

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

PRINTED: 04/30/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/15/2021	
NAME OF PROVIDER OR SUPPLIER DELMAR GARDENS OF OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 12100 W 109TH STREET OVERLAND PARK, KS 66210			
(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			F 000			
F 684 SS=D	The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 4/20/21. A revised copy of the deficiencies was sent to the provider on 04/27/21. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 100 residents. The sample included 21 residents. Based on observation, record review, and interview the facility failed to provide necessary assessments, treatments, and cares to maintain appropriate wheelchair positioning for one sampled resident, Resident (R) 28. Findings Included: - R28's "Annual Minimum Data Set" (MDS), dated 04/04/2021, recorded the resident had modified independent skills for decision making, with short and long term memory problems. The MDS recorded R28 required extensive staff assistance with positioning and transfers, impaired balance required staff assistance to			F 684			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/20/2021

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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F 684	Continued From page 1 stabilize, and used a wheelchair for mobility. The "Activities of Daily Living Care Plan," dated 04/05/21, recorded R28 was at risk for chronic pain due to scoliosis (curvature of the spine), and directed staff to routinely assist the resident with repositioning. The care plan recorded R28 used a wheelchair for mobility, and directed staff to provide positioning and support devices in the wheelchair to maintain posture and reduce pain. The "Occupational Therapy" (OT) evaluation, dated 05/22/20, recorded OT staff implemented a seat platform underneath R28's wheelchair cushion to align the resident's pelvis and back, and maintain the resident's appropriate wheelchair positioning. The "Occupational Therapy" evaluation, dated 04/16/21, recorded non-therapy staff removed the approved platform and seat cushion from R28's wheelchair, and placed an incorrect cushion in the resident's wheelchair that caused R28 to lean to the right. The evaluation recorded OT staff placed the appropriate platform and seat cushion in R28's wheelchair, and corrected the resident's leaning posture. On 04/13/21 at 07:36 AM, observation revealed R28 sat in her wheelchair near the nurse's station, leaned to the right with her torso pressed against the wheelchair arm, and her right arm rested on the wheelchair wheel. Continued observation revealed six staff walked past R28, and made no attempts to reposition the resident in her wheelchair. On 04/13/21 at 12:25 PM, observation revealed R28 sat in her wheelchair at the dining table,	F 684			

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F 684	Continued From page 2 leaned right with her torso pressed against the wheelchair arm, and the resident's head, tilted to the right, rested on her right shoulder. Continued observation revealed R28 used her right arm to reach for her food and drinks, and four staff in the dining room made no attempts to reposition the resident in her wheelchair. On 04/14/21 at 11:02 AM, Certified Medication Aide (CMA) R stated she frequently observed R28 leaning to the right in her wheelchair, and the resident's wheelchair had no positioning devices. CMA R stated staff placed pillows and rolled blankets in R28's wheelchair at times to assist the resident from leaning in her wheelchair. On 04/14/21 at 11:35 AM, Licensed Nurse (LN) G stated R28 leaned in her wheelchair, had no positioning devices in her wheelchair, and the resident required extensive staff assistance to reposition in her wheelchair. LN G stated he had not reported R28's leaning problems to therapy services, and he was not aware if therapy staff had assessed R28 for wheelchair positioning. On 04/15/21 at 08:05 AM, Administrative Nurse D stated nursing staff should monitor R28's wheelchair positioning, and report problems to therapy staff to assess and implement interventions. On 04/15/21 at 11:09 AM, Therapy Staff GG stated nursing staff had not reported R28's wheelchair positioning problems. Therapy staff GG stated OT staff evaluated R28 in the past for wheelchair positioning, and implemented positioning devices to maintain the resident's correct wheelchair posture.	F 684			

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F 684	Continued From page 3 The facility's undated "Wheelchair" policy directed staff to monitor residents' appropriate wheelchair positioning to maintain the residents' safety, function and quality of life. The facility failed to provide necessary assessments, treatments, and cares for R28 to maintain appropriate wheelchair positioning, placing the resident at risk for decreased mobility and pain.	F 684			
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 100 residents. The sample included 21 residents. Based on observation, record review, and interview the facility failed to provide nutritional supplements and implement protective interventions to assist wound healing for one sampled resident, Resident (R) 28. Findings Included:	F 686			

