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	175281	A. BUILDING _____ B. WING _____	04/06/2022

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LIFE CARE CENTER OF KANSAS CITY	3231 N 61ST STREET KANSAS CITY, KS 66104

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00170661 and #KS00170629. The 2567 was sent electronically on 04/20/22.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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

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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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 53 residents. Based on observation, record review, and interview, the facility failed to ensure that resident's rights and dignity were respected by staff when Resident (R)6 was not offered to eat in the dining room at meals, and staff failed to provide drinks and meals to all residents at the table when meals were served to R17, R205, and five unidentified resident at the table; staff placed clothing protectors on residents from behind without asking the resident if they wanted one; and staff failed to provide privacy while providing cares for R21, which left these residents at risk for decreased self-esteem and decreased self-worth.

Findings included:

- On 04/04/22 at 09:37 AM R6 stated that she had to eat her meals in her room and not been offered the option to eat in the dining room.

On 04/05 at 08:09 AM R17 sat in Broda chair (a wheelchair that provides assistance with tilt-in-space positioning and chair functionality to people who sit all day) at a table in the commons area when he reached for an unidentified

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residents drink on the table during breakfast. R17 had not been offered anything to drink R17 had been seated at the table since 07:45 AM and repeatedly asked staff for coffee.

On 04/05/22 at 08:25 AM an unidentified staff member placed a clothing protector on two unidentified residents without asking the residents if they wanted one. The unidentified staff member also served one resident at the table their breakfast tray without speaking to the resident, then pushed the cart with the meal trays down the hallway.

On 04/05/22 at 08:25 AM R205 was agitated and stated he was starving, and an unidentified staff member told him he had to wait.

On 04/05/22 at 08:37 AM an unidentified staff member delivered meals trays to three other unidentified residents at a table in the commons area and did not speak to any of the residents while giving them their food off of the trays; the staff member then walked away.

On 04/05/22 at 08:37 AM R205 was given his morning medications while he sat at the table in the commons area during breakfast.

On 04/05/22 at 08:43 AM an unidentified dietary staff member delivered another cart with meal trays on it. R17's tray was given to him and there was no silverware or sugar on the tray. R205 asked for coffee and was not given any.

On 04/06/22 at 01:56 PM Certified Nurse Aide (CNA) N and CNA O provided peri-care (cleaning of the private area) to R21. Administrative Nurse F knocked on the room door and entered the

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room, the privacy curtain had not been pulled over, so R21's bare buttocks could be seen from the hallway.

On 04/06/22 at 02:39 PM CNA M stated that the residents had been eating in their rooms due to the COVID (highly contagious potentially life-threatening respiratory infection) outbreak and after that most of the residents chose to stay in their rooms to eat. She further stated, there was a few residents on the north hall that would come down to eat in the commons area to eat.

On 04/06/22 at 03:35 PM Licensed Nurse (LN) G stated that during COVID the residents had to eat in their rooms. She had worked at the facility for about two months and there had not been anyone in the building that has had COVID during those two months. She stated some of the residents had voiced that they wanted to go eat in the main dining room.

On 04/06/22 at 04:51 PM Administrative Nurse F stated that during COVID the residents were all eating in their rooms. Since then, some come out on the north hall to the commons area to eat. Some of the residents still chose to eat in their room but all residents have been offered to eat in the dining room.

On 04/06/22 at 06:30 PM Administrative Nurse D stated that a lot of the residents eat in their rooms and a few might go out to the north dining room or to the commons area on both sides of the facility. Administrative Nurse D further stated that it was the resident's preference where they chose to eat. All residents had been offered the option to eat in the dining rooms. Administrative Nurse D was not sure when a resident was asked about

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F 550	Continued From page 4 their dining preference but said that the dietary supervisor asked those questions. Administrative Nurse D also stated that residents had in recent months brought up in Resident Council meetings that they wanted to eat in the dining rooms again. The facility policy "Resident Rights" last revised 11/28/16 documented: the resident had the right to a dignified existence; the resident had the right to exercise his/her right s as a resident of the facility; the resident had the right to be treated with respect and dignity; the resident had the right to reside and receive services in the facility with reasonable accommodation of the resident and preferences except when to do so would endanger the health or safety of other residents; and the resident had the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care. The facility failed to ensure that resident's rights and dignity were respected when residents had to eat in their rooms instead of the dining room and failed to provide drinks and meal trays to all residents while the residents were seated at a table during meal times, failed to acknowledge resident requests during meal times, failed to obtain resident permission prior to placing clothing protectors, failed to interact with the residents in a positive manner, and failed to provide privacy to a resident while cares were provided to a residents, which left those residents at risk for decreased self-esteem and decreased self-worth.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		

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§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.
This REQUIREMENT is not met as evidenced by:
The facility identified at census of 53 residents. The sample included 16 residents. One resident was sampled for reasonable accommodations of resident needs and preferences. Based on observation, record review, and interview, the facility failed to ensure that resident (R)13's call light was within reach and able to call for assistance with personal cares. This deficient practice left R13 vulnerable for not receiving proper cares/assistance in a timely manner.

Findings included:

- R13's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbances and cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) left lower limb.

The "Admission Minimum Data Set" (MDS) dated 01/14/22 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R13 required extensive assistance of one person for all activities of daily living (ADLs) except eating, for which she was independent. R13 required assistance of one staff member for bathing. R13 had no behaviors. The MDS recorded R13

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received an antipsychotic (medication used to treat psychosis), diuretic (medication used to promote excretion of fluids) and opioids (medications use to treat pain) during the lookback period.

R13's "Cognitive Loss Care Area Assessment" (CAA) dated 01/20/22 documented staff encouraged her to use the call light for assistance with ADL's. R13 received routine antipsychotic medication, staff monitored for adverse reactions and for changes in R13 mood or behaviors.

R13's "Care Plan" dated 01/10/22 documented staff should allow extra time for her to respond to questions or instructions. The "Care Plan" lacked documentation for person centered dementia care.

On 04/05/22 at 08:23 AM R13 laid in the bed, yelled out help, that she must go to the bathroom. R13's roommate asked her to stop yelling. R13 started to cuss at R44 and threatened to slap her roommate across the face. R13's call light was located on the floor behind the bed under a blanket and pillow, out of reach.

On 04/06/22 at 07:20 AM R13 laid on the bed. R13's, call light was out of reach, on the floor.

On 04/06/22 at 02:35 PM in an interview, Certified Nurse's Aide (CNA) M stated a call light should always be in reach of the resident to call for assistance.

On 04/06/22 at 03:35 PM in an interview, Licensed Nurse (LN) G stated the call light should be within reach of the resident when in their room.

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F 558	Continued From page 7 On 04/04/22 at 04:20 PM in an interview, Administrative Nurse E stated, stated a resident's call light should always be in reach when in their room alone. The facility policy "Resident Rights" last revised 11/28/16 documented: the resident had the right to a dignified existence; the resident had the right to exercise his/her rights as a resident of the facility; the resident had the right to be treated with respect and dignity; the resident had the right to reside and receive services in the facility with reasonable accommodation of the resident and preferences except when to do so would endanger the health or safety of other residents; and the resident had the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care. The facility failed to ensure that R13's call light was within reach and call for assistance with ADL's. This placed R13 vulnerable not to receive the treatment and services to attain and/or maintain her practicable physical, mental and psychosocial well-being.	F 558		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		

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§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 53. The sample included 16 residents. Based on interview and record review, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASRR) for Individuals with Mental disorders and Individuals with Intellectual Disability was completed for Resident (R) 42. This placed the resident at risk for decreased or inadequate care and services related to his mental health diagnoses and intellectual disabilities.

Findings include:

- R42's Electronic Medical Record (EMR) recorded diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), epilepsy (brain disorder characterized by repeated seizures), obsessive-compulsive disorder (OCD - anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning),

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anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), mild intellectual disabilities, and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

The "Significant Change Minimum Data Set" (MDS) dated 12/06/22 recorded R42 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS recorded R42 was independent with no set up to supervision for most activities for daily living (ADLs), and limited assistance of one staff for personal hygiene. R42 rejected cares during the look back period but had no wandering behaviors.

The "Quarterly MDS" dated 03/02/22 recorded R42 had a BIMS of nine which indicated moderately impaired cognition. The MDS recorded R42 required supervision with set-up assistance for all ADLs. He rejected cares during the look back period but had no wandering behaviors.

The "Behavior Care Area Assessment" (CAA) dated 12/06/22 recorded R42 had behavior symptoms of rejection of care. Staff encouraged as much participation as possible during care activities.

R42's clinical record, including EMR and paper chart, lacked evidence a PASRR was completed prior to admission or within a practicable amount of time after admission during the Coronavirus (highly contagious respiratory virus which created a national pandemic) blanket waivers. The record lacked evidence of an initial Level I and/or Level II

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F 644	Continued From page 10 assessment. On 04/06/22 at 05:25 PM Administrative Nurse D stated the former social worker handled all the CARE/PASRR assessments and kept them in a file in her office. Administrative Nurse D stated she reviewed the files stored in the former social workers office and was unable to find any evidence or record regarding a PASRR for R42. She indicated she did not know much about the PASRR process. Administrative Nurse D stated the facility did not currently have a social worker and she was unsure who oversaw ensuring the PASRR assessments were completed as required. The facility did not provide a policy on the PASRR process. The facility failed to ensure R42 received a PASRR screen. This placed the resident at risk for decreased or inadequate care and services related to his mental health diagnoses and intellectual disabilities.	F 644		
F 656 SS=E	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 -	F 656		

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(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 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 identified at census of 53 residents. The sample included 16 residents with 16 residents was reviewed for comprehensive care planning. Based on observation, record review, and interview, the facility failed to implement comprehensive care plans for Residents (R)30, R44, R49, R13, and R205. This deficient practice placed the residents at risk for not receiving

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proper cares/assistance in a timely manner.

-The electronic medical record (EMR) indicated the following diagnosis for R30: muscle weakness, major depressive disorder (major mood disorder). hypertensive heart disease (chronic high blood pressure), insomnia (difficulty falling asleep), traumatic brain injury (TBI), constipation, and abnormalities of gait and coordination.

A review of R30's "Admission Minimum Data Set (MDS)" completed 02/17/22 indicated a Brief Interview for Mental Status (BIMS) score of seven indicating intact cognition. The MDS revealed she was occasionally incontinent of bowel and bladder with no toileting program

A review of R30's "Activities of Daily Living (ADL's) Care Area Assessment (CAA)" dated 02/17/22 indicated that her urinary incontinence would be addressed in her care plan. The CAA indicated that she felt urgency to void at times.

A review of R30's "Care Plan" revised 03/11/22 lacked documentation related to her bowel and bladder incontinence.

A review of R30's "Lookback report" under "Bowel and Bladder Elimination" between 02/10/22 and 04/05/22 indicated that she had incontinent episodes on 12 occasions.

A review of R30's assessment revealed no documentation showing incontinence assessment tool completed in the resident's chart.
In an interview completed on 04/05/22 at 02:22 PM with R30, she stated that she does have incontinence issues but reported them to the

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nursing staff. She reported that she is not sure if a special bowel program was started.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that staff can review the resident's care to see who has special precautions related to toileting and assisting residents to the restroom. She stated that she doesn't know if R30 has a special bowel program. She stated that if something was missing or not in the care plan it would be reported to the nurse.

In an interview completed on 04/06/22 at 02:20PM with Licensed Nurse (LN), she stated that the nursing staff review resident's care plans and updates the other staff member of changes that occur. She reported that if a resident was on a special bowel program it would in the care plan.

In an interview completed on 04/06/22 at 04:20PM with Administrative Nurse E, she stated that when residents first arrive a base line care plan with be completed and a comprehensive assessment with occur after the care plan has been established. She reported areas triggered on the MDS should be placed in the care plan and addressed on the comprehensive care plan.

A review of the facility's "Urinary Incontinence Management" revised 04/2022 stated that the facility must ensure that resident's receive services and assistance to remain continent of bowel and bladder. The policy stated that each resident who is incontinent of bladder will be identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible.

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A review of the facility's "Care Plan Policy" revised 10/2019 stated that the care plan identified and included a focus statement, measurable goals, interventions of identified problems. The policy indicated that the care plan must include identified issues from the resident's comprehensive assessment, CAA, and MDS.

The facility failed to develop care plan interventions related to R30's urinary and bowel incontinence. The deficient practices placed her at risk for complications related to incontinence care.

-The electronic medical record (EMR) indicated the following diagnosis for R44: hypertension (high blood pressure), cerebrovascular disease (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (left sided paralysis of one side of the body), dysphagia (swallowing difficulty), and muscle weakness.

A review of R44's "Quarterly Minimum Data Set (MDS)" completed 03/10/22 indicated a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS indicated that she was frequently incontinent of urine and occasionally incontinent of bowel with no toileting program in place. Her MDS revealed she required extensive assistance from one staff member for transferring, dressing, bathing, personal hygiene, and toileting.

A review of R44's "Urinary Incontinence CAA" dated 12/09/21 stated that staff were to provide routine checks and assistance with incontinence cares as needed.

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R44's "Care Plan" revised 12/03/21 stated that staff were to provide routine incontinence checks and provide cares when needed but failed to provided interventions related to improving or preventing incontinence episodes.

A review of R44's EMR under "Assessments" indicated on two occasions (03/02/22 and 12/02/22) that she was a candidate for toileting program, but lacked documentation sit was implemented.

A review of R44's "Lookback report" under "Bowel and Bladder Elimination" between 01/01/22 and 04/05/22 indicated that she had incontinent episodes on 63 occasions.

On 04/04/22 at 08:35AM R44 reported that she has had bowel and bladder accidents waiting for staff to respond to the call lights. She reported that she does have problems with incontinence but does not remember if she had any special programs for it.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that staff can review the resident's care to see who has special precautions related to toileting and assisting residents to the restroom. She stated that she doesn't know if R44 has a special bowel program. She stated that if something was missing or not in the care plan it would be reported to the nurse.

In an interview completed on 04/06/22 at 02:20PM with Licensed Nurse (LN), she stated that the nursing staff review resident's care plans and updates the other staff member of changes

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that occur. She reported that if a resident was on a special bowel program it would in the care plan.

In an interview completed on 04/06/22 at 04:20PM with Administrative Nurse E, she stated that when residents first arrive a base line care plan with be completed and a comprehensive assessment with occur after the care plan has been established. She reported areas triggered on the MDS should be placed in the care plan and addressed on the comprehensive care plan.

A review of the facility's "Urinary Incontinence Management" revised 04/2022 stated that the facility must ensure that resident's receive services and assistance to remain continent of bowel and bladder. The policy stated that each resident who is incontinent of bladder will be identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible.

A review of the facility's "Care Plan Policy" revised 10/2019 stated that the care plan identified and included a focus statement, measurable goals, interventions of identified problems. The policy indicated that the care plan must include identified issues from the resident's comprehensive assessment, CAA, and MDS.

The facility failed to develop care plan interventions related to R44's urinary and bowel incontinence. The deficient practices placed her at risk for complications related to incontinence care.

-The electronic medical record (EMR) indicated the following diagnosis for R49: chronic obstructive pulmonary disorder (COPD-

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progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) hypertension (high blood pressure), bipolar disorder, major depressive disorder (major mood disorder), type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), acute respiratory failure, hypoxia (inadequate supply of oxygen), dysphagia, lack of coordination, and insomnia (inadequate supply of oxygen).

A review of R49's "Significant Change Minimum Data Set (MDS)" completed 03/02/22 indicated a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated he received oxygen therapy while a resident and he required extensive assist from staff for toileting, personal hygiene, transfers, and bed mobility.

A review of R49's " Activities of Daily Living (ADL's) Care Area Assessment" completed on 03/02/22 indicated he required extensive assistance for his ADL's and had a history of being verbally aggressive with staff with cares provided.

A review of R49's 'Care Plan" revised 04/04/22 indicated that he had asthma and COPD but failed to include oxygen therapy treatment, goals, and interventions.

R49's "Medication Administration Report (MAR)" in the EMR revealed an active physicians order dated 01/25/22 to give six liters of oxygen delivered by nasal canula (tubing that delivers oxygen directly through both nostrils of the nose) while resident is out of bed and three liters of

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oxygen while he is in bed. The physician's order revealed that the oxygen tubing should be changed every Sunday evening.

On 04/04/22 at 08:12 AM R49 reported that he never uses his oxygen and often refuses when staff asks him to wear his nasal cannula. An inspection of his oxygen machine revealed the outside of the machine had collected dust and no storage bag was present for the oxygen tubing. The nasal cannula and oxygen tubing rested on the ground behind the machine. The tubing and cannula appeared dirty and visibly soiled. An inspection of the machine revealed it was dated 03/20/22 and expired two weeks ago. An inspection of his wheelchair's portable oxygen tank revealed no date on his oxygen tubing.

On 04/06/22 at 07:39 AM a walkthrough of R49's room revealed his oxygen therapy tubing and nasal canula still had not been changed. R49's tubing and nasal canula were sitting on top of his dusty machine with no storage bag present. R49's oxygen machine was on and running but not being used by the resident.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she reported that nasal cannulas and oxygen tubing should be dated and stored in a plastic bag when not in use. She stated that the tubing gets changed out weekly. She stated that the tubing or nasal cannula should be replaced if contaminated. CNA M stated that staff are to make sure that the residents are using their oxygen machines but are not responsible for cleaning them.

In an interview completed on 04/06/22 at 04:15

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PM with Administrative Nurse F, she stated that the oxygen machines are cleaned by the maintenance department. She reported that the tubing should be changed out every Sunday night and staff should be storing the nasal canula and tubing in a plastic bed when not in use.

A review of the facility's "Care Plan Policy" revised 10/2019 stated that the care plan identified and included a focus statement, measurable goals, interventions of identified problems. The policy indicated that the care plan must include identified issues from the resident's comprehensive assessment, CAA, and MDS.

The facility failed to develop care plan interventions related to R49's oxygen therapy. This deficient practice placed him at risk for complications related to breathing treatments.
- R13's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbances and cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) left lower limb.

The "Admission Minimum Data Set" (MDS) dated 01/14/22 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R13 required extensive assistance of one person for all activities of daily living (ADLs) except eating, for which she was independent. R13 required assistance of one staff member for bathing. R13 had no behaviors. The MDS recorded R13 received an antipsychotic (medication used to treat psychosis), diuretic (medication used to

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promote excretion of fluids) and opioids (medications use to treat pain) during the lookback period.

R13's "Cognitive Loss Care Area Assessment" (CAA) dated 01/20/22 documented staff encouraged her to use the call light for assistance with ADL's. R13 received routine antipsychotic medication, staff monitored for adverse reactions and for changes in R13 mood or behaviors.

R13's "Care Plan" dated 01/10/22 documented staff should allow extra time for her to respond to questions or instructions. The "Care Plan" lacked documentation for person centered dementia care.

On 04/03/22 at 10:15 AM R13 refused to be interviewed by the surveyor. R13 appeared agitated and did not want to anyone to approach her due to being upset.

On 04/05/22 at 07:22 AM R13 laid on her bed and watched TV. No behaviors of distress noted at this time.

On 04/05/22 at 08:23 AM R13 laid in the bed, yelled out help, that she must go to the bathroom. R13's roommate asked her to stop yelling. R13 started to cuss at the roommate and threatened to slap her roommate across the face. R13's call light was located on the floor behind the bed under a blanket and pillow.

On 04/05/22 at 12:20 PM 13 asleep in bed. No behaviors or distress noted.

On 04/06/22 at 07:20 AM R13 laid on the bed, her head turned toward the wall. R13 appeared calm,

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call light on the floor.

On 04/06/22 at 02:35 PM in an interview, Certified Nurse's Aide (CNA) M stated she was able to review the care plans and that was where to find the instructions for the care of each of the resident. CNA M the care plan would have any specialized care listed each resident. CNA M stated she had not received any dementia training at the facility. CNA M stated that she would report any behaviors to the nurse and documented behaviors in the EMR.

On 04/06/22 at 03:35 PM in an interview, Licensed Nurse (LN) G stated nursing staff review resident's care plans and updates the other staff member of changes that occur. LN G stated behavioral monitoring was completed on any one that received an antipsychotic medication, which was completed by the charge nurse on the "Medication Administration Record" (MAR). LN G stated the call light should be within reach of the resident when in their room.

On 04/04/22 at 04:20 PM in an interview, Administrative Nurse E stated, she stated that when residents first arrive a base line care plan would be completed and a comprehensive assessment with occur after the care plan has been established. Administrative Nurse E reported areas triggered on the MDS should be placed in the care plan and addressed on the comprehensive care plan.

The facility's "Care Plan" policy revised 10/2019 documented that the care plan identified and included a focus statement, measurable goals, interventions of identified problems. The policy indicated that the care plan must include

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identified issues from the resident's comprehensive assessment, CAA, and MDS.

The facility failed to develop a person-centered care plan for R13 related to dementia treatment and services to attain and/or maintain her practicable physical, mental and psychosocial well-being. This deficient practice placed her at risk of increased confusion, isolation, and lack of appropriate activities and interaction.
- R205 admitted to facility on 01/07/22.

The "Diagnoses" tab of R205's Electronic Medical Record (EMR) documented diagnoses of anoxic brain injury (condition caused by a complete lack of oxygen to the brain), need for assistance with personal care, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and history of falling.

The "Admission Minimum Data Set (MDS)" dated 01/14/22, documented a Brief Interview for Mental Status (BIMS) was not completed due to R205 rarely/never understood. R205 required extensive physical assistance with two staff for bed mobility and dressing; total physical dependence with one staff for eating and personal hygiene; total physical dependence with two staff for toileting and transfers. R205 considered the following activities somewhat important to him: have books, newspapers, and magazines to read, listen to music, be around animals such as pets, keep up with the news, do things with groups of people, do favorite activities, go outside to get fresh area when weather is good, and participate in religious services or practices.

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The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 01/17/22 documented R205 had cognition loss related to short- and long-term memory loss.

R205's medical record lacked evidence of a person-centered activity care plan.

The "Assessments" tab of R205's EMR lacked evidence of an activity assessment which documented the resident's current and/or past preferences, interests and hobbies.

R205's medical record lacked evidence of activity participation.

On 04/05/22 at 11:46 AM, R205 sat in his Broda chair at table in day room, he attempted to talk to staff walking past him, but they did not acknowledge hearing him. No observations of activities being performed or offered.

On 04/05/22 at 01:51 PM, R205 laid in bed, bed had bolsters on the side to prevent falling out of bed, fall mats were on both sides of the bed. R205 appeared restless, staff were in room.

On 04/06/22 at 09:18 AM, R205 sat in his Broda chair at table in day room, he attempted to talk to anyone who passed by him but only one staff member stopped to talk to him. He appeared to want to converse with anyone. No observations of activities being performed or offered.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CNA) R stated she sometimes helped out with activities and the facility had been providing activities. She stated R205 was usually in the day

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F 656	Continued From page 24 room and he liked to talk a lot. On 04/06/22 at 04:08 PM, Administrative Nurse E stated she, the Director of Nursing, and another nurse were responsible for updating the care plan. She stated she completed quarterly activity assessments with the MDS currently. On 04/06/22 at 05:22 PM, Administrative Nurse D stated the floor nurses completed a baseline care plan on admission and if any area was missed then it was corrected with the MDS then on the care plan. The facility's "Area of Focus: Care Planning-Baseline, Comprehensive, and Routine Updates" policy, not dated, directed the comprehensive care plan was completed within seven days of the CAAs, the care plan was updated with each MDS assessment and periodically. The facility failed to complete and implement a person-centered activity care plan for R205. This deficient practice had the risk miscommunication among staff, missed opportunities for activities, and a decline in physical, mental, and psychosocial well-being and independence for R205.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents.	F 677		

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The sample included 16 residents with 11 reviewed for bathing. Based on observations, record reviews, and interviews, the facility failed to provide consistent bathing per the residents' preferences and bathing schedules for Residents (R) 30, R44, R49, R225, R6, R17, R27, R39 and R45. This deficient practice placed the residents at risk for poor hygiene and impaired psychosocial well-being.

Findings Included:

-The electronic medical record (EMR) indicated the following diagnosis for R30: muscle weakness, major depressive disorder (major mood disorder). hypertensive heart disease (chronic high blood pressure), insomnia (difficulty falling asleep), traumatic brain injury (TBI), constipation, and abnormalities of gait and coordination.

A review of R30's "Admission Minimum Data Set (MDS)" completed 02/17/22 indicated a Brief Interview for Mental Status (BIMS) score of seven indicating intact cognition. The MDS reported that supervision and touch assistance were required for her bathing upon admission.

A review of R30's "Activities of Daily Living (ADL's) Care Area Assessment (CAA)" dated 02/17/22 indicated she requires assistance with ADL's and reported that here needs will be reported on her care plan.

A review of R30's "Care Plan" revised 03/11/22 lacked documentation related to her activities of daily living and if R30 required assistance to complete her ADL's.

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A review of R30's "Bathing Look Back" report from 02/10/22 to 04/05/22 revealed she had received bathing on four occasions (2/18, 2/23, 3/4, and 3/25). The clinical record lacked evidence of further bathing attempts or refusals.

On 04/04/22 at 08:30 AM R30 observed in her room watching television. She appeared well groomed and getting ready for breakfast. She appeared to be in a good mood. She reported no pain or concerns at the time of interview.

In an interview completed on 04/05/22 at 02:22 PM with R30, she stated that staff often are slow to respond to resident's request. R30 reported a recent fall and is aware that she had struggled with transfers and balance while completing her ADL's. R30 appeared clean and well groomed at time of interview.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that residents are to receive two bathes per week. She reported that the CNA staff can log into the EMR system using tablets and document when a resident has received a bath or refused.

In an interview completed on 04/06/22 at 02:20PM with Licensed Nurse (LN) G, she stated that the nursing staff will assist with bathing residents based on the care plan and personal preferences of the residents. She stated that all bathing and refusal are documented in the resident's care log.

A review of the facility's "Activities of Daily Livings" reviewed 02/2019 stated the resident will receive assistance as needed to complete activities of daily living. The policy stated that the

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facility must provided basic cares including hygiene, bathing, grooming, and oral care and any resident unable to carry out their ADL's will receive the necessary services to maintain good nutrition, grooming, and personal hygiene.

The facility failed to provide consistent bathing per the residents' preferences and bathing schedules for R30. This practice placed the resident at risk for poor hygiene and impaired psychosocial well-being.

-The electronic medical record (EMR) indicated the following diagnosis for R44: hypertension (high blood pressure), cerebrovascular disease (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (left sided paralysis of one side of the body), dysphagia (swallowing difficulty), and muscle weakness.

A review of R44's "Quarterly Minimum Data Set (MDS)" completed 03/10/22 indicated a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS indicated she required extensive assistance from one staff member for transferring, dressing, bathing, personal hygiene, and toileting.

