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	175174	A. BUILDING _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK HILLS	2121 MEADOWLARK ROAD MANHATTAN, KS 66502

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #156192. The 2567 was electronically sent to the facility on 10/18/21.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/18/2021

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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(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 127 residents. The sample included 25 residents with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to notify the physician of Resident (R) 47's heart medications held numerous times due to blood pressure or heart rate below physician ordered parameters, and R28's blood pressures out of physician ordered parameters.

Findings included:

- The "Annual Minimum Data Set" (MDS), dated 07/22/21, recorded R47 had a Brief Interview for Mental Status (BIMS) score of four (severe cognitive impairment), and disruptive behaviors. The MDS recorded R47 required limited staff assistance with most activities of daily living (ADLs), and had diagnoses of atrial fibrillation (irregular, often rapid heart rate that commonly

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causes poor blood flow), hypertension (elevated blood pressure that can cause heart disease and stroke), congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should) and coronary artery disease (narrowing of arteries that limits blood flow to the heart).

The "Medication Care Plan," dated 07/29/21, directed staff to administer R47's medications as ordered by the physician, and monitor the medications for effectiveness, or adverse side effects.

The "Physician's Order," dated 01/07/20, directed staff to administer Coreg (medication used to treat hypertension and heart failure) 6.25 milligrams (mg) two times a day for R47's hypertension, and to hold the medication if R47's systolic blood pressure (top number measures force as the heart beats) less than 100 and/or heart rate less than 55.

The "Physician's Order," dated 01/17/20, directed staff to administer digoxin (medication used to treat heart failure and irregular heart rates) 125 (micromilligrams) mcg every morning for R47's atrial fibrillation, and to hold the medication if R47's systolic blood pressure less than 100 and/or heart rate less than 55.

Review of the August, September and October 2021 Medication Administration Record (MAR) recorded staff held R47's Coreg medication due to systolic blood pressure was less than 100 or heart rate less than 55 the following number of times:
August 2021 - 39 times
September 2021 - 24 times

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F 580	Continued From page 3 October 2021 thru the 12th - seven times Review of the August, September and October 2021 Medication Administration Record (MAR) recorded staff held R47's digoxin medication due to systolic blood pressure was less than 100 or heart rate less than 55 the following number of times: August 2021 - 12 times September 2021 - six times October 2021 thru the 12th - one time On 10/11/21 at 10:13 AM, observation revealed R47 ambulated independently in his wheelchair in the hall. Continued observation revealed R47 well groomed, neatly dressed, and responded appropriately to staff conversation. On 10/12/21 at 02:32 PM, Licensed Nurse (LN) G stated staff had not notified the physician of R47's heart medications held numerous times due to the resident's blood pressure or heart rate below physician ordered parameters. On 10/12/21 at 03:33 PM, Administrative Nurse E stated staff had not notified the physician of R47's heart medications held numerous times due to the resident's blood pressure or heart rate below physician ordered parameters. The facility's "Physician Notification," policy, dated November 2014, directed staff to notify the physician, when residents have vital signs outside baseline or normal limits related to adverse medication reactions. The facility failed to notify the physician of R47's heart medications held numerous times due to blood pressure or heart rate below physician	F 580		

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ordered parameters, placing the resident at risk for continued adverse medication side effects.

- R28's "Physician Order Sheet" (POS), dated 04/26/21, documented the resident had a diagnosis of hypertension (high blood pressure).

The "Annual Minimum Data Set" (MDS), dated 10/29/20, documented the resident had severely impaired cognition, required extensive assistance of two staff for bed mobility, toileting, transfers and extensive assistance of one staff for dressing and personal hygiene.

The "Quarterly MDS," dated 07/12/21, documented the same as the 10/29/20 MDS.

The "Black Box Warning Medication Care Plan," dated 07/27/21, directed staff to administer all medications as ordered and observe for and report alterations, side effects or adverse reactions promptly to nurse and physician accordingly.

The "Physician's Order," dated 11/03/20, directed staff to obtain blood pressure once a week every Tuesday and notify the physician if the systolic blood pressure (the top number that measures the pressure in the arteries when the heart beats) was less than 110.

The "Vital Sign Blood Pressure Report," for January, September and October 2021 documented the following blood pressures:

01/29/21 at 06:42 PM 108/620
9/06/21 at 01:56 PM 108/60
10/12/21 at 10:13 AM 100/64

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F 580	Continued From page 5 On 10/11/21 at 09:44 AM, observation revealed the resident self-propelled himself out of the dining room. On 10/13/21 at 08:02 AM, Licensed Nurse (LN) K verified the physician had not been notified regarding the three instances the resident's systolic blood pressure was less than 110. On 10/13/21 at 09:19 AM, Administrative Nurse D verified the staff are to notify the physician when the systolic blood pressure was below 110. The facility's "Protocol for Notification of a Procedure for Physician Notification," dated November 2014, documented the appropriate procedure for physician notification were timelines of immediate which means, to call the on-call physician immediately and non-immediate means, the nurse shall leave a voicemail or fax the physician immediately and a follow up phone call needs to be made the next business day. The facility failed to notify R28's physician of out of parameter blood pressures, placing the resident at risk for a decline in condition.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		

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use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 127 residents. Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary and comfortable environment for the residents that resided in two of the seven households in the facility.

