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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00165404, KS00164939, and KS00164735. The 2567 was electronically sent on 11/05/21.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		

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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by:
The facility reported a census of 42 residents with 12 sampled including one for hospitalization. Based on observation, interview, and record review the facility failed to provide a copy of the facility bed hold policy to Residents (R) 12 or her representative for her facility-initiated hospitalizations.

Findings Include:

- Review of R12's "Minimum Data Set" (MDS) tracking form dated May 2020 documented the resident discharged to the hospital on 05/08/20 and returned to the facility on 05/11/20.

Review of R12's "Minimum Data Set" (MDS) tracking form dated February 2021 documented the resident discharged to the hospital on 02/03/21 and returned to the facility on 02/05/21.

Review of R9's "Electronic Health Record" lacked evidence of written notification of the facility-initiated hospitalization transfers and bed holds to R12 or her representative.

Observation on 10/27/21 at 10:27 AM revealed R12 sat in her wheelchair in her room watching television, and she had all needed items within her reach.

On 10/28/21 at 08:20 AM Social Service Designee (SSD) E stated she would call the family following their allotted time away to check and see if they would like to keep their current bed at the current rate. She stated she did not believe there was any form the nurses sent with residents upon discharge to the hospital. SSD E stated she went over the bed-hold policy with the

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F 625	Continued From page 2 resident and their representative upon admission. On 10/28/21 at 08:29 AM Licensed Nurse (LN) F stated she did not send a bed-hold policy with the resident when they discharged to the hospital. On 10/28/21 at 08:35 AM Administrative Nurse A stated the SSD covered the bed-hold policy on admission, but she would not send a policy with a resident when they went to the hospital. She stated she did not know it was required. On 10/28/21 at 02:05 PM Administrative Nurse G confirmed the facility must provide a bed hold policy at time of discharge to the hospital. The "Bed-Hold Policy Notice" revised 11/28/17 documented a written notice which specifies the duration, or the bed-hold policy will be provided at the time of transfer of a resident for hospitalization. The facility failed to provide a copy of the bed hold policy for R12 or her representative for her 05/08/20 and 02/03/20 hospitalizations.	F 625		
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.	F 657		

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(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 42 residents with 12 residents included in the sample. Based on observation, interview, and record review the facility failed to revise the care plan related to the use of psychotropic medications (Haldol/Haloperidol/Remeron) for Resident (R)40.

Findings included:

- R40's "Order Summary Report" signed by the physician on 10/04/21 revealed a diagnosis of vascular dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain.)

The "Quarterly Minimum Data Set" (MDS) dated 07/16/21 revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating a BIMS score could not be determined, and noted R40

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received an antipsychotic medication for three days and an anti-depressant medication two days during the seven-day lookback period.

The "Annual MDS" dated 10/08/21 revealed a BIMS score of 00, indicating a BIMS score could not be determined and R40 received an antipsychotic medication daily and an anti-depressant three days during the seven-day lookback period.

The "Psychotropic Drug Use Care Area Assessment" (CAA) dated 10/08/21 revealed R40 received Haldol both PRN and scheduled.

The "Care Plan" dated 07/09/21 revealed R40 had a diagnosis of dementia and did not always understand what was going and would often refuse cares. R40 would often become frustrated and had behaviors such as raising his voice, raising his hand in a fist and shook it, or tried to hit or kick at staff.

A review of the "Physician Orders" included the following:
Order dated 07/13/21 for Haldol one milligram (mg), inject intramuscularly PRN for agitation, if the resident refused the Haldol by mouth (PO).
Order dated 07/13/21 for Haloperidol one mg, give one tablet PO two times a daily with meals and did not include a diagnosis.
Order dated 07/27/21 for Haldol 40 mg, inject intramuscularly in the evening every month for vascular dementia with behavioral disturbance.
Order dated 10/17/21 for Remeron (antidepressant medication) 30 mg, one tablet by mouth in the evening related to vascular dementia with behavioral disturbance.

