

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

PRINTED: 09/07/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2021
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 #KS00165079.	F 000			
F 623 SS=D	The 2567 was sent to the facility on 09/07/21. 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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F 623	Continued From page 1 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	F 623			

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F 623	Continued From page 2 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 identified a census of 37 residents. The sample included 13 residents; one resident sampled for hospitalization. Based on record review and interviews, the facility failed to provide a written notification of transfer, as soon as was practicable, to Resident (R) 178 or to her family/durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to). This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare services.	F 623			

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F 623	Continued From page 3 Findings included: - R178 was admitted to facility on 07/12/21, transferred to hospital 07/22/21, returned to facility 07/23/21, discharged to hospital 07/23/21, readmitted to facility 07/28/21, then discharged to hospital 08/06/21. R178's Electronic Medical Record (EMR) documented diagnoses of fracture of unspecified part of right clavicle (bone that connects the breastplate to the shoulder), cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) of face, and repeated falls. The "Baseline Person Centered Care Plan" dated 07/12/21 documented R178 was alert and oriented to person, place, time, and situation. R178's medical record lacked documentation of a written notification of transfer to resident or family for the transfers to the hospital on 07/22/21, 07/23/21, and 08/06/21. Facility unable to provide written notification of transfer for transfers to hospital on 07/22/21, 07/23/21, and 08/06/21. On 09/01/21 at 11:08 AM, Administrative Nurse D stated the facility did not provide a written notification of transfer to resident or family. She stated the residents who were transferred to the hospital were in an emergency and were not coherent enough to understand. She stated the family was notified of transfers by phone call. On 09/01/21 at 03:26 PM, Licensed Nurse (LN) G	F 623			

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F 623	Continued From page 4 stated when a resident was transferred to the hospital, the family was notified by phone call. LN G had not heard of a written notification of transfer to family or resident. On 09/01/21 at 03:50 PM, Administrative Nurse D stated the facility did not provide written notification of transfers to resident or family because the facility did not know if the resident was discharged or if the resident would return to facility. The facility's "Transfer Agreement" policy, not dated, lacked direction of a written notification of transfer to resident or family/DPOA. The facility failed to provide a written notification of transfer to R178 or her family/DPOA. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare services.	F 623			
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 identified a census of 37 residents. The sample included 13 residents with three residents sampled for falls. Based on	F 689			

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F 689	Continued From page 5 observations, record reviews, and interviews, the facility failed to investigate causative factors and ensure interventions were followed for the prevention of falls for Resident (R) 8. This deficient practice placed R8 at increased risk for further falls, possible injuries from falls, and unwarranted physical complications. Findings included: - R8's Electronic Medical Record (EMR) documented a diagnosis of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (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) affecting right dominant side. The "Admission Minimum Data Set" (MDS) dated 07/22/21, documented R8 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R8 required extensive physical assistance with one staff for bed mobility, transfers, dressing, and toileting. R8 had not fallen since admission at time of assessment. The "Falls Care Area Assessment" (CAA) dated 07/22/21, documented R8 was at risk for falls related to weakness and nursing encouraged her to use call light for assistance with all mobility. The "Care Plan" dated 08/03/21, documented R8 was identified at risk for falls and documented an intervention with a start date of 08/22/21 for 15 minute checks. The "Care Plan" lacked interventions for fall on 08/19/21.	F 689			

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F 689	Continued From page 6 A "Progress Note" in R8's EMR on 08/19/21 at 06:26 AM documented the Certified Nurse Aide (CNA) found R8 on the floor. R8 was on the floor on the left side of her bed wrapped with blankets and stated she turned on her side then slide out of bed. Hourly checks initiated. The investigation provided by facility for fall on 08/19/21 documented R8 was on hourly checks for fall prevention. The investigation lacked a root cause analysis. A "Progress Note" in R8's EMR on 08/20/21 at 08:02 AM documented R8 was found at the side of the bed on the floor next to the dresser. R8 complained of back and left lower extremity pain and had a bleeding skin tear on her left upper extremity. R8 was not moved per protocol and Emergency Medical Technicians (EMTs) were notified and transported R8 to the hospital. A "Progress Note" in R8's EMR on 08/20/21 at 04:52 PM documented R8 returned to facility around 11:30 AM and continued on 30 minute checks. The investigation provided by facility for fall on 08/20/21 documented R8 was on hourly checks for fall prevention then every 30 minute checks and then 15 minute checks for fall prevention. The investigation lacked a root cause analysis. The "Orders" section of R8's EMR documented an order with a start date of 08/23/21 for every 15 minute checks every shift for fall prevention. The "Room Visual Checks" documentation in R8's medical record revealed six out of 12 available pages were dated 08/19/21 and listed	F 689			

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F 689	Continued From page 7 R8 was on hourly checks. Three pages dated 8/24/21, 08/25/21, and 08/26/21 listed R8 was on hourly checks and lacked documentation from 06:15 AM to 09:45 PM. A page dated 08/27/21 documented R8 was on hourly checks and lacked documentation from 12:00 AM to 01:45 PM and from 10:15 PM to 11:45 PM. A page dated 08/30/21 documented R8 was on hourly checks and lacked documentation from 07:00 AM to 11:45 PM. A page dated 08/31/21 documented R8 was on 15 minute checks and lacked documentation from 12:00 AM to 05:45 AM. On 08/31/21 at 04:46 PM, R8 laid in bed, staff assisted her with repositioning in bed for comfort. She appeared comfortable and without signs of discomfort or distress. On 08/31/21 at 11:02 AM, Administrative Nurse D stated the root cause analysis was completed on the back of the investigations and new interventions were documented there as well On 09/01/21 at 10:32 AM, Administrative Nurse F stated she was unable to locate any resolved fall interventions on R8's care plan. On 09/01/21 at 03:15 PM, CNA M stated if a resident fell, she immediately called for help from the nurse. While she waited for help, she asked the resident what happened. She stated new interventions for fall prevention were passed on during report and there was communication with the nurse. She stated there was a document that listed what room numbers were on visual checks and stated R8 was on visual checks, was previously hourly checks but currently required 15 minute checks. CNA M stated visual checks were documented on paper. She was unsure of a way	F 689			

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F 689	Continued From page 8 to look up the interventions in the computer. On 09/01/21 at 03:26 PM, Licensed Nurse (LN) G stated when a resident fell, she investigated and assessed the resident. She found out who last saw the resident and how they fell if it was unwitnessed. LN G stated interventions were put into place to prevent further falls, R8 received a perimeter mattress since she rolled out of bed. She stated new interventions were placed on the "Treatment Administration Record" (TAR) and CNAs were notified each morning which residents were on visual checks. It was the nurse's responsibility to let the aide know and the aide was to grab a new visual check sheet to complete during the shift for the correct duration. On 09/01/21 at 03:50 PM, Administrative Nurse D stated if a resident was found on the floor, the staff member who found them reported it to the nurse. An incident report was filled out, unwitnessed falls were placed on neurological checks and the incident report went into her box. The Interdisciplinary Team met every morning to discuss falls and what interventions were to be implemented. Interventions were placed in the EMR as orders. The CNA was to get a new visual check sheet at the beginning of the shift or day. The facility's "Fall Prevention" policy, not dated, directed safety interventions were implemented and monitored with appropriate documentation as indicated. The assigned LN was responsible for ensuring the safety checks were in place as care planned and initialed the Treatment Administration Record indicating checks were completed. According to the Centers for Medicare and	F 689			