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Findings included:

- On 10/07/21 at 08:30 AM, the initial tour revealed the following:

Sloan Household;

R119's carpet area with a large stain on the entrance of the room approximately 12 inches x 18 inches, and numerous circular brownish black stains approximately 1-inch in circumference extending from the entrance of the room to the other side of the room.

R38's bed B carpet area with numerous reddish brown stains in front of the wheelchair approximately 4 inches x 2 inches, and brownish black 1 inch x 0.5 inch circular stains in front of the resident's recliner.

R98's carpet area with small brownish black spots, 1 inch x 0.5 inch extending from the hall -door entrance to bed B, brownish black stains and a black stain in front of the TV approximately 1 inch x 2 inches.

Honstead Household;

R13's bed B carpet area with greyish black stains in front of the resident's recliner approximately 12 inches x 6 inches and one brownish black stain approximately 8 inches x 2 inches.

R45's bed A carpet area in front of recliner approximately 6 inches x 10 inches with brownish black shoe skid marks and numerous 1-inch x 0.5-inch circular black stains extending from the door entrance to the middle of the room.

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F 584	Continued From page 8 On 10/07/21 at 10:30 AM, Licensed Nurse (LN) J verified the stains on the carpet and stated the aides would clean and vacuum the rooms and would spot clean carpets when they observed a stain. On 10/12/21 at 03:00 PM, Administrative Staff A verified the above environmental findings and stated they have a carpet cleaning maintenance man who cleaned carpets on a rotating 90 days cycle and verified some of the stains would not come out. Administrative Staff A stated they have the capitol funds to replace the carpet but do not have anywhere to move the residents while the carpet layers are installing the new carpet as they are at full census. The facility's "Carpet Cleaning" policy dated November 2014, documented once every 90 days the facility's Housekeeping and Laundry Team would spot clean as need and contact the Housekeeping and Laundry Leader for assistance with stains as necessary. The facility failed to provide a safe, functional, sanitary environment, placing the residents who resided in two households in the facility at risk for an unhomelike environment.	F 584		
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	F 623		

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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 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;

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(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 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

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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 had a census of 127 residents. The sample included 25 residents. Based on observation, interview, and record review, the facility failed to notify the Ombudsman for one sampled resident discharged to the hospital, Resident (R) 126.

Findings included:

- R126's "Physician Order Sheet" (POS), dated 05/21/21, documented diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion), cerebral vascular accident (CVA-stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Admission Minimum Data Set" (MDS), dated 05/27/21 documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS documented the resident required extensive assistance of one staff with most activities of daily living (ADLs).

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The "ADL Care Plan," dated 05/30/21 documented the resident had a decline with left side weakness post Cerebral Vascular Accident (CVA).

The "Nurses Note," dated 08/04/21 at 01:11 PM, documented the resident was very lethargic, refused breakfast. The notes documented the resident opened his eyes to words refused medications and water. Vital signs were within normal limits.

The "Nurses Note," dated 08/13/21 at 02:41 PM, documented the resident had two episodes of vomiting , lung sounds clear and administered Zofran (medication to prevent nausea and vomiting).

The "Nurses Note," dated 08/16/21, at 02:13 PM, documented the resident was less responsive, increased pulse and respiratory rattle. Upon assessment the resident was non-responsive to words and touch. The resident's lower extremities were cool to the touch with mottling (blotchy, red-purpolish marbling of the skin due to inadequate circulation) to both knees. The resident had a blood pressure of 138/78 (normal 120/80 mg), pulse 147 beats per minute (bpm-normal resting 60bpm), respirations 20 breaths per minute (normal 12-16 breaths per minute) and oxygen saturation level of 90% (normal 95-100%). The notes documented the facility transported the resident to the hospital.

The "Nurses Notes," dated 08/17/21 at 08:51 AM, documented the facility received word from the hospital the resident passed away 08/16/21 at 06:15 PM.

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F 623	Continued From page 13 R123's "Medical Record" lacked documentation staff notified the ombudsman of the resident's transfer to the hospital. On 10/13/21 at 10:30 AM, Administrative Staff B stated the facility failed to send the ombudsman notice for R126 when he was discharged to the hospital on 08/17/21, and failed to notify the ombudsmans of anyresident's discharges in July, August, September and until October 13, 2021, but was aware the facility should send the notices. Upon request, the facility was unable to provide a discharge policy. The facility failed to notify the Ombudsman's office of R126's discharge to the hospital, placing the resident at risk to not have the Ombudsman advocate for him.	F 623		
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).	F 657		

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An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 127 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to update and revise the care plan for one of three residents reviewed for pressure ulcers, Resident (R) 63.

Findings included:

- The "Physician Order Sheet" dated 10/06/21 recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, and chronic peripheral venous insufficiency (abnormal condition affecting the blood vessels that affects blood flow to the extremities).

R63's "Significant Change Minimum Data Set" (MDS), dated 08/16/21, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment revealed the resident required limited assistance of one staff for bed mobility, personal hygiene, and limited assistance of two staff for transfers. The MDS further documented

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the resident had one Stage 3 (full thickness skin loss potentially extending into the subcutaneous tissue layer) pressure ulcer with moisture associated skin damage (MASD: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous.) The MDs recorded R63 was at risk for pressure ulcers. He had no venous or arterial ulcers at the time of the assessment. The MDS documented R63 had a pressure reducing device to his bed and wheelchair and was on a turn and repositioning program. R63 did not receive treatments to his feet.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA), dated 08/18/21, documented the resident had a significant decline post heart attack and hospitalization from 08/05/21 until 08/10/21. The CAA documented the resident was weak, unsteady, and required assistance with ADLs.

