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	175385	A. BUILDING _____ B. WING _____	05/09/2022

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PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation # 166644. This 2567 was electronically sent to the facility on 05/11/22.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/11/2022

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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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 87 residents. The sample included 23 residents with one resident reviewed for choices. Based on observation, interview, and record review, the facility failed to provide choices for Resident, (R)30 related to food.

Findings included:

- Review of the Resident (R) 30's undated "Physician Orders," revealed diagnoses included, dry mouth, gastroesophageal reflux (backflow of stomach contents to the esophagus), and type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Annual Minimum Data Set" (MDS) dated 02/24/22, documentation included the resident's "Brief Interview for Mental Status" (BIMS) score of 15, which indicated cognitively intact. She reported feeling down. The resident interview regarding preferences revealed she thought it was somewhat important to have snacks available between meals. She received a mechanically altered and therapeutic diet.

The "Communication Care Area Assessment" (CAA), dated 03/10/22, identified risk factors which included mood decline, weight loss, and behavioral issues. The "CAA," noted to proceed to "Care Plan," to decrease risk for mood decline, behaviors, and monitoring dietary intake and hydration status.

The "Care Plan," (CP), dated 03/18/22, directed staff the resident was independent with set up for

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eating. The facility should provide her alternate food according to her preference if she did not like the featured meal of the day. She liked almost all foods except tuna.

On 05/03/22 at 08:11 AM, the resident stated she was not happy and that the residents were told what they can and cannot eat. She does not have a choice. The resident stated the evening before she was served a cold plate of tuna salad, with pasta salad and when she asked for an alternate meal, she was told they did not have anything else. She described the meal's appearance as looking like they dumped a can of tuna on a salad.

On 05/04/22 at 12:30 PM, observation of the resident's lunch included chicken strips, buttered carrots, watermelon and mashed potatoes. She fed herself 100%.

On 05/05/22 at 12:15 PM, observation of the resident's meal included lasagna, broccoli floret, carrot and raisin salad, and garlic bread sticks. She fed herself 100%. The resided stated the food was delicious and confirmed she received what she ordered.

On 05/03/22 at 03:34 PM, Certified Medication Aide (CMA) TT, reported staff were universal workers (worked all areas of patient care, dietary, nursing, laundry, and housekeeping). The staff dish the food out to the residents sitting in the dining room and then serve the resident's that were in their rooms. The facility has a list of alternative meals that included chicken strips, hamburger patties, or staff could make breakfast if they do not like what is on the menu. Resident's dislikes are posted in the kitchen. The

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food comes from the assisted living kitchen and the staff in the greenhouses cook it or heat it up. Some staff are lazy and do not look at the resident's food choices or preferences. CMA TT confirmed the resident does not like tuna and the supper meal for Monday, 05/02/22, was tuna casserole and pasta salad. She stated the staff should have checked the diet card for the resident's dislikes and offered an alternative.

On 05/03/22 at 04:14 PM, Certified Nurse Aide (CNA) MM reported she worked everywhere including the kitchen. She reported she got complaints about the food from the residents frequently. CNA MM stated she did not always give the resident what they were serving on the menu, she would cook them what they want. Sometimes, the residents ask for stuff we do not have.

On 05/04/22 at 11:50 AM, Licensed Nurse (LN) G, stated that nursing staff were universal staff. He confirmed that not everybody can cook. Staff need to know how to prepare the food, but some don't. The facility should have alternates for main menu and offer them to residents who do not want the items on the main menu.

On 05/05/22 at 01:12 PM, Administrative Nurse E, reported the nursing staff worked as universal staff and worked in the kitchen and prepared food. The main menu was posted, and an alternative menu was available to the residents who did not want the main meal. She expected staff to offer alternatives to the residents that did not want the items on the main menu.

The facility policy "Resident's Rights," lacked address for alternate food choices.

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F 561	Continued From page 4 The facility failed to provide choices for this resident, related to food.	F 561		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		

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whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 87 residents with 23 residents selected for review. Based on observation, interview and record review, the facility failed to develop comprehensive care plans for three residents. Resident (R)18 and 68 for oxygen maintenance, and R27 for restorative cares.

Findings included:

- Review of Resident (R)27's electronic medical record (EMR), under the "Med Diag (Diagnosis)" tab, included a diagnosis of muscle weakness.

The admission "Minimum Data Set" (MDS), dated 02/28/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. She required extensive assistance of two staff for transfers, her balance was not steady, and she had impairment on one side of her lower extremities.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment", dated 02/28/22, documented the resident had impaired balance and transition during transfers. The care plan would be initiated to maintain current ADL status and functional ability.

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The care plan for ADLs, revised 02/24/22, instructed staff the resident had self -care performance deficit. The resident required two staff for transfers with the use of a mechanical lift. The care plan lacked staff instruction for restorative cares or range of motion (ROM) exercises.

On 05/05/22 at 08:34 AM, the resident sat in her wheelchair in her room watching TV. Her feet rested on the foot pedals of her wheelchair. The resident demonstrated how she was unable to straighten her right leg with her knee at a 45-degree angle.

On 05/03/22 at 11:00 AM, the resident stated she had not been able to straighten her right knee since before her admission. The contracture had not gotten worse, it was the same as when she admitted to the facility. The resident stated she'd asked the staff about therapy or restorative care to help loosen her leg, but staff had told her she could not receive restorative care as she was on hospice.

On 05/09/22 at 09:38 AM, Licensed Nurse (LN) L stated the resident had a contracture to her right knee but did not receive restorative care. LN L was unsure of who was responsible for the care plans.

On 05/05/22 at 09:02 AM, Administrative Nurse E stated the facility only had a part-time restorative aide. The resident would need to be evaluated by therapy for her to receive restorative services and that had not been done because the resident was currently on hospice. The contracture was something that should be included on the care

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plan.

The facility policy for "Elder Directed Care Plans", undated, included: It was the policy of the facility to provide an individualized plan of care for all elders that was appropriate to the elder's needs, strengths and limitations.

The facility failed to develop an individualized comprehensive plan of care for this dependent resident with a contracture.

- Review of Resident (R)68's "Physician Order Sheet," dated 03/16/22, revealed diagnoses that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness,) osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain,) and atrial fibrillation (rapid, irregular heartbeat.)

The "Significant Change Minimum Data Set" (MDS), dated 04/13/22, assessed the resident with normal cognitive function and received oxygen therapy.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 04/13/22, assessed the resident required assistance with ADLs due to generalized weakness and decreased functional ability.

The "Care Plan," revised 04/08/22, instructed staff the resident received hospice services,

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which provided equipment and supplies. The "Care Plan," instructed staff to monitor for respiratory distress/decreased respirations due to pain medications. The "Care Plan" lacked instruction for oxygen therapy and maintenance of equipment.

A "Physician's Order," dated 04/07/22, instructed staff to administer oxygen at two to five liters per minute per nasal cannula as needed for air hunger.

Observation, on 05/02/22 through 05/05/22 revealed the resident's oxygen concentrator contained oxygen tubing draped over the top of the concentrator attached to a half full humidifier canister. The oxygen tubing contained a piece of tape with the date 04/21/22. Observation, on 05/09/22 revealed the oxygen concentrator in the resident's closet with the oxygen tubing draped over the top of the concentrator attached to the half full humidifier canister. The oxygen tubing contained a piece of tape dated 04/21/22.

Interview, on 05/09/22 at 09:30 AM, with the resident, revealed she did not have difficulty breathing and placed the concentrator in her closet today.

Interview, on 05/09/22 at 09:45 AM, with Certified Medication Aide (CMA) SS, confirmed the resident had an order for oxygen as needed on the "Treatment Administration Record" (TAR), but lacked instruction on changing the tubing/humidifier canister. CMA SS thought the resident used the oxygen once.

Interview, on 05/09/22 at 9:55 AM, with Administrative Nurse E, revealed she would

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expect the care of the oxygen equipment to be documented on the TAR and in the care plan and would expect staff to change the oxygen tubing weekly.

The facility policy for "Elder Directed Care Plans", undated, included: It was the policy of the facility to provide an individualized plan of care for all elders that was appropriate to the elder's needs, strengths and limitations.