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F 689	Continued From page 9 Medicaid Services (CMS) the definition of a Root Cause Analysis (RCA) is a structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective actions. The RCA process provides the facility with a way to identify breakdowns in processes and systems that contributed to the event and how to prevent future events. . The facility failed to investigate causative factors and ensure interventions were followed for the prevention of falls for R8. This deficient practice had the risk for further falls, possible injuries from falls, and unwarranted physical complications.	F 689			
F 756 SS=E	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	F 756			

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F 756	Continued From page 10 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 identified a census of 37 residents. The sample included 13 residents with five residents sampled for unnecessary medication review. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported to the facility irregularities (bowel monitoring was not being documented daily for Resident (R)23, weights were not obtained as ordered for R81 and R82, blood sugars were not obtained as ordered for R78). This deficient practice placed the residents at increased risk for complications related to unnecessary medications and adverse effects. Findings included: -The electronic medical record (EMR) for R23 documented diagnoses of fractures (broken bone) of lumbar spine, hemiplegia (paralysis of	F 756			

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F 756	Continued From page 11 one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (disrupted blood flow to the brain), constipation (difficulty passing stools), and aphasia (condition with disordered or absent language function), chronic low back pain. The "Admission Minimum Data Set" (MDS) dated 08/09/21 documented a Brief Interview for Mental Status (BIMS) was not performed and R23 was hardly ever understood. He required supervision to extensive assistance of one staff for activities of daily living (ADLs), had impairment of the lower extremity on one side, and used a walker and/or a wheelchair for mobility. R23 was continent of bowel. The "Urinary Incontinence Care Area Assessment" (CAA) for R23 dated 08/16/21 documented he required limited to extensive assist with toileting. He was able to use his call light as needed for assistance. Nursing was to encourage R23 to use call light as needed for assistance with toileting and assist as needed. The "Pain Care Plan" revised 8/23/21, instructed staff to monitor for adverse side effects of medication regimen; consult with physician as needed. The "Orders" tab dated 08/03/21 recorded an order for the Certified Nurse Aide (CNA) to document bowel movements (BM) every shift (day 06:00 AM to 02:00 PM, evening 02:00 PM to 10:00 PM, night 10:00 PM to 06:00 AM) for constipation. The "Orders" tab recorded an order dated 08/03/21 for general day three (Bowel Brigade)	F 756			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2021
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
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F 756	Continued From page 12 administer milk of magnesia (a medication used to treat constipation) 30 cubic centimeter (cc's) by mouth in the morning as needed (PRN). The "Orders" tab recorded an order dated 08/03/21: Day 4 (Bowel Brigade) administer Dulcolax (a medication taken by mouth or rectally for constipation) 10 milligrams (mg) by mouth or by rectum in the am PRN for constipation. The "Orders" tab recorded an order dated 08/03/21: Day 5 (Bowel Brigade) administer Fleets enema (introduction of a solution into the rectum for cleansing or therapeutic purposes). The "Orders" tab recorded an order dated 08/03/21: Day 6 (Bowel Brigade), if no BM in greater than five days notify physician for further orders as needed. The "Vitals" and "Progress Notes" tab in the EMR reviewed from 08/03/21 to 08/31/21 lacked any documentation of R23 having a bowel movement prior to 08/16/21. Review of R23's "Medication Administration Record" for the month of August 2021 lacked documentation R23 received any ordered as needed bowel brigade treatment for no bowel movement for three days or more as ordered. On 08/31/21 at 1:15 PM, R23 was upright, sitting in his wheelchair, he had his back brace on, at the bedside table was in front of him with meal tray on it, call light was within reach. In an interview with CNA N on 09/01/21 at 2:23 PM, she stated she normally would go into each resident's room and ask them if they have had a	F 756			

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F 756	Continued From page 13 BM. CNA N stated the facility CNAs monitor BM's to make sure that a resident is not getting constipated. BM's are charted under the outputs in the EMR and should be done each shift. In an interview on 09/01/21 at 2:37PM Licensed Nurse (LN) H stated, BM's are monitored daily by Administrative Nurse E, she prints out a daily report of residents that have gone three days without a BM and the Bowel Brigade protocol would begin. BM's show up under vitals as output and in a progress note. The aides are supposed to ask a resident every time the vital signs are obtained if they have had a BM. In an interview with Administrative Nurse D on 09/01/21 at 3:51PM she stated each morning a report is ran that shows who has gone three days without a BM. That list is given to the staff nurses and the Bowel Brigade protocol would be started. In an interview with CP GG on 09/02/21 at 11:28 AM stated, she does a monthly review of resident's records and looked at documentation, and charting. She also looked at insulins, and other medications, behaviors, bowels, duplicate medications, and appropriate medications. She would notify Administrative Nurse D if any irregularities were noted and make recommendations when needed. The undated facility policy "Drug Regimen Review Policy" documented: a licensed pharmacist with review the resident drug regimen including the resident chart at least once a month. The CP will report in writing, any irregularities to the attending physician, the facility's medical director and the director of nursing to be acted upon. The object of this requirement is to try to minimize or prevent	F 756			

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F 756	Continued From page 14 adverse consequences or to prevent residents from receiving unnecessary drugs. The CP will complete the drug regimen review by reviewing the comprehensive assessment information of the resident, identifying irregularities, syndromes potentially related to medication therapy, adverse medication consequence, as well as potential for adverse drug reactions and medication errors. The undated facility policy "Bowel Brigade" documented each patient will receive bowel care per general orders on a routine and consistent basis. The purpose of this policy is to ensure adequate bowel evacuation in order to prevent complications or discomfort that may arise related to acute constipation or fecal impaction. The facility failed to ensure the CP identified and reported irregularities of no bowel monitoring being documented for R23, which had the potential for increased risk for constipation due to lack of PRN bowel medications as ordered. - The electronic medical record (EMR) for R81 documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), chronic kidney disease (loss of kidney function), acute respiratory failure (condition in which your blood does not have enough oxygen or has too much carbon dioxide causing shortness of breath and feeling extremely tired). The "Admission Minimum Data Set" (MDS) dated 08/22/21 for R81 documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R81 required supervision to limited assistance of one for "activities of daily living" (ADLs) and she used the	F 756			

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F 756	Continued From page 15 assistance of a walker for ambulation. R81 received a diuretic (a medication to promote the formation and excretion of urine). The "Nutritional Status Care Area Assessment" (CAA) dated 08/26/21, documented R81 was at alteration in weight due to the diagnosis of CHF. She was also on a 2000 milliliter (ml) a day fluid restriction. Staff was to continue to monitor weight weekly. The "Baseline Nutrition Care Plan" dated 08/16/21 documented daily weights to be obtained and a fluid restriction of 2000 milliliters a day. The "Orders" tab recorded an order dated 08/16/21 for daily weight for diagnosis CHF. The order directed staff to notify the physician of a weight gain greater than two pounds in a day or five pounds in a week. The "Treatment Administration Record" (TAR) in the EMR for the month of August 2021 for R81, lacked documentation for a daily weight on five of the 16 days reviewed. A note was charted on the TAR by the nurse that the Certified nurse Aid (CNA) was unable to obtain weight with no explanation as to why. Review of R81's weights on the TAR revealed she had a weight increase of 4.5 pounds between the dates of 08/24/21 and 08/26/21 (no weight was obtained on 08/25/21). The clinical record lacked evidence the physician was notified. Review of the "Physician Progress Notes" in R81's chart noted no reference to the change in R81's weight on the above dates.	F 756			