The "Braden Scale Assessment" for predicting pressure ulcer risk, dated 08/04/21 and 08/10/21, documented a score of 16.0 which indicated the resident was at risk for pressure ulcer development.

The "ADL Care Plan," dated 07/14/21 directed the staff to encourage the resident to reposition every two hours, and to encourage good nutrition and hydration to promote healthier skin. The "Care Plan" directed staff to provide a pressure reducing mattress and pillows to protect R63's skin while in bed. The "ADL Care Plan," updated 8/18/21 lacked documentation and interventions regarding the resident's heels, including pressure relieving preventions and treatments to the left

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heel pressure ulcer.

The "Progress Note," dated 08/05/21 at 05:31 PM, recorded R63 transferred to the hospital for chest pain and elevated blood pressure.

The "Progress Note," dated 08/10/21 at 04:00 PM, recorded R63 discharged from the hospital and returned to the facility.

The "Skin Assessment," dated 08/10/21, documented R63 had one open area noted on his coccyx (a small triangular bone at the base of the spinal column), measuring 2.0 centimeters (cm) x 2.0 cm.

The "Skin Assessment," dated 08/20/21, documented R63's left heel had "bruising" which measured 4.0 cm x 3.0 cm.

The "Weekly Wound Observation Tool," dated 08/23/21, documented the left heel pressure with suspected deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the area was boggy (mushy, spongy texture), closed, and purple. The form documented staff would provide heel float boots, no shoes or socks when R63 rested, and the resident was not ambulatory.

The "Progress Note," dated 08/25/21 at 05:01 AM, documented the resident was on alert charting for a left heel pressure ulcer. The notes documented the area was soft, non-blanching, purple discoloration, and moderate amount of serosanguinous (discharge that contains both blood and a clear liquid know as blood serum) drainage on the dressing. The notes recorded

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R63 had slight discomfort with the dressing change and heel protectors on the resident while in bed.

The "Weekly Wound Observation Tool" dated 08/30/21, documented the left heel pressure ulcer was 5.3 cm x 3.5 cm, purple, boggy, and intact.

The "Weekly Wound Observation Tool," dated 09/06/21, documented the left heel pressure ulcer 5.3 cm x 3.5 cm, purple, boggy, and intact. The assessment documented staff would apply a heel cup, secure with kerlix gauze, and change every three days.

The "Weekly Wound Observation Tool," dated 09/27/21, documented the left heel pressure ulcer 5.0 x 3.5 cm, purple with bogginess, hardened, and dark purple. Staff noted an odor on 09/24/21, followed by a physician visit with a wound culture along the unattached edge. The physician ordered the wound covered with a special dressing, a heel cup, secured with gauze, and directed staff to change the dressing every three days.

The "Weekly Wound Observation Tool," dated 10/04/21, documented the left heel pressure ulcer was 4.0 x 2.0 cm, with slough (a mass of dead tissue separating from an ulcer) noted to the wound bed, wound edges unattached, maceration [skin that is soggy, soft and white in appearance] to the peri wound [tissue surrounding a wound]). A strong, foul odor was present. The physician ordered a wound consult appointment for the resident and documented the resident received doxycycline (antibiotic) and Cipro (antibiotic) for the wound infection. The physician ordered staff to cover with a special

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dressing, a heel cup, secure with gauze, and dressing change every three days.

The "Physician Order," dated 10/04/21 ordered staff to consult the wound clinic for suspected deep tissue injury (SDTI) to the left heel.

The "Weekly Wound Observation Tool," dated 10/08/21, documented the unstageable left heel pressure ulcer measured 3.7 x 2.2 x 0.3 cm, wound edges unattached and macerated. The wound care clinic debrided (the medical removal of dead, damaged, or infected tissue) the wound on 10/06/21. The wound bed had slough, wound edges unattached, macerated with a strong, foul odor. The physician ordered staff to use heel float boots and no shoes or socks when resting.

In a letter dated 10/12/21 Consultant HH wrote, based on a review of hospital notes, R63 had developed erythema (redness) on his heels during his second hospital admission along with a sacral ulcer. Due to R63's weakness, he had not been out of bed in several days and required extensive "help" to transfer. Consultant HH wrote his initial wound assessment revealed the skin on R63's left heel remained intact, however it progressed rapidly to its current state. Consultant HH further wrote based on R63's guarded medical condition, significant weakness, heart failure resulting in poor circulation and poor nutrition, Consultant HH felt the left heel ulcer was unavoidable.

On 10/11/21 at 03:00 PM R63 laid in bed on his back. He had a pressure relieving boot on his left heel, but none on his right foot.