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F 686	Continued From page 4 - R28's "Annual Minimum Data Set" (MDS), dated 04/04/2021, recorded the resident had modified independent skills for decision making, with short and long term memory problems. The MDS recorded R28 required extensive staff assistance with positioning and transfers, was at risk to develop pressure ulcers and had Moisture Associated Skin Damage (MASD). The "Pressure Ulcer and Wound Care Plan ," dated 04/05/21, recorded R28 was at risk for skin breakdown, and directed staff to consult wound care specialist to evaluate wounds, develop interventions, and implement wound treatments for the resident. The care plan directed staff to notify the Registered Dietician (RD) to assess R28's nutritional needs for wound healing. The "Wound Consultant" evaluation, dated 02/03/21, recorded R28 had a wound on her right lateral ankle due to a laceration from a foreign body (wheelchair). The evaluation recorded staff placed a dressing on the wound and installed padding on the wheelchair. The "Wound Consultant" evaluation, dated 03/08/21, directed staff to continue current treatment for R28's right ankle wound, apply a Prevelon boot (padded boot to prevent injuries) on the resident's right foot at all times, and ensure no shoe placed on the resident's right foot. The "Wound Consultant" evaluation, dated 04/04/21, recorded R28's right ankle wound improved, covered with eschar (dry dark scab), no drainage or signs of infection, and directed staff to continue with current treatment.	F 686			

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F 686	Continued From page 5 Review of R28's medical record lacked documentation the Registered Dietician assessed the resident's nutritional needs to assist with wound healing, or staff provided R28 with nutritional supplements to enhance wound healing. On 04/13/21 at 07:36 AM, observation revealed R28 sat in a wheelchair near the nurse's station, and wore lace-up athletic shoes on both feet. On 04/14/21 at 07:49 AM, observation revealed R28 sat in a wheelchair in the dining room, and wore lace-up athletic shoes on both feet. On 04/14/21 at 11:39 AM, observation revealed R28 rested in bed while Licensed Nurse (LN) G completed her dressing change and wound treatment. Continued observation revealed R28's right ankle wound was approximately half an inch in diameter with a pink wound bed, no drainage, and no signs of infection. On 04/13/21 at 04:37 PM, Dietary Consultant HH stated she was not aware R28 had a wound for the past two months, and a nutritional assessment should be completed to implement nutritional interventions to assist with wound healing. On 04/14/21 at 01:14 PM, LN I stated R 28 had a wound on her right outer ankle for several months, and the resident had not received nutritional supplements or fortified foods to enhance wound healing. LN I stated R28 usually refused to wear the pressure relief boot, and wore lace-up athletic shoes on both feet.	F 686			

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F 686	Continued From page 6 On 04/14/21 at 03:10 PM, Certified Nurse Aide (CNA) M stated R28 had a wound on her right outer ankle, and wore lace-up athletic shoes on both feet. CNA M stated she was not aware R28 wore a pressure boot on her right foot until today. On 04/15/21 at 08:05 AM, Administrative Nurse E stated R28 had a right ankle wound for two months, staff had not notified the RD to complete a nutritional assessment for wound healing, and staff had not provided the resident nutritional supplements or fortified foods to enhance wound healing. Administrative Nurse E stated R28 refused the pressure relief boot most times, but staff should not place a shoe on the resident's right foot. The facility's "Wound Care" policy, dated August 2018, directed staff to notify the RD to assess residents with wounds, and provide the resident with supplements and foods as recommended by the RD. The policy directed staff to identify and implement interventions to protect the wound and prevent further damage. The facility failed to provide nutritional supplements and implement protective interventions to assist wound healing for R28, placing the resident at risk for worsened wound conditions.	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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F 689	Continued From page 7 §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 100 residents. The sample included 21 residents with five reviewed for accidents. Based on observation, record review, and interview, the facility failed to initiate a safety assessment for an electric lift recliner for Resident (R) 82 who fell from the recliner and sustained a fractured (broken bone) leg and failed to complete fall risk assessments as stated in the facility's policy. The facility also failed to use a properly sized lift sling for a transfer of R24 resulting in a near miss fall and failed to initiate an assessment for safe smoking for R41. Findings included: - R82's "Physician Order Sheet," dated 03/29/21, documented diagnoses of osteoarthritis (degenerative change to one or may joints characterized by swelling and pain), difficulty walking, fracture of femur (the bone in the thigh), major depression (major mood disorder), and anxiety disorders (mental or emotional disorders characterized by apprehension, uncertainty, and irrational fear). The "Annual Minimum Data Set (MDS)," dated 10/18/20, revealed she had a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. The resident needed extensive assistance of 1 person for bed mobility, needed extensive assistance of 2 persons for transfers, and walking did not occur. The resident had functional limitations in range of motion on both sides of her lower extremities and	F 689			

