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	175306	A. BUILDING _____ B. WING _____	02/25/2020

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00149709.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		

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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from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 33 residents with 12 sampled including three for indwelling catheters. Based on observation, interview, and record review the facility failed to promote dignity for one Resident (R) 29 by not providing a privacy bag for his indwelling catheter drainage bag while in bed.

Findings included:

- Review of R29's "Physician Order Sheet" dated 02/03/20 revealed the following diagnoses; chronic kidney disease (kidney disease in which there is gradual loss of kidney function) and neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

Review of the "Admission Minimum Data Set" (MDS) dated 01/21/20 revealed a brief interview for mental status (BIMS) of 14, indicating intact cognition. The resident had an indwelling catheter.

Review of the "Care Area Assessment" (CAA) for "Urinary Incontinence and Indwelling Catheter" revealed the resident had a permanent indwelling urinary catheter in place due to neurogenic bladder diagnosis.

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Review of the "Care Plan" dated 02/07/20 revealed staff were to assist R29 with catheter care every shift and more often as needed, and they were to ensure R29's dignity by placing the tubing/catheter under clothing or bedding.

Observation on 02/24/20 at 07:35 AM revealed R29 rested in bed with a catheter drainage bag hung on the side of the bed with no privacy covering.

Observation on 02/25/20 at 07:01 AM R29 rested in bed with his indwelling catheter drainage bag hung on the side of his bed with no privacy covering.

Interview on 02/25/20 at 07:32 AM with "Certified Nurse Aide" (CNA) N revealed the catheter collection bag should be in a privacy bag.

On 02/25/20 at 07:33 AM LN H stated she did not think it necessary to have a privacy bag to cover the urinary catheter bag when the residents were in their rooms.

Interview on 02/24/20 at 07:50 AM with CNA M revealed she expected the catheter drainage bag to be in a privacy bag.

On 02/24/20 at 07:57 AM Licensed Nurse (LN) G verified R29 did not have a privacy bag covering his indwelling catheter drainage bag and that she knew the facility had the bag covers but did not know why R29 did not have one.

On 02/24/20 at 07:59 AM Administrative Nurse D stated when a resident was out of their room the drainage bag would be covered, but when they

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F 550	Continued From page 3 were in their rooms, they typically would not have them covered. She stated they planned to initiate it right now. Review of the facilities "Resident Rights and Responsibilities" policy dated 04/22/19 documented that the community would ensure the residents' right to a dignified existence. The facility failed to promote dignity for one R29 by not providing a privacy bag for his indwelling catheter drainage bag while in bed.	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		

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(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(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

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the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility census totaled 33 residents (R) with 12 residents in the sample and two residents reviewed for hospitalizations. Based on interview and record review the facility failed to ensure staff completed notifications of transfer and discharge hospitalization paperwork for R22's and R14's facility-initiated hospitalization transfers to include

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notification to the State Ombudsman.

Findings included:

- Review of resident (R) 22's 01/23/20 "Significant Change MDS" revealed diagnoses included Chronic Obstructive Pulmondary Disease (COPD, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and stroke/Cerebrovascular Accident (CVA, a 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).

Review of "Progress Note" dated 11/19/19 at 04:26 PM revealed the facility initiated a hospitalization transfer of the resident for COPD exacerbation and pneumonia.

Review of "Progress Note" dated 01/13/20 at 08:34AM the facility sent the resident to the emergency room (ER) for right sided weakness, slurred incoherent speech, and adventitious lung sounds.

The record lacked documentation/indication the facility staff notified the resident's Durable Power of Attorney (DPOA) of the 01/13/20 hospitalization transfer.

A request of transfer logs for the resident's hospitalizations from Social Services (SS) X on 02/24/20 at 08:23 AM for the time period of October 2019 to February 2020 and SS X verified the facility staff did not complete those logs.

Interview with Social Services (SS) X on 02/24/20 at 09:01 AM revealed the facility did not transmit

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the hospitalization transfers to the LTC Ombudsman.

Interview with Administrative Nurse D on 02/24/20 at 10:31 AM revealed she expected the faciltiy to send the hospital transfers to the State Ombudsman monthly. Administrative Nurse D stated she "did speak with the resident's DPOA when she went out to the hospital on 01/13/20 but did not document it in the progress notes".