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F 756	Continued From page 16 In an interview on 09/01/21 at 2:23 PM with CNA N she stated that she never had to get a weight for a resident because typically the day shift aides get weights. She would get a weight at the beginning of her shift if she needed to get one for a resident. In an interview on 09/01/21 at 3:15PM with CNA M, she stated the only time a weight would not get done was if they got far behind. The nurse prints out a sheet that has a list of residents that need weighed that day. She would let the nurse know if a resident refused or if she was unable to get the weight done. Weights results are written on the weight sheet and then she would chart the weight under "Vitals" in the EMR. In an interview on 09/01/21 at 2:37PM with Licensed Nurse (LN) H, LN H stated that daily weights are obtained for resident's that have CHF or are on a fluid restriction, or if they were on dialysis. The CNA's are who obtain the weights and they typically tried to get them done before a resident has had breakfast. The aide should try at least twice to get the weight, then tell they nurse that they were unable to get the weight or if the resident refused, then she would go in herself and ask the resident if she could get there weight. If they still refused, then she would chart a note on their TAR as well as a progress note. The weights are charted by the nurses. The nurse manager monitors the weights and reports changes to the physician. If a weight has not been obtained for more than three days, then she would call the physician to notify him if there was a change of two pound or more. In an interview on 09/01/21 at 3:27 PM LN G stated that a resident could sign a refusal form to	F 756			

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F 756	Continued From page 17 refuse getting their weight taken; but staff should try at least twice to obtain the weight before having the resident sign a refusal form. The physician should be notified when there is a weight change of more than two pounds in a day or five pounds in a week. In an interview on 09/01/21 at 3:51 PM Administrative Nurse D stated that weights were done as ordered either daily or weekly by the CNA. If CNA staff were unable get the weight, the nurse should try to get a weight and if they were unable to obtain the weight, they would chart not able to obtain. Weight changes, if noticed by CP, would be noted on a physician progress note. The physician will note any weight changes in his progress notes as he was in the facility daily. In an interview with CP GG on 09/02/21 at 11:28 AM stated, she does a monthly review of resident's records and looked at documentation, and charting. She also looked at insulins, and other medications, behaviors, bowels, duplicate medications, and appropriate medications. She would notify Administrative Nurse D if any irregularities were noted and make recommendations when needed. The undated facility policy "Drug Regimen Review Policy" documented: a licensed pharmacist with review the resident drug regimen including the resident chart at least once a month. The CP will report in writing, any irregularities to the attending physician, the facility's medical director and the director of nursing to be acted upon. The object of this requirement is to try to minimize or prevent adverse consequences or to prevent residents from receiving unnecessary drugs. The CP will complete the drug regimen review by reviewing	F 756			

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F 756	Continued From page 18 the comprehensive assessment information of the resident, identifying irregularities, syndromes potentially related to medication therapy, adverse mediation consequence, as well as potential for adverse drug reactions and medication errors. The undated facility policy "Weights" documented: The clinical nurse manager will post all residents requiring charting for weight variances, please chart every shift three times daily speaking to the problem; ensure physician is notified of weight change. The facility failed to ensure that the CP identified and reported missing daily weights and/or increases in R81's daily weight, which had the potential for unnecessary medication administration or complications related to CHF. - R82's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension (elevated blood pressure). The "Admission Minimum Data Set" (MDS) dated 08/19/21 documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented that R82 required extensive assistance of one staff member for activities of daily living (ADL's). The MDS documented R82 received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication for six days.	F 756			

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F 756	Continued From page 19 anticoagulant (class of medications used to prevent the formation of blood clots) medication for seven days, and antibiotic (class of medication used to treat bacterial infections) medication for four days. R82's " Nutritional Status Care Area Assessment" (CAA) dated 08/26/21 documented she was at risk for alteration in weight related to her increase edema and staff to monitor her weight. R82's "Baseline Care Pan" dated 08/13/21 directed staff to monitor weight daily. Review of the EMR under the "Orders" revealed physician orders: Daily weight, diagnosis CHF dated 08/13/21. Fluid restriction: 200 cubic centimeter (CC) daily (360cc with breakfast, 240cc with lunch, 240cc with dinner, 580cc each shift in room, diagnosis CHF and hyponatremia (low sodium), dated 08/13/21. Lasix (diuretic- medication to promote the formation and excretion of urine) tablet 20 milligrams (mg) by mouth, diagnosis edema (swelling due to fluid accumulation) dated 08/30/21. Review of the EMR under "Medication Administration Record" documented on 08/17/21 resident refused weight; 08/19/21 "Certified Nurse Aide" (CNA) did not obtain weight; 08/20/21 CNA did not obtain weight; 08/21/21 CNA did not obtain weight; 08/25/21 resident unavailable; 08/29/21 resident was unavailable.	F 756			

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F 756	Continued From page 20 Review of the clinical record lacked physician notification of physician notification of daily weight not completed or resident refusal. Review of the EMR under "Progress Notes" dated 08/30/21 at 11:43 AM R82 was transferred out of the facility to the hospital, per request of her representative related to increased bilateral lower extremity edema. Review of the clinical record lacked physician notification of physician notification of daily weight not completed or resident refusal. On 08/30/21 at 11:43 AM R82 was transported out of the facility on gurney by two emergency medical staff. The "Monthly Medication Review" (MMR), performed by the CP, reviewed August 2021 did not identify the lack of weight monitoring related to R82's CHF. On 09/01/21 at 02:35 PM in an interview, CNA N stated she had never obtained a weight for a resident. On 09/01/21 at 02:45 PM in an interview, Licensed Nurse (LN) H stated a daily weight were obtained for a resident with CHF to monitor for increased edema. LN H stated that a daily weight would be obtained prior to breakfast by the CNA and reported to the nurse. LN H stated that the physician would be notified if a daily weight was not obtained for several days. On 09/01/21 at 03:35 PM in an interview, CNA M stated the nurse notified the CNA of who needed a daily weight and if dayshift could not get the	F 756			

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F 756	Continued From page 21 weight, then evening shift would attempt to weigh the resident. On 09/01/21 at 03:53 PM in an interview, Administrative Nurse D stated the CNA obtained the weekly or daily weights as ordered by the physician. Administrative Nurse D stated the physician was in the facility every day and would have documented weight changes in their progress notes. On 09/02/21 at 11:28 AM in an interview, CP GG stated she reviewed the resident's record monthly. CP GG stated that she reviewed medications, blood glucose readings, bowel monitoring, duplicate medication, documentation and appropriate medication, then notified the director of nursing of any irregularities and make recommendations when needed. The facility "Drug Regimen Review" policy lacked a date documented a licensed pharmacist would review a resident's drug regimen including the resident's chart monthly. The CP may need to conduct the medication regimen review more frequently depending on the resident condition, review of the short stay residents and risk of adverse consequences. The licensed pharmacist will report irregularities to the attending physician, the facility's medical director and the director of nursing to be acted upon. The facility failed to ensure the CP identified and reported the lack of consistent daily weights for R82 to monitor for fluid retention related to CHF, which had the potential of unnecessary diuretic medication administration thus leading to possible harmful side effects.	F 756			