A review of R44's "Activities of Daily Living (ADL'S) Care Area Assessment (CAA)" dated 12/09/21 stated she had an ADL functional impairment related to her existing medical conditions and that she required extensive assistance for all ADL's and transfer from at least one staff member.

R44's "Care Plan" revised 03/14/22 stated that

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she has an ADL self-care deficit related to her medical conditions and she is a total assist by staff for bathing. The care plan stated that she is to receive two bathing opportunities weekly and as needed.

A review of R44's "Bathing Look Back" report from 01/01/22 to 04/05/22 revealed she had received bathing on six occasions (1/13, 1/27, 2/4, 2/24, 3/22, and 3/31). The clinical record lacked evidence of further bathing attempts or refusals.

In an interview on 04/05/22 at 08:40 AM R44 reported that staff do give her baths but sometimes not twice a week. She reported that she did receive a bath this week. R44 appeared clean and well-groomed at the time of interview.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that residents are to receive two bathes per week. She reported that the CNA staff can log into the EMR system using tablets and document when a resident has received a bath or refused.

In an interview completed on 04/06/22 at 02:20PM with Licensed Nurse (LN) G, she stated that the nursing staff will assist with bathing residents based on the care plan and personal preferences of the residents. She stated that all bathing and refusal are documented in the resident's care log.

A review of the facility's "Activities of Daily Livings" reviewed 02/2019 stated the resident will receive assistance as needed to complete activities of daily living. The policy stated that the facility must provide basic cares including

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hygiene, bathing, grooming, and oral care and any resident unable to carry out their ADL's will receive the necessary services to maintain good nutrition, grooming, and personal hygiene.

The facility failed to provide consistent bathing per the residents' preferences and bathing schedules for R44. This practice placed the resident at risk for poor hygiene and impaired psychosocial well-being.

-The electronic medical record (EMR) indicated the following diagnosis for R49: chronic obstructive pulmonary disorder (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing)hypertension (high blood pressure), bipolar disorder, major depressive disorder (major mood disorder), type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), acute respiratory failure, hypoxia (inadequate supply of oxygen), dysphagia, lack of coordination, and insomnia (inadequate supply of oxygen).

A review of R49's "Significant Change Minimum Data Set (MDS)" completed 03/02/22 indicated a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated he received oxygen therapy while a resident and he required extensive assist from staff for toileting, personal hygiene, transfers, and bed mobility.

A review of R49's " Activities of Daily Living (ADL's) Care Area Assessment" completed on 03/02/22 indicated he required extensive assistance for his ADL's and had a history of

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being verbally aggressive with staff with cares provided.

A review of R49's 'Care Plan" revised 04/04/22 indicated that he has an ADL self-care deficit related to his medical diagnosis. The plan indicated that staff should provide a sponge bath when a full bath cannot be tolerated, and he prefers having two baths each week in the evenings.

A review of R49's "Bathing Look Back" report from 01/13/22 to 04/05/22 (82 days reviewed) revealed he had received bathing on 13 occasions (1/26, 1/27, 2/2, 2/7, 2/8, 2/12, 2/20, 2/24, 3/1, 3/7, 3/8, 3/21,and 3/28). The clinical record lacked evidence of further bathing attempts or refusals.

On 04/05/22 at 08:12 AM R49 reported that he has refused bathing in the past but not always. He stated he had not received his bath for the week yet. The resident's hair appeared combed but greasy. The resident remained in bed most of the morning asleep.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that residents are to receive two bathes per week. She reported that the CNA staff can log into the EMR system using tablets and document when a resident has received a bath or refused. She stated that R49 has had a history of refusing cares offered by staff.

In an interview completed on 04/06/22 at 02:20PM with Licensed Nurse (LN) G, she stated that the nursing staff will assist with bathing residents based on the care plan and personal

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preferences of the residents. She stated that all bathing and refusal are documented in the resident's care log.

A review of the facility's "Activities of Daily Livings" reviewed 02/2019 stated the resident will receive assistance as needed to complete activities of daily living. The policy stated that the facility must provide basic cares including hygiene, bathing, grooming, and oral care and any resident unable to carry out their ADL's will receive the necessary services to maintain good nutrition, grooming, and personal hygiene.

The facility failed to provide consistent bathing per the residents' preferences and bathing schedules for R49. This practice placed the resident at risk for poor hygiene and impaired psychosocial well-being.

- The electronic medical record (EMR) indicated the following diagnosis for R225: metabolic encephalopathy (inflammatory condition of the brain), type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia (swallowing difficulty), insomnia (inability to sleep), urinary retention (lack of ability to urinate and empty the bladder), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) , and constipation.

A review of R225s "Admission Minimum Data Set (MDS)" completed 03/21/22 indicated a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated total dependence for staff related to hygiene, transfers, bathing, toileting, personal

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cares, and eating.

A review of R225's "Activities of Daily Living (ADL's) Care Area Assessment" (CAA) dated 03/21/22 stated she had worked to regain current level of functioning after being recently hospitalized from a fall before her admission.

R225's "Care Plan" revised 03/18/2022 noted that she had an ADL self-care deficit related to activity intolerance. The care plan stated that she was dependent on staff assist for all ADL's and encouraged to use her call light for assistance. The care plan indicated that she prefers to shower two times per week and as needed.

A review of R225's "Bathing Look Back" report from 03/14/22 to 04/05/22 (22 days reviewed) revealed she had received bathing on two occasions (3/18 and 3/25). The clinical record lacked evidence of further bathing attempts or refusals.

On 04/04/22 at 12:40 PM R225 observed sitting in her room watching television. The resident appeared to be engaged in her television show. R225 reported that she has received bathing since her admission but not this week. She reported that she prefers to yell out to staff instead of using her call light because staff respond more quickly.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that residents are to receive two bathes per week. She reported that the CNA staff can log into the EMR system using tablets and document when a resident has received a bath or refused. She stated that R225 has a history of refusing cares

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offered by staff.

In an interview completed on 04/06/22 at 02:20PM with Licensed Nurse (LN) G, she stated that the nursing staff will assist with bathing residents based on the care plan and personal preferences of the residents. She stated that all bathing and refusal are documented in the resident's care log.

A review of the facility's "Activities of Daily Livings" reviewed 02/2019 stated the resident will receive assistance as needed to complete activities of daily living. The policy stated that the facility must provide basic cares including hygiene, bathing, grooming, and oral care and any resident unable to carry out their ADL's will receive the necessary services to maintain good nutrition, grooming, and personal hygiene.

The facility failed to provide consistent bathing per the residents' preferences and bathing schedules for R225. This practice placed the resident at risk for poor hygiene and impaired psychosocial well-being.
- R6's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of chronic respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide and the lungs are unable to carry the blood to the organs), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and bipolar (major mental illness that caused people to have episodes of severe high and low moods) mood disorder.

The "Significant Change Minimum Data Set"

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(MDS) dated 10/15/21 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R6 required limited assistance of one staff member for activities of daily living (ADL's). The MDS documented R6 required physical help of one staff member for set up or assistance as part of the bathing activity during the look back period. The MDS documented R6 received oxygen therapy during the look back period.

The "Quarterly MDS" dated 01/05/22 documented no changes documented from previous MDS assessment.

R6's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 10/25/21 documented she has required limited assist by staff for bathing/showers.

R6's "Care Plan" last revised 03/04/21 documented she required maximum assistance and a lot of encouragement from staff with her bath/showers twice weekly during the evening and as needed.

Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed from 01/01/22 to 04/04/22 (94 days) revealed R6 received two baths/showers (02/28/22 and 03/16/22). The "Bathing" task was documented "Activity Did Not Occur" 32 occasions on the following dates: 01/03/22, 01/04/22, 01/06/22, 01/13/22, 01/24/22, 01/27/22, 01/31/22, 02/01/22, 02/03/22, 02/04/22, 02/07/22, 02/08/22, 02/10/22, 02/14/22, 02/17/22, 02/21/22, 02/24/22, 03/02/22, 03/03/22, 03/07/22, 03/10/22, 03/14/22, 03/17/22, 03/19/22, 03/20/22, 03/21/22, 03/23/22, 03/24/22,

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03/28/22, 03/31/22, 04/01/22 and 04/04/22. The clinical record lacked evidence of resident refusal for bathing.

On 04/06/22 at 11:25 AM R6 pushed her wheelchair down the south hallway as she talked to the hospice staff. R6's hair was uncombed, and her clothes were clean.

On 04/06/22 at 02:35 PM in an interview, Certified Nurses Aide (CNA) M stated residents received a bath/shower at; east two times weekly, which was documented bath/shower or the refusal in the EMR and on bath sheets. CNA M stated that when residents refused their bath/shower she would report the refusal to the charge nurse and she would wash the resident up and get them as clean as possible.

On 04/06/22 at 03:25 PM in an interview, Certified Medication Aide (CMA) R stated R6 refused her bath/shower frequently. CMA R stated hospice came to the facility weekly and bathed R6 but was not sure what days that occurred.

On 04/06/22 at 03:35 PM in an interview, Licensed Nurse (LN) G stated when a resident refused a bath/shower he/she would sign a bath sheet. LN G stated a progress note should be written indicating the refusal in the EMR. LN G stated R6 never refused her bath/shower.

On 04/06/22 at 05:35 PM in an interview, Administrative Nurse D stated residents have preferences for bath/showers, a list was developed to by room number and by resident's choices. Administrative Nurse D stated a resident could change their bath/shower time, CNA's charted the bath/shower in the EMR and on bath

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sheets. Administrative Nurse D stated R6 was on hospice services, which hospice staff came out to the facility at least two times weekly to bath/shower her. Administrative Nurse D stated the facility staff would bath R6 if she refused a bath from hospice but was insure where that documentation of hospice bathing was located.

The facility "Activities of Daily Living "policy last reviewed 04/22/19 documented the facility would identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. The policy documented for all ADL's the facility utilized "Lippincott Procedures" and provided a link to click.

The facility failed to ensure a shower/bath was provided for R6, who required assistance with ADL's, which had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing.

- R17's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of dementia without behaviors (progressive mental disorder characterized by failing memory, confusion) and muscle weakness.

The "Annual Minimum Data Set" (MDS) dated 09/27/21 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R17 was totally dependent on two staff members assistance for activities of daily living (ADL's). The MDS documented R17

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was totally dependent on one staff member for bathing and refused care four to six days during the look back period.

The "Quarterly MDS" dated 12/16.21 documented no changes documented from previous MDS assessment.

R17's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 10/04/21 documented he required total assistance of staff for bathing/showers and incontinence care.

,
R17's "Care Pan" last revised 12/20/21 documented he was totally dependent on staff to provide showers twice weekly on dayshift and as needed.

Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed from 01/01/22 to 04/04/22 (94 days) revealed R17 received ten baths/showers (01/04/22, 01/11/22, 02/01/22, 02/17/22, 03/10/22, 03/15/22, 03/16/22, 03/22/22, 03/24/22, and 03/29/22). The "Bathing" task was documented "Activity Did Not Occur" 20 occasions on the following dates: 01/13/22, 01/20/22, 01/25/22, 01/27/22, 02/01/22, 02/02/22, 02/07/22, 02/10/22, 02/24/22, 03/01/22, 03/02/22, 03/07/22, 03/14/22, 03/19/22, 03/20/22, 02/21/22, 03/22/22, 03/31/22, 04/01/22 and 04/04/22. The clinical record lacked evidence of resident refusal for bathing.

On 04/05/22 at 07:46 AM R17 sat in high back wheelchair with foot pedals intact at the table in the common area, waiting for a hot cup of coffee. R17's bilateral pressure reducing boots were on lower extremities.

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On 04/06/22 at 02:35 PM in an interview, Certified Nurse's Aide (CNA) M stated residents received a bath/shower at least two times weekly, which was documented bath/shower or the refusal in the EMR and on bath sheets. CNA M stated that when residents refused their bath/shower she would report the refusal to the charge nurse and she would wash the resident up and get them as clean as possible.

On 04/06/22 at 03:25 PM in an interview, Certified Medication Aide (CMA) R stated R17 never refused his bath/shower. CMA R stated hospice came to the facility weekly and bathed R17 but was not sure what days that occurred.

On 04/06/22 at 03:35 PM in an interview, Licensed Nurse (LN) G stated when a resident refused a bath/shower he/she would sign a bath sheet. LN G stated a progress note should be written indicating the refusal in the EMR. LN G stated R17 never refused his bath/shower.

On 04/06/22 at 05:35 PM in an interview, Administrative Nurse D stated residents have preferences for bath/showers, a list was developed to by room number and by resident's choices. Administrative Nurse D stated a resident could change their bath/shower time, CNA's charted the bath/shower in the EMR and on bath sheets. Administrative Nurse D stated R17 was on hospice services, which hospice staff came out to the facility at least two times weekly to bath/shower him. Administrative Nurse D stated the facility staff would bath R17 if he refused a bath from hospice but was insure where that documentation of hospice bathing was located.

The facility "Activities of Daily Living "policy last

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reviewed 04/22/19 documented the facility would identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. The policy documented for all ADL's the facility utilized "Lippincott Procedures" and provided a link to click.

The facility failed to ensure a shower/bath was provided for R17, who required total assistance with ADL's, which had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing.

- R27's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety(mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Annual Minimum Data Set" (MDS) dated 11/18/21 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R27 required extensive assistance of one to staff members for all activities of daily living (ADLs) except eating and locomotion for which she was independent. R27 required assistance of two staff members for bathing. The MDS recorded R27 rejected cares

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daily during the lookback period. The MDS recorded R27 was at risk for pressure injuries but had no pressure injuries. She had a pressure reducing device in her chair and bed but was not on a turning/repositioning program. R27 received an antipsychotic (medication used to treat psychosis), antidepressant (medication used to treat depression) and an antibiotic (medication used to treat bacterial infections) for seven days of the look back period. The MDS documented R27 required physical assistance of one staff member for bathing during look back period.

The "Quarterly MDS" dated 02/08/22 recorded R27 had a BIMS score of 12 which indicated moderately impaired cognition. The MDS recorded R27 required extensive assistance of one to staff members for all activities of daily living (ADLs) including locomotion and supervision of two staff for eating. R27 was totally dependent on one staff for bathing. R27 had verbal behavioral symptoms directed at other for one to three of the lookback days and rejected cares for four to six of the lookback days. The MDS recorded R27 was at risk for pressure injuries but had no pressure injuries. She had a pressure reducing device in her chair and bed but was not on a turning/repositioning program. R27 received an antipsychotic, antidepressant, antibiotic, anticoagulant (medication used to thin blood), insulin (hormone used to treat high blood glucose) and received injections during the lookback period. The MDS documented R27 was totally dependent of two or more staff for bathing activity during the look back period.

R27's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 11/22/21 documented she required extensive assistance of

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two staff members and a mechanical lift for all transfers. showers/bathing and toileting.

R27's "Care Plan" dated 03/04/21 documented she preferred a bath/shower twice weekly or provided a sponge bath when a full bath could not be tolerated.

R27's "Care Plan" dated 11/23/21 documented she required extensive assistance for shower/bath two times weekly and as needed or as desired.

Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed from 01/01/22 to 01/16/22 (16 days), reviewed from 02/01/22 to 03/26/22 (54 days) and reviewed from 03/29/22 to 04/04/22 (7 days) revealed R27 received four baths/showers (01/11/22, 02/03/22, 02/14/22, and 03/02/22) The "Bathing" task was documented "Activity Did Not Occur" 20 occasions on the following dates: 01/04/22, 01/13/22, 02/02/22, 02/04/22, 02/07/22, 02/08/22, 02/10/22, 02/17/22, 02/21/22, 02/28/22, 03/07/22, 03/10/22, 03/14/22, 03/17/22, 03/19/22, 02/20/22, 03/21/22, 03/31/22, 03/31/22 and 04/01/22. The clinical record lacked evidence of resident refusal for bathing.

On 04/05/22 at 07:44 AM R27 laid on her back in bed. R27 stated she was waiting for breakfast, no behaviors or distress noted. A low air loss mattress on the bed and R27 had a pressure reliving boot on left foot.

On 04/06/22 at 02:35 PM in an interview, Certified Nurse's Aide (CNA) M stated residents received a bath/shower at least two times weekly, which was documented bath/shower or the refusal in the

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EMR and on bath sheets. CNA M stated that when residents refused their bath/shower she would report the refusal to the charge nurse and she would wash the resident up and get them as clean as possible.

On 04/06/22 at 03:25 PM in an interview, Certified Medication Aide (CMA) R stated R27 could be talked into taking her bath/shower.

On 04/06/22 at 03:35 PM in an interview, Licensed Nurse (LN) G stated when a resident refused a bath/shower he/she would sign a bath sheet. LN G stated a progress note should be written indicating the refusal in the EMR. LN G stated R27 never refused her bath/shower.

On 04/06/22 at 05:35 PM in an interview, Administrative Nurse D stated residents have preferences for bath/showers, a list was developed to by room number and by resident's choices. Administrative Nurse D stated a resident could change their bath/shower time, CNA's charted the bath/shower in the EMR and on bath sheets. Administrative Nurse D stated R27 refused her shower/bath frequently and was offered alternates.

The facility "Activities of Daily Living "policy last reviewed 04/22/19 documented the facility would identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. The policy documented for all ADL's the facility utilized "Lippincott Procedures" and provided a link to click.

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The facility failed to ensure a shower/bath was provided for R27, who required total assistance with ADL's, which had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing.

- R39 admitted to facility on 03/02/22.

The "Diagnoses" tab of R39's Electronic Medical Record (EMR) documented diagnoses of bipolar (major mental illness that caused people to have episodes of severe high and low moods) disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, developmental disorder of scholastic skills, and history of falling.

The "Admission Minimum Data Set (MDS)" dated 03/09/22, documented R39 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. R39 was independent with bed mobility, transfers, walking, dressing toileting, and personal hygiene; independent with setup help for bathing.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 03/09/22, documented R39 had cognitive loss related to a BIMS score less than 13 and staff allowed extra time for R39 to respond to questions and instructions.

The "Care Plan" dated 03/14/22 documented R39 had potential to be verbally aggressive related to ineffective coping skills and developmental disorder and directed staff gave the resident as many choices as possible about his care and

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activities.

The "Care Plan" dated 03/02/22 documented R39 was a risk for falls and directed staff assisted him with activities of daily living (ADL) as needed. The care plan did not address how R39 performed ADLs or how much assistance he required.

The "Documentation Survey Report" for 03/02/22 to 03/31/22 documented a task for "ADL- bathing" as needed (PRN) and revealed R39 received a sponge bath on 03/14/22.

The "Documentation Survey Report" for 04/01/22 to 04/06/22 lacked a task for bathing.

The facility's "Shower Schedule" documented showers scheduled by room number. R39's showers were scheduled for evening shift on Tuesday and Thursdays.

On 04/05/22 at 01:58 PM, R39 ambulated independently in day room and poured himself a cup of water with staff supervision. He sat down in a chair in the day room to watch television. R39 wore a red shirt and jeans.

On 04/06/22 at 07:35 AM, R39 stood beside a table in the day room and conversed with another resident. He appeared to be wearing the same clothes as the previous day.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated bathing was completed by the CNAs and residents received bathing twice a week. The CNAs had a calendar they followed for who received baths that day and documented bathing on Point of Care (POC- EMR system for CNA documentation). If bathing was completed, it

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was documented in POC with type of bathing provided. If a resident refused bathing then she asked another aide to try then the nurse, refusals were documented as well. CNA M stated R39 refuses bathing and it was documented in POC.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) G stated CNAs completed bathing and let the nurse know if a resident received a shower or if they refused. If a resident refused bathing, she tried to get resident to take a bath, if they still refused then refusals get documented in a progress note. LN G stated the unit manager audited bathing. She stated R39 did not refuse to take showers and if they received a shower then it was documented in POC. If there was a blank in the bathing documentation then she questioned if they received bathing, it the documentation stated the activity did not occur then bathing did not happen.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated the shower schedule went by room numbers and the facility had a bath aide during the week. Bathing was documented in the shower book and in PCC which was the most important place for documentation. Administrative Nurse D stated showers were audited weekly, if it's documented as activity did not occur then bathing did not occur and if it was not documented then it did not occur. She stated R39 refused bathing and showers were still documented if the resident was independent with setup help.

The facility's "ADLs" policy, dated 12/11/18, directed the resident received assistance as needed to complete ADLs and any change in the ability to perform ADLs were documented and reported to licensed nurse.

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The "Bed baths and Showers" reference provided by facility, reviewed 06/14/19, directed tub baths and showers provided personal hygiene, stimulated circulation, and reduced tension for a patient and directed staff to document the procedure after completed.

The facility failed to provide consistent bathing for R39. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for R39.

- The "Diagnoses" tab of R45's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (major mood disorder) and psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing) with delusions due to known physiological condition.

The "Annual Minimum Data Set (MDS)" dated 06/29/21, documented R45 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. She required supervision with setup help only with toileting, bed mobility, transfers, walking, and eating; limited physical assistance with one staff for personal hygiene; bathing activity did not occur during the assessment period.

The "Quarterly MDS" dated 03/10/22, documented R45 had a BIMS score of 13 which indicated intact cognition. She was independent with no setup help with bed mobility, transfers, walking, locomotion, and personal hygiene; independent with setup help only for dressing and

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eating; and supervision with setup help only with toileting; and supervision with no setup help for bathing.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 07/12/21, documented R45 required supervision assistance with ADL function, risk included self-care deficit, care planned to minimize risks.

The "Care Plan" initiated 04/23/19, directed R45 had an ADL self-care performance deficit related to cognitive and behavior problems and directed she required setup and supervision by staff with bathing/showering twice weekly during the day and as necessary. R45 needed a lot of encouragement to bathe, staff needed to keep going back and asking her as she eventually would bathe.

The "Documentation Survey Report" for 01/01/22 to 04/06/22 documented a task for ADL bathing twice weekly and as needed (PRN). The "Documentation Survey Report" revealed the following bathing documentation: ADL activity itself did not occur on 01/03/22, 01/10/22, 01/20/22, 01/24/22, 01/27/22, 01/31/22, 02/03/22, 02/28/22, 03/03/22, 03/10/22, 03/24/22, and 04/04/22; lack of documentation on 01/06/22, 01/13/22, 01/17/22, 02/07/22, 02/10/22, 02/17/22, 02/21/22, 02/24/22, 03/14/22, 03/17/22, 03/21/22, and 03/31/22; received shower on 02/14/22, 03/07/22, and 03/28/22.

The "Shower Schedule" documented showers scheduled by room number. R45 was scheduled for showers on Monday and Wednesday day shift.

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On 04/06/22 at 09:18 AM, R45 ambulated independently in the hallway, no signs of distress or discomfort.

On 04/06/22 at 10:24 AM, R45 stated she did not receive bathing regular and she did not like that she stinks and wishes the facility would figure out why she smells.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated bathing was completed by the CNAs and residents received bathing twice a week. The CNAs had a calendar they followed for who received baths that day and documented bathing on Point of Care (POC- EMR system for CNA documentation). If bathing was completed, it was documented in POC with type of bathing provided. If a resident refused bathing then she asked another aide to try then the nurse, refusals were documented as well.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) stated R45 sometimes refused bathing.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) G stated CNAs completed bathing and let the nurse know if a resident received a shower or if they refused. If a resident refused bathing, she tried to get resident to take a bath, if they still refused then refusals get documented in a progress note. LN G stated the unit manager audited bathing. She stated R45 took her showers and if they received a shower then it was documented in POC. If there was a blank in the bathing documentation then she questioned if they received bathing, it the documentation stated the activity did not occur then bathing did not happen.

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F 677	Continued From page 49 On 04/06/22 at 05:22 PM, Administrative Nurse D stated the shower schedule went by room numbers and the facility had a bath aide during the week. Bathing was documented in the shower book and in PCC which was the most important place for documentation. Administrative Nurse D stated showers were audited weekly, if it's documented as activity did not occur then bathing did not occur and if it was not documented then it did not occur. She stated R45 refused bathing and showers were still documented if the resident was independent with setup help. The facility's "ADLs" policy, dated 12/11/18, directed the resident received assistance as needed to complete ADLs and any change in the ability to perform ADLs were documented and reported to licensed nurse. The "Bed baths and Showers" reference provided by facility, reviewed 06/14/19, directed tub baths and showers provided personal hygiene, stimulated circulation, and reduced tension for a patient and directed staff to document the procedure after completed. The facility failed to provide consistent bathing for R45. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for R45.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 679		

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program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 53 residents. The sample included 16 residents; three residents reviewed for activities. Based on observations, record reviews, and interviews, the facility failed to consistently provide activities for Resident (R) 205, R6, and R17. This deficient practice had the risk for a decline in physical, mental, and psychosocial well-being and independence.

Findings included:

- R205 admitted to facility on 01/07/22.

The "Diagnoses" tab of R205's Electronic Medical Record (EMR) documented diagnoses of anoxic brain injury (condition caused by a complete lack of oxygen to the brain), need for assistance with personal care, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and history of falling.

The "Admission Minimum Data Set (MDS)" dated 01/14/22, documented a Brief Interview for Mental Status (BIMS) was not completed due to R205 rarely/never understood. R205 required extensive physical assistance with two staff for bed mobility and dressing; total physical dependence with one staff for eating and

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personal hygiene; total physical dependence with two staff for toileting and transfers. R205 considered the following activities somewhat important to him: have books, newspapers, and magazines to read, listen to music, be around animals such as pets, keep up with the news, do things with groups of people, do favorite activities, go outside to get fresh area when weather is good, and participate in religious services or practices.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 01/17/22 documented R205 had cognition loss related to short and long term memory loss.

R205's medical record lacked evidence of a person-centered activity care plan.

The "Assessments" tab of R205's EMR lacked an activity assessment after admission or quarterly.

R205's medical record lacked evidence of activity participation.

On 04/04/22 at 08:54 AM, R205 sat in his Broda (specialized wheelchair with the ability to tilt and recline) chair in the day room, he wore a helmet to protect his head from injury. No observations of activities as being performed or offered.

On 04/04/22 at 04:15 PM, R205 sat in his Broda chair in the day room, helmet not on at that time. No observations of activities as being performed or offered.

On 04/05/22 at 08:21 PM, R205 sat in his Broda chair at a table in the day room, helmet not on at

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that time but was observed on the table. No observations of activities as being performed or offered.

On 04/05/22 at 11:40 AM, R205 sat in his Broda chair at table in day room, helmet not on at that time but was observed on the table. Staff conversed with resident and encouraged him to put helmet back on which he did.

On 04/05/22 at 11:46 AM, R205 sat in his Broda chair at table in day room, he attempted to talk to staff walking past him, but they did not acknowledge hearing him. No observations of activities being performed or offered.