Review of 10/02/19 "Transfer/Discharge Notice" policy revealed the resident/responsible party will be notified in writing of all discharges or transfers thirty (30) days prior to the transfer, unless the resident's medical condition warranted immediate transfer. A note would be sent to the State Ombudsman. In the event the resident's condition warranted immediate transfer, the resident or responsible party were notified verbally of the transfer and received written verification within 24-48 hours of the transfer.

The facility failed to ensure staff completed notifications of transfer and discharge hospitalization paperwork for R22's facility-initiated hospitalization transfer and did not submit them to the State Ombudsman.

- Review of the "Minimum Data Set" (MDS) tracking form dated February 2020 revealed R14 discharged to the hospital on 02/03/20 and returned to the facility on 02/08/20.

Review of R14's medical record lacked pricing on the written notification of the facility-initiated hospitalization transfer form for Resident (R)14.

Interview with Licensed Nurse G on 02/24/20 at

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F 623	Continued From page 8 10:44 AM revealed the expectation were for staff to notify the durable power of attorney (DPOA) and fill out the transfer paperwork and did not know when the price line would be filled out. Interview with Administrative Nurse D on 02/25/20 at 09:27 AM revealed this resident did not receive Medicaid so the facility should have filled out the price line information for them. Review of 10/02/19 "Transfer/Discharge Notice" policy revealed the resident/responsible party will be notified in writing of all discharges or transfers thirty (30) days prior to the transfer, unless the resident's medical condition warrants immediate transfer. In the event the resident's condition warrants immediate transfer, the resident or responsible party will be notified verbally of the transfer and have written verification within 24-48 hours of the transfer. The facility failed to ensure staff completed notifications of transfer and discharge hospitalization paperwork for R14's facility-initiated hospitalization transfer.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625		

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return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 33 residents with 12 residents in the sample with two reviewed for hospitalization. Based on interview and record review the facility failed to send a copy of the notice to transfer to a representative of the Office of the State Long-Term Care Ombudsman for Residents (R)14 and R22.

Findings included:

- Review of R14's "Minimum Data Set" (MDS) tracking form dated February 2020 revealed the resident discharged to the hospital on 02/03/20 and returned to the facility on 02/08/20.

Review of R14's medical record lacked evidence of written notification of the facility-initiated hospitalization transfer and bed hold to R14's Office of the State Long-Term Care Ombudsman.

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In a 02/24/20 response at 08:23 AM to a request for logs of R14's transfers from the facility to the hospital in the time period from October 2019 to February 2020, Social Services Staff X reported the facility failed to complete such transfer logs and also failed to transmit the record of hospital transfers to the Office of the State Long-Term Care Ombudsman.

Interview with Administrative Nurse D on 02/24/20 at 10:31 AM revealed she expected staff to send the logs of hospital transfers to the State Ombudsmen's office monthly.

The 05/28/19 "Bed/Unit-Hold" policy included, " ...options and arrangements will be communicated to the residents of the community according to state and federal regulations ..."

The facility failed to send a copy of the notice to transfer to a representative of the Office of the State Long-Term Care Ombudsman when R14 transferred to the hospital.

- Review of R22's 01/23/20 "Significant Change MDS" revealed diagnoses included COPD and stroke/Cerebrovascular Accident (CVA, a 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).

Review of "Progress Note" dated 11/19/19 at 04:26 PM revealed hospital admission for COPD exacerbation and pneumonia.

Review of "Progress Note" dated 01/13/20 at 08:34AM the resident was sent to the emergency room (ER) for right sided weakness, slurred

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incoherent speech, and adventitious lung sounds.

Review of "Bed Hold" dated 11/19/19 revealed lack of the DPOA's signature and was not filled out to completion. There were no "Bed Hold" forms completed for R22's 01/13/20 and 02/16/20 hospitalizations. The Director of Nursing (DON) filled out a "Bed Hold" on 02/24/20 for the 02/16/20 hospitalization, after the surveyor asked for the documentation.

Interview with Licensed Nurse G on 02/24/20 at 10:44 AM revealed the staff were to notify the DPOA and fill out the transfer paperwork, which included the bed hold signature.