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F 689	Continued From page 8 used a wheelchair for mobility. She had one fall that was not a major injury since prior assessment. The "Quarterly MDS," dated 03/06/21, documented the resident had moderately impaired cognition with a BIMS score of 12, which indicated moderately impaired cognition. The resident required extensive assistance of two staff for bed mobility, dressing, toilet use, and transfers. The MDS recorded the resident had a fall in the last month prior to her re-entry into the facility, a fall in the last 2-6 months prior to her re-entry to the facility, and a fracture related to a fall in the last 6 months prior to her re-entry into the facility. The "Fall Care Area Assessment" (CAA), dated 10/18/20, recorded R82 as being a 95 year old female that had a history of osteoarthritis and difficulty walking. She required extensive assistance for transfers. The CAA recorded R82 received psychotropic (drugs that affect mental changes) medications which increased the risk of falling due to sedation and dizziness. The "Fall Care Plan," dated 02/26/21, documented the resident was at risk for falls related to weakness, history of anxiety, depressive disorder, osteoarthritis, fainting episodes, and possible side effects of medications. Fall Risk assessment should be performed on admission to the facility and quarterly thereafter. The Fall Care plan directed staff to keep the call light and frequently used items within reach of the resident. The following interventions dated 10/21/18 were included in the current care plan: Keep environment free from clutter. Assist resident with referral to therapy as	F 689			

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F 689	Continued From page 9 needed for decline and encourage participating in restorative therapy. Be alert for any complaints of dizziness with position changes. Before leaving the room make sure call light and other frequently used items are within reach. Encourage resident to use call light for assistance. Uses a wheelchair for mobility and depends on staff for assistance. Resident will wear safe footwear with transfers. Perform fall risk assessment upon admission and quarterly per facility protocol. After the fall on 02/24/21 the following interventions were added to the care plan: Resident has an electric chair in her room that she can power control up and down independently. The resident will continue to use the electric chair with controls without injury. Staff will assess my competency with the use of the control for safety. The "Johns Hopkins Fall Scale," (an assessment for predicting fall risk) completed 10/02/19, score was 15 indicating the resident was a high risk for falls. The "Morse Fall Scale," (an assessment for predicting fall risk) completed 04/09/21, a month after her re-admission to the facility, revealed a score of 45 which indicated the resident was a high risk for falls. Review of R82's "Medical Record" lacked a safety assessment for the use of an electric lift recliner chair. The 02/24/21 "Nursing Progress Note," stated the resident slid out of her lift recliner because the chair had gone all of the way up. The resident was found on the floor in front of the recliner with her left leg bent behind her and the resident was in a lot of pain. R82 transferred to a local hospital	F 689			

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F 689	Continued From page 10 for X-rays. The X-ray result revealed the resident had an impacted (broken ends of the bone are jammed together by the force of the injury) fracture of the left femur (upper leg bone). The 02/25/21 "Fall Team Meeting" included "Corrective Actions," that stated the resident's chair functioned properly and the resident upon return to the facility from the hospital would be re-evaluated for safety using her electric lift recliner. Family was agreeable to a different type of recliner if therapy determined R82 was unsafe upon her return. The 03/04/21 "Occupational Therapy Evaluation," noted they would collaborate with the resident's family to obtain an electric recliner without the lift function for safety to increase her time out of bed. Occupational therapy determined the resident was unsafe to operate a lift recliner and recommended a standard electric recliner without the lift component. On 04/13/21 at 10:20 AM, observation revealed the resident sat in the lift recliner watching TV. She stated she currently sat in the recliner that she fell out of six weeks ago when she broke her bone. The remote control for the chair was on the table next to the chair. On 04/14/21 at 12:30 PM, observation revealed the resident sat in the same lift recliner eating her lunch with the chair control next to her on the table. Interview on 04/14/21 at 01:50 PM with the resident's family member revealed neither Occupational Therapy or facility staff contacted them about the electric lift recliner being unsafe,	F 689			

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F 689	Continued From page 11 nor had they talked to them about buying an electric chair that was not a lift chair. On 04/14/21 at 01:20 PM, Certified Nurse Aide (CNA) N stated he did not know if the resident was safe to operate her electric lift recliner as she became confused at times. On 04/14/21 at 01:10 PM, Licensed Nurse (LN) J stated that she did not think the facility had a safety assessment for electric lift recliners, but Physical Therapy and Occupational Therapy could perform a safety evaluation on new admissions to the facility to determine whether they were okay to use the electric lift recliner. The Morse Fall Scale should be completed quarterly. On 04/14/21 at 01:14 PM, LN K stated she was unaware of any formal assessment for evaluating the safety of a resident using an electric lift recliner. On 04/14/21 at 02:50 PM, Administrative Nurse D verified there were only two fall assessments completed for the resident since the time of her admission. He verified the fall assessments should be completed quarterly. He stated when new admissions came to the facility Occupational Therapy and/or Physical Therapy would evaluate the resident regarding their safety in running a lift recliner. On 04/15/21 at 12:51, Administrative Nurse E stated that when a new admission came into the facility with an electric lift recliner, Occupational Therapy would do an assessment to ensure the resident was safe to operate the chair. The facility's "Fall Risk/Prevention Program"	F 689			