The facility failed to include this resident's as needed use of oxygen on the care plan to ensure management and assessment of the resident's oxygen equipment.

- Review of the Resident's (R) 18 "Physician Orders," dated 03/10/22 revealed diagnosis which included chronic respiratory failure and sleep apnea (breathing stops during sleep).

The "Admission Minimum Data Set" (MDS) dated 05/17/21, documentation included the "Brief Interview for Mental Status" (BIMS) score of 15, which indicated cognitively intact. She reported trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy for two to six days of the look back period. She required extensive assistance of staff with activities of daily living (ADLs) for bed mobility and transfers. The resident used Oxygen.

The "Quarterly MDS," dated 02/17/22, documented changes which included the resident required supervision of staff for transfers, and limited assistance for walking.

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The "Care Area Assessment" (CAA), dated 05/19/22, documentation did not address the use of oxygen.

The "Care Plan," (CP), dated 02/16/22, directed staff the resident with altered respiratory status/difficulty breathing related to sleep apnea and chronic respiratory failure. The oxygen setting for the concentrator was set for three liters via nasal cannula. The care plan did not include maintenance of oxygen tubing, concentrator filter, humidifier bottle, distilled water nor storage of cannula/tubing when not in use. Additionally, the care plan did not address the use nor maintenance of the Continuous Positive Air Pressure (CPAP) machine and/or mask and tubing storage when not in use.

Review of the "Physician's Order," dated 03/10/22, documented an order initiated on 02/04/22 to change the humidifier bottle once weekly. Wipe down the concentrator and clean the filter. Change the oxygen cannula/tubing, once weekly on Saturday and as needed. Please assist the elder in placing C-pap on at bedtime, initiated 05/25/2021.

Review of the "Treatment Administration Record," (TAR), dated 03/01/22 through 05/02/22, documentation revealed the oxygen humidifier and tubing changes, clean concentrator filter signed out as done on 03/5/22, 03/12/22, 03/19/22, 03/26/22, 04/02/22, 04/09/22, and 04/23/22. Staff failed to document/ sign on 04/16/22 and 04/30/22,

On 05/03/22 at 10:01 AM, the resident stated her brother put water in the oxygen bottle, as the staff do not take care of the oxygen. "The jug sitting on

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the floor only had a little water left in it so they will need to get me more." The staff have not changed the tubing more than three times this year, if that many times. She reported she never had a bag to put her CPAP in and verified she used it every night. She would use the oxygen on during the day, but never had a bag for it either.

On 05/03/22 at 10:27 AM, the resident had her oxygen cannula and tubing in place with oxygen at three liter per minute via nasal cannula. The oxygen tubing date was 02/22/22, the humidifier bottle was not labeled, a partially empty unlabeled jug of distilled water sat directly on the floor. There was not a storage bag present for storing the cannula and tubing when not in use. The concentrator filter had a thick layer of dust. The CPAP hose hung across the bed rail without having a bag present for storage when not in use.

On 05/03/22 at 04:14 PM, Certified Aide (CNA) stated the nurse should change the tubing and humidifier bottle every two weeks. There should be a bag to store the tubing and mask when the oxygen and CPAP were not in use. The storage bags should be dated. Additionally, she reported the distilled water was to fill the humidifier bottle on the oxygen concentrator and should be stored in the bathroom off the floor. The distilled water should be dated when opened.

On 05/04/22 at 09:36 AM, CNA M, confirmed the above findings. Additionally, she confirmed there was two jugs of distilled water directly on the floor by the concentrator, neither labeled and one partially empty. She stated she was not aware an oxygen concentrator had a filter that needed to be cleaned. She reported she thought the tubing and cannulas were changed two times a week by

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the nurse, but she did not know.

On 05/04/22 at 11:50 AM, Licensed Nurse G reported, staff should change the oxygen tubing monthly. He was not aware of the system in this facility for changing out the tubing or cleaning the concentrator filter. The tubing should be labeled when changed. Night shift usually changes it out. The resident uses her CPAP at night, but was unaware where staff should store oxygen when not in use. In addition, he was unaware of the system for changing out the oxygen tubing or the humidifier bottle.

On 05/05/22 at 09:26 AM, Licensed Nurse (LN) H reported staff should change the oxygen tubing and humidifier bottles weekly. The tubings should be stored in a labeled bag when not in use. Night shift staff change the tubing/ humidifier bottles/ nebulizer tubings. The resident's CPAP mask and hose should be stored in a labeled bag when not in use.

On 05/09/22 at 10:20 AM, Administrative Nurse D stated nurses should change the oxygen cannulas/tubing weekly and as needed. The tubing, humidifier bottles should be labeled with the date when changed. The tubing for oxygen and CPAP should be stored in a labeled bag when not in use. Additionally, the nurse should document on the TAR when tubing, humidifier, and concentrator filters are changed and cleaned.

The facility undated policy for "Elder Directed Care Plans," documentation included ".it is the policy of this facility to provide an individualized, interdisciplinary plan of care for all elders that is appropriate to the elder's needs, strengths, and limitations.

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F 656	Continued From page 13 The facility failed to develop and implement a plan of care related to the use of oxygen and CPAP for this resident. for respiratory equipment.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility reported a census of 87 residents with 23 residents sampled, including one resident reviewed for restorative services. Based on observation, interview, and record review, the facility failed to provide restorative services for one sampled Resident (R)27 to maintain or prevent decline in range of motion (ROM) ability. Findings included: - Review of Resident (R)27's electronic medical	F 688		

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record (EMR), under the "Med Diag (Diagnosis)" tab, included a diagnosis of muscle weakness.

The admission "Minimum Data Set" (MDS), dated 02/28/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. She required extensive assistance of two staff for transfers, her balance was not steady, and she had impairment on one side of her lower extremities.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment", dated 02/28/22, documented the resident had impaired balance and transition during transfers. The care plan would be initiated to maintain current ADL status and functional ability.

The care plan for ADLs, revised 02/24/22, instructed staff the resident had self -care performance deficit. The resident required two staff for transfers with the use of a mechanical lift.

Review of the resident's EMR lacked documentation of the resident having a contracture (a permanent shortening of muscle, tendon, or scar tissue producing deformity or distortion) to her right knee. Documentation lacked evidence of a restorative plan for the resident.

On 05/05/22 at 08:34 AM, the resident sat in her wheelchair in her room watching TV. Her feet rested on the foot pedals of her wheelchair. The resident demonstrated how she was unable to straighten her right leg with her knee at a 45-degree angle.

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On 05/03/22 at 11:00 AM, the resident stated she had not been able to straighten her right knee since before her admission. The contracture had not gotten worse, it was the same as when she admitted to the facility. The resident stated she'd asked the staff about therapy or restorative care to help loosen her leg, but staff had told her she could not receive restorative care as she was on hospice.

On 05/04/22 at 03:02 PM, Certified Nurse Aide (CNA) O stated the resident was on hospice. CNA O stated the resident did not receive restorative care.

On 05/04/22 at 12:02 PM, CNA N stated the resident did not receive restorative care because she was on hospice. CNA N confirmed the resident had a contracture to her right knee.

On 05/09/22 at 09:38 AM, Licensed Nurse (LN) LL stated the resident had a contracture to her right knee but did not receive restorative care.

On 05/05/22 at 09:02 AM, Administrative Nurse E stated the facility only had a part-time restorative aide. The resident would need to be evaluated by therapy for her to receive restorative services and that had not been done because the resident was currently on hospice.

The facility policy for "Restorative Nursing", revised 05/17, included: The facility will provide restorative care for residents requiring contracture prevention and management, including passive range of motion (PROM), active range of motion (AROM) and splint/brace assistance.