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F 756	Continued From page 22 - R78's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and chronic kidney disease (damaged kidneys and unable to filter blood the way they should). The "Admission Minimum Data Set" (MDS) dated 08/13/21 documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented that R78 required extensive assistance of one staff member for activities of daily living (ADL's). The MDS documented R78 had received antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions) medication for six days, and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medication for seven days during the look back period. R78's "Dehydration/Fluid Maintenance Care Area Assessment" (CAA) dated 08/19/21 documented he was at risk for alteration in fluid volume to chronic kidney disease and him receiving dialysis (is a process of removing excess water, solutions and toxins from the blood). Staff to monitor fluid. R78's "Nutritional Status CAA" dated 08/19/21 documented nursing staff was to monitor blood glucose levels as ordered by the physician to monitor for hypoglycemia (less than normal	F 756			

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F 756	Continued From page 23 amount of sugar in the blood) and hyperglycemia (greater than normal amount of glucose in the blood). R78's was at risk alteration in weight related to dialysis and staff was to continue to monitor weight. R78's "Care Plan" dated 08/27/21 documented medication and treatment would be administered per physician orders and bowel protocol to was to be followed. The "Care Plan" documented to obtain blood glucose levels and monitor for adverse side effects of medications and to notify the physician as needed. The "Care Plan" documented the CP was to review medications and alert the physician of any recommendations. Review of the EMR under the "Orders" revealed physician orders: MiraLAX (laxative- medication used to stimulate or facility evacuation of the bowels) powder 17 grams by mouth daily for constipation (hold for loose stools) dated 08/07/21. Tradjenta (medication used to lower blood glucose levels) tablet five milligrams (mg) by mouth daily for diabetes dated 08/07/21. Check blood glucose every morning. Notify physician if blood glucose is less than (<) 60 or greater than (>) 400 dated 08/07/21. Weight Monday, Wednesday and Friday dated 08/09/21. Review of the EMR under "Vitals" for bowel movements (BM) for August 2021 revealed 08/08/21 to 08/11/21 (four days) no documented BM; 08/25/21 to 08/29/21 (four days) no BM	F 756			

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F 756	Continued From page 24 documented. The clinical record lacked documentation any as needed medication or physician was notified. Review of the EMR under "Vitals" for weights revealed: 08/11/21 Certified Nurse Aide (CNA) did not obtain weight; 08/13/21 CNA did not obtain weight; 08/18/21 due to condition weight was not obtained; 08/20/21 CNA did not obtain weight; 08/25/21 resident refused weight; 08/27/21 resident was not available to obtain weight. The clinical record lacked documentation that the physician was notified of resident's refusal or of the weights not consistently obtained as ordered by physician. Review of the EMR under "Medication Administration Record" (MAR) for blood glucose levels for August 2021 revealed: 08/10/21 resident at dialysis; 08/18/21 resident refused; 08/19/21 resident was unavailable; 08/20/21 resident refused; 08/21/21 resident was at dialysis; 08/24/21 resident was at dialysis; 08/26/21 resident was unavailable; 08/28/21 resident was at dialysis; 08/29/21 resident refused; 08/31/21 resident was at dialysis. The clinical record lacked documentation that the physician was notified of resident refusal or staff was unable to monitor blood glucose levels as ordered. The "Monthly Medication Review" (MMR), performed by the CP, reviewed August 2021 did not identify the lack of weight monitoring, bowel monitoring and monitoring blood glucose levels for R78 who received dialysis. 09/01/21 at 10:37 AM nursing staff assisted R78 on to his bed, head of bed was elevated, no	F 756			

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F 756	Continued From page 25 complaint of pain or discomfort was noted. R78 lacked his skin protective sleeves to his upper extremities for protection and his pressure reducing device for his left lower extremity was not applied. On 09/01/21 at 02:35 PM in an interview, CNA N stated she had never obtained a weight for a resident. CNA N stated she monitored residents bowel movements to prevent constipation and everyone was able to document in the computer for bowel movements. On 09/01/21 at 02:45 PM in an interview, Licensed Nurse (LN) H stated a daily weight were obtained for a resident with CHF to monitor for increased edema. LN H stated that a daily weight would be obtained prior to breakfast by the CNA and reported to the nurse. LN H stated that the physician would be notified if a daily weight was not obtained for several days. LN H stated blood glucose should be obtained prior to breakfast to monitor for diabetes mellitus, should someone refuse for several days in row the physician would be notified and documented in the nurses note. LN H stated that the unit manager prints off the bowel monitoring sheet of the residents who had not had a bowel movement for 72 hours and the nurse would follow up with the bowel protocol or notify the physician. LN H stated that if as needed medication (PRN) was given for constipation it would have been documented on the MAR. On 09/01/21 at 03:35 PM in an interview, CNA M stated the nurse notified the CNA of who needed a daily weight and if dayshift could not get the weight, then evening shift would attempt to weigh the resident.	F 756			

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F 756	Continued From page 26 On 09/01/21 at 03:53 PM in an interview, Administrative Nurse D stated the CNA obtained the weekly or daily weights as ordered by the physician. Administrative Nurse D stated the physician was in the facility every day and would have documented weight changes in their progress notes. Administrative Nurse D stated bowel monitoring sheet is printed off by the nurse manager and given to the unit nurse to follow up. Administrative Nurse D stated that if a PRN was given it would be charted on the MAR. Administrative Nurse D stated if a resident refused a blood glucose test for several days the physician would have been aware, because she was at the facility almost everyday and would have documented on the physician progress note. On 09/02/21 at 11:28 AM in an interview, CP GG stated she reviewed the resident's record monthly. CP GG stated that she reviewed medications, blood glucose readings, bowel monitoring, duplicate medication, documentation and appropriate medication, then notified the director of nursing of any irregularities and make recommendations when needed. The facility "Drug Regimen Review" policy lacked a date documented a licensed pharmacist would review a resident's drug regimen including the resident's chart monthly. The CP may need to conduct the medication regimen review more frequently depending on the resident condition, review of the short stay residents and risk of adverse consequences. The licensed pharmacist will report irregularities to the attending physician, the facility's medical director and the director of nursing to be acted upon.	F 756			

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F 756	Continued From page 27 The facility failed to ensure the CP reported irregularities related weight monitoring to monitor fluid retention related to dialysis, blood glucose monitoring for hyperglycemia and hypoglycemia, and bowel monitoring for constipation for R78. This deficit practice had the potential for unnecessary medication use and unwarranted side effects for R78.	F 756			
F 757 SS=E	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 identified a census of 37 residents. The sample included 13 residents with five residents sampled for unnecessary medication	F 757			

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F 757	Continued From page 28 review. Based on observation, record review, and interview, the facility failed to ensure that bowel monitoring was being documented daily and bowel medications administered as ordered for Resident (R)23 and R78, weights were obtained as ordered for R81, and R82, and blood sugars were obtained as ordered for R78. This deficient practice placed the residents at increased risk for complications related to unnecessary medications and adverse effects. Findings included: - The electronic medical record (EMR) for R23 documented diagnoses of fractures (broken bone) of lumbar spine, hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (disrupted blood flow to the brain), constipation (difficulty passing stools), and aphasia (condition with disordered or absent language function), chronic low back pain. The "Admission Minimum Data Set" (MDS) dated 08/09/21 documented a Brief Interview for Mental Status (BIMS) was not performed and R23 was hardly ever understood. He required supervision to extensive assistance of one staff for activities of daily living (ADLs), had impairment of the lower extremity on one side, and used a walker and/or a wheelchair for mobility. R23 was continent of bowel. The "Urinary Incontinence Care Area Assessment" (CAA) for R23 dated 08/16/21 documented he required limited to extensive assist with toileting. He was able to use his call light as needed for assistance. Nursing was to encourage R23 to use call light as needed for	F 757			

