

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2022
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF LEAWOOD - IRON HORSE HLTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5401 W 143RD STREET LEAWOOD, KS 66224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations #KS167910 and KS169253. The 2567 was electronically sent to the facility on 03/10/22.	F 000			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/10/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 655	Continued From page 1 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents. Based on record review and interview, the facility failed to develop a baseline care plan for one sampled resident, Resident (R) 50, upon admission. This placed the resident at risk for inappropriate care. Findings included: - The Electronic Medical Record (EMR) for R50 recorded diagnoses of type 2 diabetes mellitus (when a body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), and malignant neoplasm of lower inter quadrant of the left breast (breast cancer). R50's EMR recorded the resident was admitted to the facility on 01/14/22. R50's EMR lacked documentation a baseline	F 655			

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F 655	Continued From page 2 care plan was developed upon admission to the facility. The "Nurse's Note," dated 01/14/22 at 12:27 PM, documented R50 had been living at home with home health services and had become weak and required more assistance. The note further documented the resident was able to voice all needs, used a walker with stand by assistance, had a history of breast cancer, and received cancer treatments. The "Nurse's Note," dated 01/18/22 at 03:59 PM, documented R50 had an oncology (a branch of medicine that deals with the prevention, diagnosis, and treatment of cancer) appointment and the resident's physician admitted her to the hospital due to nausea. The resident's medications were sent with R50's sister and her room was cleaned out. On 03/03/22 at 01:17 PM, Licensed Nurse (LN) H stated initial care plans were completed upon admission and verified an initial care plan was not completed for R50. On 03/07/22 at 11:00 AM, Administrative Nurse D stated an initial care plan should be completed upon admission. The facility's "Comprehensive Person Centered Care Planning" policy, dated 01/15/22, documented, within 48 hours of the resident's admission the facility would develop and implement a base line care plan that included instructions needed to provide effective and person centered care: the base line care plan would include minimum healthcare information necessary to properly care for a resident	F 655			

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F 655	Continued From page 3 including, but not limited to initial goals based on admission orders, physician orders, therapy services, and social services.	F 655			
F 656 SS=D	The facility failed to develop a baseline care plan for R50, placing her at risk for inappropriate care. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656			

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F 656	Continued From page 4 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for Resident (R) 39, who had a fluid restriction related to his dialysis (the process of removing excess water, solutes and toxins from the blood in people whose kidneys can no longer perform). This placed R39 at risk of complications related to fluid overload or dehydration. Findings include: - R39's diagnoses include end stage renal disease (ESRD), dependence on renal (kidney) dialysis, polycystic kidney disease (noncancerous sacs of fluid on the kidneys that lead to need of dialysis), obesity (condition of being overweight), and anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues). The "Quarterly Minimum Data Set", dated 02/09/22, recorded R39 had intact cognition, required supervision to extensive assistance with activities of daily living, on a therapeutic diet, and	F 656			

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F 656	Continued From page 5 received dialysis. The "Nutritional Care Area Assessment (CAA)", dated 07/27/21, recorded R39 was at risk for alteration in nutrition related to ESRD, obesity, dementia (progressive mental disorder characterized by failing memory, confusion) and anemia. The "Alternation in Nutrition Care Plan", dated 02/01/22, documented R39 was at risk for alteration in nutrition related to diagnosis of ESRD, obesity, anemia, dementia, required assistance of one staff with activities of daily living, and diet as ordered by the physician. The "Care Plan" lacked documentation of a fluid restriction. The "Physician Order", dated 12/16/21, directed staff to implement a renal and cardiac regular texture diet and a 1500 cubic centimeter (cc) fluid restriction. The "Registered Dietician Progress Note" dated 12/16/21 recorded a quarterly review triggered for clinically significant weight changes related to dialysis. The note documented R39 continued on a renal diet and a 1500 cc fluid restriction. Review of the electronic record "Fluid Intake Task" for March 2022 documented the following daily fluid intakes: 03/01/22 2300 cc 03/02/22 285 cc 03/03/22 1400 cc 03/04/22 2300 cc 03/05/22 1150 cc 03/06/22 1450 cc	F 656			

