STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY	445 N WESTVIEW DR DERBY, KS 67037

(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 Investigation KS00166376, KS00163412, KS00164980, KS00162786, KS00162772, KS00159463, and KS00155658.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		

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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be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility census totaled 42 residents (R) with 12 included in the sample and two residents reviewed for transfers out of the facility. Based on observation, interview, and record review the facility failed to ensure staff completed notifications to the ombudsman for R38s transfer to the hospital and R45's discharge to another long-term care (LTC) facility.

Findings included:

- R38's pertinent diagnoses from "Physician's Orders" in the "Electronic Medical Record (EMR)"

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dated 07/19/21 revealed a fracture (broken bone) to his right femur (thigh bone).

The 07/16/21 "Discharge Assessment Return Anticipated Minimum Data Set (MDS)" revealed he discharged to an acute hospital.

The 07/16/21 "Progress Notes" revealed R38 was hospitalized after a fall with fracture due to the resident's non-compliance with ADLs.

Review of the facility provided documentation of monthly notifications to the State LTC Ombudsman of transferred/discharged residents from 01/01/20 to 09/01/21, revealed no documentation of ombudsman notification completed for R38's facility-initiated hospitalization transfer.

Observation of R38 on 09/27/21 at 03:02 PM revealed the resident laid on his bed talking with family on the phone, call light in place, no signs or symptoms of distress noted.

Interview with Administrative Nurse B on 09/30/21 at 08:00 AM revealed she did not know the facility was supposed to be send resident transfers/discharges notifications to the State LTC Ombudsman.

Interview with Social Services Designee N on 09/30/21 at 02:00 PM revealed she did not know she was supposed send notification of transfers/discharges to the State LTC Ombudsman and then stated she spoke with the facility's consultant and was advised the report should be submitted monthly for transfers/discharges, and would do so from now on.

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The facility did not provide a policy regarding notification of transfers/discharge as requested on 09/30/21.

The facility failed to ensure staff completed notifications to the State LTC Ombudsman for R38's 07/16/21 facility-initiated hospitalization transfer.

- R45's pertinent diagnoses from the 06/23/20 "Physician's Order" in the electronic medical record (EMR) documented chronic obstructive pulmonary disease (COPD, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM, a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), and heart failure (HF, low heart output).

The 07/16/21 "Annual Minimum Data Set" (MDS) documented a brief interview for mental status (BIMS) of seven, indicating severely impaired cognition.

The 07/16/21 "Return to Community Care Area Assessment" (CAA) documented that the area did not trigger.

The 07/16/21 "Comprehensive Care Plan" documented he would remain long term in the care facility.

The 07/26/21 "Physician Orders" documented R45's expected discharge to another Long-Term Care Facility on 07/27/21.

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F 623	Continued From page 5 Review of the facility provided documentation of monthly notifications to the State LTC Ombudsman of transferred/discharged residents from 01/01/20 to 09/01/21, revealed no documentation of ombudsman notification completed for R45's facility transfer. Interview with Administrative Nurse B on 09/30/21 at 08:00 AM revealed she did not know the facility was supposed to be send resident transfers/discharges notifications to the State LTC Ombudsman. Interview with Social Services Designee N on 09/30/21 at 02:00 PM revealed she did not know she was supposed send notification of transfers/discharges to the State LTC Ombudsman and said she spoke with the facility's consultant and was advised the report should be submitted monthly for transfers/discharges, and would do so from now on. The facility did not provide a policy regarding notification of transfers/discharge as requested on 09/30/21. The facility failed to ensure staff completed notifications to the State LTC Ombudsman for R45's 07/27/21 facility transfer.	F 623		
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	F 625		

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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 by:
The facility census totaled 42 residents (R) with 12 residents in the sample and one resident reviewed for hospitalization. Based on observation, interview, and record review the facility failed to notify R38's representative in writing and complete the bed hold for the resident's facility initiated hospitalization transfer.

Findings included:

- R38's pertinent diagnoses from "Physician's Orders" and "Progress Note" for diagnosis in the "Electronic Medical Record (EMR)" dated

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07/19/21 revealed a fracture (broken bone) to his right femur (thighbone).

The 06/08/21 "Quarterly Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of 15, indicating intact cognition. The resident experienced no falls during the review period.

The 07/16/21 "Discharge Assessment Return Anticipated MDS" revealed he was discharged to an acute hospital.

The 09/13/21 "Annual MDS" revealed a BIMS of 09, indicating moderately impaired cognition. The resident experienced one minor injury fall during the review period.

The 09/13/21 "ADL Care Area Assessment" (CAA) revealed cognitive loss. He may need assistance from staff with Activities of Daily Living (ADLs) due to history of hip fracture.

The 02/17/19 "Comprehensive Care Plan" revealed a revision dated 07/16/21 noting a "Call Don't Fall" sign placed in the resident's room.

The 07/16/21 "Progress Notes" revealed the hospitalization of R38after a fall with fracture due to the resident's non-compliance with ADLs.

The requested documentation of monthly notifications to ombudsman of transferred/discharged residents from 01/2020 to 09/2021 revealed no documentation of completed ombudsman notifications.

Observation of R38 on 09/27/21 at 03:02 PM revealed the resident laid on his bed talking with

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F 625	Continued From page 8 family on the phone, call light in place, and no signs or symptoms of distress noted. Interview with Licensed Nurse I on 09/29/21 at 09:23 AM revealed for facility-initiated hospitalization resident transfers, the nurse did not complete the bed hold and she did not know who completed them. Interview with Administrative Nurse B on 09/30/21 at 08:00 AM revealed she did not know the bed holds had to be completed for each facility-initiated hospitalization transfer to the hospital. Interview with Social Services Designee N on 09/30/21 at 02:00 PM revealed the bed holds should be completed by the nurses and should be sent with the resident to the hospital. She then stated, "we do not complete them with the resident's representative." The 02/2014 "Bed Hold Policy and Agreement Form" revealed the bed hold agreement was to be obtained for each occurrence- hospital or therapeutic home leave. When hospital or therapeutic leave was reported on the midnight census, the business office would notify the resident/responsible party to sign the bed hold agreement. The facility failed to notify R38's representative in writing and complete the bed hold for the resident's facility-initiated hospitalization transfer.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		

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The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 42 residents with 12 residents (R) in the sample. Based on observation, interview, and record review the facility failed to ensure the accuracy of the completed Minimum Data Set (MDS) regarding falls experienced by R9, which were not noted on the MDS.

Findings included:

- R9's 09/14/20 "Quarterly Minimum Data Set (MDS)" revealed he experienced no falls in the review period since last Quarterly MDS assessment on 06/07/20.

The 06/16/20 at 05:33 AM "Fall Investigation" and 06/17/20 "Fall Risk Data Collection" revealed R9 experienced an unwitnessed fall in his bathroom with no injuries.

The 06/19/20 at 06:45 PM "Fall Investigation" and 06/19/20 at 09:50 PM "Health Status Note" revealed R9 experienced an unwitnessed fall in his room.

Observation of 09/27/21 at 01:05 PM revealed R9 sat in his recliner with the call light within reach.

Interview with Consultant Nurse staff O on 10/05/21 at 08:43 AM revealed the resident's MDS lookback period for falls was from prior assessment to current assessment and said the 09/14/20 MDS should have indicated two or more non-injury falls.

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F 641	Continued From page 10 Review of the 10/2019 "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual" revealed the review period for fall is from the day after the Assessment Reference Date (ARD) of the last MDS assessment to the ARD of the current assessment. Staff must review all available sources for any falls since the last assessment. The facility failed to ensure the accuracy of the completed MDS for R9 regarding falls.	F 641		
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 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	F 657		

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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 (R) in the sample. Based on observation, interview, and record review the facility failed to ensure the resident's comprehensive "Care Plans" reflected the needs of the residents to ensure person-centered care. R10's comprehensive care plan lacked information regarding hospice care, R36's comprehensive care plan lacked information/interventions regarding dialysis (a procedure where impurities or wastes were removed from the blood) services received, and R9's comprehensive care plan lacked revisions related to fall interventions.

Findings included:

- R10's pertinent diagnoses from "Physician's Orders" and "Progress Note" in the "Electronic Medical Record (EMR)" dated 08/12/21 revealed adult failure to thrive (includes not doing well, feeling poorly, weight loss, poor self-care that could be seen in elderly individuals) and dementia (a progressive mental disorder characterized by failing memory, confusion).

The 04/30/21 "Significant Change Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of three, indicating severely impaired cognition. The resident required one staff assistance for walking and had a lower extremity (limb) impairment; she used a wheelchair for mobility. The MDS noted her life expectancy to be less than six months and she

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received hospice care.

The 04/30/21 "Cognitive Area Assessment" (CAA) revealed R10 had dementia and currently received hospice for end of life care.

The 07/07/21 "Quarterly MDS" revealed a BIMS of three with no change in assistance in walking or mobility assistance. The MDS noted R10's life expectancy to be less than six months and she received hospice care.

