STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		

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

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F 656	Continued From page 1	F 656		

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 census totaled 35 residents, with 12 included in the sample. Based on interview and record review the facility failed to develop a comprehensive care plan to include the use of oxygen (O2) for Resident (R)23.

Findings included:

- R23's "Physician Progress Note" dated 10/21/21 revealed a diagnosis of chronic respiratory failure with hypoxia (inadequate supply of oxygen.)

The "Admission Minimum Data Set" (MDS) dated 09/15/21 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition and received oxygen.

Review of R23's "Care Plan" lacked any interventions concerning the use of O2.

A "Physician Order" dated 09/10/21 revealed R23 was to have O2 at 2-4 Liters (L) per minute per nasal canula (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) as needed (PRN) for dyspnea (difficulty breathing) to keep O2 saturation at 90% or greater.

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F 656	Continued From page 2	F 656		

The September to November 2021 "Electronic Treatment Administration Record" (ETAR) and "Electronic Medication Administration Record" (EMAR) did not include anything concerning oxygen use or changing of O2 tubing for R23.

An observation on 11/03/21 at 01:04 PM revealed R23 used O2 via an oxygen concentrator and also had a portable O2 tank for use when she was not in her room.

In an interview on 11/03/21 at 12:03 PM, Certified Nurse Aide (CNA) F stated R23 used O2 continuously and when not in use, staff rolled up the O2 tubing and placed it in the handle of the oxygen concentrator. CNA F stated the nightshift nurse was the one to change out the O2 tubing and stated that she believed the tubing should be dated.

In an interview on 11/04/21 at 08:54 AM, Certified Medication Aide (CMA) H stated the O2 tubing was replaced once a month by the medication aide and documentation of O2 tubing changed was documented on the EMAR. CMA H stated when O2 tubing was not in use they rolled up the O2 tubing and stuck it in the handle of the O2 concentrator in order to keep the O2 tubing off the floor.

In an interview on 11/04/21 at 12:30 PM, Licensed Nurse (LN) I stated R23 used O2 and the night shift usually changed O2 tubing on a monthly basis. LN I stated this should be documented on the nurses ETAR/EMAR.

In an interview on 11/04/21 at 03:21 PM, Administrative Nurse B stated she expected the care plan to include the use of R23's oxygen.

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F 656	Continued From page 3 The facility did not provide a policy regarding "Care Plans" as requested. The facility failed to ensure the care plan included information about the use of oxygen for R23.	F 656		
F 661 SS=D	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 non-medical services. This REQUIREMENT is not met as evidenced	F 661		

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F 661	Continued From page 4	F 661		

by:
The facility reported a census of 35 resident, with 12 included in the sample, and one resident reviewed for discharge. Based on interview and record review the facility failed to document a recapitulation of the resident's stay upon discharge for the Resident (R) 41.

Findings included:

- The 08/20/21 "Physician Orders" for R41 indicated the following diagnoses left proximal humerus fracture (broken bone) and left hip fracture (broken bone).

The Admission "Minimum Date Set" (MDS) dated 08/28/21 revealed a "Brief Interview Mental Status" (BIMS) score of 13 indicating intact cognition. R41 required extensive assistance with "Activities of Daily Living" (ADL).

The "Activities of Daily Living" (ADL)/Rehabilitation Potential Care Area Assessment" (CAA) dated 08/20/21 revealed R41 required continued assistance from staff, and the staff were to assist the resident only to the degree needed while allowing/encouraging R41 to remain as independent as possible.

The "Care Plan" dated 08/24/21 indicated R41 wished to discharge to her home after completing a skilled stay and noted R41's family members would be available to assist with any needs and transportation to appointments, if needed after discharge, and considered home health services with the options for physical therapy and occupation therapy. The "Care Plan" documented the staff were to establish a pre-discharge plan with R41 or R41's family and or care givers.

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F 661	Continued From page 5	F 661		

The "Nurses Notes" dated 10/07/21 at 10:10 AM documented the discharge of R41 from the facility with her medication list (faxed to the pharmacy) and two cards of controlled medication.