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F 689	Continued From page 12 policy, dated 01/01/21, stated the "Morse Fall Scale" assessment will be completed by the charge nurse on admission, re-admission, quarterly, or when there was a change in risk. The facility failed to provide a policy regarding safety assessment for electric lift/recliner chairs. The facility failed to complete the Morse Fall Scale quarterly assessments and failed to initiate a safety assessment for electric lift/reclining chair which placed R82 at risk while operating the recliner. R82 fell from her recliner on 02/24/21 and sustained a broken leg. - R24's undated "Physician Order Sheet," documented the resident had diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body, dementia (progressive mental disorder characterized by failing memory and confusion), and repeated falls. The "Annual Minimum Data Set" (MDS), dated 01/11/21 documented the resident had moderately impaired cognition. R24 required extensive to total dependence of one to two staff members for bed mobility and transfers. R24's weight was 101 pounds. The "Fall Care Area Assessment" (CAA), dated 01/11/21, documented the resident was at risk for falls due to her decreased cognition and poor safety awareness. The resident was non-ambulatory, but would try to self-transfer at times. The "Fall Care Plan," dated 03/30/21, documented the resident had a previous fall out of her Broda chair (a tilt in space positioning	F 689			

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F 689	Continued From page 13 chair), directed staff to observe the resident frequently and place the resident in a supervised area when out of bed and to provide checks on the resident when in her room as she was not likely to call for assistance. The care plan directed staff to use the Hoyer lift (an assistive device that allows for residents to be transferred between a bed and a chair) for transfers with two staff assistance. (The Care Plan lacked direction regarding the type of lift sling for staff to use during transfers.) The "John Hopkins Fall Scale,"(an assessment for predicting fall risk) completed on 10/16/19 and 07/22/20, recorded R24 as being a high risk for falls. On 04/07/21 R24's weight was 87.4 pounds. On 04/13/21 at 01:55 PM, Certified Nurse Aide (CNA) O and CNA P assisted R24 back to bed after lunch. The resident sat in the Broda chair with a lift sling underneath her. The two CNAs hooked up the lift sling to the Hoyer lift hooks. CNA P operated the Hoyer lift and placed the resident approximately four feet in the air. CNA O guided the resident over to the bed. When the top of the resident's body was over the edge of the bed, the resident slid out of the lift sling, with her buttocks first and her head second. R24's upper shoulders and head rested on the bed. R24's legs and feet were entangled in the lift sling. CNA P lowered the Hoyer lift and both aides were able to untangle the residents' legs from the lift sling and position her on the bed. CNA O verified they used an extra large lift sling for the transfer. On 04/13/21 at 03:44 PM, observation with Administrative Nurse E revealed the facility had	F 689			

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F 689	Continued From page 14 multiple sized lift slings available in the clean utility room which included two small lift slings and four medium lift slings. On 04/13/21 at 02:11 PM, CNA O stated that she just grabbed a lift sling out of the clean utility room, there were no small lift slings, so she just grabbed one that was available. CNA O verified the lift sling she used was an extra large and was too large for R24. CNA O stated that she received annual training on the use of lifts. On 04/13/21 at 02:11 PM, CNA P stated the CNAs don't have a lot of choice on the size of slings they use and sometimes they have to use what slings are available to get things done. On 04/13/21 at 02:29 PM, Licensed Nurse (LN) K stated the resident required two staff assistance with transfers using the Hoyer lift. On 04/15/21 at 03:35 PM, Administrative Nurse E verified both CNAs received training on the use of the Hoyer lift and slings. According to Joerns Healthcare sizing chart (who make the slings the facility was using), the extra small sling fits residents weighing 35-100 pounds. The small sling fits residents weighing 75-125 pounds. The extra large sling fits residents weighing 275 - 500 pounds. The facility's "Lift, Mechanical Full Body" policy, dated January 2017, stated to gather the necessary equipment and make sure you are using the correct pad (sling) for the lift selected. The facility failed to use the proper size of lift sling on R24, placing her at risk for falls and injury	F 689			