The 03/12/19 "Comprehensive Care Plan" revealed a revision 09/27/21 noting R10 received hospice services through a contracted company for a terminal (predicted to lead to death, especially slowly; incurable) diagnosis of senile degeneration of brain. Staff offered Chaplin services and Activities of Daily Living by hospice provider. R10 received symptom management by hospice, and the facility staff were to work cooperatively with hospice. The care plan lacked the frequency of hospice visits or how hospice staff communicated the care provided to R10 to the facility staff.

Observation of R10 on 09/27/21 at 04:23 PM revealed the resident sat at the nursing station in her wheelchair, calm, and dressed/groomed with shoes in place.

Interview with Administrative Nurse B 09/30/21 at 01:00 PM revealed hospice care services and frequency of visits should be documented on the care plan.

The facility did not provide a policy regarding care plan revision as requested on 09/30/21.

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The facility failed to ensure staff updated R10's comprehensive care plan to include hospice care frequency of visits or how hospice communicated the care provided to the facility staff.

- R36's pertinent diagnoses from the "Physician's Orders" in the "Electronic Medical Record (EMR)" dated 09/21/21 revealed end-stage renal disease (ESRD, a terminal disease because of irreversible damage to kidneys) and chronic kidney disease (CKD, a condition characterized by a gradual loss of kidney function over time).

Review of the 06/10/21 "Annual Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of 15, indicating intact cognition. Her diagnosis included ESRD and R36 received dialysis.

Review of the 09/10/21 "Quarterly MDS" revealed a BIMS of 15, indicating intact cognition. Her diagnosis included ESRD, and she received dialysis.

Review of 05/22/20 "Comprehensive Care Plan" revealed a revision on 01/12/21 noting R36 received dialysis. The care plan lacked information about the frequency of dialysis, location and assessment of dialysis access site, required monitoring of vital signs, weights, and/or fluid intake, and required labs.

Observation on 09/30/21 at 09:08 AM revealed R36 out of the facility for Hemodialysis.

Interview with Administrative Nurse B on 09/30/21 at 01:00 PM revealed R36s Dialysis information should be updated on her care plan.

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The facility failed to provide a policy regarding care plan revision as requested on 09/30/21.

The facility failed to ensure R36's comprehensive care plan included information/interventions in regard to the dialysis (a procedure where impurities or wastes were removed from the blood) services received, such as frequency and fistula evaluation.

- R9's pertinent diagnoses from "Physician's Orders" and "Progress Note" for diagnoses in the electronic medical record (EMR) dated 09/23/21 revealed muscle weakness, benign prostatic hyperplasia (BPH, a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and dementia (a progressive mental disorder characterized by failing memory, confusion).

The 09/14/20 "Quarterly MDS" revealed a BIMS of zero, indicating severely impaired cognition. He required no staff assistance for transfers/ambulating and limited one staff assist for toileting. He experienced no falls in the review period.

The 12/28/20 "Annual MDS" revealed a BIMS of zero, indicating severely impaired cognition. The resident required limited one staff assistance for transfers/toileting, supervision of one staff for walking and used a walker for ambulation. He experienced two or more non-injury falls in the review period.

The 12/28/20 "Falls Care Area Assessment" (CAA) revealed R9 was at risk for falls but could not understand to call for help when needing

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assistance and ambulated with use of a walker.

The 11/19/19 "Comprehensive Care Plan" revealed a revision on 12/12/19 the resident required a four-wheeled walker for ambulation and needed toileting assistance at times. He was at risk for falls and a revision on 11/19/19 indicated he required the call light in reach and staff encouraged call light use. A revision on 01/27/21 noted he required an unobstructed path to the bathroom. A revision on 06/17/20 noted the resident would place himself on the floor and crawl around, and the staff were to assist him to the chair/bed, he had an actual fall in the bathroom that day. A revision 06/19/20 noted the resident had a fall in his room and the staff must keep the bedside table in reach for all meals and the resident's room free of clutter.

The 06/16/20 at 05:33 AM "Fall Investigation" and 06/17/20 "Fall Risk Data Collection" revealed R9 experienced an unwitnessed fall in his bathroom with no injuries.
The "Care Plan" lacked revisions to prevent further falls for R9.

The 06/19/20 at 06:45 PM "Fall Investigation" and 06/19/20 at 09:50 PM "Health Status Note" revealed R9 experienced an unwitnessed fall in his room, found on his right knee in front of recliner, which was tilted forward, trying to get his side table.
The "Care Plan" lacked revisions to prevent further falls for R9.

Observation of 09/27/21 at 01:05 PM revealed R9 ambulated with a walker slowly to the room with shoes in place. R9 sat in his recliner with the call light within reach.

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F 657	Continued From page 16 Interview with Administrative Nurse B on 09/30/21 at 03:13 PM revealed the facility staff completed a fall huddle after each resident fall, completed a root cause analysis and initiated interventions for the fall which were updated on the resident's care plan. The facility did not provide a policy regarding care plan revisions as requested on 09/30/21. The facility failed to ensure R9's comprehensive care plan included revisions after each fall to prevent further falls for R9.	F 657		
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	F 661		

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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 by:
The facility reported a census of 42 residents, with 12 sampled, including one for discharge to the community. Based on interview and record review the facility failed to complete a discharge summary to include the recapitulation of Resident (R) 45's stay in the discharge summary.

Findings included:

- R45's pertinent diagnoses from 06/23/20 "Physician Order" in the electronic medical record (EMR) documented encephalopathy (damage or disease that affects the brain), Dementia (progressive mental disorder characterized by failing memory, confusion) and major depressive disorder (MDD, major mood disorder).

The 07/16/21 "Annual Minimum Data Set" (MDS) documented no plans for the resident's discharge.

The 07/16/21 "Care Area Assessment" (CAA) did not trigger for discharge to the community.

The 04/15/21 "Quarterly MDS" documented no plans for discharge.

The 07/16/21 "Care Plan" documented R45 would remain long term in the facility.

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The "Electronic Health Records (EHR) Physician Orders" documented an order to discharge to another facility and to continue the current medications dated 07/26/21.

R45's EHR lacked evidence of a completed discharge summary or discharge papers, which included a recapitulation of stay for the resident.

Interview with Licensed Nurse (LN) I on 09/30/21 at 10:17 AM revealed when she discharged a resident from the facility, she completed a discharge note with information regarding where the resident discharged to, how the facility transferred the resident , vital signs, and what items the resident left with. LN I provided a completed recapitulation of the resident's stay to the resident and/or the resident's family.

Interview with Administrative Nurse B on 09/30/21 at 02:49 PM revealed when R45 discharged to another facility, Social Services Director (SSD) N faxed the medication administration record, history and physical completed by the provider, lab work and results, R45's face sheet, discharge order, and any instructions from the provider to the new facility. The facility staff sent a copy of the paperwork with the resident upon transfer but lacked documentation in the resident's chart. Administrative Nurse B expected her staff to write a progress note about the discharge of the resident.

The facility did not provide a policy regarding resident discharge and documentation, as requested on 09/30/21.

The facility failed to document the discharge summary, including the recapitulation of stay for

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F 661	Continued From page 19 R45.	F 661		
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 census totaled 42 residents with 12 residents (R) in the sample and one sampled for hospice care. Based on observation, interview, and record review the facility failed to ensure hospice care/services were documented and communicated to staff for the continuity of care regarding R10. Findings included: - R10's pertinent diagnoses from "Physician's Orders" and "Progress Note" in the "Electronic Medical Record (EMR)" dated 08/12/21 revealed adult failure to thrive (includes not doing well, feeling poorly, weight loss, poor self-care that could be seen in elderly individuals) and dementia (a progressive mental disorder characterized by failing memory, confusion). The 04/30/21 "Significant Change Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of three, indicating severely impaired cognition. The resident required one	F 684		

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staff assistance for walking and had a lower extremity (limb) impairment; she used a wheelchair for mobility. Her life expectancy was noted to be less than six months and received hospice care.

The 04/30/21 "Cognitive Area Assessment" (CAA) revealed R10 had Dementia and currently received Hospice for end life care.

The 07/07/21 "Quarterly MDS" revealed a BIMS of three with no change in assistance in walking or mobility assistance. The MDS noted R10's life expectancy to be less than six months and she received hospice care.

The 03/12/19 "Comprehensive Care Plan" revealed a revision 09/27/21 noting R10 received hospice services through a contracted company for a terminal (predicted to lead to death, especially slowly; incurable) diagnosis of senile degeneration of brain. Staff offered Chaplin services and Activities of Daily Living by hospice provider. R10 received symptom management by hospice, and the facility staff were to work cooperatively with hospice. The care plan lacked the frequency of hospice visits or how hospice staff communicated the care provided to R10 to the facility staff.

The 04/22/21 "Physician Orders" revealed the facility could consult hospice of choice if R10's family agreed, for R10's diagnosis of end stage dementia and failure to thrive.

The 04/27/21 "Physician Orders" revealed the facility could consult hospice of family choice.

The 09/27/21 "Physician Orders" revealed the

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facility admitted R10 to a contracted hospice company on 04/2721.

The "Hospice Notebook" for R10, revealed the notebook lacked Hospice care documentation from 06/01/21 to 08/31/21.