Interview with Licensed Nurse (LN) I on 11/04/21 at 08:41 AM revealed LN I had never done a recapitulation of a residents visit. LN I stated the nurses go over the medication(s) call the pharmacy for medications at home, but the Social Service staff or the "Assisted Director of Nursing" do the recapitulation of the residents stay.

Interview with "Social Service Designee" SSD P on 11/04/21 at 08:33 AM revealed during the discharge of R41, SSD P was out of the facility.

Interview with Administrative Nurse J on 11/04/21 at 08:33 AM indicated at the time of R41's discharge from the facility Administrative Nurse J was too busy to do the discharge that day and said we usually do the recap of the visit.

Interview with "Administrative Nurse" B on 11/04/21 at 02:21 PM indicated Administrative Nurse J took care of the discharges, but she was doing the SSD job since she was out of the facility. Administrative Nurse B stated both the SSD staff and the Administrative Nurse J completed the recapitulation together and she did not expect the LN to complete this task.

The facility policy "Prairie Sunset Home Dischage Care Plan Policy" undated indicated residents will be assessed for their discharge goals, preferences and care needs to meet their goals. The resident will be periodically reassessed to identify changes that require modification of the

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F 661	Continued From page 6 discharge plans and update the plans as needed. A discharge summary will be completed upon discharge to include: a recapitulation of the resident's stay in the facility (diagnoses, course of illness/treatment,therapy,lab,radiology and consultation reports). A final summary of residents status medication reconcilitation and post discharge plan of care developed with the resident and resident representative. The facility failed to document a discharge summary including a recapitulation of R41's stay at the facility upon discharge as required.	F 661		
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 census totaled 35 residents, with 12 included in the sample, and five residents reviewed for oxygen (O2) use. Based on observation, interview, and record review the facility failed to provide necessary respiratory care and/or services consistent with professional standards of practice when they failed to change disposable O2 equipment for Resident (R)23 and R27. Findings included:	F 695		

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F 695	Continued From page 7	F 695		

- R23's "Physician Progress Note" dated 10/21/21 revealed a diagnosis of chronic respiratory failure with hypoxia (inadequate supply of oxygen.)

The "Admission Minimum Data Set" (MDS) dated 09/15/21 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition and received oxygen.

Review of R23's "Care Plan" lacked any interventions concerning the use of O2.

A "Physician Order" dated 09/10/21 revealed R23 was to have O2 at 2-4 Liters (L) per minute per nasal canula (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) as needed (PRN) for dyspnea (difficulty breathing) to keep O2 saturation at 90% or greater.

The September to November 2021 "Electronic Treatment Administration Record" (ETAR) and "Electronic Medication Administration Record" (EMAR) did not include anything concerning oxygen use or changing of O2 tubing for R23.

An observation on 11/03/21 at 01:04 PM revealed R23 used O2 via an oxygen concentrator and also had a portable O2 tank for use when she was not in her room.

In an interview on 11/03/21 at 12:03 PM, Certified Nurse Aide (CNA) F stated R23 used O2 continuously and when not in use, staff rolled up the O2 tubing and placed it in the handle of the oxygen concentrator. CNA F stated the nightshift nurse was the one to change out the O2 tubing

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and stated that she believed the tubing should be dated.

In an interview on 11/04/21 at 08:54 AM, Certified Medication Aide (CMA) H stated the O2 tubing was replaced once a month by the medication aide and documentation of O2 tubing changed was documented on the EMAR. CMA H stated when O2 tubing was not in use they rolled up the O2 tubing and stuck it in the handle of the O2 concentrator in order to keep the O2 tubing off the floor.

In an interview on 11/04/21 at 12:30 PM, Licensed Nurse (LN) I stated R23 used O2 and the night shift usually changed O2 tubing on a monthly basis. LN I stated this should be documented on the nurses' ETAR/EMAR.