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F 656	Continued From page 6 On 03/02/22 at 08:44 AM, observation revealed R39 leaving the dining room after finishing his breakfast. He took a 480 cc glass of lemonade to his room. On 03/02/22 at 09:02 AM, R39 reported he was to be on a fluid restriction and admitted he did not always stick to the parameters. Observation revealed two clear, empty 500 cc cups/pitcher on the table in the resident's room. On 03/07/22 at 11:21 AM, Certified Nurse Aide (CNA) M stated she was not sure if R39 was on a fluid restriction. CNA M said it was the nurses' responsibility to record the fluid intake. CNA M reported the resident had milk for his cereal and 240 cc of water at breakfast. On 03/07/22 at 11:23 AM, Licensed Nurse (LN) G reviewed R39's electronic physician order to verify the resident was on a fluid restriction. LN G stated the nurse was responsible for the documentation of fluid intake for the resident. On 03/07/22 at 12:08 PM, Administrative Nurse D reported it was the Assistant Director of Nursing who monitored the fluid restrictions. She stated it was her expectation the fluid restrictions were care planned and followed by nursing staff. Administrative Nurse D stated the fluid restriction was not included on the care plan. The facility's "Comprehensive Person-Centered Care Planning" policy, dated 01/15/22 documented the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet resident's medical, nursing, mental and psychosocial needs	F 656			

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F 656	Continued From page 7 that are identified in the comprehensive assessment. The care plan developed by the IDT will include the resident's needs, identified in the comprehensive assessment, any specialized services. In the event that a resident refuses certain services posing a risk to the resident's health and safety, the comprehensive care plan will identify care or services declined, the associated risks, IDT's efforts to educate the resident or resident representative and any alternated means to address risk. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment. The facility failed to develop a comprehensive care plan related to R39's fluid restriction, placing the resident at risk for possible fluid overload or dehydration.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657			

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F 657	Continued From page 8 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents, with three reviewed for skin condition not pressure related. Based on observation, record review, and interview, the facility failed to revise the care plan with interventions to prevent skin tears for one sampled resident, Resident (R) 157, who received two skin tears during cares. This placed R157 at risk for further injury. Findings included: - The Electronic Medical Record (EMR) for R157 documented diagnoses of cerebral infarction (sudden loss of circulation to an area of the brain that results in an acute loss of cerebral function), hemiplegia (paralysis of one side of the body) and displaced fracture of the later malleolus of the left fibula (broken ankle). The "Admission Minimum Data Set" (MDS), dated 02/27/22, documented R157 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, dressing and toileting. The MDS further documented the resident did not have any skin issues.	F 657			

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F 657	Continued From page 9 The "Skin Integrity Care Plan," dated 02/21/22, directed staff to administer ointment to the resident's face for rosacea (a skin condition causing red patches and visible blood vessels on the face), monitor skin underneath the boot as ordered for signs of skin irritation or breakdown, complete a skin assessment as ordered, and report to the physician as needed. The "Care Plan" lacked interventions to prevent skin tears on the resident. The "Nurse's Note," dated 02/26/22 at 01:00 PM, documented the resident sustained a "self-inflicted skin tear" on the back of his left hand as his hand bumped against the toilet seat during positioning to transfer to the toilet. The note further documented the nurse applied pressure to stop the bleeding, cleansed the skin tear, and applied a band-aid. The "Physician Order," dated 03/03/22, directed staff to cleanse the wound to R157's left forearm skin tear with wound cleanser, apply bacitracin (an antibiotic ointment typically used topically for skin), cover with a nonadherent pad, wrap with kerlex (a white gauze dressing), secure with tape, every dayshift for wound management, and may discontinue when healed. The medical record lacked documentation how the resident received the skin tear to his left forearm. R157's clinical record lacked evidence of analysis of the root cause for the skin tears, and lacked evidence preventative measures were evaluated and implemented. On 03/02/22 at 09:33 AM, observation revealed	F 657			