Observation of R10 on 09/27/21 at 04:23 PM revealed the resident sat at the nursing station in her wheelchair, calm, and dressed/groomed with shoes in place.

Interview with Certified Nurse Aide (CNA) J on 09/29/21 at 11:20 AM revealed she knew R10 received Hospice care, but she stated, "she was unsure how often Hospice staff came in to work with the resident or what they did."

Interview with CNA K on 09/29/21 at 02:58 PM revealed she knew R10 received Hospice care, and thought they came at least once a week, and if there were any changes with R10 the Hospice staff tell the facility staff. CNA K stated the nurse's station held the Hospice notebook which contained hospice notes.

Interview with CNA L on 09/30/21 at 09:05 AM revealed the hospice aides came to the facility twice a week and the hospice nurses came once a week, she thought. She did not know what services Hospice provided to R10.

Interview with Licensed Nurse I on 09/29/21 at 09:23 AM revealed R10 received hospice care, she stated, "once or twice week". A hospice aide, nurse, and social worker worked with the resident and said the hospice. The Hospice aides assisted the resident with showers, trimming fingernails, sitting with her and talking, tidying room, etc.

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F 684	Continued From page 22 When the hospice nurse cared for R10, she told facility staff about any updates on R10. She then stated, "the Hospice staff documented (care/notes) in a hospice notebook for R10." Interview with Administrative Nurse B 09/30/21 at 01:00 PM revealed the hospice nurses gave a verbal report to the facility staff after caring for R10 and sent the facility staff the hospice notes for documentation. She stated the facility had a notebook for (R10's) hospice documentation but found the hospice staff had not been utilizing the notebook. When Administrative Nurse B requested the hospice notes from the hospice company, she said they only sent the two notes noted in the review. The facility did not provide a policy regarding Hospice as requested on 09/30/21. The facility failed to ensure hospice care/services were documented and communicated to staff for the continuity of care regarding R10.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 42 residents, with 12 sampled and three reviewed for falls.	F 689		

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Based on observation, interview, and record review the facility failed to adequately complete fall investigations, to include identifying causal factors related to falls and implement interventions to prevent further falls for Resident (R) 4, R9, and R26.

Findings included:

- R4's pertinent diagnoses from 05/20/20 "Physician's Order" in the electronic medical records (EMR) included documented: dementia (progressive mental disorder characterized by failing memory, confusion), anoxic (lack of oxygen) brain damage, psychosis (any major mental disorder characterized by a gross impairment in reality testing) and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The 12/16/20 "Quarterly Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of three, indicating severely impaired cognition. R4 was able to ambulate around the facility independently. R4 had one fall with injury since previous MDS.

The 06/23/21 "Annual MDS" documented a BIMS of three, indicating severely impaired cognition. R4 required supervision while ambulating around the unit. R4 had no falls since last MDS.

The 06/23/21 "Falls Care Area Assessment CAA" documented R4 was at risk for falls due to dementia and taking antidepressant and psychotropic medications and paced the hallways at times. R4 had no safety awareness while walking.

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The 09/23/21 "Quarterly MDS" documented a BIMS of two, indicating severely impaired cognition. R4 required supervision while ambulating around the unit. R4 had no falls since last MDS.

The 07/01/21 "Care Plan" documented R4 was to wear appropriate footwear when ambulating, initiated on 12/14/20 after the fall on 12/14/20.

The "Fall Risk Assessment" completed on 09/15/20, noted R4 had a score of eight, indicating low risk for potential falls and had no history of falls.

The 12/14/20 "Progress Note" documented that R4 was found on the floor in the hallway at approximately 07:30 PM with no shoes on her feet, only regular socks. R4 had been pacing up and down the hallway prior to fall with little success from staff to redirect. Vital signs were taken, and neurological checks initiated per provider request.

The 12/14/20 "Fall Investigation" provided by the facility lacked documentation regarding circumstances surrounding the fall, including causal factors related to the fall, post fall interventions, post fall meeting, witness statements, and neurological (memory and functionality) checks.

Observation of R4 on 09/29/21 at 12:44 PM revealed R4 was wandering/pacing throughout the facility independently, but staff were noted to be watching resident. Non-slip socks noted to be on feet.

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Observation of R4 on 09/30/21 at 11:41 AM revealed R4 walked into the dining room with staff assistance for lunch. R4 had non-slip socks on her feet and did not sit long at the dining table. Staff were able to redirect her back to her table for lunch.

Interview with Administrative Nurse B on 09/30/21 at 03:13 PM revealed the facility staff completed a fall huddle after each resident fall, completed a root cause analysis and initiated interventions for the fall which were updated on the resident's care plan. There was a "fall bucket of interventions" that could be used to implement with residents who have fallen. She did not have the nurses fill out a root cause analysis paper but would add that to the fall investigations, so they can be more complete. This was charted in "Risk Management" but the facility did not complete a "fall packet".

The "Fall Policy" revised on 09/17/19 documented the facility staff were to complete an occurrence report for any falls. Details of the fall would be recorded, and potential causal factors identified and investigated. Interventions would be implemented, and care plans updated. Occurrence reports were to be reviewed at clinical meetings to ensure completeness.

The facility failed to complete fall investigations with all documentation including root cause analysis and interventions to prevent future falls for R4.

- R26's pertinent diagnoses from the 08/20/21 "Physician's Order" EMR documented: right femur fracture (leg break), osteoarthritis (degenerative changes to one or many joints

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characterized by swelling and pain), and Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure).

The 01/06/21 "Annual MDS" documented a BIMS of zero, indicating severely impaired cognition. R26 could ambulate independently around the facility and had no history of falls since the previous MDS.

The 01/06/21 "Falls CAA" documented R26 was at risk for falls due to vision impairment, depression, and dementia, and R26 wandered in the hallways.

The 08/24/21 "Quarterly MDS" documented a BIMS of three, indicating severely impaired cognition. R26 required limited assistance from one staff member to ambulate in the facility. R26 had no history of falls since the previous MDS.

The "Fall Risk Assessment" completed on 07/19/21, noted R26 with a score of six, indicating low risk for potential falls and had no history of falls.

The 08/05/21 "Care Plan" documented R26 was to wear gripper socks when not wearing shoes, initiated on 11/16/19.

The 08/13/21 "Progress Note" documented the staff found R26 on the floor by the front door with reported pain to her right hip. The staff obtained vital signs and notified the provider. The facility sent R26 to the hospital for evaluation and surgery.

The 08/13/21 "Fall Investigation" provided by the

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facility lacked documentation regarding circumstances surrounding the fall, including causal factors related to the fall, post fall interventions, post fall meeting, witness statements, and neurological (memory and functionality) checks.

Observation on 09/28/21 at 01:00 PM of resident revealed R26 sat in her wheelchair, propelled to her room with staff assistance.

Interview with Administrative Nurse B on 09/30/21 at 03:13 PM revealed the facility staff completed a fall huddle after each resident fall, completed a root cause analysis, and initiated interventions for the fall which were updated on the resident's care plan. There was a "fall bucket of interventions" that could be used to implement with residents who have fallen. She did not have the nurses fill out a root cause analysis paper but would add that to the fall investigations, so they can be more complete. This was charted in "Risk Management" but the facility did not complete a "fall packet".

The "Fall Policy" revised on 09/17/19 documented the facility staff were to complete an occurrence report for any falls. Details of the fall would be recorded, and potential causal factors identified and investigated. Interventions would be implemented, and care plans updated. Occurrence reports were to be reviewed at clinical meetings to ensure completeness.

The facility failed to complete a thorough fall investigations to include causal factors and interventions to prevent future falls for R26.

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- R9's pertinent diagnoses from "Physician's Orders" and "Progress Note" for diagnoses in the electronic medical record (EMR) dated 09/23/21 revealed muscle weakness, benign prostatic hyperplasia (BPH, a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and dementia (a progressive mental disorder characterized by failing memory, confusion).

The 09/14/20 "Quarterly MDS" revealed a BIMS of zero, indicating severely impaired cognition. He required no staff assistance for transfers/ambulating and limited one staff assist for toileting. He experienced no falls in the review period.

The 12/28/20 "Annual MDS" revealed a BIMS of zero, indicating severely impaired cognition. The resident required limited one staff assistance for transfers/toileting, supervision of one staff for walking and used a walker for ambulation. He experienced two or more non-injury falls in the review period.

The 12/28/20 "Falls Care Area Assessment" (CAA) revealed R9 was at risk for falls but could not understand to call for help when needing assistance; ambulated with walker.

The "Fall Assessments" completed for R9's risk of fall identified on 03/09/20, 06/08/20, 06/17/21 the resident was a low risk for falls and on 06/19/21 identified R9 as a high risk for falls.

The 11/19/19 "Comprehensive Care Plan" revealed a revision on 12/12/19 the resident required a four-wheeled walker for ambulation

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and needed toileting assistance at times. He was at risk for falls and a revision on 11/19/19 indicated he required the call light in reach and staff encouraged call light use. A revision on 01/27/21 noted he required an unobstructed path to the bathroom. A revision on 06/17/20 noted the resident would place himself on the floor and crawl around, and the staff were to assist him to the chair/bed, he had an actual fall in the bathroom that day. A revision 06/19/20 noted the resident had a fall in his room and the staff must keep the bedside table in reach for all meals and the resident's room free of clutter.