In an interview on 11/04/21 at 03:21 PM, Administrative Nurse B stated R23 used oxygen and stated oxygen tubing should be changed out monthly or as needed and should be documented on the standard EMAR.

The "Oxygen" policy dated 03/06/20 revealed, "The Unit Nurse or CMA must document in the resident's chart:...Weekly and PRN tubing changes on TAR."

The facility failed to ensure staff changed out oxygen tubing for R23 consistent with professional standards of practice and according to facility policy.

- Review of the R27's signed "Physician Orders" dated 09/14/21 indicated the following diagnosis: chronic obstructive pulmonary disease

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(progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The Significant Change "Minimum Data Set" (MDS) dated 03/31/21 revealed the Brief Interview for Mental Status (BIMS) score 15, indicating intact cognition. R27 required extensive assistance of one staff with all "Activities of Daily Living" (ADL) except eating no respiratory treatment noted.

The "Care Plan" dated 09/02/20 lacked use of nebulizer treatment for R27.

The "Electronic Medical Record" EMR indicated R27 received Ipratropium-Albuterol Solution 0.5-2.5 milligram(mg) in three milliliters (ml) one dose inhale orally three times a day related to chronic obstructive pulmonary disease, with an order date of 06/26/21.

Observation on 11/02/21 at 08:19 AM revealed the nebulizer mask laying on the bedside table with a date of 09/22/21, (over a month ago) indicating the last time the mask had been changed out.

Interview with Certified Medication Aide (CMA) K on 11/04/21 at 08:11 AM indicated the nebulizer mask should be changed out monthly.

Interview with Licensed Nurse I on 11/04/21 at 08:53 AM indicated the nebulizer mask were to be changed out by the CMA staff, since they administered the breathing treatments.

Interview with the Administrative Staff B on 11/04/21 at 02:25 PM indicated she expected the

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F 695	Continued From page 10 staff to change out the nebulizer mask on a monthly basis and as needed. Review of the facility policy "Handheld Nebulizer" dated 07/01/2018 revealed the instructions for staff to change the nebulizer mask/pipe and tubing on a monthly schedule. The facility failed to change the nebulizer mask and tubing on a monthly schedule for R27.	F 695		
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,	F 756		

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action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 35 residents with five residents reviewed for unnecessary medications. Based on interview and record review the facility failed to ensure the pharmacist identified and reported missing documentation concerning physician notifications for blood pressures that exceeded parameters for Resident (R)35 and R36.

Findings included:

- R35's "Medication Review Report" dated 03/25/21 revealed a diagnosis of hypertension (elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 01/04/21 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition and received a diuretic (medication to promote the formation and excretion of urine) six days during the seven-day lookback period.

The "Quarterly MDS" dated 07/06/21 revealed a BIMS score of 15, indicating intact cognition and received a diuretic medication daily.

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The "Care Plan" dated 02/02/18 revealed R35 received medications that had the potential for adverse effects to include Metoprolol (antihypertensive medication) for hypertension.

A review of the "Physician Orders" included the following:
Order dated 06/30/20 for Hydrochlorothiazide (antihypertensive medication) 25 mg, one tablet, by mouth, daily for hypertension.
Order dated 03/17/20 for Metoprolol (antihypertensive medication) 50 mg, one tablet, by mouth, daily for hypertension.
Order dated 03/17/20 for Lisinopril (antihypertensive medication) 40 mg, one tablet, by mouth, daily for hypertension.
Order dated 03/17/20 for Amlodipine (antihypertensive medication) 10 mg, one tablet, by mouth, daily for hypertension.
Order dated 10/05/21 to notify practitioner if blood pressure was less than 90/40 millimeter of mercury (mmHg) or greater than 180/115 mmHg.
Order dated 10/05/21 for Clonidine (antihypertensive medication) 0.1 milligrams (mg), by mouth two times a day for hypertension.

The August 2021 "Electronic Medication Administration Record" (EMAR) lacked evidence the facility staff notified the physician for R35's blood pressure of 194/85 mmHg on 08/12/21.