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F 657	Continued From page 10 R157 had on a light weight jacket with the sleeves pulled up on his forearms. He had a band aid to the top of his left hand, and a skin tear to left forearm that was bleeding. Certified Nurse Aide (CNA) O stated the skin tear was obtained during a transfer. On 03/03/22 at 11:11 AM, observation revealed R157 wore short sleeves and had a bandage to his left forearm and a bandage to the top of his left hand. R157 had multiple scars from previous skin injuries. On 03/02/22 at 09:20 AM, Certified Nurse Aide (CNA) O stated facility staff did not put long sleeves on the resident but they tried to be careful during transfers On 03/03/22 at 02:00 PM, R157 stated he had very thin skin, like an onion and had many skin tears before he was admitted to the facility. R157 further stated he obtained a new skin tear during a transfer in the bathroom. R157 stated staff do not usually put long sleeves on him but further stated he would wear them as he had some in his drawer. On 03/03/22 at 02:18 PM, Licensed Nurse (LN) H stated staff try to prevent skin tears by having two staff transfer the resident and would look for other interventions like putting long sleeves on the resident. On 03/07/22 at 11:00 AM, Administrative Staff D stated the care plan should have interventions to prevent skin tears due to his fragile skin. The facility's "Comprehensive Care Plan" policy, dated 01/15/22, documented the residents	F 657			

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F 657	Continued From page 11 comprehensive care plan would be reviewed and or revised by the interdisciplinary team after each assessment.	F 657			
F 661 SS=D	The facility failed to revise R157's care plan with interventions to prevent skin tears for R157, who had fragile skin and had obtained two skin tears, placing the resident at risk for further injury. Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and	F 661			

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F 661	Continued From page 12 non-medical services. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents with one resident reviewed for discharge. Based on observation, record review, and interview, the facility failed to complete a discharge summary for Resident (R) 49 that included a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) summary of the resident's stay in the facility. This placed R49 at risk for miscommunication or interruptions in the continuum of care after discharge. Findings included: - R49's medical record revealed the resident admitted to the facility on 01/14/22. The "Admission Minimum Data Set" (MDS) was not completed for R49. The "Discharge Care Plan," dated 01/19/22, directed staff to establish a pre-discharge plan with R49 and care giver and to evaluate and revise the plan as needed as the resident wished to return to home. R49's "Admission Social Service Assessment," dated 01/21/22, documented the resident had a care giver at home and the resident planned to discharge to home with home health services as he was here for a short rehabilitation stay. The "Nurse's Note," dated 01/15/22, documented R49 had a right hip arthroplasty (hip replacement), was weight bearing as tolerated, and hoped to regain his strength and return			F 661			

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F 661	Continued From page 13 home. The "Nurse's Note," dated 01/22/22 at 02:22 PM, documented R49's care giver was rolling the resident's belongings on a cart outside and stated the resident was leaving and there was nothing the nurse could do to change that. The noted further documented the nurse verbalized the risks. The resident was given a "against medical advice" form to sign and left the facility. R49's medical record lacked a summary of his overall wellness, to included significant changes identified throughout the assessment process, and current condition at the time of discharge. On 03/03/22 at 11:00 AM, Administrative Staff A verified they had not been completing discharge summaries or recapitulations for residents when discharged from the facility. The facility "Admission/Discharge/Transfer and Continuum of Care" policy, dated January 2022, documented, when a discharge was anticipated and not an emergency discharge, hospitalization for an acute condition or due to the resident's death, the facility would complete a discharge summary or a recapitulation that included a recapitulation of the residents stay that included but was not limited to the diagnosis, course of illness, treatment or therapy, and pertinent lab, radiology, and consultation results. The policy further documented the final summary of the residents status at the time of the discharge that was available for release to authorized personal and agencies with the consent of the resident or resident's representative reconciliation of all pre-discharge medications with the resident's post discharge medications.	F 661			

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F 661	Continued From page 14	F 661			
F 676 SS=D	The facility failed to develop a discharge summary that included a recapitulation summary of R49's stay in the facility. Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676			

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F 676	Continued From page 15 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents, with one reviewed for communication. Based on observation, record review, and interview, the facility failed to use alternative communication methods for one sampled resident, Resident (R) 17, who had a diagnosis of cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of cognition). This placed the resident at risk for ineffective communication and frustration. Findings included: - The Electronic Medical Record (EMR) documented R17 had diagnoses of cognitive communication deficit, cerebral infarction (sudden loss of circulation to an area of the brain that results in an acute loss of cerebral function), vascular dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion caused by decreased blood flow to the brain), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R17's "Significant Change Minimum Data Set" (MDS), dated 01/13/22, documented the resident's cognition could not be assessed, and he required limited assistance of one staff for all	F 676			