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F 688	Continued From page 16 The facility failed to provide restorative services for this dependent resident in order to maintain or prevent decline in her ROM ability.	F 688		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility reported a census of 87 residents with 23 selected for review, including five reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to change the oxygen tubing for Resident (R)73, failed to change the oxygen tubing for R18 and to clean the concentrator and filter, failed to change the oxygen tubing for R68, failed to date the oxygen tubing, humidifier bottle and tubing, nebulizer tubing and store those items in a sanitary manner when not in use as well as the nebulizer kit after cleansing and allowing to air dry for R335, and failed to date the oxygen tubing and nebulizer tubing and kit when changed and to store items in a sanitary manner when not in use for R72. These practices increased the risk of these five residents for developing a respiratory infection. Findings included:	F 695		

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- The "Discharge Summary," for Resident (R)72, included a diagnosis of chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Admission Minimum Data Set" (MDS), dated 04/25/22, for Resident (R)72, assessed her with a "Brief Interview of Mental Status" (BIMS) score of 12, indicating moderately impaired cognition. R12 had shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat. She required the use of oxygen and had a diagnosis of COPD.

The "Baseline Care Plan," dated 04/20/22, included R72 required oxygen via a nasal cannula at four liters per minute continuously.

The "Care Plan," dated 05/03/22, revealed R72 required oxygen therapy at four liters via nasal cannula, monitor for signs and symptoms of respiratory insufficiency, and give aerosol medications as ordered.

The electronic medical record (EMR), included these orders on 04/19/22:

1. Oxygen at four liters continuous via a nasal cannula.

2. Ipratropium-Albuterol (a bronchodilator medication-used to relax and open the air passages to the lungs to make breathing easier) solution, 0.5-2.5 (3) milligrams (mg)/three milliliters (mL), one vial, inhale orally, every six hours, as needed, for COPD.

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The electronic "Medication Administration Record," dated 05/2022, revealed the staff administered a breathing treatment three times on 05/02/22.

A new order, dated 05/04/22 at 08:01 PM, instructed the staff to change the oxygen cannula/tubing and humidifier bottle once weekly on Saturday during the second shift and as needed. This was 15 days after R72 admitted to the facility. The order lacked when to change out the nebulizer tubing/kit.

On 05/03/22 at 07:50 AM, observed R72 in her room with oxygen in place at four liters per a nasal cannula per the oxygen concentrator. The concentrator did not have a humidifier bottle in place. A nebulizer mask kit stored in the drawer of the bedside table, connected and not stored in a sanitary manner. The nebulizer tubing and kit and the oxygen tubing lacked a date when the staff changed it.

On 05/03/22 at 10:40 AM, observed a nasal cannula hanging from the handle of the portable oxygen bottle cart with the nasal prongs in direct contact with the handle of the regulator. The nasal cannula lacked a date the staff changed the tubing. There were no changes to the nebulizer mask kit from prior observation.

On 05/04/22 at 10:23 AM, R72 was in her room, nasal cannula in place and lacked a date the staff changed the tubing. The nebulizer kit was stored on the holding spot on the machine and connected.

On 05/05/22 at 12:24 PM, Certified Medication Aide (CMA) RR, stated the oxygen tubing,

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humidifier bottle, and nebulizer kit were to be changed once a week and dated when changed. After the staff administer a nebulizer treatment, it is expected to rinse it out, wipe it out, then put it in a basket, disassembled. It should not be left out after use.

On 05/05/22 at 12:36 PM, CMA RR confirmed with observation that R72's oxygen tubing connected to the concentrator and the portable oxygen bottle lacked a date the staff changed the tubing. The nasal cannula connected to the portable bottle was coiled and hanging from the handle of the cart. CMA RR stated the tubing should be in a bag, then removed the tubing and placed in a fabric bag. Furthermore, the kit should be rinsed and wiped out then reassembled so it would be ready when she needed a treatment. The kit lacked a date the staff changed the tubing.

On 05/05/22 at 12:40 PM, R72 stated that sometimes the staff clean it and leave it lay out on a towel in the bathroom by the sink.

On 05/09/22 at 11:28 AM, Administrative Staff D stated the oxygen tubing and the nebulizer tubing/kit should be changed weekly and was on the MAR to prompt the staff to do so. The staff were educated regarding this on 03/16/22 and 04/20/22. When staff change the items then it should include a date. When the items were not in use, the tubing should be stored in a black mesh bag. After staff administer a nebulizer treatment, staff should wash the kit with soap and water, rinse, and set the items out to dry. Staff should not wipe the nebulizer mask and medication cup of the kit after rinsing and should place the items on a clean paper towel each time.

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Storage of the kit to dry next to the sink could place the kit at risk for contamination.

The facility policy "Cleaning Respiratory Equipment," dated 05/01/17, instructed the staff to replace masks and/or cannulas used within seven days and PRN when obviously contaminated. When not in used, store masks and cannula in plastic bags labeled with the resident's name and date. For small volume nebulizers, replace every 48-72 hours. This includes hand-held nebulizers for medication. Rinse with water and air dry between treatments on the same resident. For humidification addressed prefilled humidifier bottles only which instructed following manufacturer's instructions, usually every seven to ten days. The purpose policy was to provide a safe and healthy environment for residents and to minimize or prevent the spread of infections.

The facility failed to date the oxygen and nebulizer tubing/kit when changed and failed to store in a sanitary manner when not in use, increasing the risk of R72 of developing a respiratory infection.

- The "Discharge Summary," dated 04/25/22, for Resident (R)335, included diagnoses of acute respiratory failure with hypoxia (abnormal deficiency in the concentration of oxygen in arterial blood) and aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit).

The "Admission Minimum Data Set," (MDS), dated 05/09/22, assessed R335 with a "Brief

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Interview of Mental Status " (BIMS) score of 15, indicating intact cognition. He had shortness of breath or trouble breathing with exertion and required the use of oxygen.

The "Baseline Care Plan," dated 04/27/22, included a diagnosis of aspiration pneumonia and required oxygen at one liter per nasal cannula to keep oxygen saturations above 90% (percent).

The comprehensive "Care Plan," dated 04/25/22, included a problem dated 05/02/22, which revealed R335 was on antibiotic therapy related to a respiratory infection. An additional problem, dated 04/29/22, revealed R335 had chronic respiratory failure and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and required oxygen via a nasal cannula at one to two liters as needed.

The electronic medical record (EMR) included the following orders on 04/25/22:

1. Oxygen to keep saturation 90-94%, lowest flow possible, one to two liters.

2. DuoNeb (respiratory inhalant medication used to treat COPD) solution, 0.5-2.5 (3) milligrams (mg)/three milliliters (mL), inhale orally, via nebulizer, every three times a day for hypoxemia and every four hours as needed for shortness of breath.

3. Budesonide (steroid medication) suspension 0.5 mg/mL, one application, inhale orally, two times a day.

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The EMR, contained additional orders, dated 04/26/22:

1. Change the humidifier bottle once weekly on Sunday during the day shift and as needed, start on 05/01/22.

2. Change the oxygen cannula/tubing once weekly on Sunday during the day shift, to start on 05/02/22.

On 05/02/22 at 03:46 PM, R335's nebulizer tubing was on the floor, the oxygen tubing and humidifier connected to the oxygen concentrator lacked a date the staff changed the tubing and the humidifier bottle.

On 05/03/22 at 11:02 AM, observed R335's nebulizer tubing was hanging off the bedside table. The humidifier bottle and oxygen tubing connected to the concentrator lacked a date the staff changed the tubing and the humidifier bottle.

On 05/04/22 at 07:54 AM, R335 was resting in his bed without oxygen in place. The nasal cannula connected to the concentrator was on the floor beside his bed and lacked a date the staff changed the tubing. The humidifier bottle continued to lack a date the when staff changed the bottle. The tubing from the nebulizer was dangling between the bedside table and the wall and lacked a date the staff changed the tubing.

On 05/04/22 at 07:57 AM, observed Certified Medication Aide (CMA) T replace the nasal cannula that had been on the floor with a new one. CMA T did not date the new nasal cannula.

On 05/04/22 at 08:49 AM, CMA T prepared the

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nebulizer treatment for R335, she removed the nebulizer kit from paper towels located in the bathroom on the counter right next to the sink. She connected the administration kit to the tubing that was dangling between the bedside table and the wall.