The September 2021 "EMAR" lacked evidence the facility staff notified the physician for R35's blood pressure of 184/84 mmHg on 09/24/21.

The October 2021 "EMAR" lacked evidence the facility staff notified the physician for R35's blood pressures of 193/79 mmHg on 10/21/21 and

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193/79 mmHg on 10/28/21.

The "Progress Notes" and documents scanned under the "Miscellaneous" tab of the Electronic Health Record lacked evidence of physician notifications regarding the blood pressures greater than 180/115 mmHg.

The "Pharmacy Reviews" from 11/24/20 through 10/27/21 failed to identify lack of physician notifications for blood pressures that exceeded parameters.

In an interview on 11/03/21 at 04:30 PM, Certified Medication Aide (CMA) D stated R35 received medications for hypertension which had parameters. CMA D stated staff took R35's blood pressure before giving her blood pressure medications. CMA D stated staff held blood pressure medications and notified the nurse if R35's blood pressure exceeded the parameters.

In an interview on 11/04/21 at 12:35 PM, Licensed Nurse (LN) I stated R35 received medications for hypertension with parameters of less than 90/40 or greater than 180/115 and nursing staff were to contact the primary care physician when blood pressures exceeded parameters. LN I stated notifications to the physician should be documented in a progress note.

In an interview on 11/04/21 at 02:52 PM, Consultant Pharmacist Q stated she expected the facility to follow through with calling the physician with notifications for blood pressures that were outside of parameters. Consultant Pharmacist Q stated she made multiple notes concerning the facility not doing this, she had talked to the

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Director of Nurses (DON) about this concern, as the physician has made the parameters very clear, and the nurses have been told about following through with this expectation.

In an interview on 11/04/21 at 04:45 PM, Administrative Nurse B stated the consultant pharmacist did not make her aware of blood pressures outside of parameters.

The "Consultant Pharmacist Reports" policy dated 01/20/21 revealed, "The consultant pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review."

The facility failed to ensure the consultant pharmacist identified and reported missing documentation concerning blood pressures that exceeded physician ordered parameters for R35.

- R36's "Medication Review Report" signed 03/22/21 revealed a diagnosis of hypertension (elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 10/15/20 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.

The "Quarterly MDS" dated 07/14/21 revealed a BIMS score of 15 indicating intact cognition and received a diuretic (medication to promote the formation and excretion of urine) daily.

The "Care Plan" dated 10/15/19 revealed R36 took medications that had the potential for adverse effects to include Lasix (diuretic

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medication.)

A review of the "Physician Orders" included the following:
Order for 10/11/19 Doxazosin (antihypertensive medication) 4 mg, one tablet by mouth daily for hypertension.
Order for 10/12/19 Diltiazem (antihypertensive medication) 240 mg, give one capsule by mouth, daily for hypertension.
Order dated 03/05/20 to notify practitioner or office if blood pressure was less than 90/40 or greater than 180/115.
Order dated 07/28/21 for Metoprolol (antihypertensive medication) 25 mg, give one tablet by mouth, two times a day for hypertension.
Order dated 05/06/21 for Lasix 40 mg, give one tablet by mouth two times a day for heart failure.
Order dated 09/28/21 for Clonidine (antihypertensive medication) 0.2 milligrams (mg), give 0.2 mg by mouth, two times a day for hypertension.

Review of the August 2021 "Electronic Medication Administration Record" (EMAR) lacked evidence the facility staff notified the physician for R36's elevated blood pressure of 195/75 mmHg on 08/04/21 and 182/81 mmHg on 08/13/21.

Review of the October 2021 "EMAR" lacked evidence the facility staff notified the physician of R36s elevated blood pressure of 190/73 mmHg on 10/31/21.

Review of the "Progress Notes" and documents scanned under the "Miscellaneous" tab of the Electronic Health Record did not reveal any physician notification about blood pressures greater than 180/115 mmHg.