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F 676	Continued From page 16 activities of daily living (ADLs) except for dressing with required extensive assistance of one staff. The assessment further documented R17 had clear speech and could make himself understood during the look-back period. The "Communication Care Area Assessment," dated 01/13/22, documented staff used communication techniques which enhanced interaction that allowed the resident adequate time to respond. The "Communication Care Plan," dated 01/19/22, directed staff to identify, anticipate and meet R17's needs, assist with work finding as needed and appropriate, and encourage him to continue stating thoughts even if resident was having difficulty by focusing on a word or phrase that made sense. The "Care Plan" further directed staff to use communication techniques which enhanced interaction, use simple brief consistent words or cues and to use alternative communication tools such as the resident communication board, writing pad, gestures and to monitor for nonverbal indicators of distress. It directed staff not to rush the resident. On 03/02/22 at 10:54 AM, observation revealed R17 sat in the dining room and attempted to talk to Certified Nurse Aide (CNA) O. CNA O had difficulty understanding what R17 wanted and asked the resident questions. R17 finally spelled out what he wanted, which was a felt tip pen. CNA O stated "Lets go back to your room so we can see if you have a felt tip pen in your room." CNA O ambulated with R17 back to his room, sat him in his recliner and continued to ask him questions regarding the pen. R17 was unable to verbalize what he wanted to CNA O so she	F 676			

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F 676	Continued From page 17 handed him his television remote and left his room. On 03/02/22 at 11:00 AM, observation revealed R17 tried to get up out of his recliner without assistance. Upon request, CNA N entered the room and asked R17 what he needed. R17 held his television remote in his hand and pointed to the calendar on the wall and to his bed. CNA N took the remote and asked R17 if he needed to set the remote down on the nightstand. R17 shook his head "no" and tried to verbalize what he needed but it was unintelligible (difficult to understand). A communication board was observed on R17's wall by his recliner. The board had various pictures of items in the room which staff could point at to assist in determining R17's needs. CNA N did not use the board, and continued to ask R17 what he wanted repeatedly. R17 had a frown on his face and kept shaking his head "no." On 03/02/22 at 11:10 AM, observation revealed Licensed Nurse (LN) I entered R17's room and asked R17 what she could do to help him. R17 pointed to the small calendar on the wall. LN I assisted R17 up from the recliner and walked with him closer to the calendar and asked him if he wanted something written on the calendar. R17 was unable to say what he wanted. LN I asked R17 several more times what he wanted but R17 was unable to tell her. LN I asked R17 if he wanted to lay down in bed and he nodded "yes." LN I and CNA N sat R17 down on the bed and put his legs onto the bed. Continued observation revealed R17 laid in bed and appeared uncomfortable. He had a scowl (angry expression) on his face and LN I stated, "you do not look comfortable," and tried to arrange him to	F 676			

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F 676	Continued From page 18 a better position in bed. LN I asked R17 if there was something else she could do for him, but R17 did not answer. LN I stated, "he is not happy." On 03/02/22 at 11:00 AM, CNA N stated she had not worked with R17 before and did not know how else to communicate with him except to keep asking him questions and try to figure out what he wanted. CNA N verified she had not tried to use the communication board on R17's wall. On 03/02/22 at 11:15 AM, LN I stated she knew R17 wanted something written on his calendar but could not figure out what he wanted and verified he got frustrated. On 03/07/22 at 11:00 AM, Administrative Staff D stated she expected staff to use the communication board. She stated she would work with Speech Therapy to make a smaller book with more pictures for staff and planned to educate staff on the communication book. The facility's "Non-Verbal Communication" policy, dated January 2022, documented the policy of the facility was that all residents who are nonverbal would be able to communicate their needs as desired by the resident. The facility would supply residents, staff and or family members with the use of a communication board/binders/signage that has universally known drawings, whenever desired, The resident, family, and staff caring for the resident would be familiarized with the communication tool and it would be maintained in the resident's room for use as needed. The facility failed to effectively communicate with	F 676			

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F 676	Continued From page 19 R17 by using his communication board placing the resident at risk for ineffective communication and frustration.	F 676			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents, with three reviewed for skin condition not pressure related. Based on observation, record review, and interview, the facility failed to implement interventions to prevent skin tears for one sampled resident, Resident (R) 157, who received two skin tears during cares. This placed R157 at risk for further injury. Findings included: - The Electronic Medical Record (EMR) for R157 documented diagnoses of cerebral infarction (sudden loss of circulation to an area of the brain that results in an acute loss of cerebral function), hemiplegia (paralysis of one side of the body) and displaced fracture of the later malleolus of the left fibula (broken ankle). The "Admission Minimum Data Set" (MDS),	F 684			