On 05/04/22 at 09:06 AM, CMA T disconnected the nebulizer tubing from the administration kit and placed the tubing directly on the bedside table. Next, CMA T disassembled the kit and rinsed the kit with water without gloves on and placed the kit on the paper towels that she previously removed the kit from. CMA T confirmed the kit and tubing lacked a date the staff changed the tubing, but it did display on the Medication Administration Record when to be changed, and did not know the frequency, and the tubing does not get stored in a bag when not in use.

On 05/04/22 at 10:55 AM, CMA T observed disconnecting the nasal cannula from the extension tubing connected to the concentrator and draped the extension tubing across the overbed table and the end dangled over the table. The extension tubing fell to the floor when the resident exited the room. CMA T picked up the extension tubing, placed the tubing back onto the bedside table.

On 05/04/22 at 11:05 AM CMA T stated she had never seen a bag to store the tubing in when not in use.

On 05/04/22 at 11:06 AM, observed a round hairbrush with hair present in the bristles laying on the paper towel within an inch of the nebulizer mask right next to the sink. The paper towels

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were located to the right of the sink counter next to the mirror above the sink, which could cause contamination to the nebulizer kit when moving hands from sink after washing to paper towel location.

On 05/04/22 at 01:50 PM CMA T stated the staff store the nebulizer kit at the sink and was at risk for getting water splashed on it during handwashing and when getting paper towels, and new paper towels should be used each time after rinsing the kit.

On 05/05/22 at 12:24 PM CMA RR stated the oxygen tubing, humidifier bottle, and nebulizer kit were to be changed once a week and dated when changed. After the staff administer a nebulizer treatment, it is expected staff to rinse the nebulizer kit out, wipe it out, then put it in a basket, disassembled. It should not be left out after use. CMA RR confirmed the oxygen tubing, humidifier bottle, and nebulizer kit lacked a date.

On 05/09/22 at 11:28 AM, Administrative Staff D stated the oxygen tubing and the nebulizer tubing/kit should be changed weekly and was on the MAR to prompt the staff to do so. The staff had been educated regarding this on 03/16/22 and 04/20/22. When staff changed the items then it should include a date. When the items were not in use, the tubing should be stored in a black mesh bag. After staff administer a nebulizer treatment, staff should wash the kit with soap and water, rinse, and set the items out to dry. Staff should not wipe the nebulizer mask and medication cup of the kit after rinsing and should place the items on a clean paper towel each time. Storage of the kit to dry next to the sink could place the kit at risk for contamination.

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The facility policy "Cleaning Respiratory Equipment," dated 05/01/17, instructed the staff to replace masks and/or cannulas used within seven days and PRN when obviously contaminated. When not in used, store masks and cannula in plastic bags labeled with the resident's name and date. For small volume nebulizers, replace every 48-72 hours. This includes hand-held nebulizers for medication. Rinse with water and air dry between treatments on the same resident. For humidification addressed prefilled humidifier bottles only which instructed following manufacturer's instructions, usually every seven to ten days. The purpose policy was to provide a safe and healthy environment for residents and to minimize or prevent the spread of infections.

The facility failed to date the oxygen and nebulizer tubing/kit when changed for this resident and failed to store the items in a sanitary manner when not in use, increasing the risk of R335 of developing a respiratory infection.

- Review of Resident (R)68's "Physician Order Sheet," dated 03/16/22, revealed diagnoses that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness,) osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain,) and atrial fibrillation (rapid, irregular heartbeat.)

The "Significant Change Minimum Data Set" (MDS), dated 04/13/22, assessed the resident with normal cognitive function and received

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oxygen therapy.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 04/13/22, assessed the resident required assistance with ADLs due to generalized weakness and decreased functional ability.

The "Care Plan," revised 04/08/22, instructed staff the resident received hospice services, which provided equipment and supplies. The "Care Plan," instructed staff to monitor for respiratory distress/decreased respirations due to pain medications. The "Care Plan" lacked instruction for oxygen therapy and maintenance of equipment.

A "Physician's Order," dated 04/07/22, instructed staff to administer oxygen at two to five liters per minute per nasal cannula as needed for air hunger.

Observation, on 05/02/22 through 05/05/22 revealed the resident's oxygen concentrator contained oxygen tubing draped over the top of the concentrator attached to a half full humidifier canister. The oxygen tubing contained a piece of tape with the date 04/21/22. Observation, on 05/09/22 revealed the oxygen concentrator in the resident's closet with the oxygen tubing draped over the top of the concentrator attached to the half full humidifier canister. The oxygen tubing contained a piece of tape dated 04/21/22.

Interview, on 05/09/22 at 09:30 AM, with the resident, revealed she did not have difficulty breathing and placed the concentrator in her closet today.

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F 695	Continued From page 27 Interview, on 05/09/22 at 09:45 AM, with Certified Medication Aide (CMA) SS, confirmed the resident had an order for oxygen as needed on the "Treatment Administration Record" (TAR), but lacked instruction on changing the tubing/humidifier canister. CMA SS thought the resident used the oxygen once. Interview, on 05/09/22 at 9:55 AM, with Administrative Nurse E, revealed she would expect the care of the oxygen equipment to be documented on the TAR and would expect staff to change the oxygen tubing weekly. The facility policy "Infection Control," revised 05/01/17, instructed staff to replace the cannula within seven days and store in a plastic bag labeled with the resident's name and date. The facility failed to maintain this resident's oxygen cannula/tubing/humidifier canister in a sanitary manner to prevent the spread of infection. - Review of Resident (R)73's electronic medical record (EMR), under the "Med Diag (Diagnosis)" tab, included a diagnosis of chronic obstructive pulmonary disease [(COPD) progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing.] The significant change "Minimum Data Set" (MDS), dated 11/01/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive	F 695		

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impairment. She used oxygen.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 11/01/21, documented the resident had memory and recall deficits.

The quarterly "MDS," dated 04/16/22, documented the resident had a BIMS score of six, indicating severe cognitive impairment and she used oxygen.

The care plan, dated 03/27/22, instructed staff the resident had a diagnosis of COPD. The resident was to have her oxygen settings at 2 liters (L) by nasal cannula (NC), per minute, continuously.

Review of the resident's EMR, under the "Orders" tab, included an order to change the oxygen cannula and tubing weekly and as needed (PRN). Documentation showed staff completed this task on a weekly basis.

On 05/02/22 at 04:13 PM, the resident's oxygen concentrator sat in her room. The oxygen tubing, dated 03/26/22, was on top of the resident's bed side table. The resident was in the dining room, in her wheelchair, with an oxygen tank with oxygen tubing dated 04/23/22.

On 05/03/22 at 08:17 AM, the resident's oxygen concentrator sat in her room. The oxygen tubing, dated 03/26/22, was on top of the resident's bed side table. The resident was in the dining room, in her wheelchair, with an oxygen tank with oxygen tubing dated 04/23/22.

On 05/04/22 at 03:02 PM, Certified Nurse Aide (CNA) O stated the resident used her oxygen at all times. The resident used the oxygen

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concentrator whenever she was in her bed. The resident was unable to put the oxygen on herself.

On 05/05/22 at 09:53 AM, CNA N stated the resident required her oxygen to be on at all times. The resident would use the oxygen concentrator in her room when she was in bed and the oxygen tank when she was out of her room. CNA N confirmed the date of 03/26/22 on the oxygen tubing.

On 05/04/22 at 02:09 PM, Licensed Nurse (LN) L stated staff were to change the oxygen tubing every week. Either the nurse or the Certified Medication Aide (CMA) could change the tubing. Staff document this on the treatment administration sheet (TAR).

On 05/09/22 at 09:38 AM, LN LL stated the CMAs would change the oxygen tubing on the resident's oxygen concentrators each week during the evening shift. Staff should put the date on the tubing when putting on new tubing.

On 05/09/22 at 09:55 AM, Administrative Nurse E stated staff were to change the oxygen tubing every week and document on the TAR. Staff were to date the tubing with the date it was changed.

The facility policy for "Cleaning Respiratory Equipment", revised 05/01/17, included: Replace masks and/or cannulas used by an individual resident within seven days and as needed (PRN) when obviously contaminated.

The facility failed to change the oxygen tubing for this dependent resident who used oxygen continuously, in a timely manner.