On 10/12/21 at 08:00 AM, observation revealed

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the resident laid in bed on his back with the lights off and his eyes closed. R63 laid on a low air loss mattress and had a pressure relieving boot on the left foot only. License Nurse (LN) J removed the resident's pressure relieving boot, sock, gauze, and dressing. Observation revealed a blackened area on the left heel approximately 3.7 x 2.2 centimeters. Continued observation revealed LN J cleansed the area with normal saline, applied skin prep (protective skin barrier) around the wound, then applied a special dressing, a gauze pad, then secured with tape. LN J applied a tube grip dressing, then the resident's sock and the pressure relieving boot to the left foot only. LN J stated R63 only needed a boot on the left heel.

On 10/13/21 at 07:45 AM R63 laid in bed with pressure relieving boots on both right and left foot.

On 10/12/21 at 03:30 PM, Administrative Nurse D verified the resident was hospitalized from 08/05/21 thru 08/10/21 after suffering a myocardial infarction (heart attack) at the facility. The resident was re-admitted to the facility on 08/10/21 with a sacral (wedge like bone at the center of the back) pressure wound. The initial skin assessment on 08/10/21 and weekly skin assessment 8/18/21 lacked any documented skin concerns with the resident's left heel. On 08/20/21 the facility identified a large purple bruise on the residents left heel. Administrative Nurse D verified the resident developed the left heel pressure ulcer after return from his hospital stay. Administrative Nurse D verified the resident skin or pressure ulcer care plan was not updated to document the resident had developed a left heel pressure ulcer with new interventions after development.

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On 10/13/21 at 07:55 AM LN J stated R63 now had pressure relieving boots on both feet and his plan of care had been updated to reflect the need for the boot to both feet.

On 10/14/21 at 04:55 PM Consultant HH stated the facility had their own protocol they followed regarding pressure ulcer prevention and he expected the facility to follow that protocol. Consultant HH stated R63 was at risk for pressure or skin wounds due to his compromised condition after hospitalization.

The "Pressure Ulcer Prevention," policy dated 11/20/2014, documented the facility utilizes a pressure ulcer prevention and management program to reduce the risk and incidence of pressure ulcers and help maintain residents skin integrity. The facility would provide residents at the facility with proper care while ensuring they are treated with dignity. All residents are assessed at move in for their risk of developing pressure ulcers and plans are implemented to reduce this risk and prevent pressure ulcers. The policy documented upon move-in, all residents/guests shall be provided heel protectors on while in bed, an alternating air mattress on the bed, and a cushion in their chair and/or wheelchair. These interventions are temporary and will be evaluated for appropriateness by the Clinical Coordinator, and they will at this time assess the resident and determine whether to continue the interventions. The policy documented a licensed nurse would conduct a skin assessment on the admission day and weekly thereafter.

The facility's "Residents Direct Care Plan" policy,

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F 657	Continued From page 21 dated October 2017, documented the Household and/or Clinical Coordinator would serve as the coordinator for the care planning process. The care plan coordinator would implement a system to ensure that the care plans of residents living in the household are reviewed at least every three months and whenever there is a significant change in condition or reassessment performed. The care plan may be amended at any time the team determines it is necessary to ensure the resident receives appropriate care and services. The facility failed to update R63's care plan after he developed a pressure ulcer on his left heel, placing the resident at risk for further skin breakdown.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 127 residents. The sample included 25 residents with one reviewed for pressure ulcers. Based on observation, record	F 686		

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review, and interview, the facility failed to initiate interventions according to the standards of care to prevent the development of heel pressure ulcers (localized injury to the skin and/or underlying tissue usually over a boney prominence, as a result of pressure, or pressure in combination with shear and/or friction) for Resident (R) 63 who was at risk for pressure ulcers.

Findings included:

- The "Physician Order Sheet" dated 10/06/21 recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, and chronic peripheral venous insufficiency (abnormal condition affecting the blood vessels that affects blood flow to the extremities).

R63's "Significant Change Minimum Data Set" (MDS), dated 08/16/21, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment revealed the resident required limited assistance of one staff for bed mobility, personal hygiene, and limited assistance of two staff for transfers. The MDS further documented the resident had one Stage 3 (full thickness skin loss potentially extending into the subcutaneous tissue layer) pressure ulcer with moisture associated skin damage (MASD: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous.) The MDs recorded R63 was at risk for pressure ulcers. He had no venous or arterial ulcers at the time of the assessment. The MDS documented R63 had a pressure reducing device to his bed and

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wheelchair and was on a turn and repositioning program. R63 did not receive treatments to his feet.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA), dated 08/18/21, documented the resident had a significant decline post heart attack and hospitalization from 08/05/21 until 08/10/21. The CAA documented the resident was weak, unsteady, and required assistance with ADLs.

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The "ADL Care Plan," dated 07/14/21 directed the staff to encourage the resident to reposition every two hours, and to encourage good nutrition and hydration to promote healthier skin. The "Care Plan" directed staff to provide a pressure reducing mattress and pillows to protect R63's skin while in bed. The "ADL Care Plan," updated 8/18/21 lacked documentation and interventions regarding the resident's heels, including pressure relieving preventions and treatments to the left heel pressure ulcer.

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The "Progress Note," dated 08/10/21 at 04:00 PM, recorded R63 discharged from the hospital and returned to the facility.

The "Skin Assessment," dated 08/10/21,

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documented R63 had one open area noted on his coccyx (a small triangular bone at the base of the spinal column), measuring 2.0 centimeters (cm) x 2.0 cm.

