed to treat certain types of mental illness). This deficient practice placed R5 and R10 at risk for continued use of antipsychotic medications without an appropriate diagnosis.

Findings included:

- R5's "Physician Order Sheet" (POS), dated 05/10/22, documented diagnoses of anxiety disorder (persistent feeling of anxiety or dread), vascular dementia (dementia caused by an impaired supply of blood to the brain), and recurrent major depression (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).

The "Quarterly Minimum Data Set" (MDS), dated 03/29/22, documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS

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documented R5 was independent with eating, required staff assistance for all other activities of daily living and received antipsychotic medication seven days of the lookback period.

The "Medication Care Plan," dated 05/14/22, documented R5 had a behavior problem of excessive crying and her depression was exacerbated by reminiscing of history of abuse done to her. When the resident was noted to be crying, staff were to just sit and listen to resident and allow her to vent and validate her feeling. The care plan directed staff to monitor the amount of times R5 had excessive crying, and difficulty sleeping. The care plan documented the consult pharmacist to review medications, staff were to review pharmacy consult recommendations and follow up as indicated.

The "Physician Order," dated 12/09/21, directed staff to administer Abilify (antipsychotic), 5 milligrams (mg) at bedtime for depression and anxiety.

The "Psychiatric Nurse Practitioner Notes," dated 05/05/22 and 06/07/22, documented the resident received Abilify and ordered staff to continue the medication without changing the diagnosis.

On 06/14/22 at 08:00 AM, observation revealed Certified Medication aide (CMA) R administered ten medications to R5 in her room.

On 06/15/22 at 09:40 AM, Administrative Nurse D verified Abilify lacked an appropriate diagnosis.

The facility's policy for "Proper Diagnosis for Antipsychotic Medications," dated 10/04/2016, documented upon finding improper diagnosis for

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F 758	Continued From page 64	F 758		

antipsychotic medications, nurse management will notify the prescribing physician in writing and advise of acceptable diagnoses of Huntington's, Tourette's, or schizophrenia for antipsychotic medications per CMS.

The facility failed to obtain an appropriate diagnosis for the antipsychotic medication Abilify, placing R5 at risk of inappropriate use of the antipsychotic.

- R10's "Physician Order Sheet" (POS), dated 05/10/22, documented diagnoses of dementia with behavioral disturbance (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), restlessness and agitation.

The "Admission Minimum Data Set" (MDS), dated 04/18/22, documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented no mood or behavior issues, R10 independent with eating and required limited assistance of one staff for all other activities of daily living (ADL). The MDS documented R10 had impaired balance, used a walker, had history of falls, and one non-injury fall since prior assessment. The MDS documented R10 received antipsychotic medication seven days of the lookback period.

The "Psychotropic Drug Use," Care Area Assessment (CAA), dated 04/20/22, documented behaviors were noted while R10 was in the hospital and R10 has had no behaviors since admission to the facility. R10 was admitted with an order for Zyprexa (antipsychotic medication).

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The "Medication Care Plan," dated 04/20/22, documented the consultant pharmacist was to review medications. The resident will have fewer episodes of yelling weekly due to use of Zyprexa.

The "Physician Order," dated 04/11/22, directed staff to administer Zyprexa 5 milligrams (mg) (1/2 tab) at bedtime for restlessness and agitation.

On 06/13/22 at 09:20 AM, observation revealed Certified Medication Aide (CMA) R administered medications to R10 who took the pills whole with bites of pudding. R10 did not speak during the observation and no agitation was noted.

On 06/15/22 at 02:36 PM, Administrative Nurse D verified the diagnosis for Zyprexa was not correct per regulations and the pharmacist had noted that 05/04/22. She stated the physician ordered a psychiatric consult to obtain the correct diagnosis, but the resident had not seen the psychiatric practitioner yet.

The facility's undated policy for "Physician Orders for Medications and Treatments" documented orders for medication will include clinical rationale or diagnosis for the order.

The policy for "Proper Diagnosis for Antipsychotic Medications," dated10/04/2016, documented upon finding improper diagnosis for antipsychotic medications, nurse management will notify the prescribing physician in writing and advise of acceptable diagnoses of Huntington's, Tourette's, or schizophrenia for antipsychotic medications per CMS.

The facility failed to obtain an appropriate

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F 758	Continued From page 66 diagnosis for the antipsychotic medication Zyprexa, placing R10 at risk of inappropriate use of the antipsychotic.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents. Based on record review and interview, the facility failed to ensure medication was administered per physician orders for Resident (R) 18, who received the wrong dosage of Sinemet (dopamine promoter medication) nine times a day for eight days. This placed R18 at risk for adverse side effects and complications related to medications errors. Findings included: - The Electronic Medical Record (EMR) documented R18 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, mask like faces, shuffling gait, muscle rigidity and weakness). emotional disorder (chronic and often recurrent psychiatric disorders that are associated with significant impairment in quality of life, productivity, and interpersonal functioning), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and intellectual impairment (problems	F 760		

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	17E658	A. BUILDING _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

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F 760	Continued From page 67	F 760		

with general mental abilities that affect functioning, intellectual and functional).