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- Review of the Resident's (R) 18 "Physician Orders," dated 03/10/22 revealed diagnosis which included chronic respiratory failure and sleep apnea (breathing stops during sleep).

The "Admission Minimum Data Set" (MDS) dated 05/17/21, documentation included the "Brief Interview for Mental Status" (BIMS) score of 15, which indicated cognitively intact. She reported trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy for two to six days of the look back period. She required extensive assistance of staff with activities of daily living (ADLs) for bed mobility and transfers. The resident used Oxygen.

The "Quarterly MDS," dated 02/17/22, documented changes which included the resident required supervision of staff for transfers, and limited assistance for walking.

The "Care Area Assessment" (CAA), dated 05/19/22, documentation did not address the use of oxygen.

The "Care Plan," (CP), dated 02/16/22, directed staff the resident with altered respiratory status/difficulty breathing related to sleep apnea and chronic respiratory failure. The oxygen setting for the concentrator was set for three liters via nasal cannula. The care plan did not include maintenance of oxygen tubing, concentrator filter, humidifier bottle, distilled water nor storage of cannula/tubing when not in use. Additionally, the care plan did not address the use nor maintenance of the Continuous Positive Air

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Pressure (CPAP) machine and/or mask and tubing storage when not in use.

Review of the "Physician's Order," dated 03/10/22, documented an order initiated on 02/04/22 to change the humidifier bottle once weekly. Wipe down the concentrator and clean the filter. Change the oxygen cannula/tubing, once weekly on Saturday and as needed. Please assist the elder in placing C-pap on at bedtime, initiated 05/25/2021.

Review of the "Treatment Administration Record," (TAR), dated 03/01/22 through 05/02/22, documentation revealed the oxygen humidifier and tubing changes, clean concentrator filter signed out as done on 03/5/22, 03/12/22, 03/19/22, 03/26/22, 04/02/22, 04/09/22, and 04/23/22. Staff failed to document/ sign on 04/16/22 and 04/30/22,

On 05/03/22 at 10:01 AM, the resident stated her brother put water in the oxygen bottle, as the staff do not take care of the oxygen. "The jug sitting on the floor only had a little water left in it so they will need to get me more." The staff have not changed the tubing more than three times this year, if that many times. She reported she never had a bag to put her CPAP in and verified she used it every night. She would use the oxygen on during the day, but never had a bag for it either.

On 05/03/22 at 10:27 AM, the resident had her oxygen cannula and tubing in place with oxygen at three liter per minute via nasal cannula. The oxygen tubing date was 02/22/22, the humidifier bottle was not labeled, a partially empty unlabeled jug of distilled water sat directly on the floor. There was not a storage bag present for storing

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the cannula and tubing when not in use. The concentrator filter had a thick layer of dust. The CPAP hose hung across the bed rail without having a bag present for storage when not in use.

On 05/03/22 at 04:14 PM, Certified Aide (CNA) stated the nurse should change the tubing and humidifier bottle every two weeks. There should be a bag to store the tubing and mask when the oxygen and CPAP were not in use. The storage bags should be dated. Additionally, she reported the distilled water was to fill the humidifier bottle on the oxygen concentrator and should be stored in the bathroom off the floor. The distilled water should be dated when opened.

On 05/04/22 at 09:36 AM, CNA M, confirmed the above findings. Additionally, she confirmed there was two jugs of distilled water directly on the floor by the concentrator, neither labeled and one partially empty. She stated she was not aware an oxygen concentrator had a filter that needed to be cleaned. She reported she thought the tubing and cannulas were changed two times a week by the nurse, but she did not know.

On 05/04/22 at 11:50 AM, Licensed Nurse G reported, staff should change the oxygen tubing monthly. He was not aware of the system in this facility for changing out the tubing or cleaning the concentrator filter. The tubing should be labeled when changed. Night shift usually changes it out. The resident uses her CPAP at night, but was unaware where staff should store oxygen when not in use. In addition, he was unaware of the system for changing out the oxygen tubing or the humidifier bottle.

On 05/05/22 at 09:26 AM, Licensed Nurse (LN) H

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F 695	Continued From page 33 reported staff should change the oxygen tubing and humidifier bottles weekly. The tubings should be stored in a labeled bag when not in use. Night shift staff change the tubing/ humidifier bottles/ nebulizer tubings. The resident's CPAP mask and hose should be stored in a labeled bag when not in use. On 05/09/22 at 10:20 AM, Administrative Nurse D stated nurses should change the oxygen cannulas/tubing weekly and as needed. The tubing, humidifier bottles should be labeled with the date when changed. The tubing for oxygen and CPAP should be stored in a labeled bag when not in use. Additionally, the nurse should document on the TAR when tubing, humidifier, and concentrator filters are changed and cleaned. The facility policy for "Cleaning Respiratory Equipment," dated 05/01/2017, documentation included ". . . Replace masks and/or cannula used by an individual resident within seven days and as needed (PRN) when obviously contaminated. When not in use, store masks and cannula in plastic bags labeled with the resident's name and date. Clean oxygen concentrator filter weekly. The facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice.	F 695		
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,	F 697		

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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 reported a census of 87 residents with 23 selected for review including two residents reviewed for pain management. Based on interview and record review, the facility failed to order one resident's narcotic (class of medication used to treat moderate to severe pain) medication in a timely manner, resulting in four missed scheduled doses and an increased pain level, for Resident (R)63.

Findings included:

- The "Order Summary Report," dated 04/07/22, for Resident (R)63, included diagnoses of neuralgia (nerve pain), pain in unspecified joint, pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral (area of the lower back near the spine region), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The "Admission Minimum Data Set" (MDS), dated 04/15/22, assessed R63 with a "Brief Interview of Mental Status" (BIMS) score of 15, indicating intact cognition. She frequently had pain or hurting in the last five days of the assessment period rated as an "8" on the 0-10 pain scale, where zero equals no pain and ten equals the worst possible pain. The pain made it hard for her to sleep at night and limited her day-to-day activities. She received scheduled

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pain medication, as needed pain medication, and non-medication intervention for pain.

The "Pain Care Area Assessment," dated 04/20/22, revealed R63 complained of pain during the pain interview and had pain related to her recent surgery, pressure ulcer, therapy, mobility, and had a history of pain. The physician was to be immediately notified if there was no pain relief from the current regimen.

The "Care Plan," dated 04/13/22, included a problem dated 04/30/22 which revealed R63 had acute/chronic pain related to surgical debridement (procedure to remove debris or infected/dead tissue from a wound) of sacrum, pressure ulcer, neuralgia (severe pain due to damaged nerves), osteoarthritis and to administer analgesics per orders. The staff were to notify the physician if interventions were unsuccessful or if current complaint of pain was a significant change from her past experience of pain. R63 preferred to have her pain controlled by medication as prescribed by the physician. Additionally, a problem was added to the care plan, dated 05/02/22, indicating R63 was on pain medication therapy, to administer the analgesic (pain reliever) as ordered by the physician.

A fax sheet, dated 04/26/22, from the wound clinic to the facility revealed a request for the facility to contact the primary care physician, as R63 requests to have her as needed pain medications be given/provided throughout the night as ordered so she can stay on top of her pain.

The electronic medical record (EMR), included an order dated 04/27/22, for

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hydrocodone-acetaminophen (narcotic analgesic), 10-325 milligrams (mg), give one tablet, by mouth, every four hours, for pain. A previous order, dated 04/14/22, was to give hydrocodone-acetaminophen, every four hours, while awake.

The "Medication Reorder Form," for the hydrocodone-acetaminophen, 10-325 mg, had a date of 05/01/22.

The individual count sheet, for the hydrocodone-acetaminophen, 10-325 mg, revealed staff administered the last dose on the individual medication packet on 05/01/22 at 06:00 PM. The next count sheet, revealed on 05/02/22 at 02:36 PM, the facility received 60 tabs of the hydrocodone-acetaminophen from the pharmacy, and then staff administered the medication after the medication was available. The count sheet lacked what time the staff administered the first dose given on 05/02/22.