The "Skin Assessment," dated 08/20/21, documented R63's left heel had "bruising" which measured 4.0 cm x 3.0 cm.

The "Weekly Wound Observation Tool," dated 08/23/21, documented the left heel pressure with suspected deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the area was boggy (mushy, spongy texture), closed, and purple. The form documented staff would provide heel float boots, no shoes or socks when R63 rested, and the resident was not ambulatory.

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The "Weekly Wound Observation Tool" dated 08/30/21, documented the left heel pressure ulcer was 5.3 cm x 3.5 cm, purple, boggy, and intact.

The "Weekly Wound Observation Tool," dated 09/06/21, documented the left heel pressure ulcer 5.3 cm x 3.5 cm, purple, boggy, and intact. The

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assessment documented staff would apply a heel cup, secure with kerlix gauze, and change every three days.

The "Weekly Wound Observation Tool," dated 09/27/21, documented the left heel pressure ulcer 5.0 x 3.5 cm, purple with bogginess, hardened, and dark purple. Staff noted an odor on 09/24/21, followed by a physician visit with a wound culture along the unattached edge. The physician ordered the wound covered with a special dressing, a heel cup, secured with gauze, and directed staff to change the dressing every three days.

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The "Physician Order," dated 10/04/21 ordered staff to consult the wound clinic for suspected deep tissue injury (SDTI) to the left heel.

The "Weekly Wound Observation Tool," dated 10/08/21, documented the unstageable left heel pressure ulcer measured 3.7 x 2.2 x 0.3 cm, wound edges unattached and macerated. The

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wound care clinic debrided (the medical removal of dead, damaged, or infected tissue) the wound on 10/06/21. The wound bed had slough, wound edges unattached, macerated with a strong, foul odor. The physician ordered staff to use heel float boots and no shoes or socks when resting.

In a letter dated 10/12/21 Consultant HH wrote, based on a review of hospital notes, R63 had developed erythema (redness) on his heels during his second hospital admission along with a sacral ulcer. Due to R63's weakness, he had not been out of bed in several days and required extensive "help" to transfer. Consultant HH wrote his initial wound assessment revealed the skin on R63's left heel remained intact, however it progressed rapidly to its current state. Consultant HH further wrote based on R63's guarded medical condition, significant weakness, heart failure resulting in poor circulation and poor nutrition, Consultant HH felt the left heel ulcer was unavoidable.

On 10/11/21 at 03:00 PM R63 laid in bed on his back. He had a pressure relieving boot on his left heel, but none on his right foot.

On 10/12/21 at 08:00 AM, observation revealed the resident laid in bed on his back with the lights off and his eyes closed. R63 laid on a low air loss mattress and had a pressure relieving boot on the left foot only. License Nurse (LN) J removed the resident's pressure relieving boot, sock, gauze, and dressing. Observation revealed a blackened area on the left heel approximately 3.7 x 2.2 centimeters. Continued observation revealed LN J cleansed the area with normal saline, applied skin prep (protective skin barrier) around the wound, then applied a special dressing, a gauze

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pad, then secured with tape. LN J applied a tube grip dressing, then the resident's sock and the pressure relieving boot to the left foot only. LN J stated R63 only needed a boot on the left heel.

On 10/13/21 at 07:45 AM R63 laid in bed with pressure relieving boots on both right and left foot.

On 10/12/21 at 03:30 PM, Administrative Nurse D verified the resident was hospitalized from 08/05/21 thru 08/10/21 after suffering a myocardial infarction (heart attack) at the facility. The resident re-admitted to the facility on 08/10/21 with a sacral (wedge like bone at the center of the back) pressure wound. The initial skin assessment on 08/10/21 and weekly skin assessment 8/18/21 lacked any documented skin concerns with the resident's left heel. On 08/20/21 the facility identified a large purple bruise on the residents left heel. Administrative Nurse D verified the resident developed the left heel pressure ulcer after return from his hospital stay.

On 10/13/21 at 07:55 AM LN J stated R63 now had pressure relieving boots on both feet and his plan of care had been updated to reflect the need for the boot to both feet.

On 10/14/21 at 04:55 PM Consultant HH stated the facility had their own protocol they followed regarding pressure ulcer prevention and he expected the facility to follow that protocol. Consultant HH stated R63 was at risk for pressure or skin wounds due to his compromised condition after hospitalization.

The "Pressure Ulcer Prevention," policy dated

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F 686	Continued From page 28 11/20/2014, documented the facility utilizes a pressure ulcer prevention and management program to reduce the risk and incidence of pressure ulcers and help maintain residents skin integrity. The facility would provide residents at the facility with proper care while ensuring they are treated with dignity. All residents are assessed at move in for their risk of developing pressure ulcers and plans are implemented to reduce this risk and prevent pressure ulcers. The policy documented upon move-in, all residents/guests shall be provided heel protectors on while in bed, an alternating air mattress on the bed, and a cushion in their chair and/or wheelchair. These interventions are temporary and will be evaluated for appropriateness by the Clinical Coordinator, and they will at this time assess the resident and determine whether to continue the interventions. The policy documented a licensed nurse would conduct a skin assessment on the admission day and weekly thereafter. The facility failed to initiate interventions per the standard of care to prevent the development of pressure ulcer to R63's heels. R63, who was at risk for pressure ulcers and required staff assistance for mobility. The facility further failed to identify the risk and implement protective measures for R63's right heel.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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§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 had a census of 127 residents. The sample included 25 residents with nine reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision and assistance to prevent accidents for one sampled resident, Resident (R) 28.