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F 757	Continued From page 29 assistance with toileting and assist as needed. The "Pain Care Plan" revised 8/23/21, instructed staff to monitor for adverse side effects of medication regimen; consult with physician as needed. The "Orders" tab dated 08/03/21 recorded an order for the Certified Nurse Aide (CNA) to document bowel movements (BM) every shift (day 06:00 AM to 02:00 PM, evening 02:00 PM to 10:00 PM, night 10:00 PM to 06:00 AM) for constipation. The "Orders" tab recorded an order dated 08/03/21 for general day three (Bowel Brigade) administer milk of magnesia (a medication used to treat constipation) 30 cubic centimeter (cc's) by mouth in the morning as needed (PRN). The "Orders" tab recorded an order dated 08/03/21: Day 4 (Bowel Brigade) administer Dulcolax (a medication taken by mouth or rectally for constipation) 10 milligrams (mg) by mouth or by rectum in the am PRN for constipation. The "Orders" tab recorded an order dated 08/03/21: Day 5 (Bowel Brigade) administer Fleets enema (introduction of a solution into the rectum for cleansing or therapeutic purposes). The "Orders" tab recorded an order dated 08/03/21: Day 6 (Bowel Brigade), if no BM in greater than five days notify physician for further orders as needed. The "Vitals" and "Progress Notes" tab in the EMR reviewed from 08/03/21 to 08/31/21 lacked any documentation of R23 having a bowel movement	F 757			

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F 757	Continued From page 30 prior to 08/16/21. Review of R23's "Medication Administration Record" for the month of August 2021 lacked documentation R23 received any ordered as needed bowel brigade treatment for no bowel movement for three days or more as ordered. On 08/31/21 at 1:15 PM, R23 was upright, sitting in his wheelchair, he had his back brace on, at the bedside table was in front of him with meal tray on it, call light was within reach. In an interview with CNA N on 09/01/21 at 2:23 PM, she stated she normally would go into each resident's room and ask them if they have had a BM. CNA N stated the facility CNAs monitor BM's to make sure that a resident is not getting constipated. BM's are charted under the outputs in the EMR and should be done each shift. In an interview on 09/01/21 at 2:37PM Licensed Nurse (LN) H stated, BM's are monitored daily by Administrative Nurse E, she prints out a daily report of residents that have gone three days without a BM and the Bowel Brigade protocol would begin. BM's show up under vitals as output and in a progress note. The aides are supposed to ask a resident every time the vital signs are obtained if they have had a BM. In an interview with Administrative Nurse D on 09/01/21 at 3:51PM she stated each morning a report is ran that shows who has gone three days without a BM. That list is given to the staff nurses and the Bowel Brigade protocol would be started. The undated facility policy "Drug Regimen Review" documented: Monitoring is the ongoing	F 757			

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F 757	Continued From page 31 collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to- ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal; detect any complications or adverse consequences of the condition or of the treatments; and support decisions about modifying, discontinuing, or continuing any interventions. The undated facility policy "Bowel Brigade" documented each patient will receive bowel care per general orders on a routine and consistent basis. The purpose of this policy is to ensure adequate bowel evacuation in order to prevent complications or discomfort that may arise related to acute constipation or fecal impaction. The facility failed to ensure bowel monitoring was documented and as needed medications administered as ordered for R23, which had the potential for increased risk for constipation. - The electronic medical record (EMR) for R81 documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), chronic kidney disease (loss of kidney function), acute respiratory failure (condition in which your blood does not have enough oxygen or has too much carbon dioxide causing shortness of breath and feeling extremely tired). The "Admission Minimum Data Set" (MDS) dated 08/22/21 for R81 documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R81 required	F 757			

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F 757	Continued From page 32 supervision to limited assistance of one for "activities of daily living" (ADLs) and she used the assistance of a walker for ambulation. R81 received a diuretic (a medication to promote the formation and excretion of urine). The "Nutritional Status Care Area Assessment" (CAA) dated 08/26/21, documented R81 was at alteration in weight due to the diagnosis of CHF. She was also on a 2000 milliliter (ml) a day fluid restriction. Staff was to continue to monitor weight weekly. The "Baseline Nutrition Care Plan" dated 08/16/21 documented daily weights to be obtained and a fluid restriction of 2000 milliliters a day. The "Orders" tab recorded an order dated 08/16/21 for daily weight for diagnosis CHF. The order directed staff to notify the physician of a weight gain greater than two pounds in a day or five pounds in a week. The "Treatment Administration Record" (TAR) in the EMR for the month of August 2021 for R81, lacked documentation for a daily weight on five of the 16 days reviewed. A note was charted on the TAR by the nurse that the Certified nurse Aid (CNA) was unable to obtain weight with no explanation as to why. Review of R81's weights on the TAR revealed she had a weight increase of 4.5 pounds between the dates of 08/24/21 and 08/26/21 (no weight was obtained on 08/25/21). The clinical record lacked evidence the physician was notified. Review of the "Physician Progress Notes" in	F 757			

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F 757	Continued From page 33 R81's chart noted no reference to the change in R81's weight on the above dates. In an interview on 09/01/21 at 2:23 PM with CNA N she stated that she never had to get a weight for a resident because typically the day shift aides get weights. She would get a weight at the beginning of her shift if she needed to get one for a resident. In an interview on 09/01/21 at 3:15PM with CNA M, she stated the only time a weight would not get done was if they got far behind. The nurse prints out a sheet that has a list of residents that need weighed that day. She would let the nurse know if a resident refused or if she was unable to get the weight done. Weights results are written on the weight sheet and then she would chart the weight under "Vitals" in the EMR. In an interview on 09/01/21 at 2:37PM with Licensed Nurse (LN) H, LN H stated that daily weights are obtained for resident's that have CHF or are on a fluid restriction, or if they were on dialysis. The CNA's are who obtain the weights and they typically tried to get them done before a resident has had breakfast. The aide should try at least twice to get the weight, then tell they nurse that they were unable to get the weight or if the resident refused, then she would go in herself and ask the resident if she could get there weight. If they still refused, then she would chart a note on their TAR as well as a progress note. The weights are charted by the nurses. The nurse manager monitors the weights and reports changes to the physician. If a weight has not been obtained for more than three days, then she would call the physician to notify him if there was a change of two pound or more.	F 757			

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F 757	Continued From page 34 In an interview on 09/01/21 at 3:27 PM LN G stated that a resident could sign a refusal form to refuse getting their weight taken; but staff should try at least twice to obtain the weight before having the resident sign a refusal form. The physician should be notified when there is a weight change of more than two pounds in a day or five pounds in a week. In an interview on 09/01/21 at 3:51 PM Administrative Nurse D stated that weights were done as ordered either daily or weekly by the CNA. If CNA staff were unable get the weight, the nurse should try to get a weight and if they were unable to obtain the weight, they would chart not able to obtain. Weight changes, if noticed by CP, would be noted on a physician progress note. The physician will note any weight changes in his progress notes as he was in the facility daily. The undated facility policy "Drug Regimen Review" documented: Monitoring is the ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to- ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal; detect any complications or adverse consequences of the condition or of the treatments; and support decisions about modifying, discontinuing, or continuing any interventions. The undated facility policy "Drug Regimen Review Policy" The undated facility policy "Weights" documented: The clinical nurse manager will post all residents requiring charting for weight variances, please chart every shift three times	F 757			