The electronic "Medication Administration Record," (eMAR), dated 05/2022, revealed R63 missed doses of the scheduled hydrocodone-acetaminophen at the following times:

1. On 05/01/22 at 10:00 PM.

2. On 05/02/22 at 02:00 AM.

3. On 05/02/22 at 06:00 AM.

4. On 05/02/22 at 10:00 AM, at which time her pain level rose to a "9" on the 0-10 pain scale.

The "eMAR," dated 05/2022, revealed the next

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time R63 received her narcotic pain medication was on 05/02/22 for the 02:00 PM scheduled dose.

The "Progress Notes," dated 05/02/22, revealed the hydrocodone-acetaminophen was "Not in stock." The staff provided Tylenol (analgesic for mild pain) on 05/02/22 at 05:44 AM and was effective and again at 10:53 AM and was ineffective.

On 05/03/22 at 10:01 AM, R63 stated, yesterday they did not order pain medication for me and I went half a day without pain medication, the staff had to wait for it to come in. I get the medication every four hours. Finally, Licensed Nurse (LN) I brought it to me immediately when it came in. I guess she put a big note in my chart to make sure there was enough pain medication to get me by, I do not think they ordered the medication. The medication is scheduled every four hours, but sometimes I have to ask for it because I know they are "Super busy."

On 05/03/22 at 01:45 PM, Certified Medication Aide (CMA) T stated when a medication gets down to seven pills remaining, there is a sticker that is pulled off of the medication card and placed on a fax form and sent to the pharmacy. If staff send the paper to the pharmacy by 10:00 AM, the pharmacy can fill the medication the same day.

On 05/05/22 at 08:43 AM, CMA RR stated that when a medication gets down to five or seven tablets left, staff pull the sticker off the medication card and place it on a reorder sheet and fax the sheet to the pharmacy. The process is the same for narcotic medication scheduled every four

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hours. If the pharmacy required a script from the physician to fill the medication, the pharmacy would notify the physician.

On 05/05/22 at 09:01 AM, Administrative Nurse D stated the process for reordering medication included pulling the sticker off the medication card, placing on the reorder form, and fax it to the pharmacy, or the nurse could call and request a refill. If it is a scheduled narcotic every four hours, the CMA should alert the charge nurse before the medication gets down to six pills, and alert the nurse right away if the medication was not in stock.

On 05/05/22 at 09:15 AM, Consultant pharmacy staff GG stated R63's script for the hydrocodone-acetaminophen was filled on 05/02/22. The pharmacy received the request for refill with the medication sticker on it at 05/01/22 at 09:17 PM. The facility should request a refill at least 24 hours or even two days before the medication would run out to give them a chance to get a script from the physician so they could refill the medication.

On 05/05/22 at 09:59 AM, R63 stated she had just received a pain pill, it was brought separately from the other pills, she had to ask if it was in the cup of pills, as they have to get that medication elsewhere than her room medication cabinet. R63 stated on 05/01/22 when my pain medication ran out, the staff did offer her Tylenol, she thought she took it but was not for sure, it did not really help much anyway.

On 05/09/22 at 10:53 AM, LN I stated R63 ran out of her pain medication once for her on a weekend, the pain medication had not been

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reordered, and should have been on Wednesday before going into the weekend, or if there were seven pills left on the count sheet. With R63 getting the medication every four hours, seven pills was not soon enough to reorder the medication, and it should be reordered when there are 12 pills left. The staff offered Tylenol to her when she ran out of the hydrocodone. LN I offered to call the on call physician to get something for her pain out of the emergency kit, but the resident reported it would be fine until the morning, but we encouraged her to let us know if the pain got worse. LN I talked to therapy about not seeing her until her pain medication came in, which she received the medication on 05/02/22 at 02:42 PM. R63 received Tylenol that morning, but it was not effective, and the staff repositioned her and changed the dressing to her bottom, and Occupational Therapy did some bed exercises with her. Once the staff situated R63 she was comfortable after that. I would expect the staff to order her medication timely, so it does not run out.

The facility policy "Medication Ordering and Receiving from Pharmacy," dated 04/2020, revealed the policy was for medications and related products were received from the dispensing pharmacy on a timely basis. If a medication was not automatically refilled by the pharmacy, repeat medications (refills) were to be ordered three to five days in advance of need, as directed by the pharmacy order and delivery schedule, to assure and adequate supply was on hand. The refill order was to be called in, faxed, sent electronically, or otherwise transmitted to the pharmacy. When available and legible, the pharmacy label (including bar code if used) was to be pulled and transmitted to the pharmacy.

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F 697	Continued From page 40 The facility failed to provide this resident pain management for her acute/chronic pain.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention	F 732		

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requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 87 residents, with 40 residents residing in "Nelson Hall". Based on observation, interview and record review, the facility failed to display accurate and identifiable staffing information, on a daily basis, on a "Daily Nurse Staffing" as required for the 40 residents that reside in the Nelson Hall for a period of five days.

Findings included:

- On 05/03/22 at 08:39 AM, the daily nursing staffing posted for Nelson Hall observed was 04/30/22, a total of five consecutive days without nursing staffing posted.

On 05/03/22 at 11:07 AM, Licensed Nurse (LN) L reported that the night nurse posted the daily nurse staffing. LN L verified that she was unaware that the daily nurse staffing had not been updated since 04/30/22.

On 05/05/22 at 10:21 AM, Licensed Nurse (LN) J reported that she was unsure who was responsible to post the daily nursing staffing daily.

On 05/09/22 at 09:30 AM, Administrative Nurse E verified the posted daily nursing staffing on 05/03/22 was dated 04/30/22. The night shift nurses were to be changing the daily nursing staffing.

On 05/09/22 at 12:33 PM Administrative Staff A,

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F 732	Continued From page 42 reported the daily nursing staffing form was to be posted nightly. The facility's Nursing Staff Posting Information, created 11/17, documented the facility will make nurse staffing data available to the public for review. The facility failed to display accurate and identifiable staffing information, on a daily basis, on a "Daily Nurse Staffing" for the 40 residents that reside in Nelson Hall for a period of five days, as required.	F 732		
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. (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.	F 756		

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(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 reported a census of 87 residents with five selected for review of unnecessary medications. Based on observation, interview and record review, the facility and consulting pharmacist failed to identify the need for baseline and subsequent assessment for extrapyramidal side effect of antipsychotic medications at the initiation of Seroquel (antipsychotic medication used to treat certain mental/ mood conditions)and periodically thereafter during therapy to ensure the resident did not experience adverse effects of this antipsychotic medication.

Findings included:

- Review of Resident (R)70's "Physician Order Sheet," dated 03/16/22, revealed diagnoses included vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbance.

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The quarterly "Minimum Data Set" (MDS), dated 04/14/22, assessed the resident with severe cognitive deficit and continuous inattention, disorganized thinking, and altered level of consciousness. The resident received hospice services.

The "Behavior Symptoms Care Area Assessment" (CAA), dated 10/12/21, assessed the resident was physically and verbally abusive to staff and other residents with wandering, yelling and cursing. The resident was resistant to care.

The "Psychotropic Drug Use" CAA, assessed the resident used psychotropic medications to manage the resident's psychiatric illness.

The "Care Plan," revised 02/13/22, instructed staff the resident used antianxiety medications and to report adverse effects of the medications. The "Care Plan" lacked interventions for the use of antipsychotic medications.

A "Physician's Order," dated 03/22/22, instructed staff to administer topical (on the skin) Seroquel (an antipsychotic medication) 25 milligrams (mg), twice a day, for increased anxiety and behaviors.

Review of the resident's electronic records lacked an assessment for extrapyramidal or abnormal involuntary movement scale (AIMS).

Observation, on 05/04/22 at 12:47 PM, revealed the resident seated in a recliner (with foot rest elevated) in the common living area. The resident attempted to climb out of the recliner, and CNA Q assisted the resident to transfer into her wheelchair and took the resident to the

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bathroom.

Interview, on 05/04/22 at 03:00 PM, with Licensed Nurse (LN) HH, revealed the resident did have multiple behaviors in the evenings and at night, often staying up all night wandering.