On 04/05/22 at 01:51 PM, R205 laid in bed, bed had bolsters on the side to prevent falling out of bed, fall mats were on both sides of the bed. R205 appeared restless, staff were in room.

On 04/06/22 at 07:30 AM, R205 sat in his Broda chair while staff propelled him into the day room. No observations of activities being performed or offered.

On 04/06/22 at 09:18 AM, R205 sat in his Broda chair at table in day room, he attempted to talk to any one who passed by him but only one staff member stopped to talk to him. He appeared to want to converse with anyone. No observations of activities being performed or offered.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated she had not received an activities calendar and she was not sure what types of activities were provided.

On 04/06/22 at 03:20 PM, Certified Medication

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Aide (CNA) R stated she sometimes helped out with activities and the facility had been providing activities. She stated R205 was usually in the day room and he liked to talk a lot.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) G stated the facility had a new activity director and did not have any activities organized. She was unfamiliar with activity assessments.

On 04/06/22 at 04:32 PM, Activities Z stated she had worked at the facility almost a month. She stated she was educated about activity assessments but was unaware how often they were completed. Activities Z stated she found ideas for activities from the internet. She stated R205 usually had something that required him to use his hands.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated the facility did not have activities from January to February and would have utilized floor staff and hospice to provide activities. She stated social services completed activity assessments and activity care plans on admission. Since there was no activity calendar, activity supplies were not provided.

The facility's "Therapeutic Activities Program" policy, revised 04/01/22, directed the facility implemented an ongoing resident centered activities program that incorporated the resident's interests, hobbies, and cultural preferences which was integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. The policy directed it was important for residents to have a choice about which activities they participated in, whether they were part of the formal activities

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program or self-directed and a resident's needs and choices for how they spend time, both inside and outside the facility, were also supported and accommodated. The policy directed individual interventions were developed based on each resident's assessed needs and the family was notified for any special requests; the individual program was provided according to a consistent scheduled identifying specific days of the week and time frame for which program occurred; and each resident's individual program included interventions that met the resident's social, emotional, physical, spiritual, and cognitive functioning needs, these approaches reflected the resident's lifestyle and interests and were incorporated into the interdisciplinary care plan.

The facility failed to consistently provide activities for R205. This deficient practice had the risk for a decline in physical, mental, and psychosocial well-being and independence.
- R6's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of chronic respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide and the lungs are unable to carry the blood to the organs), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and bipolar (major mental illness that caused people to have episodes of severe high and low moods) mood disorder.

The "Significant Change Minimum Data Set" (MDS) dated 10/15/21 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R6 required limited assistance

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of one staff member for activities of daily living (ADL's). The MDS documented R6 required physical help of one staff member for set up or assistance as part of the bathing activity during the look back period. The MDS documented R6 received oxygen therapy during the look back period.

The "Quarterly MDS" dated 01/05/22 documented no changes documented from previous MDS assessment.

R6's "Cognitive Loss Care Area Assessment" (CAA) dated 10/25/21 documented she was able to communicate her needs during the look back period.

R 6's "Care Plan" dated 11/20/19 documented staff were to converse with her while they provided care and introduce R6 to other resident's in the facility that had similar background, interests and staff to encourage/ facilitate interaction. Staff were to invite R6 to schedule activities. R6 seemed very interested in activities and go outside to smoke.

R6's "Care Plan" dated 11/19/20 documented she enjoyed the daily newsletters and classic romance movies. R6 enjoyed subjects related to science, visiting with others and keeping her hands busy.

On 04/04/22 at 09:31 AM R6 stated the facility never had activities available for her to attend. R6 stated she was bored and had nothing to do but smoke. R6 laid on her bed.

On 04/05/22 at 07:25 AM R6 sat on edge of her bed faced toward the open window.

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On 04/05/22 at12:42 PM R6 sat on the bed, fed herself lunch in her room.

On 04/05/22 at 03:29 PM R6 sat in a wheelchair next to the common area on the south hallway, stated she was waiting to go outside and smoke.

On 04/06/22 at 11:17 AM R6 sat in wheelchair next to the common area, stated she was waiting to go outside and smoke.

On 04/06/22 at 11:25 AM R6 pushed her wheelchair down the south hallway as she talked to the hospice staff. R6's hair was uncombed, and her clothes were clean.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated she had not received an activities calendar and she was not sure what types of activities were provided on the evening shift.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CNA) R stated she sometimes helped with activities and the facility had been providing activities on dayshift, weekends and evenings. CMA R stated sometimes on the weekends a few of the residents do BINGO.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) G stated the facility had a new activity director and did not have any activities organized. She was unfamiliar with activity assessments and the activities that occurred on her shift.

On 04/06/22 at 04:32 PM, Activities Z stated she had worked at the facility almost a month. She stated she was educated about activity assessments but was unaware how often they

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were completed.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated the facility did not have activities from January to February and would have utilized floor staff and hospice to provide activities. She stated social services completed activity assessments and activity care plans on admission. Since there was no activity calendar, activity supplies were not provided.

The facility's "Therapeutic Activities Program" policy, revised 04/01/22, directed the facility implemented an ongoing resident centered activities program that incorporated the resident's interests, hobbies, and cultural preferences which was integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. The policy directed it was important for residents to have a choice about which activities they participated in, whether they were part of the formal activities program or self-directed and a resident's needs and choices for how they spend time, both inside and outside the facility, were also supported and accommodated. The policy directed individual interventions were developed based on each resident's assessed needs and the family was notified for any special requests; the individual program was provided according to a consistent scheduled identifying specific days of the week and time frame for which program occurred; and each resident's individual program included interventions that met the resident's social, emotional, physical, spiritual, and cognitive functioning needs, these approaches reflected the resident's lifestyle and interests and were incorporated into the interdisciplinary care plan.

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The facility failed to consistently provide activities for R6. This deficient practice had the risk for a decline in physical, mental, and psychosocial well-being and independence.

- R17's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of dementia without behaviors (progressive mental disorder characterized by failing memory, confusion) and muscle weakness.

The "Annual Minimum Data Set" (MDS) dated 09/27/21 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R17 was totally dependent on two staff members assistance for activities of daily living (ADL's). The MDS documented R17 was totally dependent on one staff member for bathing and refused care four to six days during the look back period.

The "Quarterly MDS" dated 12/16.21 documented no changes documented from previous MDS assessment.

R17's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 10/04/21 documented he required total assistance of staff for bathing/showers and incontinence care.

R17's "Care Plan" dated 07/17/19 documented he required maximum involvement in decision making and activities. Limit choices and cue as needed.

R17's "Care Plan" dated 08/28/19 documented he needed assistance to attend activities. Encourage R17's family to attend activities with him to be

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supportive with participation.

R17's "Care Plan" dated 10/31/19 documented he preferred music, making people laugh, and any food/social group. R17's enjoyed drinking coffee and watch TV.

R17's "Care Plan" dated 04/28/20 documented he enjoyed sitting up front by the reception area to talk and visit most of the day while he drank coffee and looked outside.

On 04/04/22 at 08:02 AM sat in high back wheelchair in the common area with his back to the TV. R17 stated he was waiting for breakfast, no fluids or items on the table in front of him.

On 04/04/22 at 01:34 PM R17 s sat in high back wheelchair in common area with a wedge pillow on foot rest.

On 04/05/22 at 07:46 AM staff pushed R17 in a high back wheelchair to the common area. R17 asked for a cup of coffee and was informed by staff breakfast was coming soon. At 08:09 AM R17 asked for a cup of coffee from Administrative Nurse F, who stated breakfast was coming out soon. An unidentified nursing staff delivered a breakfast tray to another resident in the common area and then pushed the food cart down the hallway. At 08:43 AM R17 received his breakfast tray in the common area on a tray which contained a cup of coffee.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated she had not received an activities calendar and she was not sure what types of activities were provided on the evening shift.

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On 04/06/22 at 03:20 PM, Certified Medication Aide (CNA) R stated she sometimes helped with activities and the facility had been providing activities on dayshift, weekends and evenings. CMA R stated sometimes on the weekends a few of the residents do BINGO.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) G stated the facility had a new activity director and did not have any activities organized. She was unfamiliar with activity assessments and the activities that occurred on her shift.

On 04/06/22 at 04:32 PM, Activities Z stated she had worked at the facility almost a month. She stated she was educated about activity assessments but was unaware how often they were completed.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated the facility did not have activities from January to February and would have utilized floor staff and hospice to provide activities. She stated social services completed activity assessments and activity care plans on admission. Since there was no activity calendar, activity supplies were not provided.

The facility's "Therapeutic Activities Program" policy, revised 04/01/22, directed the facility implemented an ongoing resident centered activities program that incorporated the resident's interests, hobbies, and cultural preferences which was integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. The policy directed it was important for residents to have a choice about which activities they participated in, whether they were part of the formal activities

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F 679	Continued From page 61 program or self-directed and a resident's needs and choices for how they spend time, both inside and outside the facility, were also supported and accommodated. The policy directed individual interventions were developed based on each resident's assessed needs and the family was notified for any special requests; the individual program was provided according to a consistent scheduled identifying specific days of the week and time frame for which program occurred; and each resident's individual program included interventions that met the resident's social, emotional, physical, spiritual, and cognitive functioning needs, these approaches reflected the resident's lifestyle and interests and were incorporated into the interdisciplinary care plan. The facility failed to consistently provide activities for R17. This deficient practice had the risk for a decline in physical, mental, and psychosocial well-being and independence.	F 679		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included 16 residents with one resident sampled for stasis ulcers (a wound on	F 684		

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the leg or ankle caused by abnormal or damaged veins). Based on observations, record reviews, and interviews, the facility failed to adequately assess and identify Resident (R)27's risk for skin injuries and place specialized interventions to prevent development of skin complications. The facility further failed to provide the physician ordered wound treatments for R27 when the facility consistently omitted the primary dressing component from R27's daily wound care order and omitted the topical agent as prescribed. Subsequently, R27's wound deteriorated, became infected, and required surgical repair.

Findings included:

- R27's Electronic Medical Record (EMR) recorded diagnoses of peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), osteomyelitis (infection of the bone), type 2 diabetes mellitus (adult onset condition when the body cannot use glucose, not enough insulin [hormone which regulates blood glucose] made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), acquired absence of right leg below knee (BKA-below the knee amputation [surgical removal of limb]), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

The "Annual Minimum Data Set" (MDS) dated 11/18/21 recorded a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact

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cognition. The MDS recorded R27 required extensive assistance of one to staff members for all activities of daily living (ADLs) except eating and locomotion for which she was independent. R27 required assistance of two staff members for bathing. The MDS recorded R27 rejected cares daily during the lookback period. The MDS recorded R27 had one stasis ulcer and received a dressing to her foot. She had a pressure reducing device in her chair and bed but was not on a turning/repositioning program. R27 received an antipsychotic (medication used to treat psychosis), antidepressant (medication used to treat depression) and an antibiotic (medication used to treat bacterial infections) for all seven days of the look back period.

The "Quarterly MDS" dated 02/08/22 recorded R27 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS recorded R27 required extensive assistance of one to staff members for all activities of daily living (ADLs) including locomotion and supervision of two staff for eating. R27 was totally dependent on one staff for bathing. R27 had verbal behavioral symptoms directed at other for one to three of the lookback days and rejected cares for four to six of the lookback days. The MDS recorded R27 was at risk for pressure injuries but had no pressure injuries. The MDS recorded R27 had no stasis ulcers, but did have an infection of the foot and diabetic foot ulcer and received a dressing to her foot. She had a pressure reducing device in her chair and bed, but was not on a turning/repositioning program. R27 received an antipsychotic, antibiotic, anticoagulant (medication used to thin blood), insulin, and received injections during the lookback period.

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The "Activities of Daily Living [ADLs] Care Area Assessment" recorded R27 was at risk for skin integrity impairment due to her medical diagnoses and bowel/bladder incontinence; staff provided routine continence checks and assisted with incontinence cares as needed. R27 received preventative treatments as ordered and/or as needed; staff provided daily skin checks with cares; weekly skin assessments by a licensed nurse and communications with the physician for any skin change noted. R27 had a pressure reducing mattress and wheelchair cushion to protect her skin. R27 was treated for an arterial Ulcer to her left heel with multiple wound healing interventions in place which included outside wound physician following wound with weekly on site visits, a low air loss (LAL) mattress, oral supplementation, pressure reducing boot, as well as consul with vascular surgeon.

The "Care Plan," prior to development of the ulcer directed staff to assist the resident with mobility and ADLs as needed (02/02/21); R27 required extensive assistance from staff to turn and reposition in bed as needed (01/27/21). The "Care Plan directed staff to inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness and refer to podiatrist (foot doctor) as needed and provide weekly skin checks (05/02/21).

A "Braden Assessment" (tool used to predict pressure injury risk and assess risk factors) dated 06/05/21 recorded R27 was at mild risk. The assessment recorded she was rarely moist and had only slightly limited mobility. The risk factors in section two of the assessment inaccurately documented she had no risk factors though the

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following were listed as a potential risk: decreased or impaired chair or bed mobility, urinary or bowel incontinence, use of antipsychotics, peripheral vascular disease, edema (swelling) and diabetes.

A "Braden Assessment" dated 07/11/21 recorded R27 was at mild risk. The assessment recorded she was rarely moist and had only slightly limited mobility. The risk factors in section two of the assessment inaccurately documented her only additional risk factor was diabetes.

A "Braden Assessment" dated 08/18/21 recorded R27 was at mild risk. The assessment recorded she was rarely moist and had only slightly limited mobility. The risk factors in section two of the assessment inaccurately documented her only additional risk factor was diabetes.

A "Braden Assessment" dated 09/12/21 recorded R27 was at mild risk. The assessment recorded she was rarely moist and had no limitations in mobility. The risk factors in section two of the assessment inaccurately documented her only additional risk factors were decreased or impaired bed/chair mobility and diabetes.

The "Weekly Skin Integrity Data Collection" assessments, reviewed from 05/31/21 through 09/26/21 recorded R27 skin was intact with no issues.

A "Physician Note" dated 09/21/22 recorded Consultant GG saw R27 for a chief complaint of left lower extremity edema. R27 had pitting edema of the left lower extremity (LLE). Consultant GG encouraged R27 to elevate her extremity when it was not use and ordered a

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compression stocking (TED- anti-embolism [blood clot]) to the left leg to be on in the morning and removed at night.

The "Orders" tab revealed a physician's order dated 09/21/22, which directed to apply TED hose to the LLE one time daily and remove per schedule.

An "Alert Note" dated 09/27/21 at 11:25 AM documented the nurse was asked to look at R7's heel. Upon assessment, the nurse observed R27's left heel with a wound that was 4.5 inches wide, black, scabbed eschar (dead tissue), and dry flaky skin all around the perimeter of the wound. R27 stated it did not hurt unless it was touched. The note recorded R27 was diabetic as well. The nurse informed the director of nursing, executive director, the nurse practitioner and R27's representative at 11:20 AM. The nurse entered a skin assessment into the computer for R27. The note recorded the resident's information was sent to the wound care specialists for evaluation. R27's foot was cleansed, skin prep applied, and covered with a dry dressing.

Review of the "Orders" tab revealed an order dated 09/27/21 to cleanse R27's left heel wound with wound cleanser, apply skin prep (liquid skin protectant) to the area and around the wound edges, cover with a dry dressing. Change daily and as needed (PRN) when soiled or missing.

The "Skin Integrity Data Collection" assessment dated 09/27/22 recorded a new finding and documented an area on the left heel, which measured4.5-inches and was an eschar covered black ulcer with flaky skin noted around the entire perimeter of the wound and a dark red area

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above the back of the heel that was painful to the touch.

The "Care Plan" reflected the following interventions added on 09/27/22:

Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. (resolved on 10/13/21).
Observe for side effects of the antibiotics and over-the-counter pain medications: gastric distress, rash, or allergic reactions which could exacerbate skin injury. (resolved on 10/13/21).
Encourage good nutrition and hydration in order to promote healthier skin (resoled on 10/13/21).
Educate resident/family/caregivers of causative factors and measures to prevent skin injury (resolved on 10/13/21).
Assess location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration (soft, wet or soggy skin associated with improper wound care) to the physician (resolved on 10/13/21).
R27 was on antibiotic therapy for infection of the heel (resolved 11/23/21).

The "Heal360" wound progress note recorded a service date of 09/29/21. The note indicated the visit was the initial encounter for the wound evaluation. The "Pressure versus Non-pressure Screening Questions" sections recorded the ulcer was of mixed etiology (cause or reason), which included pressure. The note labeled the left heel wound as Wound 2 and described the wound as eschar covered. It measured 3.5 centimeters (cm) long(L) by (x) 4.2 cm width (w) x 0.2 cm

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depth (d). There was a small amount of sero-sanguineous (yellowish drainage with small amounts of blood) and had a mild odor. The wound bed was 51-75 percent (%) eschar with 1-25% slough (dead tissue which is yellow, tan, green or brown in color and may be moist, loose and stringy in appearance). The plan recorded orders to cleanse the area with hypochlorous acid (wound cleanser), apply mupirocin (topical antibiotic ointment used to treat skin infections caused by bacteria), xeroform gauze (primary wound dressing used to maintain a moist wound bed and decrease trauma to wound), and cover with a bordered gauze dressing. Change daily and PRN.

Review of R27's EMR which included the "Orders" tab and the "Medication Administration Record/Treatment Administration Record" (MAR/TAR) revealed the mupirocin and xeroform were not implemented as ordered. The order dated 09/27/22 (see above) was administered until 10/06/21.

A "Physicians Note" dated 10/05/21 recorded Consultant II saw R27 for chronic medical conditions, and approval of monthly medications and orders for pharmacy. The note documented R's27 skin was warm and moist. The plan directed to continue medication and orders. The note lacked mention of the wound and /or infection.

The "Heal360" wound progress note, dated 10/06/21 recorded the left heel wound measured 4.2 cm L x 5.8 cm W x 0.1 cm D. The wound bed was 76-100 % eschar and had no slough. The periwound (skin immediately surrounding wound) presented with signs and symptoms of infection

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and indicated topical antibiotics were prescribed. The note recorded the quality of the wound tissue and wound measurements were deteriorated since the previous visit. The plan recorded orders to paint the eschar with skin-prep and ensure the edges and periwound were covered with skin-prep as well, then cover with bordered gauze.

Review of the "Orders" and MAR/TAR for October 2021 revealed the following order dated 10/06/21 was administered daily 10/06/21 through 10/13/21: Apply skin prep to left heel every shift daily for wound care. The order lacked the instructions to ensure wound edges and surrounding skin were covered and lacked instruction to cover with bordered gauze.

The "Heal360" wound progress note dated 10/13/21, recorded the heel wound measured 3.5 cm L x 4.1cm W x 0.1 cm D. The wound bed was 76-100 % eschar with no slough. The periwound was normal in color, and had edema, and maceration and signs of infection. The note indicated topical antibiotics were prescribed. The note indicated the quality of the tissue was unchanged, but the measurements were improved from the last visit. The plan recorded orders to cleanse the wound with wound cleanser and apply skin prep to periwound. Apply mupirocin to the affected area and apply calcium alginate (highly absorptive, non-occlusive dressings made of soft, non-woven calcium alginate fibers derived from brown seaweed or kelp), and cover with bordered gauze. Change dressing daily and as needed. The note indicated it was ok to continue the current treatment orders until able to obtain supplies/medications for updated orders.

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The "Wound Observation Tool" dated 10/13/21 recorded R27 had a left heel diabetic ulcer, facility acquired on 10/06/21. It further recorded the wound specialists (WCP) followed the resident, a new treatment was ordered, the wound was debrided (removal of dead tissue) by WCP. R27 had nutritional supplements, heel protector, and an arterial doppler (test which checks circulation in arms or legs) and ankle brachial index (ABI-quick, noninvasive way to check for peripheral artery disease) would be ordered.

R27's "Care Plan" was updated on 10/13/21 to include the following interventions:
Administer medications as ordered. Administer oral supplementations to promote wound healing as ordered. Lab and/or diagnostic work as ordered and staff to report results to the physician and follow up as indicated. Provide elevating leg rests when up in wheelchair and a low air loss mattress. Staff to assist R27 with donning /doffing pressure reducing boot to left foot.

A "Skin/Wound Note" dated 10/14/21 recorded R27 received a shower and treatment to her left heel. New observation revealed increased pitting edema (3 plus-system to describe severity of edema by the depth/return of pitting present) to the LLE. R27 had TED hose orders and a wheelchair leg rest/lift in place, but she was not always compliant. Skin-prep and ensure the edges and surrounding skin were "covered with skin-prep as well, then cover with bordered gauze.

The "Orders" tab documented an order dated 10/14/21 which directed a LAL mattress for wound prevention and maintenance, check every

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shift, to be set to resident comfort/preference.

Review of the "Orders" tab and MAR/TAR for October 2021 revealed the following order dated 10/14/21 was administered daily until 10/20/21: Cleanse the left heel wound with wound cleanser, apply skin prep around the border edges of the wound, apply Bactroban (mupirocin) ointment, and apply a border gauze daily and prn when soiled. The order lacked instruction to apply the calcium alginate.

An "Infection Note" dated 10/18/21 recorded the nurse finished R27's wound care treatment to her "right [left] heel diabetic ulcer." The nurse noticed there was a significant amount of drainage. The ulcer was malodorous. The nurse cleansed the wound with wound cleanser and examined the wound. This nurse noted the wound had a significant amount of green exudate (drainage) that was moist and malodorous. R27 stated it was not sore to the touch. The nurse explained to R27 that the wound looked infected and explained the nurse would call the resident's doctor to try and get an antibiotic. No fever was noted at the time of treatment. The nurse contacted the resident's nurse practitioner and the reception was bad. The nurse then sent a text to the NP explaining the findings at 01:50 PM. The nurse informed Administrative Nurse D as well. convey the instructions.

An "Infection Note" dated 10/18/21 recorded Consultant GG called at 02:06 PM with these directives: Start Doxycycline (oral antibiotic) 100 milligrams (mg) two times daily for 10 days, get a wound culture, and lab work. The note recorded the nurse read the findings of the arterial doppler results obtained from on 10/14/21 and Consultant

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GG wanted a consultation for vascular surgery.

The "Heal360" wound progress note dated 10/20/21 recorded the left heel wound measured 4.4 cm L x3.6cm w x 0.1 cm d. There was moderate amount of sero-sanguineous drainage that had a mild odor. The wound bed was 51-75% slough and 1-25 % granulation (healthy) tissue. No eschar was present. The periwound had edema and maceration, was normal in color and exhibited signs of infection. The note documented the quality of tissue was improved, though drainage and measurements had deteriorated. The plan recorded orders to cleanse the wound with wound cleanser and apply skin prep to periwound. Apply gentamicin (broad spectrum topical antibiotic ointment) to the affected area, apply calcium alginate to wound base and cover with bordered gauze daily and PRN for soiling, saturation or unscheduled removal of dressing.

The "Wound Observation Tool" dated 10/21/21 documented a left heel diabetic ulcer facility acquired on 10/06/121. The tool recorded the treatment was as follows: "Cleanse left heel wound with wound cleanser, apply skin prep to border of wound, apply Gentamicin 0.1 % ointment, apply silver alginate, then apply bordered gauze daily on dayshift and change when soiled, or missing prn. Doxycycline 100 mg BID [twice daily] x 10 days ordered."

The "Orders" tab recorded the following order dated 10/21/22: Cleanse the left heel wound with wound cleanser, apply skin prep around the border edges of the wound, apply Gentamicin 0.1 % ointment, and apply a border gauze daily and PRN when soiled. The order lacked instruction to

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apply calcium alginate to the wound bed.

Review of the "Heal360" wound progress notes dated 11/03/21 through 11/24/21 revealed the plan recorded the following orders: Cleanse the wound with wound cleanser and apply skin prep to periwound. Apply gentamicin to the affected area, apply calcium alginate to wound base and cover with bordered gauze daily and PRN for soiling, saturation or unscheduled removal of dressing.

Review of the "Wound Observation Tool" dated 10/28/21 through 12/02/21 revealed the tool recorded the following treatment on each tool: "Cleanse left heel wound with wound cleanser, apply skin prep to border of wound, apply Gentamicin 0.1 % ointment, apply silver alginate, then apply bordered gauze daily on dayshift and change when soiled, or missing prn."

Review of the November 2021 MAR/TAR revealed the dressing order dated 10/21/21 which lacked instruction for the calcium alginate was administered daily 11/01/21 through 11/30/21 except on 11/21/21 and 11/22/21.

An "Order Administration Note" dated 11/21/21 documented the treatment was not performed because R27 did not want to lay down. The note indicated it would be passed on to the evening shift.

An "Order Administration Note" dated 11/22/21 documented the treatment was not performed because R27 was out of the facility at an appointment with vascular surgery.

Review of the November 2021 MAR/TAR lacked

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evidence the dressing was administered on 11/21/22 and 11/22/21.

A "Health Status Note" dated 11/22/21 recorded R2 left the facility for an angiogram at the hospital.

Review of R27's paper chart revealed an "Operative Report" dated 11/22/21, which documented the results of the angiogram. The report recorded the surgeon's findings which confirmed occlusions of multiple arteries. The impression recorded R27 did have a patent anterior tibial artery (artery of the leg which carries blood to the foot), which would allow for healing of the heel ulcer and continued wound care was recommended. Pressure prophylaxis was of the "utmost importance" in the course of the wound care therapy. If the ulcer, which did not involve bone at that time, penetrated deeper, amputation would be most prudent, but amputation could be avoided if wound care, nutrition, and pressure prophylaxis was ongoing.

The "Heal360" wound progress note dated 12/05/21 recorded the left heel wound measured 3.5 cm L x3 cm w x 0.4 cm d. There was moderate amount of sero-sanguineous drainage that had a mild odor. The wound bed was 26-50% slough and 51-75 % granulation tissue. No eschar was present. The periwound had edema and maceration, was normal in color and exhibited signs of infection. The note documented the wound had deteriorated slightly, debridement was performed again, and Santyl (prescription medicine that removes dead tissue from wounds so they can start to heal) was added to daily treatment The plan recorded orders to cleanse the wound with wound cleanser and apply skin

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prep to periwound. Apply Santyl to entre wound bed, edge to edge, nickel thick. Apply gentamicin (broad spectrum topical antibiotic ointment) to the affected area, apply calcium alginate to wound base and cover with bordered gauze daily and PRN for soiling, saturation or unscheduled removal of dressing.

Review of the "Orders" tab revealed the Santyl order was never entered.

A "Physicians Note" dated 12/16/21 recorded Consultant II saw R27 for chronic medical conditions, and approval of monthly medications and orders for pharmacy. The note documented R27's skin was warm and moist. The plan directed to continue medication and orders. The note lacked mention of the wound and /or wound treatment.