The 06/16/20 at 05:33 AM "Fall Investigation" and 06/17/20 "Fall Risk Data Collection" revealed R9 experienced an unwitnessed fall in his bathroom with no injuries. The investigation lacked information about how the fall occurred with supporting information, lacked causal factors or fall interventions noted.

The 06/19/20 at 06:45 PM "Fall Investigation" and 06/19/20 at 09:50 PM "Health Status Note" revealed R9 experienced an unwitnessed fall in his room, found on his right knee in front of recliner, which was tilted forward, trying to get his side table. The investigation lacked information about causal factors noted or fall interventions noted.

Observation of 09/27/21 at 01:05 PM revealed R9 ambulated with a walker slowly to the room with shoes in place. R9 sat in his recliner with the call light within reach.

Interview with Certified Nurse Aide (CNA) J on 09/29/21 at 08:08 AM revealed R9 required one staff assistance with his walker for transfers,

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walking, and toileting. She stated she did not think he had any falls and did not know of any fall interventions in place.

Interview with CNA K on 09/29/21 at 02:58 PM revealed R9 had no falls that she knew of, but she had only worked at the facility for six months. She noted R9 was steady on his feet but required one staff assistance for most Activities of Daily Living (ADLs). He would "fuss" if staff tried to assist him and he used a walker.

Interview with Licensed Nurse I on 09/29/21 at 09:23 AM revealed R9 had not experienced any falls at the facility the last month. He was steady on his feet with a walker, but still considered a fall risk. He required one staff assistance for ADLs, could be grumpy and resistive to cares, but staff were to re-approach, if needed.

Interview with Administrative Nurse B on 09/30/21 at 03:13 PM revealed the facility staff completed a fall huddle after each resident fall, completed a root cause analysis and initiated interventions for the fall which were updated on the resident's care plan. There was a "fall bucket of interventions" that could be used to implement with residents who have fallen. She did not have the nurses fill out a root cause analysis paper but would add that to the fall investigations so they can be more complete, and was included in "Risk Management" but the facility did not complete a "fall packet".

The 09/17/19 "Fall Policy" revealed following any falls, the facility staff completed an occurrence report. Details of the fall would be recorded, and potential causal factors identified and investigated. Interventions would be

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F 689	Continued From page 31 implemented, and care plans updated. Occurrence reports are reviewed at clinical meetings to ensure completeness. The facility failed to complete thorough fall investigations after each fall, when the facility did not identify causal factors and develop fall interventions to prevent further falls for R9.	F 689		
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 census totaled 42 residents (R) with 12 residents in the sample, and one resident sampled for dialysis services. Based on observation, interview, and record review the facility failed to complete pre-dialysis weights and vital signs, assess the dialysis access site, record resident fluid intake, and obtain physician ordered labs for R36. Findings included: - R36's pertinent diagnoses from the "Physician's Orders" in the "Electronic Medical Record (EMR)" dated 09/21/21 revealed end-stage renal disease (ESRD, a terminal disease because of irreversible damage to kidneys) and chronic kidney disease (CKD, a condition characterized by a gradual loss of kidney function over time).	F 698		

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Review of the 06/10/21 "Annual Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of 15, indicating intact cognition. Her diagnosis included ESRD and R36 received dialysis.

Review of the 09/10/21 "Quarterly MDS" revealed a BIMS of 15, indicating intact cognition. Her diagnosis included ESRD, and she received dialysis.

Review of 05/22/20 "Comprehensive Care Plan" revealed a revision on 01/12/21 noting R36 received dialysis. The care plan lacked information about the frequency of dialysis, location and assessment of dialysis access site, required monitoring of vital signs, weights, and/or fluid intake, and required labs.

Review of 03/03/21 "Physician Orders" revealed R36 required labs including a Renal (kidney) Panel & Complete Blood Count (laboratory blood test) every week on Wednesday for Dialysis. The residents chart lacked documentation for one and/or both of the above physician ordered labs on the following 26 dates from 03/09/21 to 09/27/21.
March: 03/10/21 and 03/17/21.
April: 04/07/21, 04/14/21, 04/21/21, and 04/28/21.
May: 05/05/21, 05/12/21, 05/19/21, and 05/26/21.
June: 06/02/21, 06/09/21, 06/16/21, 06/23/21, and 06/30/21.
July: 07/07/21, 07/14/21, 07/21/21, and 07/28/21.
August: 08/04/21, 08/11/21, 08/18/21, and 08/25/21.
September: 09/01/21, 09/15/21, and 09/22/21.

The 06/01/21 to 09/28/21 "Progress Notes" lacked dialysis access site documentation and

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the "CNA Tasks" for fluid intake from 06/01/21 to 09/28/21 lacked documentation.

Review of 06/01/21 to 09/28/21 "Dialysis Communication Record" forms revealed 39/51 forms lacked resident weights completed prior to dialysis, lacked post dialysis assessment of the dialysis access site. Most forms lacked documentation from the residents visit to the dialysis center, including no post dialysis vital signs on 06/17/21 and a note from the dialysis facility stating, "needs to watch fluid intake".

Review of 06/02/21 "Dietician Nutrition Assessment" revealed staff were to "monitor intake", did not specify fluid intake.

Observation of R36 on 09/29/21 at 08:59 AM revealed the resident in dining room, seated in her wheelchair at a table awaiting breakfast. At 09:08 AM breakfast arrived at the table, and she received two pieces of French toast and two sausage links with condiments, water, and another beverage cup as well.

Observation on 09/30/21 at 09:08 AM revealed R36 out of the facility for Hemodialysis.

Interview with resident on 09/27/21 at 12:24 PM revealed she received Dialysis on Tuesday, Thursday, and Saturday at the Dialysis center in town. Her dialysis access site was on her left arm, and she stated, the nurses looked at her dressing when she returned from dialysis, but she removes the dressing the next day, not the nurses, because she thought she was supposed to, as no one has ever told her otherwise. The nurses assessed the dialysis access site only before she left the facility for dialysis, and the

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staff were supposed to take her vital signs before she left the facility for dialysis and upon her return to the facility. The resident said the staff do not weigh her, noting the dialysis center does, and she returns to the facility with the paperwork from dialysis.

Interview with Certified Nurse Aide K on 09/29/21 at 02:58 PM revealed R36 received dialysis and left the facility on first shift, but only knew she went to dialysis on Saturday. When R36 returned from dialysis, the CNAs were supposed to weigh her and obtain vital signs and give the dialysis notebook with the forms to the nurse. She did not know if fluid intake needed documented for R36.

Interview with CNA L on 09/30/21 at 09:05 AM revealed R36 left a little before 06:00 AM to dialysis every Tuesday, Thursday, and Saturday. The nurses completed the vital signs before she leaves the facility, and when she returns. CNA L did not think the resident was on a fluid restriction, and she had never had to document fluids for her.

Interview with Licensed Nurse I on 09/30/21 at 09:23 AM revealed R36 did not have a fluid restriction that she knew of, she did not know if her fluids were documented. She stated R36 went to dialysis three days a week at the center in town. LN I said the staff obtained her vital signs and weight before she left the facility, and the nurses assessed the fistula site. There were papers in a folder the staff used to document the information that were sent with her to dialysis. Upon R36's return to the facility after dialysis, staff obtained her weight and vital signs again. The nurses were expected to assess the dialysis access site dressing, ensure the resident kept the

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F 698	Continued From page 35 dressing in place at least two hours, then removed the dressing, assess the site, and documented in the progress notes. Interview with Administrative Nurse B on 09/30/21 at 01:00 PM revealed she expected the staff to fill out the resident's dialysis paperwork completely, staff should obtain vital signs and weight before the resident lefts the facility for dialysis, and the nurses should check the paperwork upon return to ensure it was filled out. The nurses should assess the fistula site after dialysis and every shift. Review of 02/2021 "Dialysis Communication" policy revealed a dialysis communication form would be used to send information to and from the facility to the dialysis center and back. Upon return of the resident from the dialysis center, the nurse in charge of the resident would review the communication form and obtain necessary post dialysis information. The policy lacked information about pre and post dialysis monitoring and assessment of the dialysis access site. The facility failed to complete pre-dialysis weights and vital signs, assess the dialysis access site, record resident fluid intake, and obtain physician ordered labs for R36	F 698		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		

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requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
The facility census totaled 42 residents. Based on interview and record review, the facility failed to ensure five Certified Nurse Aide (CNA) staff reviewed, completed 12 hours of required in-service training annually.

Findings included:

- Review of staff training records for Certified Nurse Aide (CNA) C (hired on 05/01/20), D (hired 03/31/20), CNA E (09/26/17), CNA F (hired on 01/20/15), and CNA G (hired on 10/01/13) lacked documented evidence of in-service hours totaling 12 hours in a one-year period from hire anniversary date.

Interview with Administrative Nurse B on 09/29/21 at 12:31 PM revealed she started working for the facility in March of 2021 and did not have documentation of completed in-services for any of the facility staff prior to her arrival. Administrative Nurse B could provide documentation of completed in-services for the CNAs [listed above] from March through September of 2021.