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F 657	Continued From page 5 Review of the August - October 2021 "Electronic Medication Administration Record" (EMAR) revealed the R40 received psychoactive medications (Haldol/Haloperidol/Remeron.) Observation on 10/28/21 at 08:34 AM revealed R40 stayed in his room and did not exhibit any negative verbal or physical behaviors. In an interview on 10/26/21 at 02:21 PM, Certified Nurse Aide (CNA) M stated R40 had his days, some days he was okay, other days he would be stubborn and could get physical towards staff at times depending on who worked with him. In an interview on 10/28/21 at 08:51 AM, Licensed Nurse (LN) F stated R40 refused his medications and would resist cares, swing at staff, and curse in Spanish if staff tried to change him or bathe him. In an interview on 10/28/21 at 10:53 AM, Administrative Nurse A stated psychotropic medications should be included in the care plan if the policy stated it should be. The "Unnecessary Medications" policy revised November 2017 revealed, "...The care plan for psychotropic medication includes the name of the medication used, the indicated behaviors being treated, and the potential side effects of the medication." The facility failed to revise the care plan for R40 to include information concerning the use of the psychotropic medications (Haldol/Haloperidol/Remeron).	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 6 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 reported a census of 42 residents with 12 residents in the sample and two residents reviewed for accidents. Resident 13, and Resident 30. Based on observations, interview, and record review the facility failed to implement care planned fall prevention measures to include the use of a floor mat at night to prevent falls for Resident (R) 13 and failed to ensure staff monitoring the wander guard bracelet for R30 every shift to prevent a potential elopement. Findings include: - The "Physician Orders" dated 09/29/21 for R30 revealed the following diagnosis: schizoaffective disorder bipolar type (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The Annual "Minimal Data Set" (MDS) dated 01/15/21 revealed a "Brief Interview Mental Status (BIMS) score of 10, indicated moderate cognitive impairment. and noted R30 as independent with "Activities of Daily Living" (ADL), with no behaviors noted.	F 689		

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The Quarterly "Minimal Data Set" (MDS) dated 09/24/21 revealed a "Brief Interview Mental Status (BIMS) score of seven, indicating severely impaired cognition.

The "Care Plan" dated 07/31/19, revised on 05/18/20, revealed staff were to ensure R30's wander guard bracelet was in place and working, every shift

The "Task" reviewed from 09/27/21 to 10/27/21 revealed six days out of 30 days the Nurses did not monitor the wander guard every shift (shifts are 12 hours and run 6AM-6PM and 6PM to 6AM). The "Task" documentation revealed the following days lacked evidence of the wander guard checked as care planned:
10/3/21 wander guard checked on first shift, no documentation on second shift
10/7/21 wander guard checked on first shift, no documentation on second shift
10/11/21 wander guard checked on first shift, no documentation on second shift
10/13/21 wander guard checked on first shift, no documentation on second shift
10/15/21 wander guard checked on first shift, no documentation on second shift
10/16/21 wander guard checked on first shift, no documentation on second shift

Observations of R30 on 10/25/21 at 04:39 PM revealed he wore a wander guard on his left ankle. R30 remained in his room during the day shift with no wandering observed.

Interview with Certified Medication Aide (CMA) K on 10/27/21 at 08:34 AM revealed he/she saw R30 try to leave the facility by trying all the doors and say he was looking for his truck. CMA K said

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R30 work a a wander guard and the nurses checked the wander guard and the nurse aides did not.

Interview with Certified Medication Aide (CMA) L on 10/27/21 08:55 AM revealed R30 did wander and had tried to leave the facility, but so far had not made it outside. CMA L said the nurses are the ones that check the wander guard.

Interview with Licensed Nurse (LN) M on 10/27/21 at 10:23 AM revealed the wander guard was checked every shift and documented in the electronic charting system. LN M said the LN have two 12 hour shifts per day and R30 wanders at night looking for his truck or thinks he needs to go to work.

Interview with Administration Nurse A on 10/28/21 at 11:18 AM revealed she expected the wander guard to be checked on all shifts and said the machine will check the battery and the LN staff checked the expiration date. The new staff received orientation on residents that wander and elopement risk. Administrative Nurse A said R30 would not make it out the door, with the way the doors are set up, but if the staff did not check his wander guard and it malfunctions that could be a problem.

The facility policy "Elopement" dated November 28, 2017 revealed the facility would ensure each resident received adequate supervision and devices to deter elopement. The residents care plan would be updated to ensure wandering and potential for elopement interventions were included. The facility used an elopement monitoring bracelet if the resident was determined to be at risk for elopement, in facilities

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equipped with such a system.