Review of the December 2021 MAR/TAR revealed the dressing order dated 10/21/21 which lacked instruction for the calcium alginate and lacked instructions to apply Santyl was administered daily 12/01/21 through 12/31/21.

Review of the "Wound Observation Tool" dated 12/16/21 through 01/12/22 revealed the tool recorded the following treatment on each tool: "Cleanse left heel wound with wound cleanser, apply skin prep to border of wound, apply Gentamicin 0.1 % ointment, apply silver alginate, then apply bordered gauze daily on dayshift and change when soiled, or missing prn."

A "Physicians Note" dated 01/06/22 recorded Consultant II saw R27 for chronic medical conditions, and approval of monthly medications and orders for pharmacy. The note documented

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R27's skin was warm and moist. The plan directed to continue medication and orders. The note lacked mention of the wound and/or wound treatment.

A "Health Status Note" dated 01/16/22 recorded R27 was coughing, had a temperature of 99.7 degrees, an oxygen saturation of 85%. A Covid test was negative. Staff notified Consultant GG, administered medication to reduce temperature and applied oxygen at three liters per minute.

A "Health Status Note" dated 01/16/22 at 04:42 AM recorded R27 continued to have decreased oxygen levels, difficulty arousing, and continued with elevated temperature. She had gurgling breath sounds and was unable to cough up anything. Staff called 9ll and the ambulance arrived and transported R27 to the hospital. Staff notified Administrative Nurse D and Consultant GG.

Review of the hospital "Infectious Disease Progress Note" revealed R27 was admitted to the hospital for altered mental status, shortness of breath and cough. R27 was found to be septic (systemic infection) with several infectious sources. The note recorded R27 had a urinary tract infection and osteomyelitis of the left posterior calcaneus (heel bone). The note recorded orthopedics (bone doctors) were consulted and recommended an amputation, but R27 declined the procedure. The note further documented a left partial calcenectomy (surgical procedure where the soft tissue is debrided then parts of the calcaneus are resected with a chisel).

Observation on 04/05/22 at 12:46 PM R27 rested in bed with her eyes closed. The head of the bed

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was elevated. She wore a heel boot on her left foot and had a low air loss mattress on the bed.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated the nurses let the CNA's know who was at risk for skin issues or pressure injuries. She said if the residents were in bed or the chair, staff should turn and/or reposition them every two hours. CNA M stated if she noted a sore or skin problem, she reported that to the nurses. CNA M stated staff used different ways to prevent skin injuries which included turning the residents and keeping them dry and clean. She further stated staff should evaluate or float the heels to prevent heel sores and if the resident had heel protectors in their room, she would place the heel protectors on the resident. She said she was unsure if heel protectors were included in the residents' care plans.

On 04/06/22 at 03:35 PM Licensed Nurse (LN) G stated she was uncertain how the wound on R27's heel developed. LN G stated she had not observed the wound on R27's foot because it was always covered. She stated she was unaware of any special precautions or interventions related to R27's wound. LN G said R27 was always supposed to wear a heel boot on her foot and she was compliant with wearing the boot. LN G said the wound team made rounds in the facility every Thursday. She further reported if she had any questions regarding ordered treatments, she would contact the physician for a clarification.

On 04/06/22 at 05:00 PM LN H stated she had no personal knowledge of R27's wound when it originally developed. She said she thought it started as a diabetic ulcer. She stated that R27's wound was followed outside the facility by a

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wound specialist. LN h said at one point, the facility and the facility's wound care team were following the wound until R27 had the surgical flap repair. LN H said R27 was set to have another surgery, but the surgery was cancelled because R27 was non-compliant. LN H stated R27 continued to use her left heel to push herself up in bed, so the surgeons decided not to do the surgery. LN H stated R27 was always supposed to wear a boot and had daily wound treatments. LN H said staff repositioned R27 and assisted R27 out of bed whenever R27 wanted to get up. LN H said, in order to prevent skin issues from occurring, she would have interventions such as a low air loss mattress. She also stated licensed nurses do weekly skin assessments. She said if staff identified new skin condition the nurses received notifications and interventions were implemented as soon as possible. LN H said the facility was able to get any dressing supplies necessary and the supplies were ordered by Administrative Nurse D. LN H stated there was never any issues getting the supplies that they needed, however, if there were an issue, she would notify the physician and obtain a temporary order to use until the dressing supplies came in. She stated any communication with the physician regarding dressing orders or concerns were documented in the resident's chart. She stated when the wound team, made round, they verbally informed staff what they wanted ordered. Then, typically the next day, LN H could print out a copy of the visit which listed the orders. LN H said if the primary care physician disagreed with the wound treatment, and gave alternate orders, it would be recorded in the orders and in the resident's chart.

On 04/06/22 at 05:25 PM Administrative Nurse D

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stated R27 did not have specialized interventions in place to prevent skin /pressure injuries prior to the left heel wound because R27 was not considered high risk. Administrative Nurse D said the facility utilized the "Braden" scale to determine if a resident was high risk instead of basing it on medical conditions such as peripheral vascular disease or diabetes. Administrative Nurse D said the licensed nurses performed weekly skin assessments and performed a skin assessment the day before the left heel wound was identified. On a routine visit on 9/27/22, the podiatrist identified the wound on R27's foot. Administrative Nurse D stated she was notified of the left heel wound by the nurse on duty. Administrative Nurse D stated a referral was made to the wound care team to follow up with R27's left heel. Administrative Nurse D stated she did not have a reason why interventions were not placed on 9/27/22 but confirmed that specialized interventions such as a heel boot and low air loss mattress were implemented on 10/13/22. Administrative Nurse D reviewed the wound progress notes and R27's MAR/TAR and noted the dressing orders lacked the xeroform, calcium alginate, and Santyl ordered by the wound care specialists. Administrative Nurse D said during that time frame, October 2021 through December 2021, the wound team would come in and make rounds and did not make their notes available to the facility staff, so the facility staff did not have access to the orders until, sometimes, more than a week later. Administrative Nurse D confirmed it was the facility responsibility to act on behalf of the resident and obtain the physician's orders. She further stated she had a meeting with the wound team, and the wound team provider changed so the system had improved, and the facility was now able to get the orders in a much

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quicker timeframe. Administrative Nurse D acknowledged the lack of the primary dressings, xeroform and calcium alginate, as well as the lack of Santyl negatively impacted the wound healing process and contributed to the wound deterioration.

The facility policy "Area of focus: Basic Skin Management" recorded the facility must ensure that a resident received care consistent with professional standards of practice. All residents had preventative measures in place that include pressure redistribution mattresses on all beds, wheelchair cushions, heel boots or suspension if needed and frequent repositioning. If any skin alteration or wound were identified, it was the responsibility of the nurse to perform and document an assessment/observation, obtain treatment orders and notify the physician and personal responsible party. The policy recorded orders were required for skin and wound care. Nursing administration should monitor the wound care program daily. A review of the Medication Administration Record was utilized to review if treatment wound care omissions had occurred and should be reviewed for possible medication discrepancy reports if needed.

The facility failed to adequately assess and identify R27's risk for skin injuries and place specialized interventions to prevent development of skin complications. The facility further failed to provide the physician ordered wound treatments for R27 when the facility consistently omitted the primary dressing component from R27's daily wound care order and omitted the topical agent as prescribed. Subsequently, R27's wound deteriorated, became infected, and required surgical repair.

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included 16 residents; three residents sampled for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) review. Based on observations, record reviews, and interviews, the facility failed to ensure prevention of cross-contamination during wound care for Resident (R) 3 and failed to ensure heel protectors were worn at all times as ordered for R21 who had a history of heel wounds. This deficient practice had the risk for prolonged wound healing, development or worsening of wounds, and unwarranted physical complications for R3 and R21. Findings included: - The "Diagnoses" tab of R3's Electronic Medical Record (EMR) documented diagnoses of	F 686		

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pressure ulcer of sacral (large triangular bone between the two hip bones) region stage three (wound that extends into the subcutaneous [beneath the skin] tissue layer) and need for assistance with personal care.

The "Admission Minimum Data Set (MDS)" dated 10/01/21 documented R3 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R3 required extensive physical assistance with one staff for bed mobility, dressing, toileting, and personal hygiene; total physical dependence with two staff for transfers. R3 was at risk for pressure ulcers and had one unhealed stage three pressure ulcer at time of assessment.

The "Quarterly MDS" dated 03/21/22 documented R3 had a BIMS score of 10 which indicated moderate cognitive impairment. R3 required extensive physical assistance with two staff for bed mobility, dressing, toileting, and personal hygiene; total physical dependence with two staff with transfers. R3 was at risk for pressure ulcers and did not have any unhealed pressure ulcers at the time of assessment.

The "Pressure Ulcer Care Area Assessment (CAA)" dated 10/14/21 documented R3 had an active stage three pressure ulcer, staff provided routine continence checks and assisted with incontinence care as needed. Preventative treatments were provided as ordered and/or as needed, staff provided daily skin checks with cares, weekly skin assessments by licensed nurse and communication was made with physician for any skin change noted. R3 utilized a pressure reducing mattress and wheelchair cushion to protect skin, wound treatments were

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administered by licensed nurse and R3 was seen weekly by mobile wound physician until wound resolved/healed.

The "Care Plan" last revised 10/13/21 documented R3 had actual skin impairment of a coccyx (small triangular bone at the base of the spine) stage three pressure ulcer and directed staff administered wound treatments as ordered.

The "Care Plan" dated 10/13/21 documented R3 was at risk for skin integrity impairment and directed staff clean and dried R3 after each incontinent episode and staff performed routine continence checks and assisted/provided incontinence cares as needed.

The "Orders" tab of R3's EMR documented an order with a start date of 03/13/22 to clean coccyx with wound cleanser, pat dry, apply skin prep (a solution when applied that forms a protective waterproof barrier on the skin) around wound, apply santyl (ointment used to help the healing of burns and skin ulcers) to entire wound bed edge to edge nickel thick, apply gentamicin (broad spectrum topical antibiotic) to hydrofera blue (moist wound dressing) prior to applying calcium alginate (highly absorptive, non-occlusive dressing) to wound base, cover with dry dressing.

On 04/06/22 at 10:50 AM, Licensed Nurse (LN) H and Consultant HH entered R3's room to perform wound assessment and wound care. LN H closed the door and blinds, raised the bed, then performed hand hygiene and donned (put on) gloves. Consultant HH performed hand hygiene and donned gloves. Consultant HH stood on the left side of the bed and used the draw sheet on to roll R3 onto her right side to visualize her

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coccyx/sacral wound while LN H held R3 in that position from the right side of the bed. Consultant HH unfastened R3's brief and noticed she had some bowel movement in her brief. There was no dressing in place on R3's coccyx wound at that time. Consultant HH measured the wound with a wound measuring ruler that she removed from her bag, wound measured 0.5 x 0.2 x 0.3 centimeters (cm). Consultant HH stated the wound was improving. She used a tablet to take pictures of the wound. Consultant HH pulled out a wound imaging device from her bag that she stated was used to determine if there was bacteria in the wound. After she took a picture with the device, she used her tablet to take a picture of the device's readings then removed a curette (surgical instrument designed for scraping or debriding [removal of damaged tissue or foreign objects from a wound] biological tissue or debris in a biopsy, excision, or cleaning procedure) from her bag to debride the wound. After the debridement, she took another picture with the device to check for bacteria in the wound then used her tablet to take a picture of the device's readings. Consultant HH placed a piece of moist gauze in R3's wound then placed the wound imaging device back in her bag and placed the curette in the sharps container. She did not doff (remove) her gloves and perform hand hygiene at any point in this procedure. Consultant HH then switched sides with LN H who doffed gloves and performed hand hygiene before proceeding on with the dressing change. R3 continued to have bowel movement present. LN H did not clean the bowel movement before proceeding to the wound care procedure. LN H removed the moist gauze from the wound then doffed gloves, performed hand hygiene, and donned new gloves. LN H applied skin prep

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around the wound then applied santyl to the wound. LN H placed hydrofera blue inside the coccyx wound then applied gentamycin to the calcium alginate dressing then onto the wound. LN H pulled brief back over R3's buttocks and stated she would get the aides to come in to clean her up. LN H and Consultant HH doffed gloves then performed hand hygiene.

On 04/06/22 at 03:34 PM, LN G stated she prevented pressure ulcers by repositioning residents every two hours and she prevented cross-contamination during wound care by having supplies on a sterile field and cleaning up bowel movements before procedure. She stated hand hygiene was performed during the procedure.

On 04/06/22 at 04:51 PM, Administrative Nurse F stated cross-contamination was prevented during wound care by making sure resident was clean and free of bowel movement and change gloves/perform hand hygiene during the procedure. She stated staff should not put a clean dressing on a coccyx/sacral wound before cleaning up bowel movement as it could contribute to bacteria getting into the wound.

On 04/06/22 at 05:09 PM, LN H stated hand hygiene and changing gloves were performed during wound care to prevent wound contamination. She stated if a resident had a bowel movement, typically she changed the resident before starting the dressing change and would not put a dressing on if bowel movement was near the wound. LN H stated she should have stopped the wound care and cleaned off the bowel movement. If the bowel movement was near the wound bed, it could contaminate the wound.

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On 04/06/22 at 05:22 PM, Administrative Nurse D stated pressure ulcers were prevented by offloading, providing a low-air loss mattress, barrier creams, and heel protectors if applicable. She stated cross-contamination was prevented during wound care by having field set up prior to procedure and having an extra hand if needed. Administrative Nurse D stated staff washed hands and did not go from a clean to dirty surface to prevent contamination. If there was bowel movement present during dressing changes, staff cleaned the bowel movement before changing the dressing change.

The facility's "Pressure Ulcer/Injury Prevention and Management" policy, dated 11/27/18, directed measures to maintain and improve the patient's tissue tolerance to pressure included skin cleansing with appropriate cleanser at the time of soiling and at routine intervals.

The "Pressure Injury Management, Long-Term Care" reference provided by facility, last revised 08/16/19, directed implementation of wound care included verifying the practitioner's order for wound care, performing hand hygiene and putting on gloves as need to comply with standard precautions. Supplies including prescribed dressings, medications, sterile gauze pads, and cleaning solution and were placed on a disinfected surface to prevent cross-contamination. Dressing change with sharp conservative bedside debridement were to be completed using sterile technique (free from bacteria of other living microorganisms). Hand hygiene was performed after removing old dressings, after cleaning wound, and after applying new dressing.

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The facility's "Area of Focus: Basic Skin Management" policy, not dated, directed wound care was provided utilizing a clean technique.

The facility failed to prevent cross-contamination during wound care for R3. This deficient practice had the risk for prolonged wound healing and unwarranted physical complications for R3.

- The "Diagnoses" tab of R21's Electronic Medical Record (EMR) documented diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance.

The "Annual Minimum Data Set (MDS)" dated 07/22/21, documented a Brief Interview for Mental Status (BIMS) was not completed due to R21 rarely/never understood. R21 required extensive physical assistance with one staff for bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. R21 was at risk for pressure ulcers but did not have pressure ulcers at time of assessment.

The "Quarterly MDS" dated 01/14/22, documented a BIMS was not completed due to R21 rarely/never understood. R21 required extensive physical assistance with two staff for bed mobility, transfers, locomotion, dressing, and personal hygiene. R21 was at risk for pressure ulcers but did not have pressure ulcers at time of assessment.

The "Pressure Ulcer/Injury Care Area Assessment (CAA)," dated 08/06/21, documented R21 had an Activities of Daily Living (ADL) function impairment. The CAA did not

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address pressure ulcer risk.

The "Care Plan" last revised 11/10/21, directed R21 had a risk for skin integrity impairment related to limited mobility, incontinence, and routine medication administration. The "Care Plan" directed staff assisted R21 with putting on and taking off heel protectors for wound prevention.

The "Orders" tab of R21's EMR documented an order with a start date of 03/05/21 for bilateral heel protectors on at all times except during personal care for skin integrity.

The "Notes" tab of R21's EMR revealed a "Skin/Wound Note" on 03/02/21 at 09:12 PM that documented R21 had a two centimeter (cm) by two cm blacken tissue on back of right heel. The doctor and family were notified.

The "Notes" tab of R21's EMR revealed a "Skin/Wound Note" on 03/11/21 at 05:35 PM that documented the hospice nurse visited R21. Right heel remained unchanged with skin prep (a solution when applied that forms a protective waterproof barrier on the skin) applied every shift and heel protectors on at all times except during personal care.

On 04/04/22 at 09:48 AM, R21 laid in bed, eyes closed. R21's heel protectors were not worn by R21 as ordered. The heel protectors were in R21's wheelchair.

On 04/04/22 at 12:46 PM, R21 sat in her wheelchair in her room and watched television. Heel protectors were not worn by R21 as ordered.

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On 04/04/22 at 04:17 PM, R21 sat in her wheelchair in her room and watched television. Heel protectors were not worn by R21 as ordered. R21 had nonskid socks on.

On 04/05/22 at 08:32 AM, R21 laid in bed, head of bed elevated; R21's breakfast tray was recently delivered. Heel protectors were not worn by R21 as ordered.

On 04/06/22 at 11:14 AM, Certified Medication Aide (CMA) S removed R21's heel protectors and socks for surveyor observation. No redness or wounds noted on either heel. Socks and heel protectors reapplied by CMA S.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated she prevented pressure ulcers by repositioning every two hours, making sure residents are clean and dry, and putting on heel protectors if they have them.

On 04/06/22 at 03:20 PM, CMA R stated R21 was supposed to wear heel protectors all the time and that intervention was found in the care plan.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) G stated she prevented pressure ulcers by repositioning residents and putting on heel protectors if applicable. She stated she has seen R21 wear heel protectors.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated pressure ulcers were prevented by offloading, utilizing low-air loss mattresses, protein in the diet, and barrier creams. She stated R21 had heel protectors on and the nurse could look at the care plan for that intervention.

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F 686	Continued From page 90 The facility's "Pressure Ulcer/Injury Prevention and Management" policy, dated 11/27/18, directed measures to protect the patient against the adverse effects of external mechanical forces such as pressure, friction and shear were implemented in the care plan and included: utilizing positioning devises to keep bony prominences from direct contact and heel protection/suspension should be implemented while patient is in bed. The facility's "Area of Focus: Basic Skin Management" policy, not dated, directed all residents had preventative measures in place that included pressure redistribution mattress on all beds, wheelchair cushions, heel boots or suspension if need, and repositioning per CNA and ADL care. The facility failed to ensure heel protectors were worn at all times for R21 who had a history of heel wounds. This deficient practice placed the resident at risk for development of pressure ulcers and wound related complications.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53. The sample	F 689		

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included 16 residents with two residents reviewed for elopement. Based on observation, interviews, and record review, the facility failed to ensure a safe environment for Resident (R)42, when R42 eloped (when a cognitively impaired resident leaves the facility without staff knowledge or supervision) from the facility. This placed R42 at risk for injuries from accidents or hazards. The facility further failed to implement care planned interventions aimed to protect R225 and R205 from injuries related to falls and failed to thoroughly investigate and determine the root cause of falls for R205. This placed the residents at increased risk for injury related to falls.

Findings included:

- R42's Electronic Medical Record (EMR) recorded diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), epilepsy (brain disorder characterized by repeated seizures), obsessive-compulsive disorder (OCD - anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), mild intellectual disabilities, and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

The "Significant Change Minimum Data Set" (MDS) dated 12/06/22 recorded R42 had a Brief

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Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS recorded R42 was independent with no set up to supervision for most activities for daily living (ADLs), and limited assistance of one staff for personal hygiene. R42 rejected cares during the look back period but had no wandering behaviors.

The "Quarterly MDS" dated 03/02/22 recorded R42 had a BIMS of nine which indicated moderately impaired cognition. The MDS recorded R42 required supervision with set-up assistance for all ADLs. He rejected cares during the look back period but had no wandering behaviors.

The "Behavior Care Area Assessment" (CAA) dated 12/06/22 recorded R42 had behavior symptoms of rejection of care. Staff encouraged as much participation as possible during care activities.

The "Falls CAA" recorded R42 was at risk for falls but had no falls since his readmission; staff encouraged call button use for ADL needs and transfers and encouraged R42 to don appropriate footwear when ambulating or mobilizing in wheelchair.

The "Elopement Risk Assessments" completed on 02/19/22 documented R42 was not at risk for elopement.
The "Care Plan" recorded interventions created on 11/11/20 and resolved on 12/07/21 which directed staff to encourage participation in activities and provide for safe wandering.

The "Care Plan" intervention dated 11/11/20

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directed R42 was qt risk for changes in mood or behavior due to medical condition. It directed staff to consult with the resident on his preferences regarding customary routine.

A "Behavior Note" dated 03/31/22 at 11:07 AM documented Invega (antipsychotic medication used to treat schizophrenia) 117 milligram (mg) injection given in the left buttocks. R42 did not take his other medications but allowed the injection. R42 offered no resistance to the injections and Consultant GG was notified.

A "Nurse Note" dated 03/31/22 at 01:50 PM documented R42 was yelling, clapping his hands and quoting bible verses, and yelling out the earth was coming to an end. The nurse called Consultant GG and representative. R42's representative stated she wanted R42 sent to the acute care hospital. R42 began talking loudly and walking fast but left with emergency services without requiring restraint.

A "Health Status Note" dated 03/31/22 at 08:25 PM documented R42 returned to the facility. R42 appeared calm and quiet, moved from the stretcher to his bed. R42 quietly ate his meal and rested in his bed.

An "Event Note" dated 04/01/22 at 09:06 AM documented at 07:50 AM R42 was outside his room and refused his medications multiple times. He walked in and out of his room. He was alert to himself some confusion. At 08.07 AM staff reported to Licensed Nurse (LN) J that R42 was outside of the building. LN J and other staff rushed outside and observed Certified Nurse Aid (CNA) P escorting R42 back to the building. R42 stated "thank you, thank you, you saved my life."

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R42 stated he wanted blood. He was not able to tell staff how he got out of the building. Staff initiated 1:1 supervision of R42. R42 continued to refuse his medication. Staff notified Consultant GG of the occurrence.

An "Event Note" entered on 04/01/22 at 09:33 AM documented the nurse saw resident walk by her office and was stating "thank you, you saved my life". She went out to the hallway to make sure everything was ok and was informed that the resident had just been brought back in from outside. CNA P stated she found him outside. The nurse asked the resident what he was doing there, and he stated, "I need to get blood from the blood bank." The nurse also tried to ask how he got out of the facility and he stated, "I don't know." 1:1 was assigned at that time.

An undated "Witness Statement" from CNA P documented she saw R42 at 07:30 AM while she was taking breakfast orders. CNA P went to the kitchen to start working on the breakfast trays and was notified by dietary staff there was a lady outside who stated she may have observed a resident in the parking lot. CNA P ran out and saw R42. CNA P returned R42 to the building with no issues.

An undated "Witness Statement" from LN J recorded LN J saw R42 at 07:50 AM during the medication pass. LN J attempted to give R42 his morning medications. AT 08:05 AM, LN J received notification that R42 was outside the building. LN J rushed outside via the back door and observed CNA P as she walked R42 back to the building. LN J documented R42 was unable to recall how he got out of the facility.

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The "Facility Investigation" recorded at 07:50 AM LN J had contact with R42 during the medication pass. Around 08:05 AM a neighbor from the apartments in back notified dietary staff she saw a resident walking from the back of the building. Kitchen staff notified nursing staff and CNA P immediately went to the back of the building to meet the resident. R42 was behind the building, in the parking area approximately 100 feet from the facility. R42 wore a gown, jogging pants, socks and shoes. R42 returned to the building willingly. Staff assessed R42 for injuries with none noted. Staff notified R42's representative and Consultant GG. The facility updated R42's plan of care, applied a Wanderguard and implemented 1:1 supervision for R42.

On 04/04/22 at 07:32 AM observation revealed all exit doors were locked. The required doors had a functioning 15 second door lock release.

In an interview on 04/05/22 at 08:11 AM CNA P stated on 04/01/22 she worked with a CNA trainee and LN J. She said at around 07:30 AM she saw R42 while she and the trainee collected breakfast menus. She stated a while later, after all the menus were collected and turned in, she went to the kitchen to help get trays together. Dietary BB told CNA P there was a lady outside who stated she though she saw one of the residents outside. CNA P stated she did not speak with the lady, so she was unsure if the lady saw how the resident exited the building. CNA P stated she immediately went out back and observed R42 walking towards the bank in the parking lot. She was able to reach R42 and direct him back to the building. She stated R42 was confused and unable to say how he exited the building. CNA P said R42 had no history of exit

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seeking and was not at risk for elopement. She stated he did have a lot of behaviors like yelling and clapping and repeating bible quotes but did not actively seek exits or verbalize a desire to leave. CNA P stated residents who were at risk for elopements were added to the elopement book and wore a Wanderguard. CNA P stated the staff knew who was at risk and what special needs the residents required in nursing report and walking rounds. She stated all residents who were at risk for elopement received increased supervision.

In a telephone interview on 04/05/22 at 09:08 AM LN J stated he was R42's nurse on 04/01/22. LN J stated he attempted to give R42 his medications that morning at 07:50 AM. LN J reported R42 took the medications and walked back to his room. LN J followed to ensure R42 took the medications. Once R42 was in his room, R42 stated he did not want to take the medications, so LN J took the medications back to the medication cart. A few minutes later, R42 walked by the medication cart a few times and walked in and out of his room. LN J stated he again offered R42's medications and R42 continued to refuse. LN J reported he entered another resident's room and exited 10 minutes later. At that time, staff alerted LN J that R42 was outside of the building. LN J stated he immediately went out the back door and observed CNA P and R42 walking back to the building. LN J reported R42 thanked staff for saving his life and reported R42 said he tried to go to the bank for some blood. LN J reported R42 continued to refuse his medications but LN J asked another nurse to attempt to get R42 to take his medications and that nurse was successful. LN J stated R42 had a history of behaviors but was not

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an elopement risk prior to the incident. He further reported staff were familiar with R42's behaviors and medications refusal and when that happened, staff enlisted the aid of other staff members that R42 typically responded positively to.

In an interview on 04/06/22 at 05:25 PM Administrative Nurse D stated she was familiar with R42. Administrative Nurse D said R42's behavior was stable until recently when he had a big change in his behaviors. She said R42 was hospitalized due to his escalating behaviors and refusal to take his oral medications. She reported the facility was sending R42 out for acute care every two to four weeks related to his behaviors. Administrative Nurse D stated the day R42 exited the facility, he refused all his oral medications. Facility staff were able to administer his medications via injection. She stated R42 was able to identify his behaviors, but he was unable to control them and that caused R42 distress. Administrative Nurse D stated the facility checked all doors to ensure all alarms were functions and the doors were checked in the morning prior to the event and after the event and all were functioning properly.

The facility's policy "Behavior Management" recorded the facility must provide necessary care and services which included ensuring the necessary care and services were person-centered and reflected goals for care while maximizing the residents'' safety.