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F 684	Continued From page 20 dated 02/27/22, documented R157 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, dressing and toileting. The MDS further documented the resident did not have any skin issues. The "Skin Integrity Care Plan," dated 02/21/22, directed staff to administer ointment to the resident's face for rosacea (a skin condition causing red patches and visible blood vessels on the face), monitor skin underneath the boot as ordered for signs of skin irritation or breakdown, complete a skin assessment as ordered, and report to the physician as needed. The "Care Plan" lacked interventions to prevent skin tears on the resident. The "Nurse's Note," dated 02/26/22 at 01:00 PM, documented the resident sustained a "self-inflicted skin tear" on the back of his left hand as his hand bumped against the toilet seat during positioning to transfer to the toilet. The note further documented the nurse applied pressure to stop the bleeding, cleansed the skin tear, and applied a band-aid. The "Physician Order," dated 03/03/22, directed staff to cleanse the wound to R157's left forearm skin tear with wound cleanser, apply bacitracin (an antibiotic ointment typically used topically for skin), cover with a nonadherent pad, wrap with kerlex (a white gauze dressing), secure with tape, every dayshift for wound management and may discontinue when healed. The medical record lacked documentation how the resident received the skin tear to his left forearm.	F 684			

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F 684	Continued From page 21 R157's clinical record lacked evidence of analysis of the root cause for the skin tears, and lacked evidence preventative measures were evaluated and implemented. On 03/02/22 at 09:33 AM, observation revealed R157 had on a light weight jacket with the sleeves pulled up on his forearms. He had a band aid to the top of his left hand, and a skin tear to left forearm that was bleeding. Certified Nurse Aide (CNA) O stated the skin tear was obtained during a transfer. On 03/03/22 at 11:11 AM, observation revealed R157 wore short sleeves and had a bandage to his left forearm and a bandage to the top of his left hand. R157 had multiple scars from previous skin injuries. On 03/02/22 at 09:20 AM, CNA O stated facility staff did not put long sleeves on the resident but they tried to be careful during transfers On 03/03/22 at 02:00 PM, R157 stated he had very thin skin, like an onion and had many skin tears before he was admitted to the facility. R157 further stated he obtained a new skin tear during a transfer in the bathroom. R157 stated staff do not usually put long sleeves on him but further stated he would wear them as he had some in his drawer. On 03/03/22 at 02:18 PM, Licensed Nurse (LN) H stated staff try to prevent skin tears by having two staff transfer the resident and would look for other interventions like putting long sleeves on the resident. On 03/07/22 at 11:00 AM, Administrative Staff D	F 684			

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F 684	Continued From page 22 stated she expected staff to protect the resident's arms from skin tears and bruising by using long sleeved shirts or geri-sleeves (sleeves worn to protect fragile skin on the arms). Upon request, a policy for prevention of skin tears was not provided by the facility. The facility failed to implement interventions to prevent skin tears for R157, who had fragile skin and had obtained two skin tears, placing the resident at risk for further injury.			F 684			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents with one reviewed for dialysis (the process of removing excess water, solutes and toxins from the blood in people whose kidneys can no longer perform). Based on observation, record review, and interview, the facility failed to implement a physician ordered fluid restriction for Resident (R) 39, who had dialysis treatment. This placed R39 at risk of complications related to fluid overload or dehydration. Findings include: - R39's diagnoses include end stage renal			F 698			

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F 698	Continued From page 23 disease (ESRD), dependence on renal (kidney) dialysis, polycystic kidney disease (noncancerous sacs of fluid on the kidneys that lead to need of dialysis), obesity (condition of being overweight), and anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues). The "Quarterly Minimum Data Set," dated 02/09/22, recorded R39 had intact cognition, required supervision to extensive assistance with activities of daily living, on a therapeutic diet, and received dialysis. The "Nutritional Care Area Assessment (CAA)," dated 07/27/21, recorded R39 was at risk for alteration in nutrition related to ESRD, obesity, dementia (progressive mental disorder characterized by failing memory, confusion) and anemia. The "Alternation in Nutrition Care Plan," dated 02/01/22, documented R39 was at risk for alteration in nutrition related to diagnosis of ESRD, obesity, anemia, dementia, required assistance of one staff with activities of daily living, and diet as ordered by the physician. The "Care Plan" lacked documentation of a fluid restriction. The "Physician Order," dated 12/16/21, directed staff to implement a renal and cardiac regular texture diet and a 1500 cubic centimeter (cc) fluid restriction. The "Registered Dietician Progress Note" dated 12/16/21 recorded a quarterly review triggered for clinically significant weight changes related to dialysis. The note documented R39 continued on	F 698			