Review of the "Facility Assessment" reviewed in 2021, lacked documentation regarding required in-service hours for each staff member annually.

The facility did not provide a policy regarding total required annual in-service hours for staff, as requested on 09/30/21.

The facility failed to ensure five CNA staff reviewed completed 12 hours of in-service

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F 730	Continued From page 37 training annually.	F 730		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		

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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 42 residents with 12 residents (R) in the sample and five sampled for medication regimen reviews. Based on interview, observation, and record review the facility failed to maintain documentation of the consultant pharmacist's identified recommendations and failed to act upon recommendations for multiple months for R10, R26, and R31.

Findings included:

- Resident (R) 10's pertinent diagnoses from "Physician's Orders" and "Progress Note" in the "Electronic Medical Record (EMR)" dated 08/12/21 revealed hyperlipidemia (a condition of elevated blood lipid levels) and atherosclerotic heart disease (a condition which affects the arteries that supply the heart with blood, usually caused by atherosclerosis, a buildup of plaque inside the artery walls).

The 04/30/21 "Significant Change Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of three, indicating severely impaired cognition. She had diagnoses of hyperlipidemia and coronary artery disease.

The "Cognitive Loss Care Area Assessment" (CAA) revealed a BIMS of three, she had increased confusion, and required redirection.

The 07/07/21 "Quarterly MDS" revealed a BIMS of three. She had diagnoses of hyperlipidemia and coronary artery disease.

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The 03/12/19 "Care Plan" revealed a revision dated 08/12/19 that R10 had a diagnosis of coronary artery disease. The care plan lacked information about lipid labs.

The "Pharmacy Recommendation Reviews" revealed:
01/16/20- The pharmacist noted that a lipid panel (measures the amount of specific fat molecules called lipids in the blood) lab must be completed every 12 months, and the physician responded on 01/27/20 agreeing with this recommendation.
03/09/20- The pharmacist noted that the physician accepted the pharmacy recommendation to draw a lipid panel on 01/27/20, but the lab order had not yet been processed. The facility provided no response/reaction to this recommendation.
04/08/20- The pharmacist repeated that the physician accepted the pharmacy recommendation to draw a lipid panel on 01/27/20, but the lab order had not yet been processed. The facility documented that the lipid lab order had been placed. The facility was unable to provide proof of completion of the lipid panel per pharmacy recommendation and physician orders.
03/18/21- The facility could not provide the requested pharmacy recommendation documentation.
04/23/21- The facility could not provide the requested pharmacy recommendation documentation.

Observation of R10 on 09/27/21 at 04:23 PM revealed the resident seated at the nursing station in her wheelchair, calm, and dressed/groomed with shoes in place.

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Interview with Licensed Nurse I on 09/29/21 at 09:23 AM revealed she was not sure about pharmacy recommendation reviews, she thought Administrative Nurse B handled them.

Interview with Administrative Nurse B on 09/30/21 at 01:00 PM revealed she provided all of the pharmacy recommendation reviews that she could find. She expected the pharmacy reviews to be completed and documentation kept for each resident, along with any that the physician responded to should be scheduled/completed accordingly. Once she obtained a physician response to the pharmacy recommendations, she would give them to the nurses, and they were to complete/schedule those recommendations.

The facility failed to provide a policy regarding pharmacy recommendations and physician response as requested on 09/30/21.

The facility failed to document that the pharmacist's identified recommendations and/or failed to document the action taken or not taken to address the irregularities for multiple months for R10.

- Review of R26's pertinent diagnoses from the "Physician's Orders" in the Electronic Medical Record (EMR) dated 08/20/21 documented pneumonia (inflammation of the lungs), major depressive disorder (MDD, major mood disorder), hypertension (elevated blood pressure), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and Alzheimer's Disease (progressive mental deterioration characterized by confusion and

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memory failure).

The 01/06/21 "Annual Minimum Data Set" (MDS) documented R26 received scheduled pain medication antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression), and diuretics (medication to promote the formation and excretion of urine) for seven days of the observation period. R26 did not receive antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions).

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 01/06/21, documented R26 received Lexapro (antidepressant) due to MDD and behaviors. Behaviors increased with reduction of medication due to Alzheimer's Disease.

The 08/24/21 "Quarterly MDS" documented R26 received scheduled pain medication, antidepressants, anticoagulants (blood thinner), antibiotics (medication used to treat infection), and diuretics (medication used to increase excretion of urine) during the seven day observation period. R26 did not receive antipsychotic medication.

The 08/05/21 "Care Plan" documented R26 received Bumex (diuretic), Lexapro (antidepressant) and Voltaren Gel (pain medication). Staff were to monitor, document, and report any signs and symptoms of hypokalemia (low potassium) to the provider. Staff were to monitor potassium levels. Staff were to also monitor R26 every shift for any adverse reactions to antibiotics.

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On the 08/2020 "Medication Regimen Review" (MRR) the consultant pharmacist documented that a recommendation was made and to "see report." The facility did not provide the document "see report" referenced in the MRR and did not know what the recommendation was in the MRR.

On the 10/2020 "MRR" the consultant pharmacist recommended a "Gradual Dose Reduction" (GDR) be completed for Lexapro 15 milligram (mg). The facility did not have evidence of a GDR for the Lexapro or follow up on the recommendation.

On the 01/2021 "MRR" the consultant pharmacist recommended Lexapro 15 mg be decreased to 10 mg daily. The facility did not have evidence of a decrease in the Lexapro or follow up on the recommendation.

Observation of resident on 09/30/21 at 11:30 AM revealed resident sat in a wheelchair, eating lunch in the dining room.

Interview with Licensed Nurse I on 09/29/21 at 09:23 AM revealed she did not know about pharmacy recommendation reviews and thought Administrative Nurse B handled them.

Interview with Administrative Nurse B on 09/30/21 at 01:00 PM revealed she provided all the pharmacy recommendation reviews that she could find. She expected the pharmacy reviews to be completed and documentation kept for each resident, along with any that the physician responded to should be scheduled/completed accordingly. Once she obtained a physician response to the pharmacy recommendations, she

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would give them to the nurses, and they were to complete/schedule those recommendations.

The did not provide a policy regarding pharmacy recommendations and physician response as requested on 09/30/21.

The facility failed to act upon the consultant pharmacist's MRR recommendations for R26.

- R31's pertinent diagnoses from the 02/02/20 "Physician's Orders" documented diabetes mellitus type 2 (when the body cannot use sugar, not enough insulin made, or the body cannot respond to the insulin), congestive heart failure (CHF, a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heartbeat), chronic obstructive pulmonary disease (COPD, progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), respiratory failure with hypoxia (lack of oxygen to the brain), MDD, end stage renal disease (ESRD, inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), and hypothyroidism (condition characterized by decreased activity of the thyroid gland).

The 02/18/21 "Annual MDS" documented R31 received scheduled pain medication, antidepressants, anticoagulants (blood thinner), diuretics (medication used to increase excretion of urine) and insulin (medication to lower blood glucose) for seven days of the observation period. R31 did not receive antipsychotic medication.

The "Psychotropic Drug Use Care Area

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Assessment" (CAA), dated 02/18/21, documented R31 received antidepressant medication due to MDD and had no side effects at the time of the MDS completion.

The 08/30/21 "Quarterly MDS" documented R31 received antidepressants, anticoagulants, and diuretics daily in the seven-day review period and antibiotics for one day. R31 did not receive pain medication or antipsychotic medication.

Review of the 09/09/21 "Care Plan" documented staff were to complete lab work as ordered and report any abnormal results to the provider. Staff were to give blood pressure medication and document the response and any side effects. Staff were to monitor for signs and symptoms of hypo/hyperglycemia (low and high blood sugar).

On the 08/2020 "Medication Regimen Review" the consultant pharmacist documented a recommendation was made and to "see report." The facility did not provide the document "see report" referenced in the MRR and did not know what the recommendation was in the MRR.

On the 10/2020 "MRR" the consultant pharmacist recommended a Gradual Dose Reduction (GDR) be completed for Duloxetine (antidepressant) 30 mg. The facility did not have evidence of a GDR for Duloxetine or follow up on the recommendation.

On the 01/2021 "MRR" the consultant pharmacist recommended that a GDR be completed for Duloxetine 30 mg. The facility did not have evidence of a GDR for Duloxetine or follow up on the recommendation.

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On the 04/2021 "MRR" the consultant pharmacist documented that a recommendation was made and to "see report." The facility did not provide the document "see report" referenced in the MRR.

On the 07/2021 "MRR" the consultant pharmacist recommended the provider evaluate the resident's medication list to reduce the risk of falls. The facility did not provide evidence of the physician evaluation of the medication list and the medical record lacked evildence of follow up on this recommendation.

On the 08/2021 "MRR" the consultant pharmacist documented a recommendation was made and to "see report." The facility did not provide the document "see report" referenced in the MRR.

Observation on 09/29/21 at 08:54 AM revealed the resident sat in her wheelchair in her room, reading a magazine. The resident could converse without difficulty and took her medication without issues.