Interview with Social Services (SS) X on 02/24/20 at 09:01 AM revealed the nurses obtained the bed holds signatures, she did not know if the staff sent them out to the resident's representative. She did not know why the bed hold was not signed for the 11/19/19 hospitalization, or why the bed holds for the 01/13/20 and 02/16/20 hospitalizations were not completed.

Interview with Administrative Nurse D on 02/24/20 at 10:31 AM revealed the bed holds should be filled out completely and the facility was working on how to ensure those were completed appropriately. Administrative Nurse D stated she "did speak with the resident's DPOA when she went out to the hospital on 01/13/20 but did not document it in the progress notes".

Interview with Administrative Nurse D on 02/25/20 at 09:27 AM revealed all other areas of the bed hold form were completed as applicable.

Review of 05/28/19 "Bed/Unit-Hold" policy

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F 625	Continued From page 12 revealed bed/unit-hold options and arrangements would be communicated to the residents of the community according to state and federal regulations using the bed/unit-hold guidelines for residents. When a resident took a medical leave or non-medical therapeutic leave from the community, the social services/nursing staff or designee would review and explain the bed/unit-hold policy to the resident/responsible party ...and document attempts to reach the resident representative in the resident's file. Every attempt would be made to obtain the resident or Durable Power of Attorney (DPOA) signature. The facility failed to ensure Bed Hold forms were completed for all hospitalization transfers for R22.	F 625		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		

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director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 33 with 12 residents included in the sample and five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure the consultant pharmacist identified lack of parameters for pulses for Resident (R) 2 and R29 for medications they received.

Findings included:

- Review of R2's signed "Physician Orders" dated 02/07/20 revealed the diagnosis of atrial fibrillation (rapid, irregular heartbeat).

Review of the "Minimum Data Set" (MDS) dated 11/24/19 revealed a "Brief Interview for Mental Status"(BIMS) revealed a score of 13 indicating intact cognition.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Review of the "Medication Administration Record" (MAR) from 10/01/19 to 02/01/20 revealed Digoxin 1.25 microgram (mcg) 1 tab daily for unspecified atrial fibrillation. The documentation of the pulse on the MAR revealed the following dates where staff administered the medication and did not notify the physician of the residents pulse of less than 60 beats per minute (bmp) as per standards of practice.
10/01/19 pulse 54 bpm
10/04/19 pulse 53 bpm
10/07/19 pulse 55 bpm
10/08/18 pulse 55 bpm
10/27/19 pulse 51 bpm
11/19/19 pulse 57 bpm
01/01/20 pulse 56 bpm
01/02/20 pulse 56 bpm
01/15/20 pulse 52 bpm
01/17/20 pulse 55 bpm
01/18/20 pulse 55 bpm
01/24/20 pulse 54 bpm
01/25/20 pulse 54 bpm
01/30/20 pulse 52 bpm
01/31/20 pulse 51 bpm
02/01/20 pulse 57 bpm

Interview with R2 on 02/24/20 at 1:09 PM revealed "I do not notice having dizziness or light headedness after taking my morning medication".

Interview with Certified Medication Aide (CMA) O on 02/24/20 at 01:17 PM revealed the staff took the resident's vitals while he laid down and as soon as he got up his pulse would go up. CMA O said if his pulse was below 60 beats per minute the nurse was notified, and she would then follow the instructions from the nurse.

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F 756	Continued From page 15	F 756		

Interview with Licensed Nurse (LN) G on 02/24/20 at 01:48PM revealed R2's baseline pulse was between 60 to 70 bpm. LN G said there were no orders to hold his Digoxin if the pulse dropped below 60 bpm. LN G stated if his pulse was below 60 bpm "I would hold the medication and notify the physician and document the notification in the nurse's notes"

Interview with Administrative Nurse D on 02/24/20 at 09:47 AM revealed the physician orders were currently being updated to include parameters for pulse. Administrative Nurse D said she expected the staff nurses to notify the physician if a resident's pulse was below 60 beats per minute.

Interview on 02/24/20 at 3:11 PM with "Consultant Pharmacist" GG revealed he did not check the pulses for a resident in the monthly review unless they received a beta blocker and he would not look for parameter on pulses with the medication Digoxin.

Review of the policy Drug Regimen Review revised on 06/10/19 revealed the "Consultant Pharmacist" conducted DDR's to identify irregularities and to identify clinically significant risk and/or actual or potential adverse consequences which may result from or be associated with medications.