The "Quarterly Minimum Data Set", dated 05/12/22, documented R18 had severely impaired cognition and was dependent upon two staff for transfers, toileting. R18 requried extensive assistance of two staff for bed mobility and dressing.

The "Admission Orders," dated 04/29/22, directed staff to administer Sinemet, 10 milligrams (mg)-100 mg, 1 tablet four times a day. The order further directed staff to administer half a pill every 1.5 hours following the 07:00 AM dose and the last dose to be at 07:00 PM.

The "April 2022 Medication Administration Record (MAR)" directed staff to administer Sinemet, 10 milligrams (mg)-100 mg, 1.5 tablets every 1.5 hours following the 07:00 AM dose and the last dose to be at 07:00 PM.

Review of the MAR documented 15 times R18 received the wrong dose of medication.

The "May 2022 MAR", directed staff to administer Sinemet, 10 milligrams (mg)-100 mg, 1.5 tablets every 1.5 hours following the 07:00 AM dose and the last dose to be at 07:00 PM.

Review of the MAR documented 58 times R18 received the wrong dose of medication.

The "Nurse's Note," dated 05/07/22 at 03:43 PM, documented R18's representative contacted the facility and reported R18 was not acting her normal self. The note further documented R18's representative asked about the resident's

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F 760	Continued From page 68	F 760		

Sinemet dose and when staff told her the dosage, R18's representative stated the dosage was not correct. Licensed Nurse (LN) G reviewed the physician order and found the order was incorrect on the MAR. The note documented LN G contacted the the hospital and was directed to contact poison control by the physician and send the resident to the emergency department (ED).

The "Emergency Department Report," dated 05/07/22, documented R18 presented to the ED due to behavior and movement changes. The resident was supposed to get Sinemet 10/100, 0.5 mg, nine times per day and had been getting 1.5 mg, nine times per day for the last eight days. Poison control was contacted and recommended labs and an electrocardiogram (EKG -records the electrical signals from the heart]). The report documented R18's EKG was normal and her laboratory report was unremarkable; the resident was admitted for observation for dyskinesia (abnormality or impairment of voluntary movement).

The "ED Report," dated 05/08/22, documented R18 was very somnolent (sleepy) and would open her eyes briefly and go back to sleep. The note further documented the resident would be discharged back to the facility 05/09/22.

The "Nurse's Note," dated 05/09/22 at 12:17 PM, documented R18 returned to the facility and to resume the Sinemet per admission order.

On 06/15/22 at 02:15 PM, Administrative Nurse D stated she was unsure the status of the resident the day she went to the hospital. She said the LN on duty would be the best person to talk to. Administrative Nurse D further stated two nurses

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F 760	Continued From page 69 would double check the admission order to make sure it was correctly entered in the MAR. On 06/16/22 at 07:48 AM, LN G stated R18 was more anxious than usual, and would not answer staff appropriately. LN G stated she did not notify R18's physician regarding the change in R18 until R18's representative contacted her. The facility's "Medication Error" policy, undated, documented when an error of administration, transcription or documentation occurs, the error would be written up on a medication error form. The medication error tool would be employed to determine the severity of the occurrence. Appropriate care of the resident and documentation of events would be provided in every situation. The facility's "Physician Orders for Medications and Treatment" policy, undated, documented written orders would be implemented in the resident MAR and Treatment Administration Record (TAR). The order would be noted and placed in the scanned folder and when orders were received, a second nurse would verify the orders. The facility failed to administer the proper dosage of R18's Sinemet medication as ordered upon admission to the facility for eight days, placing the resident at risk for physical and psychosocial decline.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 70 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to prepare, store, distribute, and serve food under sanitary conditions for the 29 residents in the facility who received their meals from the facility kitchen. This placed the residents at risk for foodborne illness. Findings included: - On 06/12/22 at 07:45 AM, during initial tour, observation revealed the following: Seven 18 inches by 3 foot fluorescent lights, located above the food preparation area, with plastic light covers, with a brownish speckled discolored material in the light cover with one light cover with approximately eight inch crack. Continued observation revealed the stove hood	F 812		

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F 812	Continued From page 71	F 812		

had a grey fuzzy substance along the edges of the hood with grey fuzzy substance covering the two fire suppression spigots over the stove and on the louvers of the stove hood exhaust.

On 06/13/22 at 01:10 PM, Administrative Staff A verified the overhead fluorescent light fixture with brown substance in the covers and one cracked light cover. Administrative Staff A verified the stove hood had grey lint around the perimeter of the hood and in the exhaust louvers, and grey fuzzy substance coated the black fire suppression water spigots and lines.

The facility's "Dietary Cleaning Procedures" policy, undated, documented the facility would store, prepare, distribute and serve food under sanitary conditions to ensure that proper sanitation and food handling practices to prevent the outbreak of foodborne illnesses is attained continuously. The policy documented staff would report any defective equipment to the Environmental Service.

The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 29 residents residing in the facility, who received meals from the facility kitchen.