Findings included:

- R28's "Quarterly Minimum Data Set" (MDS), dated 07/12/21, documented the resident had severely impaired cognition, and required extensive assistance of two staff for bed mobility, transfers, toileting, unsteady balance, no upper or lower functional impairment, and had one injury fall since prior assessment.

The "Fall Care Assessment" (CAA), dated 10/29/20, documented the resident had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and was admitted to a memory secured household to receive assistance with activities of daily living (ADLs) and behavior management.

The "Fall Risk Assessments," dated 07/09/21 and 10/11/21, documented the resident a high risk for fall.

The revised "Bladder Incontinence Care Plan," dated 07/27/21, originally dated 12/03/19, directed staff to assist the resident to the

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restroom every two hours, before any outings, before and after meals, and two times overnight. The update, dated 07/15/21, directed stated to assist the resident to the restroom every three hours, before outings, before and after meals, and two times overnight.

The "Nurses Note," dated 07/14/21 at 11:45 PM, documented the resident was found on the floor lying on his left side. The resident fell out of his wheelchair and was unable to give a description as to what happened. The note further documented the resident sustained a round abrasion (a superficial rub or wearing off the skin), 2.0 inches x 2.0 inches in size. The note documented staff assisted the resident off the floor with a full body lift and placed back into his wheelchair. The staff then used a sit to stand lift to assist the resident into the bathroom and then to his bed.

The "Fall Investigation," dated 07/14/21, documented the resident was last toileted at 08:00 PM and was incontinent at the time of the fall. The staff was provided re-education for the intervention.

On 10/13/21 at 08:30 AM, CNA N placed a walking belt around the resident's waist and sat the resident on the side of the bed. CNA N and CNA O assisted the resident to stand, pivoted the resident and sat him into his wheelchair.

On 10/12/21 at 02:05 PM, Licensed Nurse (LN) K verified staff did not follow the resident's care plan and had not toileted the resident for over three hours prior to R28's fall. LN K stated staff was provided verbal education to provide resident cares prior to taking a break.

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F 689	Continued From page 31 On 10/12/21 at 02:53 PM, Administrative Nurse D verified the resident had not been toileted per care plan and stated staff had been re-educated on the importance of providing care to the residents before taking a break. On 10/13/21 at 08:11 AM, Certified Nurse Aide (CNA) M stated the resident had fallen and was determined to have gotten up on his own. CNA M stated staff provided toileting to the resident every two hours and as needed. The facility's "High Risk for Falls Procedure," dated November 2014, documented all household team members would be notified that a resident was a high risk for falls and specific behavior patterns that could lead to a fall should be identified and provided to team members in the resident's care plan. The facility failed to assist cognitively impaired R28 with toileting as care planned, placing the resident at risk for falls.	F 689		
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,	F 756		

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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 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 had a census of 127 residents. The sample included 25 residents with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility's consultant pharmacist failed to notify the Director of Nursing, medical director, or physician the lack of a stop date for Resident (R) 47's PRN psychotropic medication, medications held numerous times due to blood pressure or heart rate below physician ordered parameters, and medications administered when blood pressure

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or heart rate were below physician ordered parameters. The facility's consultant pharmacist also failed to address the lack of physician notification for R28's blood pressures out of physician ordered parameters.

Findings included:

- The "Annual Minimum Data Set" (MDS), dated 07/22/21, recorded R47 had a Brief Interview for Mental Status (BIMS) score of four (severe cognitive impairment), and disruptive behaviors. The MDS recorded R47 required limited staff assistance with most activities of daily living (ADLs), and had diagnoses of atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), hypertension (elevated blood pressure that can cause heart disease and stroke), congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should) and coronary artery disease (narrowing of arteries that limits blood flow to the heart).

The "Medication Care Plan," dated 07/29/21, directed staff to administer R47's medications as ordered by the physician, and monitor the medications for effectiveness, or adverse side effects.

The "Physician's Order," dated 01/07/20, directed staff to administer Coreg (medication used to treat hypertension and heart failure) 6.25 milligrams (mg) two times a day for R47's hypertension, and to hold the medication if R47's systolic blood pressure (top number measures force as the heart beats) less than 100 and/or heart rate less than 55.

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The "Physician's Order," dated 01/17/20, directed staff to administer digoxin (medication used to treat heart failure and irregular heart rates) 125 (micromilligrams) mcg every morning for R47's atrial fibrillation, and to hold the medication if R47's systolic blood pressure less than 100 and/or heart rate less than 55.

The "Physician's Order," dated 08/19/20, directed staff to administer alprazolam 0.25 milligrams (mg) every eight hours as needed for R47's anxiety and/or agitation.