The facility failed to monitor R30's wander guard every shift, for six days out of 30 days reviewed to prevent potential elopement.

- The "Physician Orders" in the "Electronic Health Record" (EHR) documented R13 with a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS) dated 12/07/20 documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition and the resident required extensive assistance with bed mobility, transfers, and locomotion on the unit. R13 had one fall without injury in the last month.

The "Quarterly MDS" dated 08/13/21 revealed a BIMS score of four which indicated severe cognitive impairment and had two falls since the prior assessment, without injury.

The "Activities of Daily Living (ADL's) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 12/01/20 documented R13 required extensive assistance with all ADLs due to a decline of mobility since she fell at home. R13 had increased pain and required encouragement with ADLs.

The "Falls CAA" dated 12/01/20 documented R13 had a potential for behaviors due to rejection of care.

The "Care Plan" dated 12/01/20 documented

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multiple interventions including to provide a mat on the floor beside the bed to prevent injuries in case R13 fell.

A "Fall Risk Assessment" completed on 04/27/21 documented R13 was at risk for falls.

Review of 17 fall investigations documented multiple interventions were implemented and the care plan was updated after each fall. The "Fall Investigation" dated 07/21/21 documented an unwitnessed fall without injury in which staff last saw R13 in bed at 02:15 AM. R13 did not state what she was attempting to do, she just said, "Help." The staff noted no injury at the time of the fall. The care plan was updated to include a bed mat at the bedside to break falls.

Observation on 10/27/21 09:37 AM revealed R13 slept in a recliner in the commons area with the footrest up and legs on the footrest. R13 did not appear restless and did not try get up out of the recliner.

Observation on 10/27/21 at 03:42 PM revealed no bed mat in R13's room.

On 10/26/21 09:37 AM, an unidentified family member stated R13 fell about 10 times since her admission to the facility, with no injuries. R13 forgot she could not get up and tried to go to the bathroom or somewhere else.

On 10/27/21 10:30 AM, Certified Nurse Aid (CNA) P stated R13 walked with assistance with a gait belt and walker. CNA P stated she did not know if a bedside mat was used for R13.

On 10/27/21 at 11:52 AM, CNA Q stated she did

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F 689	Continued From page 11 not know of any mat placed by R13's bed to prevent injury from falls. On 10/27/21 at 03:44 PM, CMA R stated she could not find a bed mat in R13's room. On 10/26/21 at 04:33 PM, Licensed Nurse (LN) N stated a mat was used by the bed at night to prevent injury if R13 tried to get out of bed by herself. On 10/27/21 at 03:48 PM, Administrative Nurse A verified a bed mat was in R13's care plan and she got a bed mat and placed it in R13's room today. Administrative Nurse A stated she did not know how long R13 had not had a bed mat at her bedside at night. The "Falls" policy revised 04/27/18 documented, "Individualized care plan interventions will be developed for residents identified thorough assessment as being at fall risk. Those interventions will be reviewed and updated on a regular basis and if/when a fall occurs." The facility failed to ensure staff implemented all care planned fall prevention interventions for R13 when staff did not provide a bedside mat per the care plan.	F 689		
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	F 757		

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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

§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 42 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure the physician was notified when parameters for blood sugars were exceeded for Resident (R)3 and R40.

Finding included:

- R3's signed "Order Summary Report" dated 09/23/21 revealed a diagnosis of diabetes mellitus (when the body cannot use glucose, not enough insulin was made, or the body cannot respond to the insulin.)

The "Annual Minimum Data Set" (MDS) dated 11/13/20 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition and received insulin daily.

The "Quarterly MDS" dated 07/23/21 revealed a

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BIMS score of 15 indicating intact cognition and received insulin daily.

The "Care Plan" dated 07/09/19 revealed staff were to check R40's blood sugar levels as the doctor ordered and let them know if the levels were outside the range the physician set.

A review of the "Physician Orders" included the following:
Order dated 06/16/20 for Blood Glucose Monitoring before meals and at bedtime related to diabetes mellitus. Notify physician if blood glucose was greater than 400 milligrams/deciliter (mg/dL) or less than 70 mg/dL.

Review of the August 2021 Electronic Medication Administration Record (EMAR) revealed the physician was not notified on the following dates when blood sugars were out of parameters (mg/dL):
08/02/21 for a blood sugar of 471.
08/06/21 for a blood sugar of 405.
08/13/21 for a blood sugar of 435.
08/15/21 for a blood sugar of 523.