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F 757	Continued From page 35 daily speaking to the problem; ensure physician is notified of weight change. The facility failed to ensure that daily weights were obtained and reported to the physician as ordered, which had the potential for unnecessary medication administration or complications related to CHF. - R82's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension (elevated blood pressure). The "Admission Minimum Data Set" (MDS) dated 08/19/21 documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented that R82 required extensive assistance of one staff member for activities of daily living (ADL's). The MDS documented R82 received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication for six days. anticoagulant (class of medications used to prevent the formation of blood clots) medication for seven days, and antibiotic (class of medication used to treat bacterial infections) medication for four days. R82's "Nutritional Status Care Area Assessment" (CAA) dated 08/26/21 documented she was at risk for alteration in weight related to her increase edema and staff to monitor her weight.	F 757			

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F 757	Continued From page 36 R82's "Baseline Care Plan" dated 08/13/21 directed staff to monitor weight daily. Review of the EMR under the "Orders" revealed physician orders: Daily weight, diagnosis CHF dated 08/13/21. Fluid restriction: 200 cubic centimeter (CC) daily (360cc with breakfast, 240cc with lunch, 240cc with dinner, 580cc each shift in room, diagnosis CHF and hyponatremia (low sodium), dated 08/13/21. Lasix (diuretic- medication to promote the formation and excretion of urine) tablet 20 milligrams (mg) by mouth, diagnosis edema (swelling due to fluid accumulation) dated 08/30/21. Review of the EMR under "Medication Administration Record" documented on 08/17/21 resident refused weight; 08/19/21 "Certified Nurse Aide" (CNA) did not obtain weight; 08/20/21 CNA did not obtain weight; 08/21/21 CNA did not obtain weight; 08/25/21 resident unavailable; 08/29/21 resident was unavailable. Review of the clinical record lacked physician notification of daily weight not completed or resident refusal. Review of the EMR under "Progress Notes" dated 08/30/21 at 11:43 AM R82 was transferred out of the facility to the hospital, per request of her representative related to increased bilateral lower extremity edema. On 08/30/21 at 11:43 AM R82 was transported	F 757			

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F 757	Continued From page 37 out of the facility on gurney by two emergency medical staff. On 09/01/21 at 02:35 PM in an interview, CNA N stated she had never obtained a weight for a resident. On 09/01/21 at 02:45 PM in an interview, Licensed Nurse (LN) H stated a daily weight were obtained for a resident with CHF to monitor for increased edema. LN H stated that a daily weight would be obtained prior to breakfast by the CNA and reported to the nurse. LN H stated that the physician would be notified if a daily weight was not obtained for several days. On 09/01/21 at 03:35 PM in an interview, CNA M stated the nurse notified the CNA of who needed a daily weight and if dayshift could not get the weight, then evening shift would attempt to weigh the resident. On 09/01/21 at 03:53 PM in an interview, Administrative Nurse D stated the CNA obtained the weekly or daily weights as ordered by the physician. Administrative Nurse D stated the physician was in the facility every day and would have documented weight changes in their progress notes. The facility "Drug Regimen Review" policy lacked a date documented a licensed pharmacist would review a resident's drug regimen including the resident's chart monthly. The CP may need to conduct the medication regimen review more frequently depending on the resident condition, review of the short stay residents and risk of adverse consequences. The licensed pharmacist will report irregularities to the attending physician,	F 757			

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F 757	Continued From page 38 the facility's medical director and the director of nursing to be acted upon. The facility failed to ensure the daily weights for R82 had been obtained to monitor for fluid retention related to CHF, which had the potential of unnecessary diuretic medication administration thus leading to possible harmful side effects. - R78's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and chronic kidney disease (damaged kidneys and unable to filter blood the way they should). The "Admission Minimum Data Set" (MDS) dated 08/13/21 documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented that R78 required extensive assistance of one staff member for activities of daily living (ADLs). The MDS documented R78 had received antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions] medication for six days, and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medication for seven days during the look back period. R78's "Dehydration/Fluid Maintenance Care Area Assessment" (CAA) dated 08/19/21 documented	F 757			

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F 757	Continued From page 39 he was at risk for alteration in fluid volume to chronic kidney disease and him receiving dialysis (a process of removing excess water, solutions and toxins from the blood). Staff to monitor fluid. R78's "Nutritional Status CAA" dated 08/19/21 documented nursing staff was to monitor blood glucose levels as ordered by the physician to monitor for hypoglycemia (less than normal amount of sugar in the blood) and hyperglycemia (greater than normal amount of glucose in the blood). R78's was at risk alteration in weight related to dialysis and staff was to continue to monitor weight. R78's "Care Plan" dated 08/27/21 documented medication and treatment would be administered per physician orders and bowel protocol to was to be followed. The "Care Plan" documented to obtain blood glucose levels and monitor for adverse side effects of medications and to notify the physician as needed. The "Care Plan" documented the Consultant Pharmacist (CP) was to review medications and alert the physician of any recommendations. Review of the EMR under the "Orders" revealed physician orders: MiraLAX (laxative- medication used to stimulate or facility evacuation of the bowels) powder 17 grams by mouth daily for constipation (hold for loose stools) dated 08/07/21. Tradjenta (medication used to lower blood glucose levels) tablet five milligrams (mg) by mouth daily for diabetes dated 08/07/21. Check blood glucose every morning. Notify	F 757			

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F 757	Continued From page 40 physician if blood glucose is less than (<) 60 or greater than (>) 400 dated 08/07/21. Weight Monday, Wednesday and Friday dated 08/09/21. Review of the EMR under "Vitals" for bowel movements (BM) for August 2021 revealed 08/08/21 to 08/11/21 (four days) no documented BM; 08/25/21 to 08/29/21 (four days) no BM documented. The clinical record lacked documentation any as needed medication or physician was notified. Review of the EMR under "Vitals" for weights revealed: 08/11/21 Certified Nurse Aide (CNA) did not obtain weight; 08/13/21 CNA did not obtain weight; 08/18/21 due to condition weight was not obtained; 08/20/21 CNA did not obtain weight; 08/25/21 resident refused weight; 08/27/21 resident was not available to obtain weight. The clinical record lacked documentation that the physician was notified of resident's refusal or of the weights not consistently obtained as ordered by physician. Review of the EMR under "Medication Administration Record" (MAR) for blood glucose levels for August 2021 revealed: 08/10/21 resident at dialysis; 08/18/21 resident refused; 08/19/21 resident was unavailable; 08/20/21 resident refused; 08/21/21 resident was at dialysis; 08/24/21 resident was at dialysis; 08/26/21 resident was unavailable; 08/28/21 resident was at dialysis; 08/29/21 resident refused; 08/31/21 resident was at dialysis. The clinical record lacked documentation that the physician was notified of resident refusal or staff was unable to monitor blood glucose levels as	F 757			