The facility failed to ensure a safe environment for R42, when exited the facility without staff knowledge or supervision. This placed R42 at risk for injuries from accidents or hazards.

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- The electronic medical record (EMR) indicated the following diagnosis for R225: metabolic encephalopathy (inflammatory condition of the brain), type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia (swallowing difficulty), insomnia (inability to sleep), urinary retention (lack of ability to urinate and empty the bladder), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) , and constipation.

A review of R225s "Admission Minimum Data Set (MDS)" completed 03/21/22 indicated a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated she had a indwelling catheter (tube placed in the bladder to drain urine into a collection bag) at the time of admission with occasional urinary continence and bowel continence not rated. The MDS indicated total dependence for staff related to hygiene, transfers, bathing, toileting, personal cares, and eating.

A review of R225's "Activities of Daily Living (ADL's) Care Area Assessment" (CAA) dated 03/21/22 stated she had worked to regain current level of functioning after being recently hospitalized from a fall before her admission.

A review of R225's "Fall CAA" dated 03/21/22 indicated resident required close monitoring related to her recent fall.

R225's "Care Plan" revised 03/18/2022 noted that she had an ADL self-care deficit related to activity intolerance. The care plan stated that she was

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dependent on staff assist for all ADL's and encouraged to use her call light for assistance.

On 03/16/22 R225's "Care Plan" initiated an injury prevention intervention of a helmet to protect the resident from head injuries. This intervention remained active until being resolved on 04/04/22.

On 04/04/22 at 08:00 Am, an observation of the room revealed no helmet. She sat in her chair watching television. R225 stated the she has never seen or heard of a helmet since she admitted in February. She reported that staff have never asked her to wear a helmet.

On 04/04/22 at 12:40 PM R225 sat in her room watching television. The resident appeared to be engaged in her television show. She did not wear an injury prevention helmet.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that she was not aware that R225 ever worn a protective helmet. She reported staff review the resident care plans frequently.

In an interview completed on 04/06/22 at 02:50PM with Licensed Nurse (LN) G, she stated that she has cared for R225 before and may have seen her with the protective helmet on last week but R225 has been in bed all day and has not worn it.

In an interview completed on 04/06/22 at 04:20PM with Administrative Nurse E, she stated that R225's protective helmet was implemented by the facility after a recent fall. She stated that the helmet was ordered but the facility was waiting for it to arrive and had discontinued the

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documented intervention.

A review of the facility's "Fall Management" policy reviewed 08/2021stated the facility will assess the resident for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls. The policy stated that each resident receives adequate supervision and assistance devices to prevent accidents. The policy noted that the facility will review and revise the care plan upon a fall event and as needed thereafter.

The facility failed to implement R225's care planned protective helmet. This deficient practice placed the resident at risk for injuries associated with falls
- R205 admitted to facility on 01/07/22.

The "Diagnoses" tab of R205's Electronic Medical Record (EMR) documented diagnoses of anoxic brain injury (condition caused by a complete lack of oxygen to the brain), need for assistance with personal care, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and history of falling.

The "Admission Minimum Data Set (MDS)" dated 01/14/22, documented a Brief Interview for Mental Status (BIMS) was not completed due to R205 rarely/never understood. R205 required extensive physical assistance with two staff for bed mobility and dressing; total physical dependence with one staff for eating and personal hygiene; total physical dependence with two staff for toileting and transfers. R205 had two or more noninjury falls since admission.

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The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 01/17/22 documented R205 had cognition loss related to short and long term memory loss.

The "Falls CAA" dated 01/20/22, documented R205 was at risk for falls related to diagnoses, routine medication administration, and impulsiveness. R205 had a fall prior to admission and three noninjury falls since admission to the facility. Staff encouraged R205 to use the call light for activities of daily living (ADL) needs and transfers and to wear appropriate footwear when ambulating or mobilizing in wheelchair.

The "Care Plan" initiated on 01/08/22, directed R205 was at risk for falls and had an actual diagnosis of frequent falls related to behaviors and directed that staff assisted with ADLs as needed, assisted with transfers, and R205's call light was within reach. The care plan documented the following interventions after falls with dates initiated:

01/09/22 actual fall, fall mat, bolsters, low bed, and assist with toileting- initiated 01/09/22

Fall on 01/12/22. Position in new Broda (specialized wheelchair with the ability to tilt and recline) chair- initiated 01/12/22

01/12/22 new order for Xanax (antianxiety medication- class of medications that calm and relax people with excessive anxiety [mental or emotional reaction characterized by apprehension, uncertainty and irrational fear], nervousness, or tension]) 0.5 milligram (mg) twice a day for restlessness/agitation- initiated

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F 689	Continued From page 102 01/12/22, revised 01/14/22 01/23/22 actual fall. Staff in resident's room during that shift to prevent fall. Remove furniture for safety- initiated 01/23/22, revised 01/27/22 01/24/22 actual fall. Staff to monitor until sleep during that shift, continue with plan of care- initiated 01/24/22, revised 02/05/22 Resident had actual fall on 02/04/22. Resident to be monitored for positioning, things to grab, and comfort while in Broda chair- initiated 02/04/22 Resident had actual fall on 02/18/22, non-injury, found on floor beside bed on mat- initiated 02/18/22 Actual fall on 02/18/22, non-injury, found on floor mat. Offer toileting and all needs met before laying in bed- initiated 03/11/22 03/12/22 education for staff anticipating residents needs such as pain, toileting, hydration, anxiety, and following medication regimen- initiated 03/12/22 03/13/22 resident to wear helmet at all times when out of bed to prevent injury to head in case of fall- initiated 03/14/22 Resident often refuses or takes helmet off and throws it. Use redirection to assist with putting it back on- initiated 03/14/22 Actual fall on 03/21/22. Anticipate and meet the resident's needs- initiated 03/21/22 03/22/22 hipsters for safety- initiated 03/22/22	F 689		

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Actual fall on 03/28/22. Continue all current interventions in place, remove bed rails from resident's bed- initiated 03/29/22

Upon request, the facility provided fall investigations for falls on 01/09/22 at 04:59 PM, 01/12/22 at 03:53 PM, 01/12/22 at 11:28 PM, 01/23/22 at 10:15 PM, 01/24/22 at 11:00 PM, 02/04/22 at 03:30 AM, 02/18/22 at 12:45 AM, 03/12/22 at 07:45 AM, 03/21/22 at 08:40 AM, 03/22/22 at 06:30 PM, 03/23/22 at 10:13 AM, and 03/28/22 at 09:24 PM. The investigations lacked evidence of a root cause analysis of the falls, to determine what caused the falls, which was needed to ensure appropriate interventions were in place to prevent further falls.

On 04/04/22 at 04:15 PM, R205 sat in his Broda chair in the day room, helmet not on at that time.

On 04/05/22 at 08:21 PM, R205 sat in his Broda chair at a table in the day room, helmet not on at that time but was observed on the table.

On 04/05/22 at 11:40 AM, R205 sat in his Broda chair at table in day room, helmet not on at that time but was observed on the table. Staff conversed with resident and encouraged him to put helmet back on which he did.

On 04/05/22 at 11:46 AM, R205 sat in his Broda chair at table in day room, he attempted to talk to staff walking past him, but they did not acknowledge hearing him.

On 04/06/22 at 09:18 AM, R205 sat in his Broda chair at table in day room, he attempted to talk to anyone who passed by him but only one staff

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member stopped to talk to him. He appeared to want to converse with anyone.

On 04/06/22 at 10:23 AM, R205's bed had 1/8 bed rails on both sides of his bed.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated when a resident fell, she asked the resident if they were okay and stayed with the resident. CNA M stated she put the call light on to get help or if the resident had a roommate that was able to call for help, she had them do so.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated R205 usually fell because he thought he was in his car and he had to get out of the facility. She stated he wore a helmet when he was up, fall mats on both sides of the bed, and bed to the floor for fall prevention for R205. CMA R stated R205 has had the same bed rails on his bed since admission and had not heard about an intervention to remove them.

On 04/06/22 at 04:08 PM, Administrative Nurse E stated after a fall occurred, she or the Director of Nursing (DON) placed new interventions on the care plan, and they tried to implement different interventions for each fall.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated if a fall occurred, the care plan was updated as needed and the interdisciplinary team (IDT) met to decide what happened and what interventions to put into place then the unit manager communicated the interventions to the team to implement them. She stated if a resident was found on the floor, the nurse was alerted and assessed the resident prior to moving the resident. Once resident was safe to move then

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F 689	Continued From page 105 staff assisted resident to the chair or to the bed. After the nurse completed the assessment, they notified the family, the doctor, and the DON. Administrative Nurse D stated the nurse interviewed the resident and any witnesses to find out the cause of the fall to decide on an intervention. The IDT met weekly and as needed, reviewed falls, made sure the assessment was completed, determined the cause of the fall, and if the intervention in place was appropriate for the fall then the care plan was updated if needed. She stated R205 had not had any new bed rails put on since admission. The facility's "Fall Management" policy, dated 06/04/20, directed the facility assessed the resident upon admission/readmission, quarterly, with change in condition, and with any fall event for any fall risks and identified appropriate interventions to minimize the risk of injury related to falls. The policy directed the IDT reviewed and revised the care plan, if indicated, upon completion of the comprehensive, significant change and quarterly MDS, upon a fall event, and as needed thereafter. The facility failed to implement interventions in place after a fall and thoroughly investigate falls for a root cause to determine if appropriate interventions were in place after each fall for R205. This deficient practice had the risk for further falls, possible injuries from falls, and unwarranted physical complications.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		

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resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 53 residents. The sample included 16 residents with three reviewed for catheter and incontinence care. Based on observations, record reviews, and interviews, the facility failed to provide consistent

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incontinence care for Resident's (R) 30 and R44, and catheter care for R225. This deficient practice placed the resident at risk for infections and impaired psychosocial well-being.

Findings Included:

-The electronic medical record (EMR) indicated the following diagnosis for R30: muscle weakness, major depressive disorder (major mood disorder). hypertensive heart disease (chronic high blood pressure), insomnia (difficulty falling asleep), traumatic brain injury (TBI), constipation, and abnormalities of gait and coordination.

A review of R30's "Admission Minimum Data Set (MDS)" completed 02/17/22 indicated a Brief Interview for Mental Status (BIMS) score of seven indicating intact cognition. The MDS revealed she was occasionally incontinent of bowel and bladder with no toileting program.

A review of R30's "Activities of Daily Living (ADL's) Care Area Assessment (CAA)" dated 02/17/22 indicated that her urinary incontinence would be addressed in her care plan. The CAA indicated that she felt urgency to void at times.

A review of R30's "Care Plan" revised 03/11/22 lacked documentation related to her bowel and bladder incontinence.

A review of R30's "Lookback" report under "Bowel and Bladder Elimination" between 02/10/22 and 04/05/22 indicated that she had incontinent episodes on 12 occasions.

A review of R30's assessment lacked evidence of

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the incontinence assessment tool was completed .

In an interview completed on 04/05/22 at 02:22 PM with R30, she stated that she does have incontinence issues but reported them to the nursing staff. She reported that she is not sure if a special bowel program was started.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that staff can review the resident's care to see who has special precautions related to toileting and assisting residents to the restroom. She stated that she doesn't know if R30 has a special bowel program. She stated that if something was missing or not in the care plan it would be reported to the nurse.

In an interview completed on 04/06/22 at 02:20PM with Licensed Nurse (LN) G, she stated that the nursing staff review resident's care plans and updates the other staff member of changes that occur. She reported that if a resident was on a special bowel program it would in the care plan.

In an interview completed on 04/06/22 at 04:20PM with Administrative Nurse E, she stated that when residents first arrive a base line care plan with be completed and a comprehensive assessment with occur after the care plan has been established. She reported areas triggered on the MDS should be placed in the care plan and addressed on the comprehensive care plan.

A review of the facility's "Urinary Incontinence Management" revised 04/2022 stated that the facility must ensure that resident's receive services and assistance to remain continent of

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bowel and bladder. The policy stated that each resident who is incontinent of bladder will be identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible.

A review of the facility's "Care Plan Policy" revised 10/2019 stated that the care plan identified and included a focus statement, measurable goals, interventions of identified problems. The policy indicated that the care plan must include identified issues from the resident's comprehensive assessment, CAA, and MDS.

The facility failed to provide consistent incontinence care to R30. This deficient practice placed the resident at risk for infections and impaired psychosocial well-being.

-The electronic medical record (EMR) indicated the following diagnosis for R44: hypertension (high blood pressure), cerebrovascular disease (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (left sided paralysis of one side of the body), dysphagia (swallowing difficulty), and muscle weakness.

A review of R44's "Quarterly Minimum Data Set (MDS)" completed 03/10/22 indicated a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS indicated that she was frequently incontinent of urine and occasionally incontinent of bowel with no toileting program in place. Her MDS revealed she required extensive assistance from one staff member for transferring, dressing, bathing, personal hygiene, and toileting.

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A review of R44's "Urinary Incontinence CAA" dated 12/09/21 stated that staff were to provide routine checks and assistance with incontinence cares as needed.

R44's "Care Plan" revised 12/03/21 stated that staff were to provide routine incontinence checks and provide cares when needed but failed to provided interventions related to improving or preventing incontinence episodes.

A review of R44's EMR under "Assessments" indicated on two occasions (03/02/22 and 12/02/22) that she was a candidate for toileting program but lacked documentation it was implemented.

A review of R44's "Lookback" report under "Bowel and Bladder Elimination" between 01/01/22 and 04/05/22 indicated that she had incontinent episodes on 63 occasions.

On 04/04/22 at 08:35AM R44 reported that she has had bowel and bladder accidents waiting for staff to respond to the call lights. She reported that she does have problems with incontinence but does not remember if she had any special programs for it.
In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated that staff can review the resident's care to see who has special precautions related to toileting and assisting residents to the restroom. She stated that she doesn't know if R44 has a special bowel program. She stated that if something was missing or not in the care plan it would be reported to the nurse.

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In an interview completed on 04/06/22 at 02:20PM with Licensed Nurse (LN) G, she stated that the nursing staff review resident's care plans and updates the other staff member of changes that occur. She reported that if a resident was on a special bowel program it would in the care plan.

In an interview completed on 04/06/22 at 04:20PM with Administrative Nurse E, she stated that when residents first arrive a base line care plan with be completed and a comprehensive assessment with occur after the care plan has been established. She reported areas triggered on the MDS should be placed in the care plan and addressed on the comprehensive care plan.

A review of the facility's "Urinary Incontinence Management" revised 04/2022 stated that the facility must ensure that resident's receive services and assistance to remain continent of bowel and bladder. The policy stated that each resident who is incontinent of bladder will be identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible.

A review of the facility's "Care Plan Policy" revised 10/2019 stated that the care plan identified and included a focus statement, measurable goals, interventions of identified problems. The policy indicated that the care plan must include identified issues from the resident's comprehensive assessment, CAA, and MDS.

The facility failed to provide consistent incontinence care to R44. This deficient practice placed the resident at risk for infections and impaired psychosocial well-being.

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- The electronic medical record (EMR) indicated the following diagnosis for R225: metabolic encephalopathy (inflammatory condition of the brain), type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia (swallowing difficulty), insomnia (inability to sleep), urinary retention (lack of ability to urinate and empty the bladder), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) , and constipation.

A review of R225s "Admission Minimum Data Set (MDS)" completed 03/21/22 indicated a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated she had a indwelling catheter (tube placed in the bladder to drain urine into a collection bag) at the time of admission with occasional urinary continence and bowel continence not rated. The MDS indicated total dependence for staff related to hygiene, transfers, bathing, toileting, personal cares, and eating.

A review of R225's "Activities of Daily Living (ADL's) Care Area Assessment" (CAA) dated 03/21/22 stated she had worked to regain current level of functioning after being recently hospitalized from a fall before her admission.

A review of R225's "Urinary Incontinence CAA" dated 03/21/22 indicated her goal was to regain control of her bladder and have the catheter removed.

R225's "Care Plan" revised 03/18/2022 noted an indwelling urinary catheter related to neurogenic bladder (dysfunction of the urinary bladder

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caused by a lesion of the nervous system). The care plan stated to position the catheter bag and tubing below the level of her bladder and provide privacy cover. The care plan noted that staff were required to complete catheter care each shift.

A review of R225's "Treatment Administration Report (TAR)" indicated her Foley catheter (tube inserted into the bladder to drain urine into a collection bag) was ordered and given on 03/14/22. The order instructed staff to complete catheter care and track urine output (amount of urine voided) on each shift.

R225's TAR revealed missed catheter care opportunities on two occasions (3/15 and 3/29) and failed to document urine output on five occasions (3/17, 3/20, 3/23, 3/29, and 4/2).

On 04/04/22 at 08:00 AM, an observation of the room revealed her in her chair watching television. Inspection of R225's catheter bag revealed a privacy cover, positioned lower than her bladder, and no leaks or obstructions. R225 appeared to be comfortable and denied pain and discomfort.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she stated the CNA staff clean the catheter site each shift and are responsible for documenting the output of each resident. She reported that the CNA care staff have access to view each resident's care plan for specific instructions but also receive instructions for the nurse.

In an interview completed on 04/06/22 at 02:50PM with Licensed Nurse (LN) G, she stated that CNA staff have access to the care plan. She

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F 690	Continued From page 114 reported that R225 can sometimes be resistive to basic cares and may refuse from time to time. A review of the "Urinary Incontinence Management" policy issues 04/2022 noted all residents are to be comprehensively assessed to achieve or maintain as much normal bladder function as possible. The facility failed to provide consistent catheter care to R225. This deficient practice placed the resident at risk for infections and impaired psychosocial well-being.	F 690		
F 695 SS=D	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 identified a census of 53 residents. The sample included 16 residents, with three residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to provide necessary respiratory care and services for Resident (R) 6, R23, and R49 when the facility failed to date and store oxygen tubing (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) for R6, and failed to clean, date and store the	F 695		

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equipment in accordance with professional standards of practice for R23 and R49. These deficient practice placed the resident's at risk for respiratory infection and/or illness.

Findings included:

- R6's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of chronic respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide and the lungs are unable to carry the blood to the organs), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and bipolar (major mental illness that caused people to have episodes of severe high and low moods) mood disorder.

The "Significant Change Minimum Data Set" (MDS) dated 10/15/21 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R6 required limited assistance of one staff member for activities of daily living (ADL's). The MDS documented R6 required physical help of one staff member for set up or assistance as part of the bathing activity during the look back period. The MDS documented R6 received oxygen therapy during the look back period.

The "Quarterly MDS" dated 01/05/22 documented no changes documented from previous MDS assessment.

R6's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 10/25/21

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documented she required limited assist by staff for bathing/showers.

R6's "Care Plan" dated 01/26/21 documented oxygen via nasal cannula (a device used to deliver supplemental oxygen or increase air flow to person in need of respiratory help) or a mask at two liters per minute as needed.

Review of the EMR under "Orders" tab revealed physician orders:

Oxygen at two liters/minute via nasal cannula as needed for shortness of breath dated 01/25/2021.

Change oxygen tubing weekly every Sunday dated 04/08/2021.

On 04/04/22 at 09:31 AM R6's undated oxygen tubing and nasal cannula laid directly on floor between the oxygen concentrator and bed side table.

On 04/05/22 at 08:51 AM R6's undated oxygen tubing and nasal cannula was coiled up and placed into the handle of the oxygen concentrator; the tubing lacked a bag.

On 04/05/22 at 12:42 PM R6's undated oxygen tubing and nasal cannula was coiled up and placed into the handle of the oxygen concentrator; the tubing lacked a bag.

On 04/05/22 03:29 PM R6's undated oxygen tubing and nasal cannula was coiled up and placed into the handle of the oxygen concentrator; the tubing lacked a bag.

On 04/06/22 at 11:25 AM R6 pushed her

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wheelchair down the south hallway as she talked to the hospice staff. R6's hair was uncombed, and her clothes were clean. R6's undated oxygen tubing and nasal cannula remained coiled in the handle of the oxygen concentrator.

On 04/06/22 at 02:20 PM in an interview, with Certified Nurse Aid (CNA) M reported that nasal cannula's and oxygen tubing should be dated and stored in a plastic bag when not in use. CNA M stated that the tubing gets changed weekly. CNA M stated that the tubing or nasal cannula should be replaced if contaminated. CNA M stated that staff are to make sure that the residents are using their oxygen machines but are not responsible for cleaning them.

On 04/06/22 at 04:15 PM in an interview, with Administrative Nurse F stated that the oxygen machines are cleaned by the maintenance department. Administrative Nurse F reported that the tubing should be changed out every Sunday night and staff should be storing the nasal cannula and tubing in a plastic bed when not in use.

A review of the facility's "Oxygen Administration, Safety, and Maintenance" policy revised 05/2020 stated to change oxygen supplies weekly and when visibly soiled. The plan indicated that equipment should be labeled with patient name and date when setup or changed out. The policy stated that oxygen and respiratory supplies should be stored in a bag labeled with the resident's name when not in use. The policy stated that machines with external filters should be checked daily and washed at least once a week with soap and water.

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The facility failed to provide necessary respiratory care and services in accordance with professional standards of practice for R6, this deficient practice placed her at risk for respiratory infection and/or illness.
-The electronic medical record (EMR) indicated the following diagnosis for R23: heart failure, type one diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (high blood pressure), chest pain, osteoporosis (chronic arthritis without inflammation), asthma (disorder of narrowed airways that caused wheezing and shortness of breath), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), muscle weakness, major depressive disorder (major mood disorder), and low back pain.

A review of R23's "Quarterly Minimum Data Set (MDS)" completed 02/02/22 indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Her MDS indicated she received oxygen therapy while a resident at the facility.

A review of R23's " Activities of Daily Living (ADL's) Care Area Assessment" completed on 11/05/21 indicated that while she had been independent for bed transfers, dressing, ambulation, toileting, and personal cares, R23 was educated to utilize her call light in her room for assistance.

A review of R23's "Care Plan" revised 03/11/22 indicated that she received oxygen therapy related to shortness of breath and asthma. The care plan interventions instructed staff to give two liters (L) of oxygen as ordered and as needed.

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R23's "Medication Administration Report (MAR)" in her EMR revealed an active physician's order dated 05/06/21 to give two liters of oxygen delivered by a nasal cannula (tubing that delivers oxygen directly through both nostrils of the nose) every evening and night shift. The physician's order revealed that oxygen tubing should be changed every Sunday evening by staff.

On 04/04/22 at 07:41 AM R23 reported that her oxygen machine was filthy and had not been cleaned this month by staff. She stated that staff had not cleaned the filter in the machine but that she would if she could. An inspection of the oxygen machine revealed dust and debris covering the machine. An inspection of the tubing revealed it was dated 03/20/22. Inspection of the external filter on the machine revealed dust covering the filter and the nasal cannula and tubing rested under the resident's blanket. An inspection of the oxygen machine revealed no plastic bag for tubing storage.

On 04/05/22 at 09:41 AM a walkthrough of R23's room revealed her nasal cannula and tubing rested underneath her blanket on her bed. The oxygen equipment remained dirty and lacked new tubing. An inspection of the oxygen machine revealed no plastic bag for tubing storage.

On 04/06/22 at 01:33 PM a walkthrough of R23's revealed oxygen tubing and nasal cannula again rested on her bed. An inspection of the oxygen machine revealed no plastic bag for tubing storage. The oxygen equipment remained dirty and lacked new tubing.

In an interview completed on 04/06/22 at 02:20

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PM with Certified Nurse Aid (CNA) M, she reported that nasal cannulas and oxygen tubing should be dated and stored in a plastic bag when not in use. She stated that the tubing gets changed out weekly. She stated that the tubing or nasal cannula should be replaced if contaminated. CNA M stated that staff are to make sure that the residents are using their oxygen machines but are not responsible for cleaning them.

In an interview completed on 04/06/22 at 04:15 PM with Administrative Nurse F, she stated that the oxygen machines are cleaned by the maintenance department. She reported that the tubing should be changed out every Sunday night and staff should be storing the nasal canula and tubing in a plastic bed when not in use.

A review of the facility's "Oxygen Administration, Safety, and Maintenance" policy revised 05/2020 stated to change oxygen supplies weekly and when visibly soiled. The plan indicated that equipment should be labeled with patient name and date when setup or changed out. The policy stated that oxygen and respiratory supplies should be stored in a bag labeled with the resident's name when not in use. The policy stated that machines with external filters should be checked daily and washed at least once a week with soap and water.

The facility failed to properly clean, maintain, and store R23's oxygen therapy equipment. This deficient practice placed her at risk for complications related to respiratory therapy.

-The electronic medical record (EMR) indicated the following diagnosis for R49: chronic

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obstructive pulmonary disorder (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) hypertension (high blood pressure), bipolar disorder, major depressive disorder (major mood disorder), type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), acute respiratory failure, hypoxia (inadequate supply of oxygen), dysphagia, lack of coordination, and insomnia (inadequate supply of oxygen).

A review of R49's "Significant Change Minimum Data Set (MDS)" completed 03/02/22 indicated a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated he received oxygen therapy while a resident and he required extensive assist from staff for toileting, personal hygiene, transfers, and bed mobility.

A review of R49's " Activities of Daily Living (ADL's) Care Area Assessment" completed on 03/02/22 indicated he required extensive assistance for his ADL's and had a history of being verbally aggressive with staff with cares provided.

A review of R49's 'Care Plan" revised 04/04/22 indicated that he had asthma and COPD but failed to include oxygen therapy goals and interventions.

R49's "Medication Administration Report (MAR)" in her EMR revealed an active physicians order dated 01/25/22 to give six liters of oxygen delivered by nasal canula (tubing that delivers oxygen directly through both nostrils of the nose)

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while resident is out of bed and three liters of oxygen while he is in bed. The physician's order revealed that the oxygen tubing should be changed every Sunday evening.

On 04/04/22 at 08:12 AM R49 reported that he never uses his oxygen and often refuses when staff asks him to wear his nasal cannula. An inspection of his oxygen machine revealed the outside of the machine had collected dust and no storage bag was present for the oxygen tubing. The nasal cannula and oxygen tubing rested on the ground behind the machine. The tubing and cannula appeared dirty and visibly soiled. An inspection of the machine revealed it was dated 03/20/22 and expired two weeks ago. An inspection of his wheelchair's portable oxygen tank revealed no date on his oxygen tubing.

On 04/06/22 at 07:39 AM a walkthrough of R49's room revealed his oxygen therapy tubing and nasal canula still had not been changed. R49's tubing and nasal canula were sitting on top of his dusty machine with no storage bag present. R49's oxygen machine was on and running but not being used by the resident.