Interview with Licensed Nurse I on 09/29/21 at 09:23 AM revealed she did not know about pharmacy recommendation reviews and thought Administrative Nurse B handled them.

Interview with Administrative Nurse B on 09/30/21 at 01:00 PM revealed she provided all the pharmacy recommendation reviews that she could find. She expected the pharmacy reviews to be completed and documentation kept for each resident, along with any that the physician responded to should be scheduled/completed accordingly. Once she obtained a physician response to the pharmacy recommendations, she would give them to the nurses, and they were to

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F 756	Continued From page 46 complete/schedule those recommendations. The facility failed to provide a policy regarding pharmacy recommendations and physician response as requested on 09/30/21. The facility failed to act upon the consultant pharmacist's MRR recommendations for R31.	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 §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 reported a census of 42 residents, with 12 sampled and five reviewed for unnecessary medications. Based on interviews	F 757		

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and record review, the facility failed to follow the physicians' orders regarding R31's diabetes when staff did not document and notify the provider of blood glucose (BG, blood sugar) values outside the designated parameter. The facility further failed to ensure blood pressure parameters for R26 and R31.

Findings included:

- Review of R26's pertinent diagnoses from the "Physician's Orders" in the Electronic Medical Record (EMR) dated 08/20/21 documented pneumonia (inflammation of the lungs), major depressive disorder (MDD, major mood disorder), hypertension (HTN; elevated blood pressure), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).
Review of the 01/06/21 "Annual Minimum Data Set" (MDS) documented R26 had a brief interview for mental status (BIMS) of zero, indicating severely impaired cognition. No behaviors noted. R26 received scheduled pain medication, as well as daily antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression) and diuretics (medication to promote the formation and excretion of urine) medication in the seven-day review period. R26 did not receive antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions).
Review of the "Psychotropic Drug Use Care Area Assessment" (CAA), dated 01/06/21, documented R26 received Lexapro (antidepressant) due to MDD and behaviors.

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When medication was reduced, behaviors increased due to Alzheimer's disease.
Review of the 08/24/21 "Quarterly MDS" documented R26 had a BIMS of three, indicating severely impaired cognition, and had no behaviors noted. R26 received scheduled pain medication, as well as daily antidepressants, anticoagulants (blood thinner), antibiotics (ABX), and diuretics medications in the seven-day review period. R26 did not receive antipsychotic medication.

Review of the 08/05/21 "Care Plan" documented R26 received Bumex (diuretic), Lexapro (antidepressant) and Voltaren Gel (pain medication). The staff were to monitor, document, and report any signs and symptoms of hypokalemia (low potassium) to the provider, monitor potassium levels, and monitor R26 every shift for any adverse reactions to the ABX.

Review of the "Electronic Health Records" (EHR) relevant "Physician Orders" documented the following:
05/13/19: Potassium Chloride 20 milli-equivalents (mEq) tablet, give one tablet twice daily (BID) for supplement.
08/21/21: vital signs every shift while on skilled nursing.
08/22/21: Lexapro 10mg tablet, give 1 tablet PO QD for MDD.
09/14/21: Bumex 1mg tablet, give 0.5 tablet by mouth (PO) once daily (QD) for HTN.
Review of the in-service completed on 05/21/21 by the facility, documented when a resident's blood pressure was checked, staff were to notify the charge nurse if the top number was greater than 180 or less than 90 and/or the bottom number was greater than 110 or less than 50.

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Review of the 06/2021 through 09/2021 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) documented three blood pressures falling outside of the parameters stated above, with no documentation of provider notification.

An interview with Certified Medication Aide (CMA) K on 09/29/21 at 03:44 PM revealed blood pressure was not checked prior to the administration of HTN medications. CMA K did obtain blood pressure once a week for R26 and tell the nurse the value.

An interview with Licensed Nurse (LN) I on 09/30/21 at 10:33 AM revealed R26 had blood pressure checked each shift while on skilled nursing care. LN I did not know of any orders for blood pressure parameters or when to notify the provider. LN I stated she would notify the provider of any blood pressure that had a top number greater than 180 or less than 90 and/or the bottom number was greater than 100 or less than 60. She would then write a progress note of the notification and any orders the provider may state.

An interview with Administrative Nurse B on 09/30/21 at 03:13 PM revealed she expected her staff to recheck any blood pressure outside of the parameters and notify the provider. She expected her staff to document a progress note of the occurrence and notification with any orders given by the provider.

An interview with Administrator A on 09/30/21 at 10:15 AM revealed the facility did not have standing orders for blood pressure or when to notify the providers. He stated that he did not know if it was the responsibility of the nurse to use nursing judgement regarding if the provider should be notified for high or low blood pressures. Administrator A stated that the facility worked

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closely with the providers and that the providers came into the building frequently for rounds and he expected open communication between the facility staff and the providers.

The facility failed to provide a policy regarding physician notification and blood pressure parameters.

The facility failed to establish blood pressure parameters and when to notify the provider for R26.

- Review of R31's pertinent diagnoses from the 02/02/20 "Physician's Orders" EMR documented diabetes mellitus type 2 (DM, when the body cannot use glucose (sugar), not enough insulin made or the body cannot respond to the insulin), congestive heart failure (CHF, a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (A-Fib, rapid, irregular heartbeat), chronic obstructive pulmonary disease (COPD, progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), respiratory failure with hypoxia (inadequate supply of oxygen), major depressive disorder (MDD, major mood disorder), end stage renal disease (ESRD, inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), and hypothyroidism (condition characterized by decreased activity of the thyroid gland).

Review of the 02/18/21 "Annual MDS" documented R31 had a BIMS of 15, indicating intact cognition. R31 received scheduled pain medication, as well as daily antidepressants, anticoagulants, diuretics, and insulin (medication

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to lower blood glucose) medications in the seven-day observation period. R26 did not receive antipsychotic medication.

Review of the "Psychotropic Drug Use Care Area Assessment" (CAA), dated 02/18/21, documented R31 received antidepressant medication due to MDD and had no side effects at the time of MDS completion.

Review of the 08/30/21 "Quarterly MDS" documented R31 had a BIMS of 15, indicating intact cognition. No behaviors noted. R31 received seven out of the seven-day observation period of antidepressants, anticoagulants, and diuretics, as well as one out of the seven-day observation period of ABX. R31 did not receive pain medication or antipsychotic medication.

Review of the 09/09/21 "Care Plan" documented staff were to complete lab work as ordered and report any abnormal results to the provider. The staff were to administer medication for hypertension (HTN) and document the response and any side effects. The staff were to monitor for signs and symptoms of hypo/hyperglycemia (low and high BG).

Review of the "Electronic Health Records" (EHR) relevant "Physician Orders" documented the following:
01/29/19: May obtain blood sugar as needed (PRN) for signs and symptoms of hyper/hypoglycemia.
01/29/19: If blood sugar remained less than 70 and unable to swallow, administer glucagon intramuscularly (IM) per manufacturer's instructions, obtain from the EDK (emergency response medications locked in a kit) . Recheck

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blood sugar in 15 minutes. If blood sugar remained less than 70, notify the MD.
01/29/19: If blood sugar remained less than 70 and the resident could swallow, administer glucose gel orally and recheck blood sugar in 15 minutes. If the blood sugar remained less than 70, notify MD.
01/29/19: If blood sugar is less than 70 and able to swallow administer food or juice. Recheck blood sugar in 15 minutes and notify MD.
02/03/20: Blood Glucose Monitoring before meals, fasting and HS, four times a day for diabetes call PCP if <60 or >300
02/03/20: Duloxetine (antidepressant) 30mg capsule, Give 1 capsule by mouth in the evening for depression
07/10/20: Weekly vital signs on Fridays
08/11/21: Tradjenta (antihyperglycemic medication) 5mg tablet, give 1 tablet PO in the afternoon for DM
08/11/21: Victoza Solution Pen-injector (diabetic medication) 18 MG/3ML, Inject 1.8 mg subcutaneously (SQ, into belly fat) in the evening for DM
08/11/21: humaLOG (insulin); inject number of units per BG sliding scale: if 301 - 350 give 4 units ; 351 - 400 give 6 units ; 401 - 450 give 8 units; 451 - 500 give 10 units; 501 - 550 give 12 units; 551 - 600 give 14 units. Notify on call provider for hyper and hypo glycemia, subcutaneously every 1 hours as needed for DM
08/11/21: Lantus Solution 100 UNIT/ML (Insulin Glargine), Inject 20 unit subcutaneously at bedtime for DM
08/11/21: HumaLOG KwikPen Solution Pen-injector 100 UNIT/ML (Insulin Lispro (1 Unit Dial)), Inject 13 unit subcutaneously before meals for DM
08/11/21: Eliquis (anticoagulant) 2.5 MG tablet,

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give 1 tablet PO BID for A-Fib
08/11/21: Carvedilol (antihypertensive, reduces blood pressure) 6.25 MG tablet, Give 1 tablet PO BID CHF, give with meals
08/12/21: Levothyroxine (treats hypothyroidism) Sodium 100mcg tablet, Give 1 tablet PO in the morning before breakfast on empty stomach, for hypothyroidism
08/11/21: Duloxetine HCl Capsule Delayed Release Particles 60 MG, Give 1 capsule PO in the evening for MDD. Give this 60 MG table with Duloxetine 30 MG to equal 90 MG
08/12/12: Losartan Potassium 25 MG tablet, Give 0.5 tablet PO QD for CHF. Give 25mg 1/2 tab to equal 12.5mg
08/12/21: Bumex Tablet 1 MG (Bumetanide), Give 1 tablet by mouth two times a day for edema

Review of the in-service completed on 05/21/21 by the facility, documented when a resident's blood pressure was checked, staff were to notify the charge nurse if the top number (systolic) was greater than 180 or less than 90 and/or the bottom number (diastolic, minimum level of blood pressure measured between contractions of the heart) was greater than 110 or less than 50.