Review of the October 2021 EMAR revealed the physician was not notified on the following dates when blood sugars were out of parameters (mg/dL):
10/22/21 for a blood sugar of 466.

Review of the "Progress Notes" and documents scanned under the "Miscellaneous" tab of the Electronic Health Record did not reveal any notification to the physician about blood sugars that were greater than 400 mg/dl.

Observation on 10/27/21 at 12:05 PM, revealed

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R3 sat in his chair in his room watching television. R3 did not show any signs or symptoms of hypoglycemia (less than normal amount of glucose in the blood) or hyperglycemia (greater than normal amount of glucose in the blood.)

In an interview on 10/28/21 at 11:10 AM, Certified Medication Aide (CMA) O stated R3 was a diabetic and the nurses were the ones who obtained blood sugars and reported any blood sugars out of parameters to the physician.

In an interview on 10/27/21 at 04:11 PM, Licensed Nurse (LN) N stated R3 was on insulin and nursing staff obtained the blood sugars. LN N stated there were parameters to call the physician if blood sugars were less than 70 mg/dL or greater than 400 mg/dL. LN N stated if blood sugars were out of parameter they would notify the physician either by fax or phone call and stated they would document in a progress note.

In an interview on 10/28/21 at 10:50 AM, Administrative Nurse A stated she expected the nursing staff to notify the physician for any results outside of the specified parameters and to document this notification in a progress note.

The "Clinician Notification" policy revised November 2017 revealed, "It is the policy that notification of physicians and other clinicians will be done on a timely basis...based on physician orders and physician specific parameters."

The facility failed to ensure the physician was notified as ordered for blood sugars greater than 400 mg/dL for R3.

- R40's "Order Summary Report" signed by the

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physician on 10/04/21 revealed a diagnosis of diabetes mellitus (when the body cannot use glucose, not enough insulin was made, or the body cannot respond to the insulin.)

The "Quarterly Minimum Data Set" (MDS) dated 07/16/21 revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating a BIMS score could not be determined, and noted R40 received insulin for three days during the seven-day lookback period.

The "Annual MDS" dated 10/08/21 revealed a BIMS score of 00, indicating a BIMS score could not be determined and R40 received insulin daily.

The "Care Plan" dated 07/09/19 revealed staff were to check R40's blood sugar levels as the doctor ordered and let them know if the levels were outside the range the physician set.

A review of the "Physician Orders" included the following:
Order dated 07/12/21 for blood glucose monitoring in the morning related to diabetes mellitus and to notify the physician if blood glucose is greater than 300 milligrams/deciliter (mg/dL) or less than 70 mg/dL.

Review of the August 2021 Electronic Medication Administration Record (EMAR) revealed the physician was not notified on the following dates when blood sugars were out of parameters (mg/dL):
08/08/21 for a blood sugar of 404.
08/14/21 for a blood sugar of 384.
08/17/21 for a blood sugar of 440.
08/25/21 for a blood sugar of 345.
08/27/21 for a blood sugar of 302.

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Review of the September 2021 Electronic Medication Administration Record (EMAR) revealed the following blood sugar results (and lacked documentation of the physician notification) on the following dates when blood sugars were out of parameters (mg/dL): 09/09/21 for a blood sugar of 397.

Review of the October August 2021 EMAR revealed the following blood sugar results (and lacked documentation of the physician notification) on the following dates when blood sugars were out of parameters (mg/dL): 10/22/21 for a blood sugar of 379.

Observation on 10/28/21 at 08:34 AM revealed R40 did not show any signs or symptoms of hypoglycemia (less than normal amount of glucose in the blood) or hyperglycemia (greater than normal amount of glucose in the blood.)

In an interview on 10/28/21 at 08:20 AM, Certified Medication Aide (CMA) S stated the nurses were the ones who took resident blood sugars.

In an interview on 10/28/21 at 08:51 AM, Licensed Nurse (LN) F stated R40 was an insulin dependent diabetic. LN F stated if blood sugars were out of parameters the nurse should notify the physician by either a phone call or fax and stated any physician notifications should be documented in a progress note.

In an interview on 10/28/21 at 10:50 AM, Administrative Nurse A stated she expected the nursing staff to notify the physician for any results outside of the specified parameters and to document this notification in a progress note.