Interview, on 05/09/22 at 10:30 AM, with LN LL, revealed when a resident needed an assessment for extrapyramidal (a group of symptoms that may occur due to antipsychotic medication) side effects of antipsychotic medications the electronic medical record system should trigger the task on the dashboard for staff to complete.

Interview, on 05/09/22 at 12:25 PM, with Administrative Nurse E, confirmed the facility failed to complete a baseline assessment for extrapyramidal side effect of antipsychotic medications at the start of Seroquel therapy on 03/22/22 or subsequently.

Interview, on 05/09/22 at 01:30 PM, with Consultant Pharmacist II, confirmed she would expect the facility to complete a baseline assessment for extrapyramidal side effect of antipsychotic medications at the start of antipsychotic therapy and periodically during therapy. Consultant Pharmacist II confirmed lack of recommendation for the assessment upon review of the resident's medications on 03/31/22 and 04/30/22.

The facility lacked a policy for assessment for assessment of extrapyramidal side effect of antipsychotic medications.

The consulting pharmacist and facility failed to complete a baseline assessment for

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F 756	Continued From page 46 extrapyramidal side effect of antipsychotic medications at the initiation of Seroquel and periodically thereafter during therapy to ensure the resident did not experience adverse effects of this antipsychotic medication.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used 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	F 758		

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in the clinical record; and

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

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 87 residents with five residents selected for review for unnecessary medications. Based on observation, interview and record review, the facility failed to assess for extrapyramidal (a group of symptoms that may occur due to antipsychotic medication) side effects for one of the five sampled residents (R)70 and failed to ensure as needed psychotropic medications did not exceed 14 day use without physician re-evaluation and specified duration for three of the five sampled residents (R) 70, 68 and 45.

Findings included:

- Review of Resident (R)70's "Physician Order Sheet," dated 03/16/22, revealed diagnosis included vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbance.

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The "Significant Change Minimum Data Set" (MDS), dated 10/12/21, assessed the resident with severe cognitive deficit and received seven days of antidepressant and antianxiety medications during the seven day look-back period.

The "Behavior Symptoms Care Area Assessment" (CAA), dated 10/12/21, assessed the resident was physically and verbally abusive to staff and other residents with wandering, yelling and cursing. The resident was resistant to care.

The "Psychotropic Drug Use" CAA,dated 10/12/21, assessed the resident used psychotropic medications to manage the resident's psychiatric illness.

The quarterly "Minimum Data Set" (MDS), dated 04/14/22, assessed the resident with severe cognitive deficit and continuous inattention, disorganized thinking, and altered level of consciousness. The resident received hospice services .

The "Care Plan," revised 02/13/22, instructed staff the resident used antianxiety medications and to report adverse effects of the medications.

A "Physician's Order," dated 04/22/22, instructed staff to administer lorazepam (a medication for anxiety) 0.5 milligrams (mg,) topically (on the skin,) every two hours, as needed, for anxiety and/or restlessness.

A "Physician's Order," dated 04/23/22, instructed staff to administer lorazepam, 0.5 mg, topically,

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every four hours, as needed, for anxiety and/or restlessness.

Interview, on 05/04/22 at 08:00 AM, with Certified Nurse Aide(CNA) Q, revealed the resident cooperated for bathing this morning, but often the resident resisted care.

Observation, on 05/04/22 at 12:47 PM, revealed the resident seated in a recliner (with foot rest elevated) in the common living area. The resident attempted to climb out of the recliner, and CNA Q assisted the resident to transfer into her wheelchair and took the resident to the bathroom.

Interview, on 05/04/22 at 03:00 PM, with Licensed Nurse (LN) HH, revealed the resident did have multiple behaviors in the evenings and at night, often staying up all night wandering.

Interview, on 05/09/22 at 09:55 AM, with Administrative Nurse E, revealed as needed antianxiety medications should be ordered for 14 days and then for six months if the resident was on hospice and the orders for lorazepam should indicate this.

The undated policy "Medication Regimen Review," instructed staff that orders for as needed psychotropic medications are limited to 14 days unless the prescribing practitioner believed it was appropriate to extend the order and must document the rational and indicate the duration for the as needed order.

The facility failed to ensure this resident's as needed lorazepam did not exceed the 14-day limitation for physician reevaluation for extension

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and duration of therapy to ensure the resident did not experience adverse effects of the psychotropic medication.

- Furthermore, review of resident (R)70's "Physician Order Sheet," dated 03/16/22, revealed diagnoses included vascular dementia V(a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbance.

The "Significant Change Minimum Data Set" (MDS), dated 10/12/21, assessed the resident with severe cognitive deficit and received seven days of antidepressant and antianxiety medications during the seven day look-back period.

The "Behavior Symptoms Care Area Assessment" (CAA), dated 10/12/21, assessed the resident was physically and verbally abusive to staff and other residents with wandering, yelling and cursing. The resident was resistant to care.

The "Psychotropic Drug Use" CAA, assessed the resident use psychotropic medications to manage the resident's psychiatric illness.

The quarterly "Minimum Data Set" (MDS), dated 04/14/22, assessed the resident with severe cognitive deficit and continuous inattention, disorganized thinking, and altered level of consciousness. The resident received hospice services.

The "Care Plan," revised 02/13/22, instructed

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staff the resident used antianxiety medications and to report adverse effects of the medications. The "Care Plan" lacked interventions for the use of antipsychotic medications.

A "Physician's Order," dated 03/22/22, instructed staff to administer topical (on the skin) Seroquel (an antipsychotic medication) 25 milligrams (mg), twice a day, for increased anxiety and behaviors.

Review of the resident's electronic records lacked an assessment for extrapyramidal or abnormal involuntary movement scale (AIMS).

Observation, on 05/04/22 at 12:47 PM, revealed the resident seated in a recliner (with foot rest elevated) in the common living area. The resident attempted to climb out of the recliner, and CNA Q assisted the resident to transfer into her wheelchair and took the resident to the bathroom.

Interview, on 05/04/22 at 03:00 PM, with Licensed Nurse (LN) HH, revealed the resident did have multiple behaviors in the evenings and at night, often staying up all night wandering.

Interview, on 05/09/22 at 10:30 AM, with LN LL, revealed when a resident needed an assessment for extrapyramidal (a group of symptoms that may occur due to antipsychotic medication) side effects of antipsychotic medications the electronic medical record system should trigger the task on the dashboard for staff to complete.

Interview, on 05/09/22 at 12:25 PM, with Administrative Nurse E, confirmed the facility failed to complete a baseline assessment for extrapyramidal side effect of antipsychotic

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medications at the start of Seroquel therapy on 03/22/22 or subsequently.

Interview, on 05/09/22 at 01:30 PM, with Consultant Pharmacist II, confirmed she would expect the facility to complete a baseline assessment for extrapyramidal side effect of antipsychotic medications at the start of antipsychotic therapy and periodically during therapy.

The facility lacked a policy for assessment for assessment of extrapyramidal side effect of antipsychotic medications.

The facility failed to complete a baseline assessment for extrapyramidal side effect of antipsychotic medications at the initiation of Seroquel and periodically thereafter during therapy to ensure the resident did not experience adverse effects of this antipsychotic medication.

- Review of Resident (R)68's "Physician Order Sheet," dated 03/16/22, revealed diagnoses that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness,) osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain,) and atrial fibrillation (rapid, irregular heartbeat.)

The "Significant Change Minimum Data Set" (MDS), dated 04/13/22, assessed the resident with normal cognitive function.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 04/13/22, assessed

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the resident used psychotropic medications to manage psychiatric illness/condition.

The "Care Plan," revised 04/08/22, instructed staff the resident received antianxiety medications and to monitor for adverse effects.

A "Physician's Order," dated 04/07/22, instructed staff to administer Ativan (an antianxiety psychotropic medication) 0.5 milligrams (mg) every four hours, as needed for shortness of breath.

Observation, on 05/04/22, at 11:44 AM, revealed the resident ambulating in the hallway with Certified Medication Aide (CMA) SS. The resident's had noticeable tremors but ambulated with a slow steady gait.

Interview, on 05/04/22 at 11:50 AM with CMA SS, revealed the resident received hospice services and included the resident to have multiple medications changed.