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F 689	Continued From page 15 during a transfer. - R41's "Quarterly Minimum Data Set" (MDS), dated 02/06/21, recorded R41 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R41 required supervision and oversight assistance of one staff for locomotion off the unit, and for transfers. The "Activities of Daily Living (ADL) Care Area Assessment", dated 02/06/21, documented the resident required one staff assistance with most ADLs, however he was able to participate in some ADLs. The 02/06/21 "Fall CAA" documented the resident was at risk for falls and the staff would observe/assess for increased fall risk due to weakness and post Cerebral Vascular Accident (CVA) 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). The "Behavioral Care Plan," dated 02/17/21, directed staff to keep the resident's cigarettes and lighter in the front office/reception area and provide R41 a time to go outdoors to a designated smoking area. The care plan lacked documentation regarding the resident's safe smoking assessment. The 02/11/21 at 11:19 AM Social Service Designee (SSD) Note documented the resident's family member discussed the resident desired to continue to smoke and shared the resident had been found smoking in a room at the last facility and bought cigarettes from other residents. The resident's family member stated if staff would	F 689			

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F 689	Continued From page 16 assist him to smoke outside, he would not try to smoke inside. The SSD discussed the process at the facility would include a smoking assessment and safety measures of keeping cigarettes and lighter at the front desk. The "Electronic Medical Record" (EMR) lacked documentation R41 had a smoking assessment since admission. On 04/12/21 at 10:20 AM, observation revealed R41 seated on the front patio smoking with the front desk receptionist and another resident. Continued observation revealed the resident used a walker to ambulate back into the building. On 04/14/21 at 07:50 AM, Administrative Nurse D verified when the resident admitted to the facility, documentation included that he smoked, and verified staff had not completed the assessment. The resident admitted to the facility on 02/02/21, was in quarantine for 10 days, and used a nicotine patch. The resident started smoking after he was out of quarantine and the facility failed to complete a smoking assessment. The facility's "Smoking" policy, dated August 2018, documented upon admission residents with a current or history of smoking who desired to keep smoking should be assessed for smoking privileges. Re-assessment/observation of smokers will be completed quarterly and/or with a significant change in condition. Residents who demonstrate judgment and insight of safety awareness will be allowed to keep their cigarettes in their room or on their person. However, the community would keep lighters and assist	F 689			

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F 689	Continued From page 17 residents during smoking times.	F 689			
F 692 SS=G	The facility failed to complete a smoking assessment for R41, who exited the facility's building, to smoke a cigarette, placing the resident at risk for accidents and injury. Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 100 residents. The sample included 21 residents with four reviewed for nutrition. Based on observation, record review, and interview, the facility failed to follow the registered dietitians' recommendations for one of four sampled residents. Resident (R) 24 had an	F 692			

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F 692	Continued From page 18 18.7% weight loss in one month (02/07/21-03/07/21) and 11.9% weight loss in 3 months (01/07/21-04/07/21). Findings included: - R24's undated "Physician Order Sheet," documented the resident had diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body, dementia (progressive mental disorder characterized by failing memory and confusion), and dysphagia (swallowing difficulty). The "Annual Minimum Data Set" (MDS), dated 01/11/21 documented the resident had moderately impaired cognition. R24 required extensive to total dependence of one to two staff members for bed mobility, and transfers and did not have any weight loss. R24 did not have any trouble with chewing or swallowing and required one staff assistance for eating. The "Nutrition Care Area Assessment" (CAA), dated 01/11/21, documented the resident received pureed diet with nectar thickened liquids. She required extensive assistance from staff to consume meals, weighed 99 pounds, and received physician ordered supplements. Resident to be weighed monthly or weekly per current orders. The "Nutrition Care Plan," dated 03/30/21, documented the resident had the potential for weight loss and inadequate fluid/food consumption related to impaired cognition, dysphagia, and spinal cord injury due to a fall. The care plan directed staff to check weights as ordered and notify the doctor, registered dietitian,	F 692			

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F 692	Continued From page 19 and family of significant weight loss greater than 5% over one month or 10% over 6 months. The Registered Dietician (RD) was to monitor weights, labs, intakes, and make recommendations as needed. The "RD Review" for weight loss, dated 03/11/21, documented an 18.7% weight loss in one month, a 16.2% weight loss for 3 months, and a 15.2% weight loss in 6 months. The RD asked nursing staff to notify the resident's family of the weight loss and ask if they would allow Mighty Shakes (a nutritional supplement with extra calories and protein) twice a day to be started. The dietitian also recommended for staff to weigh weekly. Review of the "Electronic Medical Record" revealed the following monthly weights in the "Vitals" tab revealed: 11/07/20 - 98.8 pounds 12/07/21 - 99.6 pounds 01/07/21 - 99.2 pounds 02/07/21 - 102.7 pounds 03/07/21 - 83.5 pounds 18.7% weight loss in one month from 02/07/21-03/07/21 04/07/21 - 87.4 pounds 11.9% weight loss in three months from 01/07/21-04/07/21 (The RD recommended weekly weights on 03/11/21. Review of the weights in the medical record lacked documentation of weekly weights as recommended.) The "Nursing Progress Note," dated 04/02/21, recorded the resident had a 19 pound weight loss in one month, family refused supplements like Mighty Shakes, and staff called and left a voice message with a family member to inform her about weight loss.	F 692			