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F 698	Continued From page 24 a renal diet, and a 1500 cc fluid restriction. Review of the electronic record "Fluid Intake Task" for March 2022 documented the following daily fluid intakes: 03/01/22 2300 cc 03/02/22 285 cc 03/03/22 1400 cc 03/04/22 2300 cc 03/05/22 1150 cc 03/06/22 1450 cc On 03/02/22 at 08:44 AM, observation revealed R39 leaving the dining room after finishing his breakfast. He took a 480 cc glass of lemonade to his room. On 03/02/22 at 09:02 AM, R39 reported he was to be on a fluid restriction and admitted he did not always stick to the parameters. Observation revealed two clear, empty 500 cc cups/pitcher on the table in the resident's room. On 03/07/22 at 11:21 AM, Certified Nurse Aide (CNA) M stated she was not sure if R39 was on a fluid restriction. CNA M said it was the nurses' responsibility to record the fluid intake. CNA M reported the resident had milk for his cereal and 240 cc of water at breakfast. On 03/07/22 at 11:23 AM, Licensed Nurse (LN) G reviewed R39's electronic physician order to verify the resident was on a fluid restriction. LN G stated the nurse was responsible for the documentation of fluid intake for the resident. On 03/07/22 at 12:08 PM, Administrative Nurse D reported it was the Assistant Director of Nursing who monitored the fluid restrictions. She stated it	F 698			

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F 698	Continued From page 25 was her expectation the fluid restrictions were care planned and followed by nursing staff. Administrative Nurse D stated the fluid restriction was not included on the care plan. The facility "Fluid Restriction" policy, dated February 2022, documented a fluid restriction is often prescribed for residents that are on dialysis or have fragile congestive heart failure or other medical conditions or diagnosis. Purpose to outline parameters and to accurately provide liquids for those residents that have a written order for fluid restrictions. The Dietary and Nursing departments are to ensure adequate fluids are consumed and parameters for fluid restrictions are maintained. The facility failed to incorporate a fluid restriction for R39, who had dialysis treatments. This placed R39 at risk of complications related to fluid overload or dehydration.	F 698			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents. Based on record review and interview, the facility failed to ensure medication was administered per physician orders for Resident (R) 158. This deficient practice placed the resident at risk for decreased well-being and ineffective medication regimen. Findings included:	F 760			

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F 760	Continued From page 26 - The Electronic Medical Record (EMR) for R158 recorded diagnoses of dementia without behavior disturbance (progressive mental disorder characterized by failing memory, confusion), and Parkinson's Disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R158's "Admission Minimum Data Set" (MDS), dated 09/23/21, documented the resident had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, and toileting. The "Cognition Care Plan," dated 09/16/21, documented R158 was at risk for impaired cognitive processes related to dementia and mild cognitive impairment. The "Care Plan" directed staff to identify themselves at each interaction, face the resident when speaking, make eye contact, use simple direct sentences, provide necessary cues, and to stop and return later if agitated. The "Admission Orders," dated 09/15/21, directed staff to administer Aricept (medication used to treat mild to moderate dementia), 5 milligrams (mg), by mouth, at bedtime. The "September 2021 Medication Administration Record (MAR)" lacked evidence the resident received the physician ordered Aricept until 09/24/21. (9 days after admission) The "Nurse's Note," dated 09/24/21 at 12:21 PM, documented the resident's family member requested a meeting with the Director of Nursing	F 760			