Review of the 06/2021 through 09/2021 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) documented six blood pressures falling outside of the parameters stated above, with no documentation of provider notification.

Review of the 06/2021 through 09/2021 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) documented that a total of 54 BGs were greater than 300 mg/dl and required NovoLOG insulin per

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order but was not given. There was a total of 86 BGs that were greater than 300 or less than 60 with no documentation of provider notification.

An interview with Certified Medication Aide (CMA) K on 09/29/21 at 03:44 PM revealed blood pressure was not checked prior to the administration of HTN medications. CMA K did obtain blood pressure once a week for R26 and tell the nurse the value.

An interview with Licensed Nurse (LN) I on 09/30/21 at 10:33 AM revealed R26 had blood pressure checked each shift while on skilled nursing care. LN I did not know of any orders for blood pressure parameters or when to notify the provider. LN I stated she would notify the provider of any blood pressure that had a top number greater than 180 or less than 90 and/or the bottom number was greater than 100 or less than 60. She would then write a progress note of the notification and any orders the provider may state. R31's BG was checked four times a day and LN I stated she did not know that R31 had a sliding scale for extra insulin based on BG. She stated the provider should be notified of each BG value greater than 300 and a progress note would be written.

An interview with Administrative Nurse B on 09/30/21 at 03:13 PM revealed she expected her staff to recheck any blood pressure outside of the parameters and notify the provider. She expected her staff to document a progress note of the occurrence and notification with any orders given by the provider. She expected her staff to recheck any BG that was below 70 and treat per orders, then call the provider. Administrative Nurse B expected her staff to notify the provider of every

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F 757	Continued From page 55 BG greater than 300 and to administer the sliding scale insulin. R31 was a brittle diabetic and would jump from 400 to less than 60 within a short period of time, and so her insulin was only given based on the amount of food R31 ate. Administrative Nurse B did not know if the providers were notified of the elevated BGs because there was no documentation to support it. The facility did not provide a policy regarding physician notification and BG/blood pressure parameters, as requested. The facility failed to follow the physicians' diabetic orders, notify the provider of BG and blood pressure values that were high or low and document appropriately for R31.	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	F 758		

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specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

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

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 42 residents with 12 residents (R) in the sample and five sampled for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure an appropriate diagnosis for R10s antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medications.

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Findings included:

- Resident (R) 10's pertinent diagnoses from "Physician's Orders" and "Progress Note" for diagnoses in the "Electronic Medical Record (EMR)" dated 08/12/21 revealed dementia (a progressive mental disorder characterized by failing memory, confusion) and major depressive disorder (MDD, a major mood disorder).

The 04/30/21 "Significant Change Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of three, indicating severely impaired cognition. She exhibited delusions with verbal behavioral symptoms directed toward others and rejection of care one to three days of the review period. R10 received daily routine antipsychotic medications in the seven-day review period.

The 04/30/21 "Psychotropic Care Area Assessment" (CAA) revealed the resident started Seroquel (used to treat certain mental/mood conditions) due to increased behaviors with Dementia.

The 07/07/21 "Quarterly MDS" revealed a BIMS of three. She exhibited delusions with verbal behavioral symptoms directed toward others and rejection of care one to three days of the review period and received daily routine antipsychotic medications.

The 03/12/19 "Comprehensive Care Plan" revealed the resident received Seroquel (antipsychotic) and had behaviors such as resisting care and pulling fire alarms. A revision dated 07/06/21 revealed she experienced

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depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) as well.

The 06/02/21 "Physician Orders" revealed the resident received Depakote delayed release 125 milligram (mg) tablet by mouth in the afternoon for her dementia with sundowning (a state of confusion occurring in the late afternoon and spanning into the night) and verbal/physical aggression.

The 06/02/21 "Physician Orders" revealed the resident received Seroquel Extended Release 24-hour 150 mg tablet by mouth at bedtime for dementia with sundowning and verbal/physical aggression.

Observation of R10 on 09/29/21 at 12:08 PM revealed the resident in the dining room, seated in wheelchair eating lunch with no distress or behaviors noted. Staff in dining room interacted with her and she responded appropriately.

Interview with Licensed Nurse I on 09/29/21 at 09:23 AM revealed she stated, "she figured the diagnosis for the medications were prescribed by a doctor, so she did not think to question the diagnosis for the antipsychotics."

Interview with Administrative Nurse B on 09/30/21 at 01:00 PM, she stated, "she knew that antipsychotic medication required a diagnosis, but she did not know that antipsychotics required certain diagnosis per regulations."

The 02/2021 "Psychotropic Medication Use" policy revealed antipsychotic medications shall generally be used only for the following

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F 758	Continued From page 59 conditions/diagnosis as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): schizophrenia, schizo-affective disorder, schizophreniform disorder, Tourette's disorder, Huntington's disease. The facility failed to ensure R10s antipsychotic medications had an appropriate diagnosis.	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the	F 801		

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supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for

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food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 42 residents. Based on interview and record review, the facility failed to ensure a qualified Dietician or Certified Dietary Manager (CDM) worked in the facility to carry out the functions of food and nutritional services for the 42 residents who resided in the facility and received meals from the facility kitchen.

Findings included:

- During the annual survey 09/27/21-09/30/21, the facility could not provide documentation of a Dietician evaluating Dietary Manager H or documentation of Dietician in-house to complete assessments and oversee the functions of the kitchen. Additionally, the facility could not provide evidence Dietary Manager H completed or enrolled for the CDM training classes.

Interview with Dietary Manager H on 09/27/21 at 10:35 AM revealed she was not a CDM but planned on taking the classes soon. DM H stated a Corporate Dietician worked for the facility, but she has never met that person and did not know the Corporate Dietician's name.

Interview with Administrative Nurse B on 09/28/21 at 03:00 PM revealed the facility worked with a Dietician group [name unknown] to consult with the facility. The Dietician assigned to the facility changed frequently and the current consultant

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F 801	Continued From page 62 worked out of state. Administrative Nurse B stated the facility did not have a Dietician visit the facility since March of 2021. The facility did not provide a policy regarding the use of a CDM or Dietician for kitchen oversight, as requested on 09/30/21. The facility failed to provide a Certified Dietary Manager to carry out the functions of food and nutritional services for the 42 residents who resided in the facility and received meals from the facility kitchen.	F 801		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility reported a census of 42 residents with three residents requiring a pureed diet. Based on observation, interview, and record review the facility failed to ensure the staff prepared foods by methods which conserve nutritive value, flavor, and appearance. Observation of kitchen staff not following a recipe for the preparation of the pureed lunch menu, resulted in unappetizing and runny food, with a change in nutritive value when staff substituted milk in place of other thinning ingredients as listed	F 804		

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in the recipe (such as broth and/or butter), and failed to follow the recipe measurements and staff was "eyeballing" measurements of ingredients used in the purees, meant to thin or thicken the puree, and failed to serve all items on the menu in puree form or offer substitutes for items she did not puree.

Findings included:

- Review of the "Weekly Menu, Day 17" approved on 04/17/21, documented the lunch meal included country ham, herb stuffing, buttered carrots, roasted brussels sprouts, cornbread and Texas sheet cake.

Review of the "DiningRD.com Pureed Country Ham Recipe" for three servings, documented four tablespoons (Tbsp) plus two teaspoons (tsp) of water were to be mixed with one-fourth tsp of ham base, to create a broth. The broth was to be used to puree the nine ounces (oz) of ham. If the product needed thickening, thickener was to be added gradually to achieve a smooth, pudding or soft mashed potato consistency. If the product needed to be thinned, broth was to be added gradually to achieve a smooth, pudding or soft mashed potato consistency.

Review of the "DiningRD.com Pureed Herb Stuffing" for three servings, documented one tsp of chicken base was to be mixed with one cup water to create chicken broth. The chicken broth was to be blended with one and one-half cups of herb stuffing until smooth. If the product needed thickening, thickener was to be added gradually to achieve a smooth, pudding or soft mashed potato consistency. If the product needed to be thinned, broth was to be added gradually to

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achieve a smooth, pudding or soft mashed potato consistency.

Review of the "DiningRD.com Pureed Carrots" for three servings, documented one and one-half cups of carrots were to be blended with one Tbsp plus one tsp of margarine until smooth. If the product needed thickening, thickener was to be added gradually to achieve a smooth, pudding or soft mashed potato consistency. If the product needed to be thinned, an appropriate liquid (not water), was to be added gradually to achieve a smooth, pudding or soft mashed potato consistency.