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F 757	Continued From page 17 The "Clinician Notification" policy revised November 2017 revealed, "It is the policy that notification of physicians and other clinicians will be done on a timely basis...based on physician orders and physician specific parameters." The facility failed to ensure the staff notified the physician as ordered for blood sugars greater than 300 mg/dL for R40.	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--- §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;	F 758		

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§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 census totaled 42 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure an appropriate diagnosis for the use of antipsychotic medications (Haldol/Haloperidol) for R40 and failed to ensure the staff did not administer as needed (PRN) longer than 14 days without a renewed physicians order or reason provided by the physician for the continued administration of Haldol on a PRN basis.

Findings included:

- R40's "Order Summary Report" signed by the physician on 10/04/21 revealed a diagnosis of

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vascular dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain.)

The "Quarterly Minimum Data Set" (MDS) dated 07/16/21 revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating a BIMS score could not be determined, and noted R40 received an antipsychotic medication for three days during the seven-day lookback period.

The "Annual MDS" dated 10/08/21 revealed a BIMS score of 00, indicating a BIMS score could not be determined and R40 received an antipsychotic medication daily during the seven-day lookback period.

The "Psychotropic Drug Use Care Area Assessment" (CAA) dated 10/08/21 revealed R40 received Haldol both PRN and scheduled.

The "Care Plan" dated 07/09/21 revealed R40 had a diagnosis of dementia and did not always understand what was going and would often refuse cares. R40 would often become frustrated and had behaviors such as raising his voice, raising his hand in a fist and shook it, or tried to hit or kick at staff.

A review of the "Physician Orders" included the following:
Order dated 07/13/21 for Haldol one milligram (mg), inject intramuscularly PRN for agitation, if the resident refused the Haldol by mouth (PO).
Order dated 07/13/21 for Haloperidol one mg, give one tablet PO two times a daily with meals and did not include a diagnosis.
Order dated 07/27/21 for Haldol 40 mg, inject

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intramuscularly in the evening every month for vascular dementia with behavioral disturbance.

Review of the September 2021 "Electronic Medication Administration Record" (EMAR) revealed the resident did receive PRN Haldol on 09/06/21 (beyond the 14 day time frame from the 07/13/21 order without a renewed order or reason provided by the physician for the continued use).

Review of the Mayo Clinic website on 10/28/21 at 09:06 AM at: https://www.mayoclinic.org/drugs-supplements/haloperidol-oral-route/proper-use/drg-20064173?p=1 revealed, "Haloperidol is used to treat nervous, emotional, and mental conditions (eg, schizophrenia a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). It is also used to control the symptoms of Tourette's disorder (a nervous system disorder involving repetitive movements or unwanted sounds.) This medicine should not be used to treat behavior problems in older adult patients who have dementia."

Observation on 10/28/21 at 08:34 AM revealed R40 stayed in his room and did not exhibit any negative verbal or physical behaviors.

In an interview on 10/26/21 at 02:21 PM, Certified Nurse Aide (CNA) M stated R40 had his days, some days he was okay, other days he would be stubborn and could get physical towards staff at times depending on who worked with him.

In an interview on 10/28/21 at 08:51 AM, Licensed Nurse (LN) F stated R40 refused his medications and would resist cares, swing at

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staff, and curse in Spanish if staff tried to change him or bathe him.

In an interview on 10/28/21 at 10:53 AM, Administrative Nurse A stated the use of an antipsychotic medication for dementia was not an acceptable diagnosis.

In an interview on 10/28/21 at 12:38 PM, Administrative Nurse G stated the physician order system was set up to automatically place a 14 day stop on PRN psychotropic medications with an alert provided that the 14 days is up so the physician may be contacted for further guidance. The nurse entering the order does have the capability to remove the stop date, but they have all been educated regarding the regulatory requirements for PRN psychotropic med use.
The "Unnecessary Medications" policy revised November 2017 revealed, "Each resident's drug regimen must be free from unnecessary drugs...Antipsychotic medications are indicated for the treatment of schizophrenia, Tourette's, and Huntington's (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder.). The use of antipsychotic medications for any other diagnoses must include physician documentation of the rationale ..."