The facility failed to ensure the consultant pharmacist identified lack of parameters and the continued Digoxin medication administration when R2 pulse was below 60 bpm.

- Review of R20's pertinent diagnoses from the 01/16/20 "Physician's Order Sheet" revealed

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F 756	Continued From page 16	F 756		

heart disease (disorder of the heart) and hypertension (elevated blood pressure).

Review of the 08/07/19 "Significant Change Minimum Data Set" (MDS) revealed a brief interview for mental status (BIMS) of 15, indicating intact cognition.

Review of the 01/17/20 "Quarterly MDS" revealed a BIMS of 15, indicating intact cognition.

Review of the 08/07/19 "Activities of Daily Living Care Area Assessment" (CAA) revealed R20 had multiple co-morbidities including hypertension.

Review of 08/19/19 "Polypharmacy Care Plan" revealed R20 took amlodipine (blood pressure medication) for her diagnosis of hypertension, started on 08/19/19. The black box warning (BBW, most serious side effects and adverse reactions) included bradycardia (low heart rate). She also took losartan (blood pressure medication) for her diagnosis of hypertension started on the same date.

Review of "Physician Orders" dated:
03/09/18 BBW Amlodipine 5 milligrams (mg) tablet by mouth once daily for hypertension and ordered staff to obtain blood pressure (BP) and pulse.
03/09/18 BBW Losartan 100 mg tablet by mouth once daily for hypertension and ordered staff to obtain BP.
03/09/18 May use facility standing orders for BP parameters, call physician if the systolic (the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) BP was greater than 220 millimeters of mercury (mmHg) or less than 80

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F 756	Continued From page 17	F 756		

mmHg, and call the physician if the diastolic (the phase of the heartbeat when the heart muscle relaxes and allows the chambers to fill with blood) was greater than 120 mmHg. The reviewed "Physician Orders" lacked pulse parameters for staff to follow and know when to notify the physician for R20.

Review of October 2019 to February 2020 "Medication Administration Record" (MAR) revealed the documentation of pulses under 60 beats per minute at 08:00AM medication pass on October 5th, November 19th, January 9th, 12th, 19th, 22nd, 25th, and February 3rd, 5th.

Review of 10/02/19 to 02/02/20 "ID notes" and "physician order scanned documents" revealed no documentation of physician communication about low pulses.

Review of pharmacy medication regimen reviews (MRR) dated March 2019 to February 2020 revealed the pharmacist did not identify the lack of pulse parameter for R20.

Observation of R20 on 02/20/20 at 12:29 PM revealed the resident in her wheelchair, dressed appropriately, sitting at desktop computer and fiddling with documents sitting in front of the computer with no signs or symptoms of distress noted.

Interview with Licensed Nurse (LN) J on 02/25/20 at 08:28 AM revealed R20 got monthly vital signs (VS), and daily BP and pulse for her Losartan. LN J said the BBW could be found on the MAR, and on the care plan.

Interview with Administrative Nurse D on 02/24/20

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F 756	Continued From page 18 at 09:47 AM revealed the facility faxed the physician just now for orders regarding the parameters for pulse. Interview with Administrative Nurse D on 02/25/20 at 10:45 AM revealed she expected the nursing staff to call the doctor if the resident's pulse was under 60 bpm per the parameters the facility followed. Interview with Consultant Pharmacist GG on 02/24/20 at 03:11 PM revealed he usually checked pulses on beta blockers (any of a class of drugs that are used to reduce high blood pressure), but said it depended on what medication required a pulse check. Review of 06/18/19 "Medication Administration" policy revealed that there must be a primary care provider (PCP) order that includes dosage, route, frequency, duration and other required considerations required for the administration of medication. Review of 06/10/19 "Drug Regimen Review" policy revealed the consultant pharmacist will conduct DRRs to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. The facility pharmacist failed to ensure R20 had appropriate pulse parameters included in medication orders for medications received which required pulse monitoring.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		

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§483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-

§483.45(d)(1) In excessive dose (including duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

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

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 33 residents with 12 included in the sample and five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to identify the lack of parameters for pulses for two Residents (R), R2 and R29, for medications they received outside of standards of practice.

Findings included:

- Review of R2's signed "Physician Orders" dated 02/07/20 revealed the diagnosis of atrial fibrillation (rapid, irregular heartbeat).