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F 692	Continued From page 20 The "Social Service Note," dated 04/05/21, recorded that social services spoke with the resident's family member about weight loss. The family member requested the facility continued to try and help her mother eat regular meals, but if she does not eat to try alternate items such as yogurt, Mighty Shakes, or milkshakes. The "Electronic Medication Administration" (EMAR) dated 04/14/21 recorded Mighty Shakes were implemented on 04/14/21 for three times a day. The two times the resident was recorded as taking the Mighty Shakes on 04/14/21 she drank 100%. On 04/13/21 at 12:21 PM, observation revealed staff served R24 ground Salisbury steak, mashed potatoes, pureed cream corn, pudding, water, and juice. CNA O sat down to assist her with her meal and the resident took one bite of meat, one drink of water, and pushed any further bites away. CNA O left the table and Administrative Nurse D then sat down next to the resident to assist her and the resident took several bites, pushed his hands away, and refused to take any more. A third staff, CNA P, sat down with the resident to assist her with her meal and the resident ate 50% of her meal and CNA P got her two Mighty Shakes because of her intake. The resident drank both Mighty Shakes. On 04/14/21 at 08:37 AM, observation revealed staff served R24 pureed sausage, pureed eggs, cream of rice cereal and a pureed pancake. She ate 100% of her meal with one staff assistance. On 04/13/21 at 12 :49 PM, CNA Q stated the resident did not like the food served here and her family used to bring her food into the facility, but	F 692			

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F 692	Continued From page 21 they had not been here lately. CNA Q stated it was hard to get R24 to eat. On 04/14/21 at 12:48 PM, CNA P stated the resident needed one staff assistance for eating. She ate sometimes, but other times she pushed our hands away telling us she doesn't want anything. CNA P was unaware if R24 received any kind of supplements. On 04/13/21 at 12:44 PM, Administrative Nurse D stated the resident did not eat well and sometimes if staff let her rest a bit and then reapproached her, she would take a few more bites. Administrative Nurse D stated it was hit or miss with her on whether she would eat and was unsure if the resident received supplements. On 04/13/21 at 05:15 PM, Consultant HH stated the resident had not been placed on any supplements. She stated they had placed the resident on weekly weights in March to monitor her weights. She would expect her recommendations to be followed by nursing staff. The administrator and Director of Nursing (DON) meet with her monthly to talk about the residents who triggered for weight loss. On 04/13/21 at 05:15 PM, Administrative Nurse E also stated the family did not want the resident on nutritional supplements because they did not want to pay for them. The family thought the supplements cost extra. The supplements do not cost extra. I would expect nursing staff to carry out the Registered Dietitians' recommendations within a couple of days of receiving them. The "Weight Monitoring" policy, dated November 2018, stated any resident with a weight loss of 5	F 692			

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F 692	Continued From page 22 pound will be re-weighed in 24 hours. Resident's with unplanned weight loss will be weighed weekly or as ordered by the physician. The charge nurse should immediately notify the physician, registered dietitian and resident representative of the weight loss. The Registered Dietitian will periodically review and make recommendations for dietary adjustments and the adjustments will be made. The facility failed to follow the registered dietitians' recommendations for R24 who had an 18.7% weight loss in one month and 11.9% weight loss in three months, placing the resident at risk for increased weight loss and nutritional deficit.	F 692			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding	F 693			

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F 693	Continued From page 23 including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: The facility had a census of 100 residents. The sample included 21 residents with review of one resident for G-Tube (Gastrostomy- surgical creation of an artificial opening into the stomach through the abdominal wall) feeding management. Based on observation, record review, and interview, the facility failed to provide Resident (R) 41 with appropriate physician ordered fluids before and after administration of Jevity (a high protein, fiber fortified therapeutic nutrition that provides complete, balanced nutrition for long or short term tube feeding) for 1 of 1 sampled resident. Finding included: - R41's diagnoses from the "Physician Order Sheet," signed 02/02/21, included dysphasia (swallowing disorder), gastroesophageal reflux disease (GERD) (stomach acid or bile flows into the food pipe and irritates the lining), and ataxia (the loss of full control of bodily movements). R41's "Admission Minimum Data Set" (MDS), dated 02/06/21, recorded R41 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R41 had a feeding tube, and received 51% or more nutritional supplement through tube feeding. The "Nutritional Care Area Assessment" (CAA), dated 02/06/21 summary for feeding tube recorded the resident was unable to eat at this time, received nothing by mouth, and had a	F 693			