Interview, on 05/09/22 at 09:55 AM, with Administrative Nurse E, revealed as needed antianxiety medications should be ordered for 14 days and then for six months if the resident was on hospice and the orders for lorazepam should indicate this.

The undated policy "Medication Regimen Review," instructed staff that orders for as needed psychotropic medications are limited to 14 days unless the prescribing practitioner believed it was appropriate to extend the order and must document the rational and indicate the duration for the as needed order.

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The facility failed to ensure this resident's as needed lorazepam did not exceed the 14-day limitation for physician reevaluation for extension and duration of therapy to ensure the resident did not experience adverse effects of the psychotropic medication.

- The "Physician Order Sheet" (POS), dated 03/16/22, for Resident (R)45, documented a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The significant change "Minimum Data Set" (MDS), dated 03/23/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. He had rejection of care one to three days of the assessment period and took an antianxiety (a medication or other intervention that inhibits anxiety) medication seven of the seven days of the assessment period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 03/23/22, documented the pharmacist consultant would review medications monthly and the physician would review medications with each visit.

The quarterly "MDS," dated 03/10/22, documented the resident had a BIMS score of three, indicating severe cognitive impairment. He had inattention and disorganized thinking behavior which fluctuated and verbal behavior and other behavioral symptoms not directed towards others one to three days. He received an antianxiety medication seven of the seven days of

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the look back period.

The care plan, updated 04/05/22, for polypharmacy, instructed staff the pharmacist would review and follow-up with the Ativan (an antianxiety medication), as indicated.

Review of the resident's electronic medical record (EMR), under the "Orders" tab, included the following:

Ativan 0.5 milligrams (mg), every (Q) four hours, as needed (PRN), for restlessness and agitation, ordered, 03/14/22.

On 05/04/22 at 07:44 AM, Licensed Nurse (LN) J and Certified Medication Aide (CMA) SS entered the resident's room to provide cares. The resident was restless, but cooperative with staff as they toileted and dressed him.

On 05/05/22 at 02:30 PM, the resident sat in the commons area of the unit. The resident continually attempted to stand up from his chair per self. Staff responded quickly to the resident to assist him to sit back down. Staff gave the resident activities to do in an attempt to redirect him.

On 05/04/22 at 07:44 AM, CMA SS stated, the resident takes Ativan due to agitation. He has a PRN Ativan that he takes also. CMA SS stated the PRN antianxiety medications needed to be reordered every 14 days and the nurse took care of that.

On 05/04/22 at 08:03 AM, LN J stated the resident receives PRN Ativan for agitation.

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F 758	Continued From page 56 On 05/09/22 at 08:56 AM, LN K stated the resident had an order for PRN antianxiety. Before giving the medication, staff will attempt non-medication interventions to try to calm the resident down. All PRN antianxiety medications need to have an automatic 14 day stop date unless there is documentation by the doctor to continue the medication for a longer period of time. On 05/09/22 at 09:55 AM, Administrative Nurse E stated PRN antianxiety medications should be reordered every 14 days unless the resident was on hospice. This resident was currently on hospice but did not have any stop date on the PRN Ativan. Administrative Nurse E stated she had contacted the hospice nurse who will be coming in to put a stop date on the medication. The facility policy for "Medication Regimen Review", created 11/17, included: PRN orders for psychotropic drugs are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, then he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. The facility failed to obtain a stop date for the PRN antianxiety medication.	F 758		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881		

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a minimum, the following elements:

§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 87 residents. Based on record review and interview, the facility failed to ensure nursing staff followed the principles of antibiotic stewardship in a proactive manner to ensure residents received antibiotics in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance. The facility failed to track and trend infections and causative microorganisms throughout the facility and failed to compile antibiotic use data for prescribing practitioners.

Findings included:

- Review of the "Antibiotic Log," revealed the following areas of concerns:

April 2021: One unsampled resident with a "wound infection" treated with an antibiotic for 14 days without location of wound or causative organism.

May 2021: Three unsampled residents with urinary tract infections (UTIs) treated with antibiotics, all without indication of causative organisms.

June 2021: One unsampled resident identified with MRSA(methicillin resistant streptococcus aureus) treated with Vancomycin (antibiotic) and lacked source of the MRSA or need for isolation.

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This same resident was treated with Cefepime and Doxycycline (antibiotics.)

One unsampled resident with community acquired MRSA infection and "wound infections" was treated with Clindamycin, Levaquin and Doxycycline (antibiotics) and lacked wound location or onset date of therapy or resolution.

July 2021: One unsampled resident with UTI treated with Methenamine (antibiotic.)

One unsampled resident treated for "Infection" with Vancomycin and lacked a causative organism.

One unsampled resident treated for "Infections" with Bactrim DS (antibiotic) and lacked causative organism.

August 2021: One unsampled resident treated with Bactrim DS (antibiotic), and lacked onset date, causative organism or diagnosis.

One unsampled resident treated with Cefdinir (antibiotic) lacked diagnosis or causative organism.

September 2021: Ten residents with UTIs, all treated with antibiotics, all lacked causative organisms.

One unsampled resident with prophylaxis (action taken to prevent disease) antibiotic for UTI.

One unsampled resident with an infection to her port (intravenous access site) treated with antibiotic and lacked causative organism and determination if facility acquired.

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October 2021: One unsampled resident for unknown diagnosis/organism treated with Invanz (antibiotic) for unknown diagnosis/organism.

One unsampled resident treated with Hiprex (antibiotic) with an unknown diagnosis/organism.

One unsampled resident treated with piperacillin/tazobactam (antibiotics) lacked diagnoses/organism.

Four unsampled residents with UTIs all treated with antibiotics and lacked causative organisms.

One unsampled resident with C Diff (clostridium difficile) treated with Vancomycin and lacked if isolation precautions instituted.

November 2021: Five unsampled residents with UTIs, and no causative organism indicated.

One unsampled resident treated with Acyclovir, and lacked diagnoses/ causative organism.

One unsampled resident treated with Trimethoprim (antibiotic) indefinitely for chronic UTI and lacked causative organism.

December 2021: Ten unsampled residents treated with antibiotics for UTIs with no causative organisms indicated.

One unsampled resident treated with Zithromax (antibiotic) lacked causative organism/diagnoses and same resident treated with Erythromycin (antibiotic) for "Allergies."

One unsampled resident treated with Keflex

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(antibiotic), lacked onset date, organism, diagnosis and stop date.

One unsampled resident treated with Cephalexin (antibiotic) for UTI for 10 days, then treated with Augmentin (antibiotic) for 10 days and lacked diagnoses causative /organisms.

January 2022: Six unsampled residents treated with antibiotics for UTI, lacked causative organisms.

February 2022 , three unsampled residents treated with antibiotics for UTIs, lacked causative organisms.

One unsampled resident treated for "Infection" lacked diagnosis/ causative organisms treated with Cefalexin (antibiotic.)

March 2022, Five unsampled resident treated with antibiotics for UTI, lacked causative organisms.

April/May 2022: One unsampled resident treated for UTI with Keflex(antibiotic) for seven days followed by seven days of Cefdinir (antibiotic), lacked causative organism.

Five other unsampled residents treated with antibiotics for UTI's lacked causative organisms.

Two unsampled resident treated with antibiotics, lacked diagnosis/organism.

Interview, on 05/09/22 at 11:30 AM, with Administrative Nurse D, confirmed incomplete data collection for tracking/trending of causative microorganisms/ diagnoses, and determination of

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F 881	Continued From page 61 antibiotic appropriateness as evidenced in the "Antibiotic Logs" provided. The facility policy "Infection Prevention and Control Program" revised 05/20/17 instructed staff to utilize a system of surveillance for identifying, reporting, investigating and preventing infections. Antibiotic Stewardship will be implemented as part of the overall infection prevention and control program. Antibiotic use protocols and a system to monitor antibiotic use will be implemented. The facility failed to ensure principles of antibiotic stewardship to ensure residents received antibiotics in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance in an ongoing, proactive manner. The facility failed to track and trend infections and causative microorganisms throughout the facility and failed to compile antibiotic use data for prescribing practitioners.	F 881		