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F 757	Continued From page 41 ordered. 09/01/21 at 10:37 AM nursing staff assisted R78 on to his bed, head of bed was elevated, no complaint of pain or discomfort was noted. R78 lacked his skin protective sleeves to his upper extremities for protection and his pressure reducing device for his left lower extremity was not applied. On 09/01/21 at 02:35 PM in an interview, CNA N stated she had never obtained a weight for a resident. CNA N stated she monitored residents bowel movements to prevent constipation and everyone was able to document in the computer for bowel movements. On 09/01/21 at 02:45 PM in an interview, Licensed Nurse (LN) H stated a daily weight were obtained for a resident with CHF to monitor for increased edema. LN H stated that a daily weight would be obtained prior to breakfast by the CNA and reported to the nurse. LN H stated that the physician would be notified if a daily weight was not obtained for several days. LN H stated blood glucose should be obtained prior to breakfast to monitor for diabetes mellitus, should someone refuse for several days in row the physician would be notified and documented in the nurses note. LN H stated that the unit manager prints off the bowel monitoring sheet of the residents who had not had a bowel movement for 72 hours and the nurse would follow up with the bowel protocol or notify the physician. LN H stated that if as needed medication (PRN) was given for constipation it would have been documented on the MAR. On 09/01/21 at 03:35 PM in an interview, CNA M stated the nurse notified the CNA of who needed	F 757			

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F 757	Continued From page 42 a daily weight and if dayshift could not get the weight, then evening shift would attempt to weigh the resident. On 09/01/21 at 03:53 PM in an interview, Administrative Nurse D stated the CNA obtained the weekly or daily weights as ordered by the physician. Administrative Nurse D stated the physician was in the facility every day and would have documented weight changes in their progress notes. Administrative Nurse D stated bowel monitoring sheet is printed off by the nurse manager and given to the unit nurse to follow up. Administrative Nurse D stated that if a PRN was given it would be charted on the MAR. Administrative Nurse D stated if a resident refused a blood glucose test for several days the physician would have been aware, because she was at the facility almost every day and would have documented on the physician progress note. The undated facility policy "Drug Regimen Review" documented: Monitoring is the ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to- ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal; detect any complications or adverse consequences of the condition or of the treatments; and support decisions about modifying, discontinuing, or continuing any interventions. The facility failed to obtain weights and blood glucose levels consistently as ordered by the physician and monitor bowel movements for R78. This deficit practice had the potential for	F 757			

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F 757	Continued From page 43 unnecessary medication use and unwarranted side effects of constipation, hyperglycemia, hypoglycemia, and fluid volume overload for related to kidney failure.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §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	F 758			

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F 758	Continued From page 44 §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 identified a census of 38 residents. The sample included 13 residents with five residents reviewed for medications. Based on record review, observations and interviews, the facility failed to ensure Resident (R)18 was free from unnecessary psychotropic (affecting mood or thinking) medications when the facility failed to ensure R18's as needed (PRN) lorazepam (psychotropic antianxiety medication) had the required stop date of 14 days. This placed R18 at risk for unnecessary medications and side effects associated with lorazepam use. Findings included: - R18's electronic medical record (EMR) recorded diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), falls and altered mental status. The "Admission Minimum Data Set " (MDS)	F 758			

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F 758	Continued From page 45 dated 08/05/21 recorded R18 had a Brief interview for mental Status (BIMS) score of eight which indicated severely impaired cognition. The MDS recorded R18 had no behaviors. The MDS recorded R18 did not receive an antianxiety medication during the lookback period. The "Cognitive Loss Care Area Assessment" (CAA) dated 08/05/21 recorded R18 was forgetful and received therapy for cognitive skills. The CAA recorded medications were reviewed by the physician and adjusted as needed. Staff provided reorientation as needed and assisted with activities of daily living (ADLs). The "Psychotropic Medication CAA" did not trigger. The "Care Plan" documented a problem, dated 08/19/21 which recorded R18 had an alteration in mood status (anxiety) evidenced by restlessness. The "Care Plan" recorded interventions dated 08/19/21 which directed staff to administer medications, Ativan (lorazepam), per physician order. It further directed staff to monitor for the side effects of the psychotropic medication which included sedation, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision and skin rash. The "Care Plan" further directed staff to monitor for increased signs of anxiety and offer counseling services as needed. The "Orders" tab of the EMR recorded a physician order dated 07/30/21 for lorazepam 0.5 milligrams (mg) give 0.25 mg by mouth every eight hours PRN. The order was "open-ended" and did not contain a specific stop date. The "Psychopharmacological Medication Review" dated 08/06/21 and signed by a nurse but lacking	F 758			

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F 758	Continued From page 46 a pharmacist signature recorded R18 received lorazepam 0.25 mg for anxiety. The frequency recorded "0." The form indicated R18 consented to the psychotropic medication and had been notified of the possible side effects. The form indicated the therapy was not initiated "in-house" and there was no duplication of therapy. The form indicated the medication as appropriate for use in geriatric (elderly) patients, was within the recommended guidelines and had an appropriate diagnosis. Side effects monitoring were in place and R18's plan of care addressed the use of the medication. The form lacked evidence the physician reviewed, indicated a need for ongoing therapy and lacked a duration for the PRN medication. R18's medical record lacked documentation of physician evaluation and rationale for continued lorazepam use and lacked a duration for the PRN order. The "Medication Administration Record" (MAR) for August 2021 recorded 18 received the PRN lorazepam on 08/13/21, 08/16/21, 08/20/21, 08/21/21, 08/22/21, 08/23/21, 08/24/21, 08/25/21, 08/26/21, 08/27/21, twice on 08/30/21, and on 08/31/21. The "Monthly Medication Review" dated 08/26/21 by Consultant Pharmacist (CP) GG documented R18 had an active order for PRN lorazepam. CP GG recommended if appropriate to extend the order beyond 14 days, ensure proper documentation existed in R18's medical record and ensure it indicated the duration for the PRN order. On 08/31/21 at 12:27 PM R18 sat up in bed and	F 758			

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F 758	Continued From page 47 ate lunch. She appeared comfortable, and no behaviors were observed. On 09/01/21 at 02:45 PM Licensed Nurse (LN) H stated she was unaware of the need for any type of evaluation or risk versus benefit review for nay medications. She also stated the only medications the required a stop date were antibiotics. On 09/01/21 at 03: 53 PM Administrative Nurse D stated medications risk versus benefit evaluations were completed by LN K. Administrative Nurse D declined to offer a further statement other than to say "they're done." The undated "Psychopharmacological Med Management "policy recorded psychotropic medication included antianxiety medication. It further directed residents admitted to the facility receiving psychotropic medications would receive a comprehensive and ongoing evaluation of their current medication regimen. Evaluation examined appropriateness of medication, dosage, duration and diagnosis. The policy further directed all PRN psychotropic medications would not exceed 14 days unless medically necessary and rational documented by the resident's physician. The facility failed to ensure R18 was free from unnecessary psychotropic medication use when the facility failed to ensure the physician evaluated and documented a rationale for continued use of PRN lorazepam and failed to ensure a specified duration for the PRN psychotropic lorazepam. This placed R18 at increased risk for unnecessary medications and increased s risk for adverse effects related to psychotropic medication use.	F 758			