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F 693	Continued From page 24 feeding tube upon admission. The CAA documented the resident received Jevity, 1.5 Calorie, to provide sufficient calories, and flushes. The "Tube Feeding Care Plan," dated 02/17/21, documented the resident was at risk for developing an infection related to the tube feeding. The "Nutritional Care Plan", dated 02/17/21, documented the resident had the potential for nutritional deficits related to the use of the feeding tube. The care plan documented the facility would consult the dietician, Speech Therapy, and would provide a balanced nutritional diet and prevent unintended weight loss. The "Physician Order" dated 02/06/21 directed the staff to give Jevity 1.5 calorie, 237 milliliters (ml), 1.5 cans at 8:00 AM, 1 can at 11:00 AM, 02:00 PM, 05:00 PM, and one-half can at 09:30 PM. The order directed staff to flush the feeding tube with 100 (ml) of water before and after the feedings. On 04/14/21 at 01:30 PM, observation revealed Licensed Nurse (LN) H, administered 30 ml of water, then 1 can of the nutritional supplement, followed by 30 ml of water through the G-tube. LN H failed to administer the correct amount of water before and after the nutritional supplement. On 04/14/21 at 07:50 AM, Administrative Nurse D verified the physician order was for 100 ml of water before and after nutritional supplement per G-tube. On 04/14/21 at 02:00 PM, LN H verified he gave 30 ml of water before and after the feeding and	F 693			

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F 693	Continued From page 25 the order was for 100 ml before and after the feeding. The "Medication Administration via Nasogastric or G Feeding Tube" policy, dated May 2009, documented the staff would administer the resident's medication per G-tube. The staff would check for placement and patency of the tube prior to any insertion of medications or water flush, and let gravity move the solution to the stomach. The facility failed to provide R41 the appropriate physician ordered fluid/flushes before and after the nutritional supplement, placing the resident at risk for inadequate hydration, and a clogged G-tube.	F 693			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755			

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F 755	Continued From page 26 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility has a census of 100 residents. The sample included 21 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to provide the physician ordered lidocaine (local anesthetic pain relief medication) gel or cream to ensure appropriate pain relief with dressing changes for one of five sampled residents, Resident (R) 48. Findings included: - R48's "Quarterly Minimum Data Set" (MDS), dated 02/22/21, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition and had a Stage two (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) pressure ulcer. The MDS recorded R48 required extensive staff assistance with Activities of Daily Living (ADLs), and had a diagnosis of diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to insulin). The	F 755			

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F 755	Continued From page 27 MDS recorded the resident had constant pain and received pain medication as needed. The "Pressure Ulcer Care Plan," dated 04/13/21, recorded R48 had a non-healing stage three pressure ulcer on his left heel and directed staff to monitor closely by the wound care team. The "ADL Care Plan," dated 04/13/21, recorded the resident had diagnosis of diabetes mellitus, neuropathy (damage, disease, or dysfunction of one or more nerves that is typically marked by burning or shooting pain, numbness, tingling, or muscle weakness and is usually caused by injury, infection and disease), and pain. The "Physician's Order" dated 03/17/21 directed staff to culture the left heel wound due to increased drainage and odor and add lidocaine 4% gel or cream to wound prior to the dressing change due to increased pain to the area. Review of the "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) lacked an order for the lidocaine. On 04/12/21 at 02:30 PM, observation revealed R28 in his bed and Administrative Nurse E and Licensed Nurse (LN) L changed the residents left heel dressing. The resident complained of pain when the nurse cleaned the wound and applied the new dressings. LN L failed to apply the lidocaine gel/cream to the residents left heel with the dressing change. On 04/12/21 at 02:45 PM, Administrative Nurse E verified the resident had an order for lidocaine to be applied to the wound prior to changing the dressing and they did not have it available. Staff	F 755			

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F 755	Continued From page 28 changed the dressing without the lidocaine since the physician order dated 03/17/21. The facility's "Wound Care Protocol" policy, dated August 2018, directed staff to assess the resident's ulcer and treatment should be determined based on the assessment. The policy documented the nurse would assess pain relative to the resident's ulcer and treatment. Notify the provider and administer medication as needed. Adjust and provide support surfaces for pain relief and pressure redistribution. The facility failed to provide R48 with the physician ordered lidocaine gel or cream to his foot wound prior to the dressing change, placing the resident at risk for pain and discomfort with cares.	F 755			
F 761 SS=D	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	F 761			