In an interview completed on 04/06/22 at 02:20 PM with Certified Nurse Aid (CNA) M, she reported that nasal cannulas and oxygen tubing should be dated and stored in a plastic bag when not in use. She stated that the tubing gets changed out weekly. She stated that the tubing or nasal cannula should be replaced if contaminated. CNA M stated that staff are to make sure that the residents are using their oxygen machines but are not responsible for cleaning them.

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F 695	Continued From page 123 In an interview completed on 04/06/22 at 04:15 PM with Administrative Nurse F, she stated that the oxygen machines are cleaned by the maintenance department. She reported that the tubing should be changed out every Sunday night and staff should be storing the nasal canula and tubing in a plastic bed when not in use. A review of the facility's "Oxygen Administration, Safety, and Maintenance" policy revised 05/2020 stated to change oxygen supplies weekly and when visibly soiled. The plan indicated that equipment should be labeled with patient name and date when setup or changed out. The policy stated that oxygen and respiratory supplies should be stored in a bag labeled with the resident's name when not in use. The policy stated that machines with external filters should be checked daily and washed at least once a week with soap and water. The facility failed to properly clean, maintain, and store R49's oxygen therapy equipment. This deficient practice placed him at risk for complications related to respiratory therapy.	F 695		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental	F 740		

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and substance use disorders.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 53 residents. The sample included 16 residents with one resident reviewed for behavioral health. Based on record review, and interviews, the facility failed to provide an environment that promoted Resident (R)42's emotional and psychosocial well-being when the facility failed to develop and implement person-centered plan of care to support R42's behavioral health needs. The facility failed to identify and implement individualized interventions specific to R42's mental health diagnoses and his behaviors and failed to identify triggers or stressors which contributed to behavioral manifestations. The facility further failed to evaluate the care and services for effectiveness related to R42's behaviors. This deficient practice placed R42 at risk for impaired psychosocial wellbeing and inadequate behavioral health care.

Findings included:

- R42's Electronic Medical Record (EMR) recorded diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), epilepsy (brain disorder characterized by repeated seizures), obsessive-compulsive disorder (OCD - anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), anxiety (mental or emotional reaction

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characterized by apprehension, uncertainty and irrational fear), mild intellectual disabilities, and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

The "Significant Change Minimum Data Set" (MDS) dated 12/06/22 recorded R42 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS recorded R42 was independent with no set up to supervision for most activities for daily living (ADLs), and limited assistance of one staff for personal hygiene. R42 rejected cares during the look back period but had no wandering behaviors.

The "Quarterly MDS" dated 03/02/22 recorded R42 had a BIMS of nine which indicated moderately impaired cognition. The MDS recorded R42 required supervision with set-up assistance for all ADLs. He rejected cares during the look back period but had no wandering behaviors.

The "Behavior Care Area Assessment" (CAA) dated 12/06/22 recorded R42 had behavior symptoms of rejection of care. Staff encouraged as much participation as possible during care activities.

R42's "Care Plan" recorded he had impaired cognitive ability and impaired thought processes due to major depressive disorder, anxiety disorder and epileptic syndrome. It listed interventions dated 11/11/00 which directed staff to allow R42 extra time to respond to questions and instructions; face R42 and speak clearly when communicating and refer to speech

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pathology.

R42's "Care Plan" recorded R42 had a communication problem due to anger. It listed an intervention dated 12/04/20 which directed staff to encourage R42 to continue stating his thoughts even if he had difficulty. It directed staff to focus on a word or phrase that made sense or respond to the feeling R42 expressed.

R42's "Care Plan" recorded R42 was at risk for falls related to his diagnoses of epilepsy, schizophrenia, OCD, and anxiety. It listed an intervention dated 12/07/21 which directed R42 had a fall on 12/07/21. Staff were educated regarding appropriately suing R42's as needed (PRN) antianxiety medications when R42 exhibited signs and symptoms of increased anxiety and agitation. An intervention on 12/04/21 directed staff to anticipate and meet the resident's needs.

R42's "Care Plan" recorded R42 was at risk for changes in mood or behavior due to his medical condition. It listed interventions dated 11/11/20 which directed staff to consult with R42 on his preferences regarding his customary routines, administer his medications as ordered and psychiatric consult as indicated.

R42's "Care Plan" recorded he received antidepressant medication, psychotropic (affecting mood or thoughts) medications due to diagnoses of depression and schizophrenia. It listed interventions dated 12/04/20 which directed staff to administer the antidepressant and psychotropic medications as ordered by the physician and monitor for side effects and effectiveness.

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R42' "Care Plan" recorded he received antianxiety medication due to anxiety. It listed an intervention dated 01/27/21 which directed staff to administer the antianxiety medication as ordered by the physician and monitor for side effects and effectiveness.

R42's "Care Plan" recorded he had depression due to his medical diagnosis of major depressive disorder. It listed interventions dated 12/04/20 which directed staff to administer medications as ordered and to encourage R42 to express his feelings and allow him time to talk.

R42's "Care Plan" recorded he was at risk for alteration in psychosocial well-being due to Covid (highly contagious respiratory infection) precautions. It listed interventions dated 12/04/20 which directed staff to encourage and facilitate alternative ways of communication with friends and family; observe for changes in mental status caused by situational stressors and report to R42's physician as appropriate. It directed staff to observe for psychosocial changes and report to R42's physician as appropriate and provide R42 opportunities to express his feelings related to situational stressors.

R42' "Care Plan" lacked specific behaviors for staff to monitor and lacked description of behaviors including triggers. The plan of care lacked direction to staff on how to approach R42 when he was experiencing behaviors and lacked direction on how to redirect. The plan of care lacked specifics regarding the resident's preferred routines and lacked indicators of personal preferences and activities to support the resident's psychosocial well-being.

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R42's clinical record lacked evidence of assessment for Level I/Level II upon admission. (see F644)

An "Alert Note" dated 04/24/21 recorded R42 paced up and down the hall and in and out of his room throughout the night. He was restless and agitated. R42 displayed erratic behaviors with movements that appeared uncontrolled. R42 grabbed at the right side of his neck excessively but stated nothing was wrong. The note lacked mention of physician notification or intervention.

A "Behavior Note" dated 04/27/21 recorded R42 stood in the corner between the outside window and office window for several hours, part of the time facing the wall and part of the time facing the out toward the Tv room. The resident did not hurt himself or anyone else. The note lacked evidence of staff intervention.

A "Behavior Note" dated 05/28/21 recorded r42 stood at the nurse's station, went behind the station, looked at papers on the nurse's desk. Staff redirected R42 several times. R42 walked from TV room to his bedroom, tapped on windows in both rooms, and stood close to the nurse and other residents which made it hard for others to get by him. R42 told staff "leave me alone, I know I am doing." The note lacked documentation redirection efforts attempted and /or which efforts were successful or unsuccessful.

A "Health Status Note" dated 07/25/21 recorded the nurse heard "squealing" coming from R42's room and observed R42 in bed, moving extremities but R42 did not follow directions of acknowledge the nurse. The note documented

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this continued for one to two minutes then R42 told the nurse "I am ok when asked.". The note lacked evidence of physician notification or intervention.

An "Event Note" dated 08/12/21 recorded R42 turned the bathroom sink on and off so many times it was broken and would not turn off. The note lacked evidence of staff intervention.

A "Behavior Note" dated 09/13/21 recorded R42 refused breakfast and his medications. The note lacked evidence the physician was notified.

A "Behavior Note" dated 09/15/21 recorded R42 paced and attempted to enter rooms. R42 was redirected by the nurse. R42 then went through drawers in the sitting rooms, knocked on walls and doors, did not respond to redirection attempts by the nurse. R42 refused his antianxiety medication. The note lacked documentation redirection efforts attempted and /or which efforts were successful or unsuccessful and lacked evidence of physician notification.

A "Behavior Note" dated 09/15/21 recorded R42 chanted "Jesus, Jesus open the door ..." for over an hour. The note documented other residents in the facility yelled at R42 in response. R42 did not respond to redirection attempts from the nursing staff, only chanted louder and faster. The note lacked evidence of physician notification or intervention.

A "Behavior Note" dated 09/16/21 recorded R42 raced up and down the hallways and named presidents, pharmacies and churches. Staff were unable to redirect. Consultant GG ordered Haldol (antipsychotic medication) 5 milligrams by mouth.

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R42 continued to collect trash out of people's rooms and yelled names. R42 talked loudly and walked up and down the hallway.

A "Health Status Note" recorded R42 received a new order for Ativan (antianxiety medication) 1 milligram three times daily for agitation.

A "Health Status Note" dated 09/20/21 recorded R42 stated he slapped his hands together to change the direction of his thoughts.

A "Behavior Note" dated 10/06/21 recorded R42 banged loudly on the bedside table, the nurse cart. He spoke of religion, parents and "dust to dust." R42 appeared agitated and was not redirectable. He continued to be loud, banged on walls and began a "tirade of religion, working and dying." R42 took his Ativan but refused his other medications. The note lacked documentation redirection efforts attempted and /or which efforts were successful or unsuccessful and lacked evidence of physician notification.

A "Behavior Note" dated 10/07/21 recorded R42 left his room after breakfast, paced and talked fast. He repeated the same things about religion and working and told staff to mind their business when he was asked not to knock on all the doors. R42 continued to knock on walls and doors. He eventually went to his room and accepted his Ativan. The note lacked evidence of nonpharmacological interventions.

A "Behavior Note" dated 10/07/21 recorded R42 was again in the TV room, knocked on doors and windows, dug through the trash for snack wrappers and tore them apart. He took the wrappers back to his room. He had short

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episodes of unpredictable movements of his body. The note lacked evidence of physician notification or intervention.

A "Behavior Note" dated 10/28/21 recorded R42 wandered in and out of other residents' rooms and stood in the doorway staring at other residents. He made unusual body movements while he stood in the hallway. R42 continued to make loud banging noises when he returned to his room.

An "Alert Note" dated 11/12/21 recorded R42 came out of his room, pounded on the desk and yelled about religion, and his mom and dad. He went to the back door nad set off the alarm. He refused to go back to his room, yelled for several more minutes then went back to his room. The note recorded the director of nursing would contact Consultant GG for supportive care.

A "Health Status Note" dated 11/12/21 recorded the hospice nurse and nurse aid visited R42. R42 appeared calm, spoke with the hospice staff for a shirt time. The hospice nurse stated R42 said he was homesick and wanted someone to talk to. The note recorded the hospice nurse stated she would send a social worker and a chaplain out the following week to talk to the resident.

A "Behavior Note" dated 11/13/21 at 07:35 AM recorded R42 paced the unit and clapped his hands and attempted to grab the fire extinguisher from outside of his room.

A "Behavior Note" dated 11/13/21 at 11:49 AM recorded R42 was calmer, took his medications and spoke with his representative. He was calmer after he spoke with his representative, he stated

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he was upset but could not communicate the reason.

A "Behavior Note" dated 11/13/21 at 01:43 PM recorded R42 paced the hallway, banged on walls and doors, quoted the bible, and spoke of four gray walls. He refused offer of ice cream. Staff called R42's representative; he spoke with his representative and appeared calmer.

A "Behavior Note" dated 11/13/21 at 05:24 PM recorded R42 continued to pace throughout the building and looked up at the ceiling. He refused his medications from four different staff members and refused snacks and his evening meals. He knocked on walls and doors to the point his knuckles were reddened. He denied pain to his knuckles. The note lacked evidence of physician notification or intervention.

A "Behavior Note" dated 11/13/21 at 07:47 PM recorded R42 paced the lobby and unit and repeated "something's stupid, something's crazy, and it's not me." The note documented redirection was not effective. The note lacked evidence of which efforts at redirection were ineffective and lacked evidence of physician notification.

A "Behavior Note" dated 11/13/21 at 09:33 PM recorded R42 walked at fast pace and clapped his hands loudly. He yelled "ambulance 911." He went to the south unit and beat on the walls.

A "Behavior Note" dated 11/14/21 at 01:37 AM recorded R42 was combative and confrontational with staff, could not be redirected or calmed. R42 was sent to the acute care center for evaluation.

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An "Event Note" dated 11/14/21 at 10:26 AM recorded R42 returned to the facility.

A "Behavior Note" dated 11/15/21 recorded staff called hospice for medication review due to R42 yelled and screamed and hit the walls despite his scheduled Ativan.

An "Alert Note" dated 11/15/21 at 09:50 PM recorded R42 refused all his medications that shift after three attempts. The note lacked evidence of physician notification or intervention.

A "Behavior Note" dated 11/17/21 recorded R42 went out of his room without any clothes on and sat at the dining room table. He was resistant to redirection and charged at the nursing staff. He laid himself on the floor and began to have seizure-like activity. He again charged at staff with a look of rage on his face. Staff notified Consultant GG who ordered R42 be sent out emergently for acute care evaluation.

A "Health Status Note" dated 11/22/21 recorded R42 readmitted to the facility.
A "Behavior Note" dated 12/03/21 recorded R42 clapped all night, off and on.

A "Behavior Note" dated 12/06/21 recorded R42 clapped in room repeatedly and was very anxious. Staff reported the change to Consultant Gg who ordered Ativan PRN.

A "Behavior Note" dated 12/07/21 recorded r42 was anxious. R42 ran in the hallway, stumbled and fell. Staff administered R42 PRN Ativan and another anxiety medication. Consultant Gg gave an order to administer 5 milligrams of Zyprexa (antipsychotic) immediately.

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A "Health Status Note" dated 12/07/21 recorded a new medication order for R42, Seroquel (antipsychotic) 25 milligrams twice daily for increased behaviors.

A "Behavior Note" dated 01/14/22 at 09:56 recorded R42 received an injection of Ativan earlier that day, but it was not effective. R42 ran through the facility, pushing on walls, door frames, exits and he was combative and ran from staff. He went into women's rooms and yelled and screamed. He screamed bible quotes and spoke nonsensically. Staff received orders to send R42 to an acute care behavioral health setting.

A "Behavior Note" dated 01/14/22 at 10:15 PM recorded emergency services and firefighters arrived at the facility. R42 screamed and yelled and was combative with the rescuers. Five rescuers, assisted by a facility nurse, transferred R4 onto a gurney where he was restrained and administered medication by emergency services. R42 was transported to the acute care hospital.

An "Admission/Readmission Note" dated 01/18/22 recorded R42 readmitted to the facility.

A "Health Status Note" dated 01/28/22 at 06:50 AM recorded R42 went to the nurse station in a panic and stated "I need and ambulance. I had snakes in my shoes." R42 paced back and forth in the hall. R42 was not redirectable. Staff administered an injection of Ativan which lessened R42's anxiety but R42 continued to pace around the building.

A 'Behavior Note" dated 01/29/22 at 03:00AM recorded R42 paced the halls all night. He

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undressed himself and touched his genitals in front of other residents. When staff attempted to redirect R42 to his room, R42 became very angry and aggressive. Staff were unable to redirect R42. Staff notified Administrative Nurse D who requested the resident be sent to the hospital.

An "Admission/Readmission Note" dated 01/29/22 recorded R42 returned from the hospital at 06:10 AM.

A "Behavior Note" dated 01/29/22 at 10:48 AM recorded R42 clapped his hands quoted bible verses. R42 continued to yell, clap his hands and was hard to redirect.

A "Behavior Note" dated 02/01/22 recorded R42 ran up nd down the hall and yelled at other residents.

A "Behavior Note" dated 02/01/22 recorded R42 ran up and down the hall. He was verbally aggressive, an unable to be calmed. Emergency services was contacted and R42 was placed on a gurney, restrained and transported to the hospital.

An "Alert Note" dated 02/02/22 documented R42 was admitted to an inpatient psychiatric hospital.

An "Admission/Readmission Note" dated 02/08/22 recorded r42 readmitted to the facility with diagnoses of schizophrenia aggressive behavior, hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there), hypertension (high blood pressure) psychosis(mental disorder characterized by a disconnection from reality) and agitation.

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An "Orders -Administration Note" dated 02/13/22 recorded R42 received an injection of Haldol 5 milligrams. R42 paced and clapped his hands loudly. He tried to clean, and dumped water all over the floor. He was not redirectable and refused oral medications. Staff obtained a new order for Haldol.

An "Alert Note" dated 02/13/22 recorded R42 fell on the south side of the building. R42 had seizure activity. R42 was transferred to the hospital.

A "Behavior Note" dated 03/20/22 at 06:07 PM recorded R42 refused his medications during the day shift. He had clapped excessively most of the shift. He opened and closed his blinds repeatedly. He tore the toilet lid off and flushed the toilet over and over. His clothes and hair were wet were wet. He was in the hallway and yelled " you have a good evening and be careful of the graveyards and the gas stations and of Jack Daniels, baseball, hot dogs, mam and dad, the Kansas city star, the Kansas City Royals and the Kansas City Chiefs." R42 refused his medication and stated he felt sick enough. The note lacked evidence of physician notification or intervention.

A "Behavior Note" dated 03/20/22 at 07:03 PM recorded R42 screamed at a male resident. Staff were unable to redirect R42. Another resident became agitated, though staff were able to separate. Staff notified law enforcement and law enforcement arrived. R42 asked the law enforcement officers to take him to the hospital. R42 left the facility with two law enforcement officers for transport to the hospital.
An "Admission/Readmission Note" dated 03/24/22 recorded R42 returned to the facility.

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A "Behavior Note" dated 03/25/22 recorded R42 appeared anxious, sat in his room and clapped and wandered through the hallways. R42 took his medications as ordered.

A "Behavior Note" dated 03/26/22 recorded R42 clapped his hands loudly and almost constantly. Staff asked R42 to stop clapping because it upset the other residents. R42 responded "No" and stated when asked why, R42 stated "I can't explain it, if I could stop, I would." The note lacked evidence of physician notification or intervention.

A "Behavior Note" dated 03/27/22 recorded R42 had not clapped as much but was still loud when he did clap.

A "Health Status Note" dated 03/30/22 at 01:35 PM recorded R42 required coaxing to take his pills and refused his afternoon Ativan and Haldol. R42 sat in his room clapping loudly, intermittently.

A "Behavior Note" dated 03/30/22 at 05:19 PM recorded R42 flushed his medication down the toilet. He clapped loudly. His eyes were red, and per R42, he lacked sleep and was anxious.

An "Orders-Administration Note" dated 03/31/22 recorded R42 refused his oral medication but allowed an Invega (antipsychotic) injection.

An "Alert Note" dated 03/31/22 at 01:50 PM recorded R42 yelled, clapped his hands, and quoted bible verse R42's representative wanted R42 sent to the hospital.

A "Health Status note" dated 03/31/22 recorded R42 returned to the facility at 08:25 PM.

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An "Event Note" dated 04/04/22 at 09:06 AM recorded R42 refused his medication multiple times. R42 left the building unsupervised. (see F689)

A "Behavior Note" dated 04/01/22 at 02:00 PM recorded R42's behaviors escalated, and he began to run from his one to one supervision. He yelled and threw furniture. Staff called 911. The note recorded R42 had to be "taken down" to the ground, handcuffed, and feet bound. R42 received an injection of versed (strong antianxiety medication typically used prior to surgery or medical procedures). Emergency discharge was initiated.

On 04/06/22 at 02:35 PM in an interview, Certified Nurse's Aide (CNA) M stated she was able to review the care plans and that was where to find the instructions for the care of each of the resident. CNA M the care plan would have any specialized care listed each resident. CNA M stated she had not received any dementia or behavior training at the facility. CNA M stated that she would report any behaviors to the nurse and documented behaviors in the EMR. She said R42 was currently out of the facility. She was aware he had behaviors and sometimes started fights with other residents. She stated she was not aware of any special directives or ways to deal with or redirect R42 when he had behaviors.

On 04/06/22 at 03:35 PM in an interview, Licensed Nurse (LN) G stated nursing staff review resident's care plans and updates the other staff member of changes that occur. LN G stated behavioral monitoring was completed on anyone that received an antipsychotic medication,

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which was completed by the charge nurse on the "Medication Administration Record" (MAR). LN G stated she was unaware of any specific interventios to deal with R42's behaviors.

On 04/06/22 at 05:25 PM Administrative Nurse D stated the facility did not have social worker. She said since she was at the facility, R42 had been there and was usually quiet. She stated his behaviors had started to change at the end of the year in 2021 and the behaviors increased. Administrative Nurse D stated the facility was sending R42 to acute care centers every two to four weeks. R42 received oral medications and he started refusing his medications. The refusals started escalating. He was hospitalized at an acute inpatient behavioral health center. R42's medications were changed and included injections of antipsychotic medications for his behaviors. Administrative Nurse D stated R42 was able to tell you that something was going on, and he couldn't control it such as his clapping. She said R42 was loud, clapped, quoted scriptures and would go up and down the halls, bothering other residents, getting in people's space but he never struck anyone. Administrative Nurse D was unable to say if there were any nonpharmacological interventions developed to assist with R42's behaviors.

The facility's "Area of Focus: Behavioral Health Recommendations" policy, not dated, directed providing behavioral health care and services was an integral part of the person-centered environment and staff monitored residents closely for expressions or indications of distress, assessed and planned care for concerns, accurately documented the changes including the frequency of occurrence and potential trigger's in

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F 740	Continued From page 140 the resident's record, shared concerns with the interdisciplinary team to determine underlying causes, ensured appropriate follow-up assessment if needed, and discussed potential modifications to the care plan. The facility's "Area of Focus: Behavior Management" policy, not dated, directed individualized approaches to care were provided as part of a supportive physical, mental, and psychosocial environment. The facility initiated behavior monitoring, behavior management care plan, and Kardex as indicated by assessment findings, resident/responsible party conversations, and observations. The policy directed that the resident's medical record showed documentation of adequate indication for a medication's use and the diagnosed condition for which a medication was prescribed. The policy directed the facility monitored medications for efficacy and adverse reactions. The facility failed to provide an environment that promoted R42's emotional and psychosocial well-being when the facility failed to develop and implement person-centered plan of care to support R42's behavioral health needs. The facility failed to identify and implement individualized interventions specific to R42's mental health diagnoses and his behaviors and failed to identify triggers or stressors which contributed to behavioral manifestations. The facility further failed to evaluate the care and services for effectiveness related to R42's behaviors. This deficient practice placed R42 at risk for impaired psychosocial wellbeing and inadequate behavioral health care.	F 740		
F 744 SS=D	Treatment/Service for Dementia	F 744		

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F 744	Continued From page 141 CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included 16 residents. Based on observation, record review, and interviews, the facility failed to provide the needed dementia (progressive mental disorder characterized by failing memory, confusion) care and services for Resident (R) 13, which placed her at risk for increased behaviors, confusion. decline in ability to maintain the highest practicable mental and psychosocial well-being. This deficient practice placed her at risk of increased confusion, isolation, and lack of appropriate activities and interaction. Findings included: - R13's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbances and cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) left lower limb. The "Admission Minimum Data Set" (MDS) dated 01/14/22 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R13 required extensive assistance of one person for all	F 744		

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activities of daily living (ADLs) except eating, for which she was independent. R13 required assistance of one staff member for bathing. R13 had no behaviors. The MDS recorded R13 received an antipsychotic (medication used to treat psychosis), diuretic (medication used to promote excretion of fluids) and opioids (medications use to treat pain) during the lookback period.

R13's "Cognitive Loss Care Area Assessment" (CAA) dated 01/20/22 documented staff encouraged her to use the call light for assistance with ADL's. R13 received routine antipsychotic medication, staff monitored for adverse reactions and for changes in R13 mood or behaviors.

R13's "Care Plan" dated 01/10/22 documented staff should allow extra time for her to respond to questions or instructions.

The "Care Plan" lacked documentation for person centered dementia care and lacked direction to staff on how to deal with R13's dementia related behaviors.

On 04/03/22 at 10:15 AM R13 refused to be interviewed by the surveyor. R13 appeared agitated and did not want to anyone to approach her due to being upset.

On 04/05/22 at 07:22 AM R13 laid on her bed and watched TV. No behaviors of distress noted at this time.

On 04/05/22 at 08:23 AM R13 laid in the bed, yelled out help, that she has to go to the bathroom. R13's roommate asked her to stop yelling. R13 started to cuss at R44 and

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threatened to slap her roommate across the face. R13's call light was located on the floor behind the bed under a blanket and pillow.

On 04/05/22 at 12:20 PM 13 asleep in bed. No behaviors or distress noted.

On 04/06/22 at 07:20 AM R13 laid on the bed, her head turned toward the wall. R13 appeared calm, call light on the floor.

On 04/06/22 at 02:35 PM in an interview, Certified Nurse's Aide (CNA) M stated she was able to review the care plans and that was where to find the instructions for the care of each of the resident. CNA M the care plan would have any specialized care listed each resident. CNA M stated she had not received any dementia training at the facility. CNA M stated that she would report any behaviors to the nurse and documented behaviors in the EMR.

On 04/06/22 at 03:35 PM in an interview, Licensed Nurse (LN) G stated nursing staff review resident's care plans and updates the other staff member of changes that occur. LN G stated behavioral monitoring was completed on any one that received an antipsychotic medication, which was completed by the charge nurse on the "Medication Administration Record" (MAR). LN G stated the call light should be within reach of the resident when in their room.

On 04/04/22 at 04:20 PM in an interview, Administrative Nurse E stated, she stated that when residents first arrive a base line care plan would be completed and a comprehensive assessment with occur after the care plan has been established. Administrative Nurse E

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reported areas triggered on the MDS should be placed in the care plan and addressed on the comprehensive care plan.

The facility's "Therapeutic Activities Program" policy, revised 04/01/22, directed the facility implemented an ongoing resident centered activities program that incorporated the resident's interests, hobbies, and cultural preferences which was integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. The policy directed it was important for residents to have a choice about which activities they participated in, whether they were part of the formal activities program or self-directed and a resident's needs and choices for how they spend time, both inside and outside the facility, were also supported and accommodated. The policy directed individual interventions were developed based on each resident's assessed needs and the family was notified for any special requests; the individual program was provided according to a consistent scheduled identifying specific days of the week and time frame for which program occurred; and each resident's individual program included interventions that met the resident's social, emotional, physical, spiritual, and cognitive functioning needs, these approaches reflected the resident's lifestyle and interests and were incorporated into the interdisciplinary care plan.

The facility did not provide a policy related to dementia care.

The facility failed to develop and implement an adequate person-centered dementia care to receive the treatment and services to attain and/or maintain her practicable physical, mental

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F 744	Continued From page 145 and psychosocial well-being for R13. This deficient practice placed her at risk of increased confusion, isolation, and lack of appropriate activities and interaction.	F 744		
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. (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	F 756		

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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 identified a census of 53 residents. The sample included 16 residents; six sampled for unnecessary medication review. Based on observations, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of behavior monitoring for R39, R13, and R27 who received psychotropic (any drug that affects brain activities associated with mental processes and behavior) medications including antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), medications; and the lack of an indication for administration for Lasix (diuretic- medication to promote the formation and excretion of urine) for R13. This deficient practice had the risk for unnecessary medication use and physical complications for all residents affected.