Review of the "DiningRD.com Pureed Roasted Brussel Sprouts" for three servings, documented one and one-half cups of brussels sprouts were to be blended with one Tbsp plus one tsp of margarine until smooth. If the product needed thickening, thickener was to be added gradually to achieve a smooth, pudding or soft mashed potato consistency. If the product needed to be thinned, an appropriate liquid (not water), was to be added gradually to achieve a smooth, pudding or soft mashed potato consistency.

Review of the "DiningRD.com Pureed Cornbread" for three servings, documented three servings of cornbread were to be blended with one Tbsp plus one tsp of melted margarine. Two-thirds cup of milk was to be added to this gradually until mixture was smooth. More milk could be added, depending upon the dryness of the cornbread. If the product needed thickening, thickener was to be added gradually to achieve a smooth, pudding or soft mashed potato consistency. If the product needed to be thinned, an appropriate liquid (not water), was to be added gradually to achieve a

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smooth, pudding or soft mashed potato consistency.

Review of the "DiningRD.com Pureed Texas Sheet Cake-No Nuts" for three servings, documented three servings of cake were to be blended with one cup milk until smooth.

Observation on 09/28/21 at 11:13 AM with Cook M, revealed she blended 12 oz of prepared ham with an unmeasured amount of milk. The ham mixture was thin and runny and poured into three individual bowls. Cook M then added an unmeasured amount of thickener to each bowl and stirred. Cook M then blended one and one-half cups of prepared herb stuffing and an unmeasured amount of milk until smooth. The mixture was spooned into three individual bowls, with no thickener added. Cook M last blended one and one-half cups of cooked carrots and an unmeasured amount of milk. The carrot mixture was thin and runny, poured into three individual bowls and then an unmeasured amount of thickener was added to each of the bowls and stirred. The brussels sprouts, cornbread and sheet cake were not pureed for the three residents.

Interview with Cook M on 09/28/21 at 11:13 AM revealed the facility had recipes to follow for each food item that was to puree (Cook M left the recipes out for the surveyor to review). Recipes were reviewed with Cook M and she said she used milk as a substitute because a previous manager told her it was ok. She also stated that she "eyeballed" the milk used in the ham, stuffing, and carrots because the facility did not have a Tbsp measuring spoon to use. Cook M stated each scoop of thickener was approximately

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one-fourth tsp and "eyeballed" it. She stirred the thickener in and left it to sit and stated the food would thicken up on its own soon. When asked about the brussels sprouts, Cook M stated the three residents did not like them. When asked about the Texas sheet cake and cornbread, Cook M stated the cornbread was hard to puree and became grainy, so she chose not to puree the cornbread. Cook M did not know she could puree the cornbread and sheet cake together for texture and flavor if the residents requested the food. Cook M also did not know the recipes stated to use broth or appropriate liquid when pureeing the lunch, instead of milk. Cook M stated she had not thought about using broth and just always used milk.

Interview with Resident (R) 28 on 09/28/21 at 01:15 PM revealed he did not like the pureed lunch served that day and would not order it again. R28 stated the ham did not taste good, nor the rest of the food.

Interview with Dietary Manager (DM) H on 09/28/21 at 01:30 PM revealed she expected her kitchen staff to follow the recipes as written. She also stated the use of milk was an appropriate substitute for pureeing meat, but said broth was a better option.

The facility did not provide a policy regarding pureed foods as requested on 09/30/21.

The facility failed to ensure the staff prepared foods by methods which conserved the nutritive value, flavor, and appearance of pureed foods. Observation of kitchen staff not following a recipe for the preparation of the pureed lunch menu, resulted in unappetizing and runny food, with a

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(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 804	Continued From page 67 change in nutritive value when staff substituted milk in place of other thinning ingredients as listed in the recipe (such as broth and/or butter), and failed to follow the recipe measurements and staff was "eyeballing" measurements of ingredients used in the purees, meant to thin or thicken the puree, and failed to serve all items on the menu in puree form or offer substitutes for items she did not puree.	F 804		
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. Based on observation, interview, and record review the facility failed ensure the safe and sanitary meal preparation, service, and storage when kitchen staff failed to adequately monitor	F 812		

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	175218	A. BUILDING _____ B. WING _____	09/30/2021

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F 812	Continued From page 68	F 812		

the daily temperatures of the refrigerators and freezers, failed to monitor the chemical sanitization of the low temperature dishwasher each shift, and failed to test the sanitizing solution used to clean surfaces in the kitchen and dining room. These failures had the ability to affect all residents served meals from the kitchen.

Findings included:

- Observation on 09/27/21 at 10:35 AM revealed no completed logs for the low temperature dishwasher or chemical sanitizer spray could be found in the kitchen. Further observation revealed no parts per million (ppm) test strips could be found in the kitchen in order to ensure the antimicrobial properties/chemical sanitization desired effect. Observation of temperature logs located on the refrigerators and freezers in the kitchen at the time of observation lacked completion of daily temperatures/were not complete.

Interview with Dietary Manager (DM) H on 09/27/21 at 10:35 AM revealed neither she or any other kitchen staff member had completed the ppm testing for the dishwasher or chemical sanitizer since she started working at the facility in August of 2021. DM H stated she did not know this needed to be completed and would obtain testing strips to complete the ppm testing, verifying none located in the kitchen area. DM H also stated she would obtain copies of the temperature logs for the kitchen refrigerators and freezers from 01/01/20 to 09/27/21.

The temperature logs for the refrigerators and freezers in the kitchen for 01/01/20 through 09/01/21, lacked documentation for the entire

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F 812	Continued From page 69	F 812		

months of March 2021, July 2021, August 2021, and September 2021.

Observation on 09/28/21 at 03:30 PM revealed DM H obtained ppm testing strips and completed testing of both the dishwasher and chemical sanitizer spray. DM H could not provide the surveyor with a ppm reading, as DM H was unsure on how to complete the test or what the results were supposed to be.

Interview with DM H on 09/28/21 at 03:30 PM said she had never completed a ppm test and did not know how to complete it. DM H said she did not know what chemical was to be tested for the low temperature dishwasher or chemical sanitizer spray, what value was acceptable, when to test the chemical, or how often. DM H stated she would reach out to her supplier for instructions.

Observation on 09/29/21 at 11:20 AM revealed a second [ppm] testing completed with DM H. The chlorine [ppm] for the dishwasher test noted a value of 25 ppm when completed twice. The ppm for the chemical sanitizer noted a value of 350 ppm when completed twice.

Interview with DM H on 09/29/21 at 11:20 AM revealed the chemical chlorine was used to clean dishes in the kitchen with the low temperature dishwasher and was to have a quality control value of 50 to100 ppm when tested. The "ultra-sanitizer" cleaner used to clean the tables, countertops, and surfaces had a quality control value of 200 ppm when tested. With the values listed, DM H verified the tested values on her tests were below the quality control and she would discuss the values with the supply representative on 10/01/21, when he came to the

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F 812	Continued From page 70 facility for quality testing. The "Warewash Preventive Maintenance Report" completed from 02/01/21 through 08/30/21, documented the chlorine test completed each month had a value of 75 ppm and the chemical sanitizer had a value of 200 ppm each month. The 07/27/21 and 08/30/21 report documented in-service training as completed with the new kitchen manager. On 10/04/21 at 03:36 PM an interview was attempted with a representative of the contracted company regarding chemical sanitization, quality testing with no response. The facility did not provide a policy regarding refrigerator/freezer temperatures and ppm testing, as requested on 09/30/21. The facility failed to ensure the safe and sanitary meal preparation, service, and storage.	F 812		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 943		

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F 943	Continued From page 71	F 943		

§483.95(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 42 residents. Based on interview and record review, the facility failed to ensure all facility staff were trained on dementia care and social media annually.

Findings included:

- Review of the staff training records for Certified Nurse Aide (CNA) C (hired 05/01/20) and CNA G (hired 10/01/13) lacked evidence of dementia care training from 05/01/20 through 09/30/21.

Review of the staff training records for CNA E (hired 09/26/17), CNA F (hired 01/20/15), and CNA G (hired 10/01/13) lacked evidence of social media training since hire date through 09/30/21.

Interview with Administrative Nurse B on 09/29/21 at 12:31 PM revealed the staff completed social media training only upon hire and not completed each year. Administrative Nurse B said the facility completed all staff in-services in-house and did not utilize online training.

The 08/27/21 "Facility Assessment" documented staff were to complete ANE training, however it did not note the frequency for the training. The "Facility Assessment" noted the expectation of staff to complete HIPAA training annually and noted all CNAs to complete dementia care training annually.

The facility "Abuse, Prevention and Prohibition Policy," reviewed in 2021, documented all staff

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F 943	Continued From page 72 would be educated on ANE upon hire, and annually. The policy failed to address social media training. The facility did not provide a policy regarding dementia training and social media training as requested on 09/30/21. The facility failed to ensure staff received training over dementia care and social media, annually.	F 943		