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The "Pharmacy Reviews" from 11/24/20 through 10/27/21 failed to identify lack of physician notifications for blood pressures that exceeded parameters.

In an interview on 11/03/21 at 04:03 PM, Certified Medication Aide (CMA) E stated R36 received medications that came with parameters. CMA E stated she notified the nurse if any blood pressures were out of parameter and the nurse would notify the physician as required.

In an interview on 11/04/21 at 12:35 PM, Licensed Nurse (LN) I stated R36 received medications for hypertension with parameters of less than 90/40 or greater than 180/115 and nursing staff were to contact the primary care physician when blood pressures exceeded parameters. LN I stated notifications to the physician should be documented in a progress note.

In an interview on 11/04/21 at 03:24 PM, Administrative Nurse B stated she expected the nurse to reassess blood pressures out of parameters and notify the physician if blood pressures were still out of parameter. Administrative Nurse B stated physician notifications should be documented in a progress note.

In an interview on 11/04/21 at 02:52 PM, Consultant Pharmacist Q stated she expected the facility to follow through with calling the physician with notifications for blood pressures that were outside of parameters. Consultant Pharmacist Q stated she has made multiple notes concerning the facility not doing this, she has talked to the

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F 756	Continued From page 17 Director of Nurses (DON) about this concern, as the physician has made the parameters very clear, and the nurses have been told about following through with this expectation. In an interview on 11/04/21 at 04:45 PM, Administrative Nurse B stated she the consultant pharmacist did not make her aware of blood pressures outside of parameters. The "Consultant Pharmacist Reports" policy dated 01/20/21 revealed, "The consultant pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review." The facility failed to ensure the consultant pharmacist identified and reported missing documentation concerning blood pressures that exceeded physician ordered parameters for R36.	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 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		

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§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 census totaled 35 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure adequate monitoring of blood pressure medication for Resident (R)35, and R36. The facility License Nurse (LN) staff did not notify the physician of elevated blood pressures which exceeded the physician ordered parameters for R35 and R36.

Findings included:

- R35's "Medication Review Report" dated 03/25/21 revealed a diagnosis of hypertension (elevated blood pressure.)

The "Annual Minimum Data Set" (MDS) dated 01/04/21 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition and received a diuretic (medication to promote the formation and excretion of urine) six days during the seven-day lookback period.

The "Quarterly MDS" dated 07/06/21 revealed a BIMS score of 15, indicating intact cognition and received a diuretic medication daily.

The "Care Plan" dated 02/02/18 revealed R35 received medications that had the potential for

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adverse effects to include Metoprolol (antihypertensive medication) for hypertension.

A review of the "Physician Orders" included the following:
Order dated 06/30/20 for Hydrochlorothiazide (antihypertensive medication) 25 mg, one tablet, by mouth, daily for hypertension.
Order dated 03/17/20 for Metoprolol (antihypertensive medication) 50 mg, one tablet, by mouth, daily for hypertension.
Order dated 03/17/20 for Lisinopril (antihypertensive medication) 40 mg, one tablet, by mouth, daily for hypertension.
Order dated 03/17/20 for Amlodipine (antihypertensive medication) 10 mg, one tablet, by mouth, daily for hypertension.
Order dated 10/05/21 to notify practitioner if blood pressure was less than 90/40 millimeter of mercury (mmHg) or greater than 180/115 mmHg.
Order dated 10/05/21 for Clonidine (antihypertensive medication) 0.1 milligrams (mg), by mouth two times a day for hypertension.

The August 2021 "Electronic Medication Administration Record" (EMAR) lacked evidence the facility staff notified the physician for R35's blood pressure of 194/85 mmHg on 08/12/21.

The September 2021 "EMAR" lacked evidence the facility staff notified the physician for R35's blood pressure of 184/84 mmHg on 09/24/21.

The October 2021 "EMAR" lacked evidence the facility staff notified the physician for R35's blood pressures of 193/79 mmHg on 10/21/21 and 193/79 mmHg on 10/28/21.