Review of the August, September and October 2021 Medication Administration Record (MAR) recorded staff held R47's Coreg medication due to systolic blood pressure less than 100 or heart rate less than 55 the following number of times:
August 2021 - 39 times
September 2021 - 24 times
October 2021 until the 12th - seven times

Review the of August, September and October 2021 MAR recorded staff administered R47's Coreg medication when his systolic blood pressure less was than 100 or heart rate less than 55 on the following dates:
08/10/21 - blood pressure 92/57
09/10/21 - heart rate 52
09/25/21 - heart rate 52
10/02/21 - blood pressure 98/63
10/12/21 - blood pressure 96/61

Review of the August, September and October 2021 Medication Administration Record (MAR) recorded staff held R47's digoxin medication due to systolic blood pressure was less than 100 or heart rate less than 55 the following number of times:

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F 756	Continued From page 35 August 2021 - 12 times September 2021 - six times October 2021 until the 12th - one time Review of the August, September and October 2021 MAR recorded staff administered R47's digoxin medication when his systolic blood pressure less than 100 or heart rate less than 55 on the following dates: 08/08/21 - blood pressure 87/51, heart rate 50 08/22/21 - blood pressure 87/54, heart rate 50 09/01/21 - heart rate 50 09/25/21 - heart rate 52 10/12/21 - blood pressure 95/61 Review of the "Monthly Pharmacist Medication Regimen Reviews," dated 08/29/20 to 09/30/21 (13 months), lacked documentation R47's PRN alprazolam required a stop date, or physician's rational for extended use. Review of the "Monthly Pharmacist Medication Regimen Reviews," dated 08/30/21 and 09/30/21, lacked documentation the pharmacist addressed Coreg and digoxin medications were administered or held when R47's blood pressure and/or heart rate were below physician ordered parameters. On 10/11/21 at 10:13 AM, observation revealed R47 ambulated independently in his wheelchair in the hall. Continued observation revealed R47 well groomed, neatly dressed, and responded appropriately to staff conversation. On 10/12/21 at 02:32 PM, Licensed Nurse (LN) H stated the pharmacist had not addressed R47's PRN psychotropic medication without a stop date, or R47's Coreg or digoxin medication	F 756		

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administered or held, when the resident's blood pressure or heart rate were below physician ordered parameters.

On 10/12/21 at 03:33 PM, Administrative Nurse E stated the pharmacist had not addressed R47's PRN psychotropic medication without a stop date, or R47's Coreg or digoxin medication administered or held, when the resident's blood pressure or heart rate were below physician ordered parameters.

The facility's "Monthly Medication Review," policy, dated November 2014, directed the pharmacist to address medications without appropriate indication for use, medications without adequate monitoring, and clinical conditions that indicate adverse medication reactions.

The facility's consultant pharmacist failed to notify the Director of Nursing, medical director, or the physician the lack of a stop date for R47's PRN psychotropic medication without a stop date, medications held numerous times due to blood pressure or heart rate below physician ordered parameters, and medications administered when blood pressure or heart rate were below physician ordered parameters, placing the resident at risk to receive unnecessary psychotropic medications and adverse medication side effects.

- R28's "Physician Order Sheet" (POS), dated 04/26/21, documented the resident had a diagnosis of hypertension (high blood pressure).

The "Annual Minimum Data Set" (MDS), dated 10/29/20, documented the resident had severely impaired cognition, required extensive assistance

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of two staff for bed mobility, toileting, transfers and extensive assistance of one staff for dressing and personal hygiene.

The "Quarterly MDS," dated 07/12/21, documented the same as the 10/29/20 MDS.

The "Black Box Warning Medication Care Plan," dated 07/27/21, directed staff to administer all medications as ordered and observe for and report alterations, side effects or adverse reactions promptly to nurse and physician accordingly.

The "Physician's Order," dated 11/03/20, directed staff to obtain blood pressure once a week every Tuesday and notify the physician if the systolic blood pressure (the top number that measures the pressure in the arteries when the heart beats) was less than 110.

The "Vital Sign Blood Pressure Report," for January, September and October 2021 documented the following blood pressures:

01/29/21 at 06:42 PM 108/620
09/06/21 at 01:56 PM 108/60

Review of R28's "Medication Regimen Reviews" for February and September 2021 failed to address the out of parameter blood pressures.

On 10/11/21 at 09:44 AM, observation revealed the resident self-propelled himself out of the dining room.

On 10/13/21 at 09:19 AM, Administrative Nurse D verified the staff are to notify the physician when the systolic blood pressure was below 110 and

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F 756	Continued From page 38 expected the Consultant Pharmacist to review the blood pressures and report any that are out of parameter as set by the physician. The facility's "Consultation by Pharmacist to Households and Procedures," dated November 2014, documented the Consultant Pharmacist assisted the facility in identifying, evaluating, and addressing medication issues that may affect resident care, medical care, and/or quality of life. The Consultant Pharmacist shall prepare a written report that included findings and recommendations. This report would be provided to the Director of Nursing Services and/or Clinical Coordinator. The facility's Consultant Pharmacist failed to report to the Director of Nursing, medical director and physician, R28's out of parameter blood pressures, placing the resident at risk for a decline in condition.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		

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§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 127 residents. The sample included 25 residents with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to hold medications when blood pressure and/or pulse were below physician ordered parameters for one sampled resident, Resident (R) 47.

Findings included:

- The "Annual Minimum Data Set" (MDS), dated 07/22/21, recorded R47 had a Brief Interview for Mental Status (BIMS) score of four (severe cognitive impairment), and disruptive behaviors. The MDS recorded R47 required limited staff assistance with most activities of daily living (ADLs), and had diagnoses of atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), hypertension (elevated blood pressure that can cause heart disease and stroke), congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should) and coronary artery disease (narrowing of arteries that limits blood flow to the heart).