The facility failed to ensure R40 did not receive unnecessary medications by the failure to ensure an appropriate diagnosis was provided for the use of Haldol and Haloperidol, and by the failure to ensure the prescribing physician provided a rationale to extend the use of the PRN Haldol beyond the 14-day limit for use of PRN psychotropic medications.

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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 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 42 residents. The facility had one main kitchen where food was stored and prepared serving two dining rooms. Based on observation, interview, and record review the facility failed to properly store food in the main kitchen refrigerator and two nourishment room refrigerators due to the lack of temperature monitoring; failed to discard expired food items; failed to ensure the dishes and cookware were washed under sanitary conditions due to the lack of chemical or temperature monitoring; failed to store clean pots and pans separate from used, soiled pots and pans; failed to use appropriate hand hygiene when handling food; failed to prepared potentially hazardous foods with the	F 812		

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potential food-borne pathogens when staff utilized unpasteurized eggs for a residents request for soft or undercooked eggs as opposed to pasteurized eggs (eggs that have been treated in order to reduce the risk of food-borne illness when eaten uncooked or lightly cooked); and failed to serve food in accordance with professional standards for food service safety and ensuring the residents remain free from infections, when observations revealed dietary staff did not hold, deliver, and transport resident food/cups in a sanitary manner.

Findings included:

- Observation on 10/25/21 at 03:42 PM revealed two boxes of "Easy Mix Simply Thick." The first box was labeled with best used by date of 03/24/21 and the second one with a best used date of 04/01/21. Liquid eggs were on the shelf next to the non-pasteurized eggs. No pasteurized eggs were present.

On 10/25/21 at 05:19 PM Certified Nurse Aide (CNA) J observed passing out and refilling beverages for residents in the dining room. CNA J touched the tops/lips of the resident beverage glasses multiple times, and CNA J's finger observed on the eating surface of the plate nearly touching the resident's food.

On 10/25/21 at 05:31 PM observed Licensed Nurse (LN) F touched her hair and other staff, touched her mask, pushed her gown sleeves up her arms, and put her hands on her hips under her gown onto her clothes. LN F did not perform hand hygiene after she touched other resident's, staff, and other items and she continued to pick up plates with food and carried them to the

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residents sitting at the tables. Observation revealed several hand sanitization stations on the walls around the room and LN F verified the hand sanitizing stations were available.

On 10/27/21 at 11:49 AM, observed revealed DS H used his gloved hands to re-tie his gown at the neck in the back, then he reached down to remove the foil from a plate without removing gloves or performing hand hygiene. On 10/25/21 at 05:39 PM CNA I observed passing out three evening meal trays with no use of hand hygiene.

On 10/25/21 at 05:50 PM CNA I stated she used hand sanitizer before she passed meal trays, and did not know she needed to use hand hygiene between each meal tray.

On 10/25/21 at 05:55 PM CNA J confirmed she did not know how and was never trained on passing drinks, she stated the dietary staff generally do it.

On 10/26/21 at 07:53 AM revealed raw whole eggs in the shell in a dish on the serving line with no pasteurization stamp.

On 10/26/21 at 07:53 AM Dietary Staff (DS) B stated uncooked whole eggs in the shell were for frying for residents who did not want scrambled eggs. DS B said the eggs were not pasteurized and they were fine to serve them sunny-side up (eggs cooked until the whites are solid and the yolk is still runny). Some residents requested eggs sunny-side up or over easy (the egg is flipped while cooking but the yolk remains runny) and she cooked them per the resident's request. DB S stated she had not been told about any cooking guidelines to ensure non-pasteurized

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eggs were fully cooked before being served to residents.

On 10/27/21 at 07:42 AM observed the nourishment room kitchen refrigerator temperature log for mornings and evenings was not filled out for the month of October except for the 8th and the 26th. The refrigerator contained one large applesauce container with an expiration date of 10/19/21. The freezer contained one opened unrecognizable item, a croissant sandwich dated 02/20/09, and an unlabeled, undated paper plate with what looked like leftover dessert. Another nourishment room kitchen refrigerator and freezer were both missing 11 temperatures in the morning and evening. The refrigerator contained a plastic clamshell with moldy strawberries, an unlabeled, undated squirt bottle which contained a white substance, a glass bottle of red liquid that had settled into different layers with a dark spot on the inside of the lid that resembled mold, a metal container with seven strawberry flavored, three chocolate flavored, and four vanilla flavored, thawed, undated, four-ounce containers of "Imperial" shakes with the label instructions to use within 14 days of thawing.