The "Progress Notes" and documents scanned

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under the "Miscellaneous" tab of the Electronic Health Record lacked evidence of physician notifications regarding the blood pressures greater than 180/115 mmHg.

Observation on 11/03/21 at 10:50 AM revealed R35 sat in her recliner reading a newspaper. R35 was calm, did not show any signs of depression, anxiety or sedation.

In an interview on 11/03/21 at 04:30 PM, Certified Medication Aide (CMA) D stated R35 received medications for hypertension which had parameters. CMA D stated staff took R35's blood pressure before giving her blood pressure medications. CMA D stated staff held blood pressure medications and notified the nurse if R35's blood pressure exceeded the parameters.

In an interview on 11/04/21 at 12:35 PM, Licensed Nurse (LN) I stated R35 received medications for hypertension with parameters of less than 90/40 or greater than 180/115 and nursing staff were to contact the primary care physician when blood pressures exceeded parameters. LN I stated notifications to the physician should be documented in a progress note.

In an interview on 11/04/21 at 03:24 PM, Administrative Nurse B stated she expected the nurse to reassess blood pressures out of parameters and notify the physician if blood pressures were still out of parameter. Administrative Nurse B stated physician notifications should be documented in a progress note.

A "Nursing Home Standing Order/Protocols"

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signed 06/06/19 included "Notify practitioner or office if blood pressure (BP) is less than 90/40 or greater than 180/115."

The facility failed to ensure the adequate monitoring of antihypertensives medications when facility staff did not notify the physician as ordered for blood pressures greater than 180/115 mmHg for R35.

- R36's "Medication Review Report" signed 03/22/21 revealed a diagnosis of hypertension (elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 10/15/20 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.

The "Quarterly MDS" dated 07/14/21 revealed a BIMS score of 15 indicating intact cognition and received a diuretic (medication to promote the formation and excretion of urine) daily.

The "Care Plan" dated 10/15/19 revealed R36 took medications that had the potential for adverse effects to include Lasix (diuretic medication.)

A review of the "Physician Orders" included the following:
Order for 10/11/19 Doxazosin (antihypertensive medication) 4 mg, one tablet by mouth daily for hypertension.
Order for 10/12/19 Diltiazem (antihypertensive medication) 240 mg, give one capsule by mouth, daily for hypertension.
Order dated 03/05/20 to notify practitioner or office if blood pressure was less than 90/40

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mmHg or greater than 180/115 mmHg.
Order dated 07/28/21 for Metoprolol (antihypertensive medication) 25 mg, give one tablet by mouth, two times a day for hypertension.
Order dated 05/06/21 for Lasix 40 mg, give one tablet by mouth two times a day for heart failure.
Order dated 09/28/21 for Clonidine (antihypertensive medication) 0.2 milligrams (mg), give 0.2 mg by mouth, two times a day for hypertension.

Review of the August 2021 "Electronic Medication Administration Record" (EMAR) lacked evidence the facility staff notified the physician for R36's elevated blood pressure of 195/75 mmHg on 08/04/21 and 182/81 mmHg on 08/13/21.

Review of the October 2021 "EMAR" lacked evidence the facility staff notified the physician of R36s elevated blood pressure of 190/73 mmHg on 10/31/21.

Review of the "Progress Notes" and documents scanned under the "Miscellaneous" tab of the Electronic Health Record did not reveal any physician notification about blood pressures greater than 180/115 mmHg.

Observation on 11/03/21 at 10:30 AM, revealed R36 was in a good mood, chatted with other residents, and took part in a resident meeting and did not exhibit any negative behaviors, depression, anxiety or sedation.