Findings included:

- R39 admitted to facility on 03/02/22.

The "Diagnoses" tab of R39's Electronic Medical Record (EMR) documented diagnoses of bipolar (major mental illness that caused people to have episodes of severe high and low moods) disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, developmental disorder of scholastic skills, and history of falling.

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The "Admission Minimum Data Set (MDS)" dated 03/09/22, documented R39 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. R39 was independent with bed mobility, transfers, walking, dressing toileting, and personal hygiene; independent with setup help for bathing. R39 received antipsychotic, antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), and hypnotic (a class of medications used to induce sleep and treat insomnia) medications seven days in the seven-day lookback period and antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medications four days in the seven-day lookback period.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 03/09/22, documented R39 had cognitive loss related to a BIMS score less than 13 and staff allowed extra time for R39 to respond to questions and instructions.

The "Behavioral Symptoms CAA" dated 03/14/22, documented R39 had behavioral symptoms related to rejection of cares and staff gave him as many choices as possible about care and activities.

The "Psychotropic Drug Use CAA" dated 03/17/22, documented R39 had psychotropic drug use due to multiple psychiatric diagnoses.

The "Care Plan" dated 03/03/22 documented R39 had a behavior problem and yelled loudly from his

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room. Staff anticipated and met his needs and explained all procedures to R39 before starting and allowed him time to adjust to changes.

The "Care Plan" dated 03/14/22 documented R39 had potential to be verbally aggressive related to ineffective coping skills and developmental disorder and directed staff analyzed key times, places, circumstances, triggers, and what de-escalated behaviors and documented.

The "Orders" tab of R39's EMR documented an order with a start date of 03/02/22 for fluvoxamine maleate (antidepressant) 100 milligram (mg) one time day for mood disorder; an order with a start date of 03/02/22 for trazodone hydrochloride (HCl) (antidepressant) 25 mg three times a day for bipolar; an order with start date of 03/02/22 for trazodone HCl 150 mg at bedtime for bipolar; olanzapine (antipsychotic) 7.5 mg three times a day for bipolar; an order with a start date of 03/02/22 for carbamazepine (anticonvulsant-medication used to treat seizures) 100 mg two times a day for bipolar, and an order with a start date of 03/02/22 for hydroxyzine HCl (antihistamine- medication used to treat allergies and also used to help control anxiety and tension caused by nervous and emotional conditions) 25 mg every six hours as needed for anxiety. The "Orders" tab of R39's EMR lacked an order for behavior monitoring.

Review of R39's "Medication/Treatment Administration Record (MAR/TAR)" since admission revealed lack of behavior monitoring for R39.

Review of R39's "Medication Regiment Review (MRR)" for March 2022 lacked evidence the CP

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identified and reported to the facility a lack of behavior monitoring.

On 04/05/22 at 01:58 PM, R39 ambulated independently in day room and poured himself a cup of water with staff supervision. He sat down in a chair in the day room to watch television.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated everybody was responsible for behavior monitoring and the CNA notified the nurse when a resident had a behavior. She stated R39 clapped his hands or yelled out in his room and sometimes refused cares.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated the nurse completed the behavior monitoring.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) M stated particular residents had behavior monitoring and behavior monitoring was completed on any resident on a psychotropic medication. She stated behavior monitoring showed up on the TAR to be completed. She stated that if there were new orders with the MRRs then the nurse put the new orders in or made necessary changes.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated behavior monitoring was documented by the charge nurse and if residents were on certain medications that required behavior monitoring, there were two separate orders for side effects of the medication and behavior monitoring and included antidepressants, hypnotic, and psychotropic medications. She stated pharmacy reviews were emailed to the Director of Nursing (DON); reviewed by DON, unit manager, MDS

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director, and doctor/nurse practitioner and new orders/changes were put in by the same people.

On 04/07/22 at 03:35 PM, Consultant II was unavailable for interview.

The facility's "Medication Regimen Review" policy, dated 11/28/16, directed the CP conducted MRRs and made recommendations based on the information available in the residents' health record. The facility encouraged the physician or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. The attending physician documented in the residents' health record that the identified irregularity was reviewed and what, if any, action was taken; if no change in the medication, the attending physician documented the rationale in the residents' health record. The policy directed the facility alerted the medical director when MRRs were not addressed by the attending physician in a timely manner. The facility maintained readily available copies of MRRs on file in facility as part of the resident's permanent health record.

The facility's "Area of Focus: Behavioral Health Recommendations" policy, not dated, directed providing behavioral health care and services was an integral part of the person-centered environment and staff monitored residents closely for expressions or indications of distress, assessed and planned care for concerns, accurately documented the changes including the frequency of occurrence and potential trigger's in the resident's record, shared concerns with the interdisciplinary team to determine underlying causes, ensured appropriate follow-up assessment if needed, and discussed potential

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modifications to the care plan.

The facility's "Area of Focus: Behavior Management" policy, not dated, directed individualized approaches to care were provided as part of a supportive physical, mental, and psychosocial environment. The facility initiated behavior monitoring, behavior management care plan, and Kardex as indicated by assessment findings, resident/responsible party conversations, and observations. The policy directed that the resident's medical record showed documentation of adequate indication for a medication's use and the diagnosed condition for which a medication was prescribed. The policy directed the facility monitored medications for efficacy and adverse reactions.

The facility's "Psychotropic Medication Use" policy, last revised 01/01/22, directed all medications used to treat behaviors had a clinical indication and was used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors were monitored for efficacy, risks, benefits, and harm or adverse consequences.

The facility failed to ensure the CP identified and reported the lack of behavior monitoring for R39 who received psychotropic medication including an antipsychotic. This deficient practice had the risk for unnecessary medication use and physical complications.

- R13's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of

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vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbances and cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) left lower limb.

The "Admission Minimum Data Set" (MDS) dated 01/14/22 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R13 required extensive assistance of one person for all activities of daily living (ADLs) except eating, for which she was independent. R13 required assistance of one staff member for bathing. R13 had no behaviors. The MDS recorded R13 received an antipsychotic (medication used to treat psychosis), diuretic (medication used to promote excretion of fluids) and opioids (medications use to treat pain) during the lookback period.

R13's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/20/22 documented staff encouraged her to use the call light for assistance with ADL's. R13 received routine antipsychotic medication, staff monitored for adverse reactions and for changes in R13 mood or behaviors.

R13's "Care Plan" dated 01/18/22 documented monitor for changes in mental status caused by situational stressors. Monitor for increased anxiety, changes in mood/behaviors.

Review of the EMR under "Orders" tab revealed physician orders:

Risperidone (antipsychotic) tablet one milligram

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(mg) by mouth in the morning for dementia with behaviors dated 01/07/22.

Furosemide (diuretic) tablet 20 mg give one tablet by mouth in the morning dated 01/07/22.

Review of the EMR under the "Reports" tab for review of "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) from 01/01/22 to 04/04/22 lacked behavior monitoring and indication for administration of diuretic medication for R13.

Review of the "Monthly Medication Review" (MMR), performed by the CP, reviewed April 2021 through March 022. MMR for October 2021 and December 2021 were not available to review. The available MMR did not address the lack of behavior monitoring for an antipsychotic medication and indication for administration of diuretic medication for R13.

On 04/03/22 at 10:15 AM R13 refused to be interviewed by the surveyor. R13 appeared agitated and did not want to anyone to approach her due to being upset.

On 04/03/22 at 10:15 AM R13 refused to be interviewed by the surveyor. R13 appeared agitated and did not want to anyone to approach her due to being upset.

On 04/05/22 at 07:22 AM R13 laid on her bed and watched TV. No behaviors of distress noted at this time.

On 04/06/22 at 07:20 AM R13 laid on the bed, her head turned toward the wall. R13 appeared calm, call light on the floor.

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On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated the charge nurse documented the behavior monitoring for the residents. CMA R stated every medication should have an indication for administration. CMA R stated she would let the charge nurse know if she noticed a medication without an indication for administration.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) M stated the nurse was responsible for monitoring and documentation of behavior monitoring. LN M stated that if there were new orders with the MRRs then the nurse put the new orders in or made necessary changes.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated behavior monitoring was documented by the charge nurse and if residents were on certain medications that required behavior monitoring, there were two separate orders for side effects of the medication and behavior monitoring and included antidepressants, hypnotic, and psychotropic medications. She stated pharmacy reviews were emailed to the Director of Nursing (DON); reviewed by DON, unit manager, MDS director, and doctor/nurse practitioner and new orders/changes were put in by the same people.

On 04/07/22 at 03:35 PM, Consultant II was unavailable for interview.

The facility's "Medication Regimen Review" policy, dated 11/28/16, directed the CP conducted MRRs and made recommendations based on the information available in the residents' health record. The facility encouraged the physician or other responsible parties receiving the MRR and

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the director of nursing to act upon the recommendations contained in the MRR. The attending physician documented in the residents' health record that the identified irregularity was reviewed and what, if any, action was taken; if no change in the medication, the attending physician documented the rationale in the residents' health record. The policy directed the facility alerted the medical director when MRRs were not addressed by the attending physician in a timely manner. The facility maintained readily available copies of MRRs on file in facility as part of the resident's permanent health record.

The facility's "Area of Focus: Behavioral Health Recommendations" policy, not dated, directed providing behavioral health care and services was an integral part of the person-centered environment and staff monitored residents closely for expressions or indications of distress, assessed and planned care for concerns, accurately documented the changes including the frequency of occurrence and potential trigger's in the resident's record, shared concerns with the interdisciplinary team to determine underlying causes, ensured appropriate follow-up assessment if needed, and discussed potential modifications to the care plan.

The facility's "Area of Focus: Behavior Management" policy, not dated, directed individualized approaches to care were provided as part of a supportive physical, mental, and psychosocial environment. The facility-initiated behavior monitoring, behavior management care plan, and Kardex as indicated by assessment findings, resident/responsible party conversations, and observations. The policy directed that the resident's medical record

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showed documentation of adequate indication for a medication's use and the diagnosed condition for which a medication was prescribed. The policy directed the facility monitored medications for efficacy and adverse reactions.

The facility's "Psychotropic Medication Use" policy, last revised 01/01/22, directed all medications used to treat behaviors had a clinical indication and was used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors were monitored for efficacy, risks, benefits, and harm or adverse consequences.

The facility failed to ensure CP II recognized and reported lack of documentation of behavior monitoring for antipsychotic medication and administration of diuretic medication for R13. This had the potential risk for harmful side effects related to unnecessary medications.

- R27's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety(mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Annual Minimum Data Set" (MDS) dated 11/18/21 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R27 required

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extensive assistance of one to staff members for all activities of daily living (ADLs) except eating and locomotion for which she was independent. R27 required assistance of two staff members for bathing. The MDS recorded R27 rejected cares daily during the lookback period. The MDS recorded R27 was at risk for pressure injuries but had no pressure injuries. She had a pressure reducing device in her chair and bed but was not on a turning/repositioning program. R27 received an antipsychotic (medication used to treat psychosis), antidepressant (medication used to treat depression) and an antibiotic (medication used to treat bacterial infections) for seven days of the look back period. The MDS documented R27 required physical assistance of one staff member for bathing during look back period.

The "Quarterly MDS" dated 02/08/22 recorded R27 had a BIMS score of 12 which indicated moderately impaired cognition. The MDS recorded R27 required extensive assistance of one to staff members for all activities of daily living (ADLs) including locomotion and supervision of two staff for eating. R27 was totally dependent on one staff for bathing. R27 had verbal behavioral symptoms directed at other for one to three of the lookback days and rejected cares for four to six of the lookback days. The MDS recorded R27 was at risk for pressure injuries but had no pressure injuries. She had a pressure reducing device in her chair and bed but was not on a turning/repositioning program. R27 received an antipsychotic, antidepressant, antibiotic, anticoagulant (medication used to thin blood), insulin (hormone used to treat high blood glucose) and received injections during the lookback period. The MDS documented R27 was totally dependent of two or more staff for bathing

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activity during the look back period.

R27's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 11/22/21 documented on routine antidepressant and antipsychotic medications. R27 was at risk for adverse reactions, staff were to monitor routinely for adverse reactions and/or for changes of mood or behavior.

R27's "Care Plan" dated 11/21 directed staff to administer psychotropic medication and antidepressant medication as ordered by the physician. monitor for any side effects and effectiveness every shift.

Review of the EMR under "Orders" tab revealed physician orders:

Escitalopram oxalate (antidepressant) tablet 10 milligrams (mg), give one tablet by mouth daily for major depressive disorder dated 02/01/22.

Risperidone (antipsychotic) tablet two mg, give one tablet by mouth at bedtime for schizophrenia dated 03/29/2022.

Review of the EMR under the "Reports" tab for review of "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) from 01/01/22 to 04/04/22 lacked behavior monitoring for R27.

Review of the "Monthly Medication Review" (MMR), performed by the CP, reviewed April 2021 through March 022. MMR for October 2021 and December 2021 were not available to review. The available MMR did not address the lack of behavior monitoring for R27, on an antipsychotic

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medication.

On 04/05/22 at 07:44 AM R27 laid on her back in bed. R27 stated she was waiting for breakfast, no behaviors or distress noted.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated the charge nurse documented the behavior monitoring for the residents. CMA R stated every medication should have an indication for administration. CMA R stated she would let the charge nurse know if she noticed a medication without an indication for administration.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) M stated the nurse was responsible for monitoring and documentation of behavior monitoring. LN M stated that if there were new orders with the MRRs then the nurse put the new orders in or made necessary changes.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated behavior monitoring was documented by the charge nurse and if residents were on certain medications that required behavior monitoring, there were two separate orders for side effects of the medication and behavior monitoring and included antidepressants, hypnotic, and psychotropic medications. She stated pharmacy reviews were emailed to the Director of Nursing (DON); reviewed by DON, unit manager, MDS director, and doctor/nurse practitioner and new orders/changes were put in by the same people.

On 04/07/22 at 03:35 PM, Consultant II was unavailable for interview.

The facility's "Medication Regimen Review"

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policy, dated 11/28/16, directed the CP conducted MRRs and made recommendations based on the information available in the residents' health record. The facility encouraged the physician or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. The attending physician documented in the residents' health record that the identified irregularity was reviewed and what, if any, action was taken; if no change in the medication, the attending physician documented the rationale in the residents' health record. The policy directed the facility alerted the medical director when MRRs were not addressed by the attending physician in a timely manner. The facility maintained readily available copies of MRRs on file in facility as part of the resident's permanent health record.

The facility's "Area of Focus: Behavioral Health Recommendations" policy, not dated, directed providing behavioral health care and services was an integral part of the person-centered environment and staff monitored residents closely for expressions or indications of distress, assessed and planned care for concerns, accurately documented the changes including the frequency of occurrence and potential trigger's in the resident's record, shared concerns with the interdisciplinary team to determine underlying causes, ensured appropriate follow-up assessment if needed, and discussed potential modifications to the care plan.

The facility's "Area of Focus: Behavior Management" policy, not dated, directed individualized approaches to care were provided as part of a supportive physical, mental, and psychosocial environment. The facility-initiated

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F 756	Continued From page 161 behavior monitoring, behavior management care plan, and Kardex as indicated by assessment findings, resident/responsible party conversations, and observations. The policy directed that the resident's medical record showed documentation of adequate indication for a medication's use and the diagnosed condition for which a medication was prescribed. The policy directed the facility monitored medications for efficacy and adverse reactions. The facility's "Psychotropic Medication Use" policy, last revised 01/01/22, directed all medications used to treat behaviors had a clinical indication and was used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors were monitored for efficacy, risks, benefits, and harm or adverse consequences. The facility failed to ensure CP II recognized and reported lack of documentation of behavior monitoring for R27 who received psychotropic medications including an antipsychotic. This had the potential risk for side effects related to unnecessary medications.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		

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F 757	Continued From page 162 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included 16 residents; six sampled for unnecessary medication review. Based on observations, record review, and interviews, the facility failed to provide consistent bowel monitoring and failed to obtain an order to administer an as needed (PRN) laxative (medication used to loosen stool or stimulate a bowel movement) for Resident (R) 45; failed to ensure carvedilol (antihypertensive- medication used to treat hypertension [high blood pressure]) was not given outside ordered parameters for R205; failed to ensure an indication for administration for Lasix (diuretic- medication to promote the formation and excretion of urine) was documented for R13. This deficient practice had the risk for unnecessary medication use and physical complications. Findings included: - The "Diagnoses" tab of R45's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (major mood disorder) and	F 757		

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psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing) with delusions due to known physiological condition.

The "Annual Minimum Data Set (MDS)" dated 06/29/21, documented R45 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. She required supervision with setup help only with toileting, bed mobility, transfers, walking, and eating; limited physical assistance with one staff for personal hygiene. R45 was always continent of bowel. R45 received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications seven days in the seven-day lookback period.

The "Quarterly MDS" dated 03/10/22, documented R45 had a BIMS score of 13 which indicated intact cognition. She was independent with no setup help with bed mobility, transfers, walking, locomotion, and personal hygiene; independent with setup help only for dressing and eating; and supervision with setup help only with toileting. R45 was always continent of bowel. R45 received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions, antianxiety (class of medications that calm and relax people with excessive anxiety [mental or emotional reaction characterized by apprehension, uncertainty and irrational fear], nervousness, or tension), and antidepressant medications seven days in the seven-day lookback period.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 07/12/21, documented

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R45 required supervision assistance with ADL function, risk included self-care deficit, care planned to minimize risks.

The "Care Plan" initiated 04/23/19 documented R45 had an ADL self-care performance deficit related to cognitive and behavior problems and directed she was able to toilet independently.

The "Orders" tab of R45's EMR documented an order with a start date of 03/24/20 for docusate sodium (laxative) 100 milligrams (mg) twice a day for bowel management. There was a lack of evidence of a PRN laxative order.

The "Documentation Survey Report" for 01/01/22 to 04/06/22 documented a task for bowel and bladder elimination and revealed the following periods of time where no bowel movement was recorded: 01/01/22 to 01/10/22, 01/20/22 to 01/25/22, 02/03/22 to 02/08/22, and 02/17/22.

The "Medication Administration Record" lacked evidence of a PRN laxative given during the above periods of time where no bowel movement was documented.

R45's medical record lacked evidence a bowel assessment was completed for the above time frames where no bowel movement was documented.

On 04/06/22 at 09:18 AM, R45 ambulated independently in hallway, appeared comfortable and without signs of distress or discomfort.

On 04/06/22 at 10:24 AM, R45 stated she had issues with having bowel movements and the facility did not give her anything for it.

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F 757	Continued From page 165 On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated the aides monitored bowel movements and documented in Point of Care (POC- EMR system for CNA documentation). If a resident was independent, she did not ask them if they had a bowel movement. On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated R45 did not have issues with bowel movements. She stated the facility had a bowel protocol and the nurse checked the computer for bowel movement alerts and let her know when to give a PRN laxative or the nurse put standing orders in the computer for her to give the resident. On 04/06/22 at 03:34 PM, Licensed Nurse (LN) M stated CNAs documented bowel movements and the nurse manager followed up to see if any residents had not had a bowel movement in three days. If a resident needed a laxative, she contacted the nurse practitioner for orders. LN M stated she did not ask independent residents about bowel movements. On 04/06/22 at 05:22 PM, Administrative Nurse D stated CNAs and nurses documented bowel movements in ADL charting if the resident had a bowel movement. If a resident had not had a bowel movement in three days, she expected staff to ask the independent resident if they had a bowel movement. If the resident needed a laxative then staff were expected to reach out to the nurse practitioner. The facility did not provide a policy on bowel management.	F 757		

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The facility failed to provide consistent bowel monitoring and failed to obtain an order to administer a PRN laxative for R45. This deficient practice had the risk for unnecessary medication use and physical complications.

- R205 admitted to facility on 01/07/22.

The "Diagnoses" tab of R205's Electronic Medical Record (EMR) documented diagnoses of anoxic brain injury (condition caused by a complete lack of oxygen to the brain), need for assistance with personal care, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension.

The "Admission Minimum Data Set (MDS)" dated 01/14/22, documented a Brief Interview for Mental Status (BIMS) was not completed due to R205 rarely/never understood. R205 required extensive physical assistance with two staff for bed mobility and dressing; total physical dependence with one staff for eating and personal hygiene; total physical dependence with two staff for toileting and transfers. R205 received antianxiety(class of medications that calm and relax people with excessive anxiety [mental or emotional reaction characterized by apprehension, uncertainty and irrational fear], nervousness, or tension) medications three days and antidepressant (medications used to treat depression) seven days in the seven-day lookback period.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 01/17/22 documented R205 had cognition loss

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related to short- and long-term memory loss.

The "Delirium (sudden severe confusion, disorientation and restlessness) CAA" dated 01/17/22, documented R205 was at risk for delirium related to confused episodes and directed staff provided medications as ordered.

The "Care Plan" dated 03/11/22, documented R205 was at risk for adverse reaction related to black box warning (BBW- warnings required by the Food and Drug Administration for certain medications that carry serious safety risks) and directed staff discussed with resident and family the number and type of medications resident was taking and the potential for drug interactions and side effects from over-medication.

The "Orders" tab of R205's EMR documented an order with a start date of 01/07/22 for carvedilol 3.125 milligrams (mg) two times a day for hypertension with instructions to hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than 100 millimeters per Mercury (mmHg) or heart rate (pulse) less than 60 beats per minute (bpm).

The "Medication Administration Record" for 01/01/22 to 04/06/22 revealed the following administrations for carvedilol given outside ordered parameters for R205: 01/09/22 evening (PM), 01/10/22 morning (AM), 01/15/22 PM, 01/22/22 AM, 03/09/22 AM/PM, 03/15/22 AM, 03/16/22 AM, 03/18/22 AM, 03/19/22 AM, 03/22/22 AM/PM, 03/23/22 PM, 03/26/22 AM/PM, 03/30/22 AM, and 04/02/22 AM.

On 04/05/22 at 11:46 AM, R205 sat in his Broda

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chair at table in day room, he attempted to talk to staff walking past him, but they did not acknowledge hearing him.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated if a blood pressure or pulse was outside of ordered parameters, she held the medication then reported it to the nurse.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) G stated if blood pressure or pulse was outside of ordered parameters, she held the medication and contacted the doctor.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated she expected staff to obtain blood pressure and/or pulse for ordered parameters and hold the medication if the blood pressure/pulse were outside ordered parameters. Staff documented if medication was held or given and if needed, documented if physician was contacted.

The facility's "Administration of Medications" policy, last revised 07/14/21, directed all medications were administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.

The facility failed to ensure that carvedilol was not administered outside of ordered parameters for R205. This deficient practice had the risk for unnecessary medication use and physical complications.
- R13's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain)

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with behavioral disturbances and cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) left lower limb.

The "Admission Minimum Data Set" (MDS) dated 01/14/22 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R13 required extensive assistance of one person for all activities of daily living (ADLs) except eating, for which she was independent. R13 required assistance of one staff member for bathing. R13 had no behaviors. The MDS recorded R13 received an antipsychotic (medication used to treat psychosis), diuretic (medication used to promote excretion of fluids) and opioids (medications use to treat pain) during the lookback period.

R13's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/20/22 documented staff encouraged her to use the call light for assistance with ADL's. R13 received routine antipsychotic medication, staff monitored for adverse reactions and for changes in R13 mood or behaviors.

R13's "Care Plan" dated 01/18/22 documented monitor for changes in mental status caused by situational stressors. Monitor for increased anxiety, changes in mood/behaviors.

Review of the EMR under "Orders" tab revealed physician orders:

Furosemide (diuretic) tablet 20 mg give one tablet by mouth in the morning dated 01/07/22.

Review of the EMR under the "Reports" tab for

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review of "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) from 01/01/22 to 04/04/22 lacked behavior monitoring and indication for administration of diuretic medication for R13.

On 04/05/22 at 08:23 AM R13 laid in the bed, yelled out help, that she must go to the bathroom. R13's roommate asked her to stop yelling. R13 started to cuss at R44 and threatened to slap her roommate across the face. R13's call light was located on the floor behind the bed under a blanket and pillow.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated the charge nurse documented the behavior monitoring for the residents. CMA R stated every medication should have an indication for administration. CMA R stated she would let the charge nurse know if she noticed a medication without an indication for administration.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) M stated the nurse was responsible for monitoring and documentation of behavior monitoring. LN M stated that if there were new orders with the MRRs then the nurse put the new orders in or made necessary changes. LN G stated every medication needed an indication for administration and she would call the physician to get a diagnosis or indication for use.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated behavior monitoring was documented by the charge nurse and if residents were on certain medications that required behavior monitoring, there were two separate orders for side effects of the medication and behavior monitoring and

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F 757	Continued From page 171 included antidepressants, hypnotic, and psychotropic medications. She stated pharmacy reviews were emailed to the Director of Nursing (DON); reviewed by DON, unit manager, MDS director, and doctor/nurse practitioner and new orders/changes were put in by the same people. Administrative Nurse D stated every medication or order needed an indication for administration. The facility's "Administration of Medication "policy revision date 07/14/21 documented a physician order that includes dosage, route, frequency, duration and other required consideration included the purpose, diagnosis or indication for use was required for administration of the medications. The facility failed to ensure R13's diuretic medication had an indication for administration, this placed her at risk for adverse consequences related to unnecessary medication and se and possible side effects.	F 757		
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---	F 758		

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F 758	Continued From page 172 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended 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 identified a census of 53 residents. The sample included 16 residents; six sampled for unnecessary medication review. Based on observations, record review, and interviews, the	F 758		

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facility failed to ensure an as needed (PRN) psychotropic (any drug that affects brain activities associated with mental processes and behavior) medication had a 14-day stop date or a documented rationale for extended duration for R39 and facility failed to provide behavior monitoring for R39, R13, and R27 who received psychotropic medications, including antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medications. This deficient practice had the risk for unnecessary medication use and physical complications for all residents affected.

Findings included:

- R39 admitted to facility on 03/02/22.

The "Diagnoses" tab of R39's Electronic Medical Record (EMR) documented diagnoses of bipolar (major mental illness that caused people to have episodes of severe high and low moods) disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, developmental disorder of scholastic skills, and history of falling.

The "Admission Minimum Data Set (MDS)" dated 03/09/22, documented R39 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. R39 was independent with bed mobility, transfers, walking, dressing toileting, and personal hygiene; independent with setup help for bathing. R39 received antipsychotic, antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), and hypnotic (a class of medications used to induce sleep and treat insomnia) medications seven days in the

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seven-day lookback period and antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medications four days in the seven-day lookback period.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 03/09/22, documented R39 had cognitive loss related to a BIMS score less than 13 and staff allowed extra time for R39 to respond to questions and instructions.