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F 760	Continued From page 27 to discuss the resident's appointment with the neurologist (a medical specialist in the diagnosis and treatment of disorders of the nervous system) and had asked why the resident had not been receiving his Aricept medication. The nurse's noted further documented an investigation would be started and corrective action taken to ensure the resident received his medication as ordered. The resident was discharged from the facility on 10/12/21 and returned to assisted living. On 03/07/22 at 11:00 AM, Administrative Staff E stated an investigation was completed and the facility had made a medication error. Administrative Staff E stated she would expect staff to make sure all the physician orders were correctly placed on the MAR. The facility's "Medication Errors" policy, dated February 2022, documented the facility would ensure that medications and treatments were delivered as ordered and to report medication errors when they occurred. A medication error was defined as failure to prescribe or administer the correct drug or formulation for a disease or condition and all orders are audited by the respective nurse manager. When an error was discovered, staff immediately notified the charge nurse, and the charge nurse would notify the physician immediately and follow orders, A medication error report would be completed, and the Director of Nursing would provide a discipline inservice or individual education. The pharmacy would act as a resource to review medication errors to identify a root cause or symptoms analysis to avoid or prevent further medication errors.	F 760			

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F 760	Continued From page 28	F 760			
F 880 SS=F	The facility failed to order R158's Aricept medication as ordered upon admission to the facility for nine days, placing the resident at risk for physical and psychosocial decline. 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: §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;	F 880			

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F 880	Continued From page 29 (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 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 53 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to handle linens appropriately in	F 880			

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F 880	Continued From page 30 order to reduce transmission of infectious diseases when the facility failed to cover clean laundry while delivering to resident rooms, and wear protective equipment (gown) when sorting soiled linens. The facility further failed to ensure appropriate use of cleaning products and techniques for disinfection of clostridioides difficile (C-Diff- a bacterium that causes diarrhea and inflammation of the colon which can be life-threatening) rooms which placed the residents and staff at increased risk for infection. Findings included: - On 03/02/22 at 02:11 PM, observation revealed Housekeeping Staff V rolled an uncovered cart with clean, folded, and hanging clothes to resident rooms. On 03/02/22 at 02:22 PM during inspection of the facility's laundry area, Housekeeping Staff V explained she wore gloves and no gown while sorting of the soiled laundry. She further stated she had not been informed of a resident with C-Diff infection in the facility. She stated she was aware of the use of bleach for sanitizing laundry. On 03/07/22 at 02:19 PM, Maintenance Staff U reported the facility used a cleaning product "Betco BTB" to clean and sanitize the C-diff precaution room. Review of the label revealed the product did not eliminate the organism for C-Diff. On 03/07/22 at 03:16 PM, observation revealed Housekeeping Staff V and W wore masks, gloves, gowns, shoe covers, and face shields to clean the C-diff room. They used a bleach solution to clean the room. They used a bristle brush to sweep the floor, then a long-handled			F 880			

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F 880	Continued From page 31 dustpan which was placed on the floor to gather loose debris off the floor. Housekeeping V and W then placed the bristled brush and dustpan outside of the room without cleaning the equipment. They gathered cleaning supplies from the housekeeping cart placed outside the room wearing the same soiled gloves as inside the C-Diff room. They further placed the mop pole back onto the housekeeping cart without sanitizing the items touched with the soiled gloves. On 03/03/22 at 10:25 AM, Maintenance Staff U verified clean laundry should be covered during transportation to resident rooms and staff should have worn gloves and gowns while sorting soiled linens. On 03/07/22 at 03:16 PM, Maintenance Staff U verified the use of bleach products to sanitize C-Diff and said staff should follow the facility policy for cleaning a C-Diff room. He also verified any equipment or supplies that are used in the C-Diff room should be sanitized before placing the items back onto the housekeeping cart. The facility's "Infection Prevention and Control Program" policy, dated April 2021, documented soiled laundry shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linens. The policy further documented anyone who handled soiled laundry should wear protective gloves and other appropriate protective equipment. The facility's undated "Resident Room Daily Cleaning Procedure, Isolation C-Diff Cleaning Protocol" policy documented staff to apply gowns, shoe covers, gloves, and goggles or facemask,	F 880			

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F 880	Continued From page 32 and use of "Clorox Healthcare Germicidal Cleaner" to high touch surfaces daily with no exceptions. The facility failed to handle linens appropriately in order to reduce transmission of infectious diseases when the facility failed to cover clean laundry while delivering to resident rooms and wear protective equipment (gown) when handling soiled linens. The facility further failed to ensure appropriate use of cleaning products and techniques for disinfection of C-Diff rooms which placed the residents and staff at increased risk for infection.	F 880			