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F 761	Continued From page 29 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 had a census of 100 residents. Based on observation, record review, and interview the facility failed to record refrigerator temperatures in two of two medication room refrigerators, failed to place a readable specific resident name on a Lantus (long acting insulin used to lower blood sugars) insulin (a hormone that regulates the level of glucose or sugar in the blood) flex pen label, failed to place an open date on Resident (R) 43's Combivent inhaler (metered-dose inhaler containing a combination of two medications which relax muscles in the airways and increase air flow to the lungs), and failed to discard an expired bottle of Aspirin (a medication used for relief of pain and fever) 325 milligram (mg). Findings included: - On 04/12/21 at 10:30 AM, observation revealed in a medication cart, on the lower level of a Lantus flex pen with a smeared unreadable resident's name on the label. Further observation revealed the April refrigerator temperature log in the lower level medication storage room, where insulins were kept, lacked documentation regarding temperatures from 04/01/21 to 04/12/21. On 04/12/21 at 10:36 AM, observation revealed	F 761			

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F 761	Continued From page 30 the refrigerator temperature log, in the upper level medication room, where insulins were kept, dated August 2020, lacked current documentation regarding refrigerator temperatures. On 04/12/21 at 10:36 AM, observation revealed a medication cart, on the upper level, had a bottle of Aspirin 325 mg, expired on 01/21, and a treatment cart, on the upper level, had R43's Combivent inhaler which lacked a date when opened. On 04/12/21 at 10:30 AM, Licensed Nurse (LN) G verified the Lantus flex pen label had an unreadable resident's name, and discarded it in the sharps container in the medication room. LN G verified the April temperature log sheet, in the lower level medication room, lacked documentation regarding refrigerator temperatures, and stated the night shift was responsible for checking and recording the medication room refrigerator temperatures. On 04/12/21 at 10:36 AM, LN H verified the Aspirin expired on 01/21 and R43's Combivent inhaler lacked an open date. On 04/12/21 at 10:36 AM, Administrative Nurse D verified the night shift had not been documenting the refrigerator temperatures in the upper level medication storage room, where insulins were kept, since August of 2020. On 04/15/21 at 08:36 AM, Administrative Nurse E verified the April refrigerator temperature log, in the upper level facility medication storage room, lacked documentation regarding refrigerator temperature logs, he talked to evening shift and they reported to him they had been checking and	F 761			

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F 761	Continued From page 31 recording refrigerator temperature logs, but could not find documentation regarding prior months logs. The facility's "Medication Storage in the Facility" policy, dated September 2016, documented outdated, contaminated or deteriorated medications would be immediately removed from stock and disposed according to procedures for medication disposal. The policy documented medications requiring refrigeration or temperatures between 36 degrees Fahrenheit (F) and 46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring. The policy documented medication storage for any multi- dose injectable vial, insulin vial, insulin pen or any medication that creates the opportunity to be used for systemic intramuscularly (IM), intravenously (IV) or subcutaneous (SQ) route should be dated when opened with an expiration date of 30 days after being opened. According to Drugs@FDA: FDA-Approved Drugs, Combivent contained the following warning: The canister should be discarded after the labeled number of actuations (uses) has been used. The correct amount of medication in each actuation cannot be assured after this point, even though the canister is not completely empty. The facility failed to record refrigerator temperatures in two of two medication room refrigerators, failed to ensure a readable resident name was written on a Lantus flex pen label, failed to place an open date on R43's Combivent inhaler, and failed to discard an expired bottle of Aspirin, placing the residents at risk for use of ineffective medications.	F 761			

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F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility had a census of 100 residents. The sample included 21 residents. Based on observation, record review and interview, the facility failed to provide effective housekeeping and maintenance services for one of six halls, Upper Level Wing C. Findings included: -On 04/15/21 at 10:00 AM, during environmental tour, with Maintenance Staff U, observation of three rooms on Wing C revealed the following: A resident room on Wing C with numerous carpet red stains beside the bed and in front of the recliner approximately 4 inches (in) by 4 in, and 2 in by 3 in. The bathroom door had a hole in the wood, approximately 2 in by 2 in and 4 foot (ft) from the floor. The North wall, on entrance to the bathroom had plaster missing 8 in by 12 in and 2 ft from the floor. An electric recliner had numerous white stains on the seat of the chair, with the smell of urine. A resident room on Wing C had numerous carpet red stains beside the bed approximately 4 in by 4 in, and 2 in by 3 in with plaster missing along the base of the wall approximately 6-ft-long and 8 in from the floor. The bathroom door had a hole in the wood, approximately 2 in by 2 in, and 4 ft from the floor.	F 921			

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F 921	Continued From page 33 A resident room on Wing C with numerous carpet red stains beside the bed and in front of the recliner approximately 4 in by 4 in, and 2 in by 3 in, with two boxes with cans of nutritional supplement on the floor directly beside the head of the resident's bed. On 04/15/21 at 10:00 AM, Maintenance Staff U verified the above findings. Upon request the facility failed to provide a policy for Preventive Maintenance. The facility failed to provide effective housekeeping and maintenance services for the residents who resided on Wing C Upper Level.	F 921			