In an interview on 11/03/21 at 04:03 PM, Certified Medication Aide (CMA) E stated R36 received medications that came with parameters. CMA E stated she notified the nurse if any blood pressures were out of parameter and the nurse

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F 757	Continued From page 23 would notify the physician as required. In an interview on 11/04/21 at 12:35 PM, Licensed Nurse (LN) I stated R36 received medications for hypertension with parameters of less than 90/40 or greater than 180/115 and nursing staff were to contact the primary care physician when blood pressures exceeded parameters. LN I stated notifications to the physician should be documented in a progress note. In an interview on 11/04/21 at 03:24 PM, Administrative Nurse B stated she expected the nurse to reassess blood pressures out of parameters and notify the physician if blood pressures were still out of parameter. Administrative Nurse B stated physician notifications should be documented in a progress note. A "Nursing Home Standing Order/Protocols" signed 06/06/19 included, "Notify practitioner or office if blood pressure (BP) is less than 90/40 or greater than 180/115." The facility failed to ensure the adequate monitoring of antihypertensives medications when facility staff did not notify the physician as ordered for blood pressures greater than 180/115 mmHg for R36.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		

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approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 35 residents. The facility had one main kitchen where food was stored and prepared for one dining room. Based on observation, interview, and record review the facility failed to store and prepare food under sanitary conditions when the facility failed to properly store food items, clean kitchen equipment, ensure refrigerator and freezer temperature were documented and dietary staff did not properly restrained hair. These failures affected all the residents of the facility.

Findings included:

- During the initial kitchen tour on 11/02/21 at 07:27 AM, the following concerns were identified:
1. The temperature log for the "Arctic Air" double door refrigerator lacked 19 entries for the month of October 2021 and lacked temperature documentation for 11/01/21.
2. Walk-in refrigerator had a large covered plastic container with a fruit dessert that was not dated.

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F 812	Continued From page 25 3. A crate with four, gallon jugs of milk stored on the floor of the walk-in refrigerator. 4. Four large cylindrical cartons of ice cream stored on the floor of the walk-in freezer. 5. Five large bags of ice stacked on top of each other stored on the floor of the walk-in freezer. 6. Seven boxes of various food items stored on the floor of the walk-in freezer. 7. A large manual can opener had brown/black grime inside the base holder, and near the puncture mechanism. 8. Dining room refrigerator located under the juice dispensers did not have a temperature log completed. During the follow-up kitchen tour on 11/04/21 at 11:08 AM revealed the following concerns: 1. An observation on 11/04/21 at 11:36 AM, revealed Dietary Staff (DS) R wore a baseball cap with hair not fully restrained and failed to wear a beard guard. 2. An observation on 11/04/21 at 11:36 AM, revealed Dietary Staff (DS) T wore a baseball cap with hair not fully restrained. 3. One opened bag of shredded cheddar cheese with no opened date or use by date. 4. One package of sliced Swiss Cheese with an expiration date of 11/01/21. 5. An observation on 11/04/21 at 11:42 AM, revealed DS R wore black disposable gloves and prepared sandwiches for the lunch meal. DS R removed slices of bread from bags and placed them on a cookie sheet. DS R touched his clothing when adjusting his pants and proceeded to use the same gloves to place meat slices, bacon, lettuce, tomatoes and the final layer of bread on to sandwiches. In an interview on 11/04/21 at 03:18 PM, Dietary	F 812		

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Staff (DS) S stated the facility provided hairnets for dietary staff and stated if staff wore a hat that still allowed hair to be exposed the staff should wear a hairnet. DS S stated beard guards should also be worn.

The "Hair covering in Kitchen" policy date 11/04/21 revealed, "Hair is to be covered at all times ..."

The "Glove Usage-To Ensure Cross Contamination is Prevented" policy dated 11/04/21 revealed, "During food prep single use gloves to be used when handling raw animal food or when working with ready to eat food ...Discard gloves when damaged, soiled, or when interruptions occur during tasks."

The undated "Food & Nutrition-Safety-Sanitization" policy revealed, " ...Containers of food are stored on clean surfaces, off the floor, and in a manner to protect them from contamination ...Effective procedures are established for the cleaning of all equipment ...Document the temperature of external and internal refrigerator gauges."

The facility failed to properly store food items, clean kitchen equipment, ensure refrigerator and freezer temperature were documented and dietary staff properly restrained hair.