The "Behavioral Symptoms CAA" dated 03/14/22, documented R39 had behavioral symptoms related to rejection of cares and staff gave him as many choices as possible about care and activities.

The "Psychotropic Drug Use CAA" dated 03/17/22, documented R39 had psychotropic drug use due to multiple psychiatric diagnoses.

The "Care Plan" dated 03/03/22 documented R39 had a behavior problem and yelled loudly from his room. Staff anticipated and met his needs and explained all procedures to R39 before starting and allowed him time to adjust to changes.

The "Care Plan" dated 03/14/22 documented R39 had potential to be verbally aggressive related to ineffective coping skills and developmental disorder and directed staff analyzed key times, places, circumstances, triggers, and what de-escalated behaviors and documented.

The "Orders" tab of R39's EMR documented an order with a start date of 03/02/22 for fluvoxamine

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maleate (antidepressant) 100 milligram (mg) one time day for mood disorder; an order with a start date of 03/02/22 for trazodone hydrochloride (HCl) (antidepressant) 25 mg three times a day for bipolar; an order with start date of 03/02/22 for trazodone HCl 150 mg at bedtime for bipolar; olanzapine (antipsychotic) 7.5 mg three times a day for bipolar; an order with a start date of 03/02/22 for carbamazepine (anticonvulsant-medication used to treat seizures) 100 mg two times a day for bipolar, and an order with a start date of 03/02/22 for hydroxyzine HCl (antihistamine andhypnotic medication used to treat allergies and also used to help control anxiety and tension caused by nervous and emotional conditions) 25 mg every six hours as needed for anxiety. The "Orders" tab of R39's EMR lacked an order for behavior monitoring.

Review of R39's "Medication/Treatment Administration Record (MAR/TAR)" since admission revealed lack of behavior monitoring for R39.

R39's medical record lacked evidence of a rationale for extended duration of use for hydroxyzine PRN.

On 04/05/22 at 01:58 PM, R39 ambulated independently in day room and poured himself a cup of water with staff supervision. He sat down in a chair in the day room to watch television.

On 04/06/22 at 02:40 PM, Certified Nurse Aide (CNA) M stated everybody was responsible for behavior monitoring and the CNA notified the nurse when a resident had a behavior. She stated R39 clapped his hands or yelled out in his room and sometimes refused cares.

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On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated the nurse completed the behavior monitoring.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) M stated particular residents had behavior monitoring and behavior monitoring was completed on any resident on a psychotropic medication. She stated behavior monitoring showed up on the TAR to be completed.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated behavior monitoring was documented by the charge nurse and if residents were on certain medications that required behavior monitoring, there were two separate orders for side effects of the medication and behavior monitoring and included antidepressants, hypnotic, and psychotropic medications. She stated PRN psychotropics had a 14-day duration.

The facility's "Area of Focus: Behavioral Health Recommendations" policy, not dated, directed providing behavioral health care and services was an integral part of the person-centered environment and staff monitored residents closely for expressions or indications of distress, assessed and planned care for concerns, accurately documented the changes including the frequency of occurrence and potential trigger's in the resident's record, shared concerns with the interdisciplinary team to determine underlying causes, ensured appropriate follow-up assessment if needed, and discussed potential modifications to the care plan.

The facility's "Area of Focus: Behavior Management" policy, not dated, directed

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individualized approaches to care were provided as part of a supportive physical, mental, and psychosocial environment. The facility initiated behavior monitoring, behavior management care plan, and Kardex as indicated by assessment findings, resident/responsible party conversations, and observations. The policy directed that the resident's medical record showed documentation of adequate indication for a medication's use and the diagnosed condition for which a medication was prescribed. The policy directed the facility monitored medications for efficacy and adverse reactions.

The facility's "Psychotropic Medication Use" policy, last revised 01/01/22, directed all medications used to treat behaviors had a clinical indication and was used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors were monitored for efficacy, risks, benefits, and harm or adverse consequences. The policy directed that PRN psychotropic medications were ordered for no more than 14 days. The policy directed for psychotropic medications, excluding antipsychotics, that the attending physician believed a PRN order for longer than 14 days was appropriate, the attending physician could extend the prescription beyond 14 days for the resident by documenting their rationale in the resident's medical record.

The facility failed to ensure a PRN psychotropic medication had a 14-day stop date or a documented rationale for extended duration for R39 and failed to provide behavior monitoring for R39 who received psychotropic medication, including an antipsychotic medication. This deficient practice had the risk for unnecessary

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medication use and physical complications.
- R13's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbances and cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) left lower limb.

The "Admission Minimum Data Set" (MDS) dated 01/14/22 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R13 required extensive assistance of one person for all activities of daily living (ADLs) except eating, for which she was independent. R13 required assistance of one staff member for bathing. R13 had no behaviors. The MDS recorded R13 received an antipsychotic (medication used to treat psychosis), diuretic (medication used to promote excretion of fluids) and opioids (medications use to treat pain) during the lookback period.

R13's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/20/22 documented staff encouraged her to use the call light for assistance with ADL's. R13 received routine antipsychotic medication, staff monitored for adverse reactions and for changes in R13 mood or behaviors.

R13's "Care Plan" dated 01/18/22 documented monitor for changes in mental status caused by situational stressors. Monitor for increased anxiety, changes in mood/behaviors.

Review of the EMR under "Orders" tab revealed

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physician orders:

Risperidone (antipsychotic) tablet one milligram (mg) by mouth in the morning for dementia with behaviors dated 01/07/22.

Review of the EMR under the "Reports" tab for review of "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) from 01/01/22 to 04/04/22 lacked behavior monitoring for R13.

On 04/03/22 at 10:15 AM R13 refused to be interviewed by the surveyor. R13 appeared agitated and did not want to anyone to approach her due to being upset.

On 04/05/22 at 07:22 AM R13 laid on her bed and watched TV. No behaviors of distress noted at this time.

On 04/05/22 at 08:23 AM R13 laid in the bed, yelled out help, that she must go to the bathroom. R13's roommate asked her to stop yelling. R13 started to cuss at R44 and threatened to slap her roommate across the face. R13's call light was located on the floor behind the bed under a blanket and pillow.

On 04/05/22 at 12:20 PM 13 asleep in bed. No behaviors or distress noted.

On 04/03/22 at 10:15 AM R13 refused to be interviewed by the surveyor. R13 appeared agitated and did not want to anyone to approach her due to being upset.

On 04/05/22 at 07:22 AM R13 laid on her bed and watched TV. No behaviors of distress noted at

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this time.

On 04/06/22 at 07:20 AM R13 laid on the bed, her head turned toward the wall. R13 appeared calm, call light on the floor.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated the charge nurse documented the behavior monitoring for the residents. CMA R stated every medication should have an indication for administration. CMA R stated she would let the charge nurse know if she noticed a medication without an indication for administration.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) M stated the nurse was responsible for monitoring and documentation of behavior monitoring. LN M stated that if there were new orders with the MRRs then the nurse put the new orders in or made necessary changes.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated behavior monitoring was documented by the charge nurse and if residents were on certain medications that required behavior monitoring, there were two separate orders for side effects of the medication and behavior monitoring and included antidepressants, hypnotic, and psychotropic medications. She stated pharmacy reviews were emailed to the Director of Nursing (DON); reviewed by DON, unit manager, MDS director, and doctor/nurse practitioner and new orders/changes were put in by the same people.

The facility's "Medication Regimen Review" policy, dated 11/28/16, directed the CP conducted MRRs and made recommendations based on the information available in the residents' health

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record. The facility encouraged the physician or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. The attending physician documented in the residents' health record that the identified irregularity was reviewed and what, if any, action was taken; if no change in the medication, the attending physician documented the rationale in the residents' health record. The policy directed the facility alerted the medical director when MRRs were not addressed by the attending physician in a timely manner. The facility maintained readily available copies of MRRs on file in facility as part of the resident's permanent health record.

The facility's "Psychotropic Medication Use" policy, last revised 01/01/22, directed all medications used to treat behaviors had a clinical indication and was used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors were monitored for efficacy, risks, benefits, and harm or adverse consequences.

The facility failed to monitor behaviors for R13 which had the potential of unnecessary psychotropic medication administration, thus leading to possible harmful potential side effects related to unnecessary medications.

- R27's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated

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feelings of sadness, worthlessness and emptiness), and anxiety(mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Annual Minimum Data Set" (MDS) dated 11/18/21 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded R27 required extensive assistance of one to staff members for all activities of daily living (ADLs) except eating and locomotion for which she was independent. R27 required assistance of two staff members for bathing. The MDS recorded R27 rejected cares daily during the lookback period. The MDS recorded R27 was at risk for pressure injuries but had no pressure injuries. She had a pressure reducing device in her chair and bed but was not on a turning/repositioning program. R27 received an antipsychotic (medication used to treat psychosis), antidepressant (medication used to treat depression) and an antibiotic (medication used to treat bacterial infections) for seven days of the look back period. The MDS documented R27 required physical assistance of one staff member for bathing during look back period.

The "Quarterly MDS" dated 02/08/22 recorded R27 had a BIMS score of 12 which indicated moderately impaired cognition. The MDS recorded R27 required extensive assistance of one to staff members for all activities of daily living (ADLs) including locomotion and supervision of two staff for eating. R27 was totally dependent on one staff for bathing. R27 had verbal behavioral symptoms directed at other for one to three of the lookback days and rejected cares for four to six of the lookback days. The MDS recorded R27 was at risk for pressure

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injuries but had no pressure injuries. She had a pressure reducing device in her chair and bed but was not on a turning/repositioning program. R27 received an antipsychotic, antidepressant, antibiotic, anticoagulant (medication used to thin blood), insulin (hormone used to treat high blood glucose) and received injections during the lookback period. The MDS documented R27 was totally dependent of two or more staff for bathing activity during the look back period.

R27's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 11/22/21 documented she was on routine antidepressant and antipsychotic medications. R27 was at risk for adverse reactions, staff were to monitor routinely for adverse reactions and/or for changes of mood or behavior.

R27's "Care Plan" dated 11/21 directed staff to administer psychotropic medication and antidepressant medication as ordered by the physician. monitor for any side effects and effectiveness every shift.

Review of the EMR under "Orders" tab revealed physician orders:

Escitalopram oxalate (antidepressant) tablet 10 milligrams (mg), give one tablet by mouth daily for major depressive disorder dated 02/01/22.

Risperidone (antipsychotic) tablet two mg, give one tablet by mouth at bedtime for schizophrenia dated 03/29/2022.

Review of the EMR under the "Reports" tab for review of "Medication Administration Record" (MAR) and "Treatment Administration Record"

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(TAR) from 01/01/22 to 04/04/22 lacked behavior monitoring for R27.

On 04/05/22 at 07:44 AM R27 laid on her back in bed. R27 stated she was waiting for breakfast, no behaviors or distress noted.

On 04/06/22 at 03:20 PM, Certified Medication Aide (CMA) R stated the charge nurse documented the behavior monitoring for the residents. CMA R stated every medication should have an indication for administration. CMA R stated she would let the charge nurse know if she noticed a medication without an indication for administration.

On 04/06/22 at 03:34 PM, Licensed Nurse (LN) M stated the nurse was responsible for monitoring and documentation of behavior monitoring. LN M stated that if there were new orders with the MRRs then the nurse put the new orders in or made necessary changes.

On 04/06/22 at 05:22 PM, Administrative Nurse D stated behavior monitoring was documented by the charge nurse and if residents were on certain medications that required behavior monitoring, there were two separate orders for side effects of the medication and behavior monitoring and included antidepressants, hypnotic, and psychotropic medications. She stated pharmacy reviews were emailed to the Director of Nursing (DON); reviewed by DON, unit manager, MDS director, and doctor/nurse practitioner and new orders/changes were put in by the same people.

The facility's "Medication Regimen Review" policy, dated 11/28/16, directed the CP conducted MRRs and made recommendations based on the

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information available in the residents' health record. The facility encouraged the physician or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. The attending physician documented in the residents' health record that the identified irregularity was reviewed and what, if any, action was taken; if no change in the medication, the attending physician documented the rationale in the residents' health record. The policy directed the facility alerted the medical director when MRRs were not addressed by the attending physician in a timely manner. The facility maintained readily available copies of MRRs on file in facility as part of the resident's permanent health record.

The facility's "Area of Focus: Behavioral Health Recommendations" policy, not dated, directed providing behavioral health care and services was an integral part of the person-centered environment and staff monitored residents closely for expressions or indications of distress, assessed and planned care for concerns, accurately documented the changes including the frequency of occurrence and potential trigger's in the resident's record, shared concerns with the interdisciplinary team to determine underlying causes, ensured appropriate follow-up assessment if needed, and discussed potential modifications to the care plan.

The facility's "Area of Focus: Behavior Management" policy, not dated, directed individualized approaches to care were provided as part of a supportive physical, mental, and psychosocial environment. The facility-initiated behavior monitoring, behavior management care plan, and Kardex as indicated by assessment

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F 758	Continued From page 186 findings, resident/responsible party conversations, and observations. The policy directed that the resident's medical record showed documentation of adequate indication for a medication's use and the diagnosed condition for which a medication was prescribed. The policy directed the facility monitored medications for efficacy and adverse reactions. The facility's "Psychotropic Medication Use" policy, last revised 01/01/22, directed all medications used to treat behaviors had a clinical indication and was used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors were monitored for efficacy, risks, benefits, and harm or adverse consequences. The facility failed to monitor behaviors for R27 which had the potential of unnecessary psychotropic medication administration, thus leading to possible harmful potential side effects related to unnecessary medications.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		

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biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 53 residents and three medication carts. Based on observation, record review, and interview, the facility failed to properly date five individual insulin (a hormone which regulates blood sugar) pens in one of the three medication carts. This deficient practice left the residents being administered these insulins at risk for adverse consequences or less effective medication treatment.

Findings included:

- On 04/05/22 at 07:50 AM, the nurse's medication cart on the south 100 hall contained the following insulin pens: one Novolin N flex pen (an intermediate-acting insulin that starts to work within two to four hours, and keeps working for 12 to 18 hours) that was opened and not dated ; one Lantus pen (a long-acting insulin) that was opened and not dated; one Novolog aspart insulin pen (a short-acting insulin that lasted four to six hours) that was opened and not dated; and Basaglar Kwik Pen (a long-acting insulin) that was opened and not dated; and one Levemir (a

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long-acting insulin) that was opened and not dated.

According to the Health Direct Pharmacy Services, Novolin, Lantus, and Basaglar insulins expired 28 days after opening. Levemir insulin expired 42 days after opening.

On 04/05/22 at 07:55 AM Licensed Nurse (LN) I stated that all/any of the insulins should be dated when they were opened for the first use. LN I gathered the undated insulin pen and disposed of them in the sharps container in the medication room and obtained new unopened insulins to replace the undated ones and dated the new insulin pens and placed them in the medication cart.

On 04/06/22 at 03:35 PM LN G stated that insulin pens should be dated as soon as they were opened. She said she would remove the insulin pens in the medication cart if she noticed that any of them were undated and dispose of them and get a new insulin pen out of the refrigerator on the medication storage room.

On 04/06/22 at 06:30 PM Administrative Nurse D stated that she expected nursing staff to date insulin pens as soon as the pen was opened to be used. The staff nurses were expected to check the medications and insulin pens in their medication cart at the beginning of each shift for undated or outdated medications. The unit manager also audited the medication carts weekly.

The facility policy "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" last revised 10/28/19 documented the

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F 761	Continued From page 189 following. Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to the expiration dates for opened medications. The facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication had a shortened expiration date once opened; if a multi-dose vial of an injectable medication had been opened or accessed, the vial should be dated and discarded within 28 days unless the manufacturer specified a different date for that opened vial. The facility personnel should inspect nursing storage areas for proper storage compliance on a regularly scheduled basis. The facility failed to ensure that nursing staff properly dated resident's insulin pens when opened, which had the potential to cause adverse consequences or ineffective treatment to the residents.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents

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identified under the facility's IPCP and the corrective actions taken by the facility.

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified 53 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to maintain a sanitary and clean wound field when providing wound care for R3, failed to ensure that facility staff properly dated, stored and cleaned supplemental oxygen (O2) equipment for resident (R)6, R23, and R49, failed to ensure that facility staff did proper hand hygiene while passing meal trays to residents, failed to ensure that facility staff properly transported clean laundry to residents, and failed to ensure that staff sanitized/cleaned a mechanical lift (a machine that assists in the transfer of a resident) after use. These deficient practices placed the residents at risk for increased infection and transmission of communicable disease.

Findings included:

- On 04/06/22 at 10:50 AM, Licensed Nurse (LN) H and Consultant HH entered R3's room to perform wound assessment and wound care. LN H closed the door and blinds, raised the bed, then performed hand hygiene and donned (put on) gloves. Consultant HH performed hand hygiene

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and donned gloves. Consultant HH stood on the left side of the bed and used the draw sheet on to roll R3 onto her right side to visualize her coccyx/sacral wound while LN H held R3 in that position from the right side of the bed. Consultant HH unfastened R3's brief and noticed she had some bowel movement in her brief. There was no dressing in place on R3's coccyx wound at that time. Consultant HH measured the wound with a wound measuring ruler that she removed from her bag. She used a tablet to take pictures of the wound. Consultant HH pulled out a wound imaging device from her bag that she stated was used to determine if there was bacteria in the wound. After she took a picture with the device, she used her tablet to take a picture of the device's readings then removed a curette (surgical instrument designed for scraping or debriding [removal of damaged tissue or foreign objects from a wound] biological tissue or debris in a biopsy, excision, or cleaning procedure) from her bag to debride the wound. After the debridement, she took another picture with the device to check for bacteria in the wound then used her tablet to take a picture of the device's readings. Consultant HH placed a piece of moist gauze in R3's wound then placed the wound imaging device back in her bag and placed the curette in the sharps container. Consultant HH did not doff (remove) her gloves and perform hand hygiene at any point in this procedure. Consultant HH then switched sides with LN H who doffed gloves and performed hand hygiene before proceeding on with the dressing change. R3 continued to have bowel movement present. LN H removed the moist gauze from the wound then doffed gloves, performed hand hygiene, and donned new gloves. LN H did not clean the bowel movement before proceeding to the wound care

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procedure. LN H applied skin prep around the wound then applied Santyl (a topical medication that helps break up and remove dead skin and tissue) to the wound. LN H placed Hydrofera Blue (a dressing that provides wound protection and treats bacteria and yeast) inside the coccyx wound then applied gentamycin (a medication used to treat infection) to the calcium alginate (an absorptive dressing) dressing then onto the wound. LN H pulled brief back over R3's buttocks and stated she would get the aides to come in to clean her up. LN H and Consultant HH doffed gloves then performed hand hygiene.

On 04/04/22 at 09:31 AM R6's O2 tubing was undated and lying on the floor.

On 04/04/22 at 10:10 AM R49's O2 tubing was missing a date sticker.

On 04/04/22 12:36 PM an unidentified staff member pushed a clothes rack that was uncovered down the hallway as he delivered clean clothes to resident rooms.

On 04/04/22 at 04:11 PM R23's O2 tubing laid on his bed under the blanket, tubing was undated.

On 04/05/22 at 07:25 AM R6 sat on the side of her bed her O2 tubing laid on the floor.

On 04/05/22 08:14 AM R23's O2 concentrator was covered in dust, the filter was dirty, the cannula was lying on the bed under the covers, no storage bag found. R23 stated that staff had not cleaned or wiped down the filter in a while.

On 04/05/22 08:23 AM, an unidentified staff member wearing gloves and a hairnet, pushed

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the meal cart with breakfast trays on it down the south hall. The food on the cart was covered with saran wrap. The unidentified staff member served a resident and removes the plastic wrap from the food. The unidentified staff member did not remove her gloves after serving the resident, she touched her mask and hairnet with her gloved hand, then grabbed another tray. The unidentified staff member kept the same gloves on as she continued to deliver other residents their trays. No hand hygiene was performed after she removed her gloves after serving trays.

On 04/05/22 at 08:51 AM R6 sat on her bed waiting for her breakfast tray, her O2 tubing was lying on the floor.

On 04/05/22 09:49 AM R49 was asleep in his bed. R49's O2 machine tubing dated 03/20/22. The nasal cannula (NC) and tubing was lying on floor behind the machine. The O2 machine was dirty/dusty and the filter needed cleaned.

On 04/05/22 at 09:53 AM R49's O2 tubing and cannula was lying on the floor.

On 04/05/22 at 03:29 PM R6's O2 tubing in her room was undated, coiled up and placed in handle of O2 concentrator, lacked a bag.

On 04/06/22 at 11:25 AM R6's O2 tubing was undated and coiled into the handle of the O2 concentrator.

On 04/06/22 at 01:47 PM CNA N and CNA O used a Hoyer lift (a mechanical lift that is used to assist with the transfer of a non-mobile resident). CNA N her washed hands and applied gloves. CNA O sanitized her hands and applied gloves.

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The two CNA's safely transferred R17 from his wheelchair to his bed. CNA O pushed the lift out of the room into the hallway and removed her gloves and sanitized her hands but did not sanitize the lift after use.

On 04/06/22 at 02:39 PM Certified Nurse Aide (CNA) M stated that O2 tubing should be stored in a plastic bag when not being used. CNA M said if she noticed that the NC and O2 tubing was on the floor, she would pick it up and throw it away and get new and clean tubing. She stated that facility equipment like the lifts should be sanitized after each use and/or in between residents. She stated hand hygiene should be performed before serving food, before and after contact with a resident, before and after putting on or taking off gloves. Every two weeks the facility has a staff meeting and management goes over hand hygiene, how to use the lifts and abuse and neglect.

On 04/06/22 at 03:35 PM Licensed Nurse (LN) G stated she thought that the O2 tubing was changed every three days or something like that. As far as she knew the filters on the concentrator was never cleaned and when the tubing was changed it was not documented anywhere that she was aware of. LN G stated that hand hygiene should be performed before and after each resident contact, after using the bathroom, when serving food trays to residents (before and after). LN G stated during wound dressing changes a sterile field should be put down to put supplies onto, hands should be washed before beginning and apply gloves, the remove the gloves after taking the dressing off and sanitize hands before applying clean gloves. She stated a resident should be cleaned up after having a bowel

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movement during a dressing change to avoid the bowel movement getting into the wound area, and make sure the wound area field was cleaned, then finish with the wound dressing change.

On 04/06/22 at 05:10 PM wound nurse LN H stated she would have typically changed the resident before she would have continued with the wound dressing change. She would stop doing wound change if a resident had or was having a bowel movement, she would make sure that none of the bowel movement got near the wound and clean the resident, and then start doing the wound care.

On 04/06/22 at 04:51 PM Administrative Nurse and Infection Preventionist F stated that hand hygiene should be done in between resident contact, after using the bathroom, when serving meals to residents and staff should not wear gloves ever while serving meal trays. Administrative Nurse F stated that all staff have hand sanitizer and she stressed to staff to not only sanitize their hand but to wash them with soap and water after every couple of residents. She further stated that the facility lifts were to be cleaned at the beginning of each shift as well as after each use. The O2 machines should be cleaned by maintenance staff. The O2 tubing was changed every Sunday night and should be dated at that time and the tubing should be stored in a plastic bag with the resident name and the date changed on the plastic bag. Administrative Nurse F stated the facility staff did not document anywhere when they changed the O2 tubing.

On 04/06/22 at 05:23 PM Administrative Nurse D stated that O2 tubing was changed weekly and as needed and should be dated and stored in a

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plastic bag when not in use. The facility holds mandatory in-services every two weeks that hand hygiene, abuse and neglect and use of lifts. Administrative Nurse D stated hand hygiene should be performed in between residents, when serving during dining time after each tray was delivered, anytime when performing a brief change or after a resident uses the bathroom, before and after using gloves. She stated she would expect staff to clean/change a resident if the resident had had a bowel movement before wound care/dressing change was performed to avoid contamination of the wound area. Any equipment such as the lifts should be sanitized after each use.

The facility policy "Standard Precautions, Transmission-based Precautions" revised 10/05/21 documented the following: standard precautions represent the infection prevention measures that apply to all resident care; regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered. Standard precautions include:
1. Hand hygiene
a. before and after all resident contact;
b. contact with potentially infectious material;
c. contact with blood, bodily fluids, or visibly contaminated surfaces;
d. before applying gloves;
e. after removal of gloves;
f. prior to removal of face shields/eye protection and/or respirator during the doffing of personal protective equipment (PPE) process;
g. after touching cloth face covering, face mask;
h. before performing a procedure such as an aseptic (free from infection) task;
i. always use soap and water if hands are visibly

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soiled or in the event of alcohol-based hand rub (ABHR) shortages.
2. Appropriate use of PPE (gloves, gowns, and facemasks)
a. gloves are worn if potential contact with blood or bodily fluid, mucous membranes, or non-intact skin;
b. gloves are removed after contact with blood or bodily fluids, mucous membranes, or non-intact skin;
c. gloves are changed, and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;
d. an isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions.
3. Respiratory hygiene and cough etiquette
4. Safer sharps practices
5. Safe handling of equipment or items that are likely contaminated with infectious body fluids
6. Cleaning and disinfecting or sterilizing of potentially contaminated surfaces and equipment between resident use.

The undated facility policy "Area of Focus: Basic Skin Management" documented: wound care is provided utilizing a clean technique.

The facility policy "Oxygen Administration/Safety/Storage/Maintenance" revised 08/02/21 documented: Change O2 supplies weekly and when visibly soiled. Equipment should be labeled with patient name and dated when setup or changed out. The humidifier bottles should be dated and replaced every seven days regardless of the water level. Store O2 and respiratory supplies in a bag labeled with the resident's name when not in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175281	A. BUILDING _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KANSAS CITY	3231 N 61ST STREET KANSAS CITY, KS 66104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 199	F 880		

Clean exterior of concentrators weekly with a disinfectant (the concentrator must be stationed where there is free air movement; and external filter should be checked daily and all dust should be removed. Filters should be washed with soap and water once each week and as needed; dry with a towel and reinsert).

The facility policy "Laundry Services" reviewed 12/31/21 documented the following: All clean linens should be stored and transported in covered carts used exclusively for this purpose and these carts should be cleaned regularly using a hospital grade disinfectant. All clean linen must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport, and unloading. Clean linen must always be kept separate from contaminated linens. The use of separate rooms, closets, or other designated spaces with a closing door provides the most secure methods for reducing the risk of accidental contamination.

The facility failed to ensure and maintain a sanitary and clean wound field when providing wound care for R3, failed to ensure that facility staff properly dated, stored and cleaned supplemental O2 equipment for R6, R23, and R49, failed to ensure that facility staff did proper hand hygiene while passing meal trays to residents, failed to ensure that facility staff properly transported clean laundry to residents, and failed to ensure that staff sanitized/cleaned a mechanical lift after use. This placed the residents at risk for increased infection and transmission of communicable disease.