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census of 37 residents, two medication carts, one treatment cart, and one medication storage room. Based on observations, record reviews, and interviews, the facility failed to discard expired medications and influenza (a common viral infection that can be deadly, especially in high-risk groups) vaccinations; failed to properly store and date Tubersol (tuberculin purified protein derivative [PPD- sterile solution of a purified protein derivative used in the diagnosis	F 761			

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F 761	Continued From page 49 of tuberculosis]); failed to properly store and date insulin (medication used to treat a chronic condition that affected the way the body processed blood sugar); failed to properly store and date medicated eye drops; and failed to properly store and date a medicated inhaler (device used for administering a medication that was breathed in to relieve asthma [disorder of narrowed airways that caused wheezing and shortness of breath] or other lung disorders). This deficient practice had the risk for unwarranted physical complications and ineffective treatment for affected residents. Findings included: - On 08/30/21 at 09:10 AM, the 200 hall medication cart revealed a bottle of cetirizine (allergy medication) that expired July 2021 and an Ozempic (non-insulin medication used to help improve blood sugars) pen not labeled with resident name or dated. On 08/30/21 at 09:18 AM, the medication storage room revealed the following: - Four vials of Flucelvax influenza vaccinations, expired 06/30/2021 - Three boxes of Afluria influenza vaccination prefilled syringes, expired 06/30/2021 - Four vials of Tubersol, opened and not dated On 08/30/21 at 09:26 AM, the 100 hall medication cart revealed the following: - One bottle of cetirizine, expired July 2021	F 761			

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F 761	Continued From page 50 Two bottles of Timolol (medication used to treat high pressure in the eye) eye drops, opened and not dated Two insulin lispro (Humalog) pens, not dated Three Lantus insulin pens, not dated One Trelegy (medication used to prevent and control symptoms of asthma) inhaler, opened and not dated On 08/30/21 at 09:10 AM, Licensed Nurse (LN) I stated the Ozempic pen was refrigerated and the resident it belonged to received it this morning. LN I stated the pen came out of a box so it was not labeled when removed from the box. On 08/30/21 at 09:21 AM, LN I stated she was not sure how long Tubersol vials were good once opened. On 09/01/21 at 04:28 PM, LN J stated the facility checked the medication storage room and medication carts every couple of months. She stated when a new insulin pen was opened, the bag was dated, and inhaler boxes were dated when opened. She had not seen a medication reference sheet for expiration dates. On 09/01/21 at 04:32 PM, Administrative Nurse D stated medical records was responsible for checking the medication storage room and medication storage carts monthly. She stated when a new insulin pen, inhaler, or eye drop bottle was opened, it was dated. The facility's "Diabetes: Insulins and Storage Requirements 2018" reference guide from	F 761			

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F 761	Continued From page 51 pharmacy directed insulin lispro pens were good for 28 days once opened or removed from refrigeration, Lantus insulin pens were good for 28 days once opened or removed from refrigeration, and Ozempic was good for 56 days once opened or removed from refrigeration. All three of these insulins were to be stored at room temperature once opened. A review of the manufacturer's instructions for Tubersol vials directed Tubersol vials were discarded 30 days after first opening. A review of the manufacturer's instructions for timolol eye drops directed timolol eye drops were discarded four weeks after opening. A review of the manufacturer's instructions for Trelegy inhaler directed Trelegy inhalers were discarded six weeks after opening the foil packet. The facility's "Medication Storage" policy, not dated, directed medications were stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The policy directed outdated medications were immediately removed stock and disposed of according to procedures for medication disposal. The policy directed drug references were available for all drugs used in the facility. The facility failed to ensure expired medications and influenza vaccinations were discarded after expiration date; failed to properly store and date Tubersol vials, insulin pens, eye drops, and an inhaler. This deficient practice had the risk for unwarranted physical complications and ineffective treatment for affected residents.	F 761			

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F 880 F 880 SS=D	Continued From page 52 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880			

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F 880	Continued From page 53 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 37 residents, the sample included 13 residents. Based on observations, record reviews, and interviews, the facility failed to perform hand hygiene after doffing (removing) gloves or before donning (putting on) gloves during dressing changes. This deficient practice had the risk to spread illness and infection to all residents and prolonged wound healing for Resident (R) 179 and 78.			F 880			

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F 880	Continued From page 54 Findings included: - On 09/01/21 at 09:30 AM, Administrative Nurse E performed hand hygiene in R179's sink. She then donned gloves and elevated R179's left arm on a pillow in preparation for the peripherally inserted central catheter (PICC- a form of intravenous access that can be used for a prolonged period of time) dressing change. She doffed gloves then donned new gloves, no hand hygiene performed between. She removed the previous dressing. On 09/01/21 at 09:34 AM, Administrative Nurse E doffed gloves and performed hand hygiene. She opened the sterile (meaning free from microorganisms) dressing change tray on R179's bedside table. She opened her additional packaged supplies that sat on the bedside table and dropped into the sterile tray appropriately. She donned sterile gloves without performing hand hygiene. She asked another nurse to bring a smaller pair of sterile gloves. She doffed sterile gloves. On 09/01/21 at 09:40 AM, Administrative Nurse E received new pair of sterile gloves from the other nurse and donned sterile gloves, no hand hygiene performed before she donned second pair of sterile gloves. After she cleansed R179's PICC line insertion site and surrounding skin, she applied the dressing as ordered. Once finished with the dressing change, she doffed sterile gloves. No hand hygiene performed after doffing gloves. She donned gloves and proceeded to assist resident. On 09/01/21 at 10:41 AM, Administrative Nurse E	F 880			

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F 880	Continued From page 55 performed hand hygiene and donned gloves. She prepared her supplies for R78's dressing change on a clean barrier which she then placed on R78's bed. R78 sat in a wheelchair in his room, Administrative Nurse E cleansed R78's left shin area and applied skin prep (a solution when applied that forms a protective waterproof barrier on the skin) then removed a soiled dressing from top of left foot. She doffed gloves then donned clean gloves, no hand hygiene between. She applied skin prep to top of left foot then applied dressing. She doffed gloves and donned clean gloves, no hand hygiene between. She assisted R78 into bed, doffed gloves and donned clean gloves, no hand hygiene between. Administrative Nurse E cleansed R78's coccyx (small triangular bone at the base of the spine) area, doffed gloves then donned clean gloves, no hand hygiene between. She applied barrier cream to coccyx region then doffed gloves. On 09/01/21 at 03:15 PM, Certified Nurse Aide (CNA) M stated hand hygiene was performed before entering or exiting resident rooms, before and after eating, after touching hair or face, and after doffing gloves. On 09/01/21 at 03:26 PM, Licensed Nurse (LN) G stated hand hygiene was performed before entering or exiting resident rooms, after doffing gloves and before putting on gloves, and whenever hands were soiled. On 09/01/21 at 03:50 PM, Administrative Nurse D stated hand hygiene was performed before entering and exiting resident rooms, between meal tray deliveries, and after doffing and before putting on gloves.	F 880			

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F 880	Continued From page 56 The facility's "Handwashing" policy, not dated, directed handwashing occurred before applying and after removing gloves, during any treatment as dictated by professional standards, before handling sterile supplies, and after contact with any equipment or environmental surface that might have been soiled or contaminated. The facility failed to perform hand hygiene after doffing and before donning gloves during dressing changes. This deficient practice had the risk to spread illness and infection and prolong wound healing for R179 and R78.	F 880			