On 10/27/21 at 09:01 AM observed approximately 11 "Resource Thicken Up" cans with an expiration date of 10/26/21 in the dry goods pantry. An unsealed bag of sharp yellow cheddar cheese in the refrigerator. There were four large baking sheets that had a dark brown/black baked on substance around the edges. There were three seven-inch frying pans with a dark brown/black hard substance inside and outside of the pans. Two of the pans had dried food particles inside. There was one eight-inch frying pan with a dark brown/black hard substance

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inside and out. There was one 10-inch and one 9.5-inch frying pans with a dark brown/black hard substance inside and outside of the pans. The surface appeared to have the non-stick coating flaking off.

On 10/27/21 at 09:01 AM dietary manager (DM) C stated she did not know if they used unpasteurized eggs, she would have to ask the cook. She stated the liquid eggs were used for scrambling eggs for breakfast. She stated the cooks always used a liner to line the baking sheets. She expected any baked-on or cooked-on grease on baking sheets or frying pans to be removed before storing. DM C said it was unacceptable to place frying pans with food particles present, back on the storage shelf with clean pans. She expected all refrigerator and freezer temperatures to be monitored and logged on the provided log sheets twice daily.

On 10/27/21 at 10:46 DS D stated whole, in-the-shell, unpasteurized eggs were used for frying sunny side up, over easy, or over hard however the resident prefers them. She knew the egg was ready to eat by looking at it and said there were no other guidelines in place to ensure unpasteurized eggs were cooked well enough for safe eating.

On 10/27/21 at 10:48 AM, DS B stated it was the dietary department's responsibility to monitor and log the temperatures of refrigerators and freezers in the snack rooms.

On 10/27/21 at 10:51 AM, DM C stated she expected staff to throw out any expired food items in the refrigerator, freezer, or dry storage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(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
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On 10/27/21 at 12:02 DM C stated that Imperial shakes should be dated at the time of removal from the freezer and used within 14 days.

On 10/27/21 at 05:17 PM observed the chemical log for the kitchen dishwasher sanitization was missing 13 entries for the breakfast shift, 15 entries for the lunch shift, and 22 entries for the dinner shift.

The "Food Storage" policy revised 04/06/21 documented: "Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety ... Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration. Leftover food items must be discarded after 7 days ... Check refrigerator temperature regularly. Check freezer temperature regularly."

The "Refrigerator/Freezer Temperatures" revised 04/27/20 documented: "In order to ensure all perishable food stays fresh and palatable, temperatures will be recorded on all refrigerators and freezers in use, including unit refrigerators in nourishment rooms ... Dining Services will be responsible for taking temperatures on all kitchen and nourishment room refrigerators and freezers, and recording temperatures on temperature logs daily, during each shift."

The "Employee Health Program and Infection Control" policy revised 08/31/21 documented: "At the time of hire and at least annually thereafter, employees will receive training regarding personal health standards and the spread of communicable disease...As part of the infection

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control program, all employees will be trained on proper hand washing, proper glove use, appropriate use of personal protective equipment (PPE), and universal infection control precautions."

The "Use of Shell Eggs and Pasteurized Eggs and Procedure for Undercooked Eggs" policy documented: "Pasteurized eggs or egg products shall be used when little or no cooking is required ... Pasteurized eggs or egg products shall be used when eggs are served undercooked and for fried eggs. Waivers to allow undercooked unpasteurized eggs for resident preference are not acceptable since pasteurized eggs are available and allow for safe consumption."

The facility failed to properly store food in the main kitchen refrigerator and two nourishment room refrigerators due to the lack of temperature monitoring; to discard expired food times before the expiration date; to ensure the dishes and cookware were washed under sanitary conditions due to the lack of chemical or temperature monitoring; to store clean pots and pans separate from used, soiled pots and pans; to use appropriate hand hygiene when handling food; to prepare potentially hazardous foods free from potential food-borne pathogens by providing pasteurized eggs for resident's requests for soft or undercooked eggs; and to serve food in accordance with professional standards for food service safety, ensuring the residents remain free from infections, when observations revealed dietary staff did not hold, deliver, and transport resident food/cups in a sanitary manner.