The "Medication Care Plan," dated 07/29/21, directed staff to administer R47's medications as

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	175174	A. BUILDING _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK HILLS	2121 MEADOWLARK ROAD MANHATTAN, KS 66502

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ordered by the physician, and monitor the medications for effectiveness, or adverse side effects.

The "Physician's Order," dated 01/07/20, directed staff to administer Coreg (medication used to treat hypertension and heart failure) 6.25 milligrams (mg) two times a day for R47's hypertension, and to hold the medication if R47's systolic blood pressure (top number measures force as the heart beats) was less than 100 and/or heart rate less than 55.

The "Physician's Order," dated 01/17/20, directed staff to administer digoxin (medication used to treat heart failure and irregular heart rates) 125 (micromilligrams) mcg every morning for R47's atrial fibrillation, and to hold the medication if R47's systolic blood pressure was less than 100 and/or heart rate less than 55.

Review of the August, September and October 2021 Medication Administration Record (MAR) recorded staff administered R47's Coreg medication when his systolic blood pressure less was than 100 or heart rate less than 55 on the following dates:
08/10/21 - blood pressure 92/57
09/10/21 - heart rate 52
09/25/21 - heart rate 52
10/02/21 - blood pressure 98/63
10/12/21 - blood pressure 96/61

Review of the August, September and October 2021 MAR recorded staff administered R47's digoxin medication when his systolic blood pressure was less than 100 or heart rate less than 55 on the following dates:
08/08/21 - blood pressure 87/51, heart rate 50

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F 757	Continued From page 41 08/22/21 - blood pressure 87/54, heart rate 50 09/01/21 - heart rate 50 09/25/21 - heart rate 52 10/12/21 - blood pressure 95/61 Review of the "Monthly Pharmacist Medication Regimen Reviews," dated 08/30/21 and 09/30/21, lacked documentation the pharmacist addressed Coreg and digoxin medications administered when R47's blood pressure and/or heart rate were below physician ordered parameters. On 10/11/21 at 10:13 AM, observation revealed R47 ambulated independently in his wheelchair in the hall. Continued observation revealed R47 well groomed, neatly dressed, and responded appropriately to staff conversation. On 10/12/21 at 02:32 PM, Licensed Nurse (LN) H stated staff should not administer R47's Coreg or digoxin medication, when the resident's blood pressure or heart rate were below physician ordered parameters. On 10/12/21 at 03:33 PM, Administrative Nurse E stated staff should not administer R47's Coreg or digoxin medication, when the resident's blood pressure or heart rate were below physician ordered parameters The facility's "Medication Administration" policy, dated November 2014, directed staff to follow physician ordered guidelines when administering medications. The facility failed to hold R 47's medications when blood pressure and/or pulse were below physician ordered parameters, placing the resident at risk for adverse side effects.	F 757		

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §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	F 758		

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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 had a census of 127 residents. The sample included 25 residents with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure a stop date for a PRN (as needed) psychotropic medication (medications that affect a person's mental state) for one of five sampled residents, Resident (R) 47.

Findings included:

- The "Annual Minimum Data Set" (MDS), dated 07/22/21, recorded R47 had a Brief Interview for Mental Status (BIMS) score of four (severe cognitive impairment), and disruptive behaviors. The MDS recorded R47 required limited staff assistance with most activities of daily living (ADLs), and received antipsychotic (class of medication used to treat behavioral and emotional mental conditions) and antidepressant medications (class of medication used to treat mood disorders and relieve symptoms of exaggerated feelings of sadness, worthlessness and emptiness) seven days a week.

The "Mood and Behavior Care Plan," dated 07/29/21, directed staff to monitor and record R47's target behaviors, administer PRN

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alprazolam (antianxiety medication to calm and relax people with excessive anxiety, nervousness or tension)as ordered by the physician, and monitor for effectiveness.

The "Physician's Order," dated 08/19/20, directed staff to administer alprazolam 0.25 milligrams (mg) every eight hours as needed for R47's anxiety and/or agitation.

Review of the "Monthly Pharmacist Medication Regimen Reviews," dated 08/29/20 to 09/30/21 (13 months), lacked documentation R47's PRN alprazolam required a stop date, or physician's rational for extended use.

On 10/11/21 at 10:13 AM, observation revealed R47 ambulated independently in his wheelchair in the hall. Continued observation revealed R47 well groomed, neatly dressed, and responded appropriately to staff conversation.

On 10/12/21 at 02:32 PM, Licensed Nurse (LN) G stated R47's PRN psychotropic medication should have a 14 day stop date, or a physician's rationale and order for extended duration of use.

On 10/12/21 at 03:33 PM, Administrative Nurse E stated PRN psychotropic medications should have a 14 day stop date, or a physician's rationale and order for extended duration of use.

The facility's "Psychotropic Medication Monitoring" policy, dated October 2017, directed staff to ensure PRN psychotropics had a 14 day stop date, or a physician's rationale for extended duration of use.

The facility failed to ensure a stop date for R47's

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F 758	Continued From page 45 PRN psychotropic medication, placing the resident at risk for receiving unnecessary psychotropic medications.	F 758		