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Review of the "Minimum Data Set" (MDS) dated 11/24/19 revealed a "Brief Interview for Mental Status"(BIMS) revealed a score of 13 indicating intact cognition.

Review of the "Medication Administration Record" (MAR) from 10/01/19 to 02/01/20 revealed Digoxin (digitalis- meducation used to treat irregular heartbeat) 1.25 microgram (mcg) one tab daily for unspecified atrial fibrillation. The documentation of the pulse on the MAR revealed the following dates where staff administered the medication and did not notify the physician of the residents pulse of less than 60 beats per minute (bmp) as per standards of practice.
10/01/19 pulse 54 bpm
10/04/19 pulse 53 bpm
10/07/19 pulse 55 bpm
10/08/18 pulse 55 bpm
10/27/19 pulse 51 bpm
11/19/19 pulse 57 bpm
01/01/20 pulse 56 bpm
01/02/20 pulse 56 bpm
01/15/20 pulse 52 bpm
01/17/20 pulse 55 bpm
01/18/20 pulse 55 bpm
01/24/20 pulse 54 bpm
01/25/20 pulse 54 bpm
01/30/20 pulse 52 bpm
01/31/20 pulse 51 bpm
02/01/20 pulse 57 bpm

Interview with R2 on 02/24/20 at 01:09 PM revealed "I do not notice having dizziness or light headedness after taking my morning medication"

Interview with Certified Medication Aide (CMA) O on 02/24/20 at 01:17 PM revealed the staff took the resident's vitals while he laid down and as

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soon as he got up his pulse went up. CMA O said if his pulse was below 60 beats per minute she notified the nurse and she would then follow the instructions from the nurse.

Interview with Licensed Nurse (LN) G on 02/24/20 at 01:48PM revealed R2's baseline pulse was between 60 to 70 bpm. LN G said there were no orders to hold his Digoxin if the pulse dropped below 60 bpm. LN G stated if his pulse was below 60 bpm "I would hold the medication and notify the physician and document the notification in the nurse's notes"

Interview with Administrative Nurse D on 02/24/20 at 09:47 AM revealed the physician orders were currently being updated to include parameters for pulse. Administrative Nurse D said she expected the staff nurses to notify the physician if a resident's pulse was below 60 beats per minute.

Review of the policy "Medication Administration" revised on 06/18/19 revealed apical pulses were taken for 30 seconds, unless irregular, before administration of digitalis and are appropriately noted in Matrix Care (a) if apical pulse is less than 60 bpm digitalis is held unless specified by a physician.

The facility failed to identify the lack of parameters and continued to administer digoxin medication when R2's pulse rate was below 60 bpm.

- Review of R20's pertinent diagnoses from the 01/16/20 "Physician's Order Sheet" revealed heart disease (disorder of the heart) and hypertension (elevated blood pressure).

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Review of the 08/07/19 "Significant Change Minimum Data Set" (MDS) revealed a brief interview for mental status (BIMS) of 15, indicating intact cognition.

Review of the 01/17/20 "Quarterly MDS" revealed a BIMS of 15, indicating intact cognition.

Review of the 08/07/19 "Activities of Daily Living Care Area Assessment" (CAA) revealed R20 had multiple co-morbidities including hypertension.

Review of 08/19/19 "Polypharmacy Care Plan" revealed R20 took amlodipine (blood pressure medication) for her diagnosis of hypertension, started on 08/19/19. The black box warning (BBW, most serious side effects and adverse reactions) included bradycardia (low heart rate). She also took losartan (blood pressure medication) for her diagnosis of hypertension started on the same date.

Review of "Physician Orders" revealed the following:
1. 03/09/18 BBW Amlodipine 5 milligrams (mg) tablet by mouth once daily for hypertension and ordered staff to obtain blood pressure (BP) and pulse.
2. 03/09/18 BBW Losartan 100 mg tablet by mouth once daily for hypertension and ordered staff to obtain BP.
3. 03/09/18 May use facility standing orders for BP parameters, call physician if the systolic (the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) BP was greater than 220 millimeters of mercury (mmHg) or less than 80 mmHg, call the physician if the diastolic (the

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phase of the heartbeat when the heart muscle relaxes and allows the chambers to fill with blood) was greater than 120 mmHg.

The reviewed "Physicians Orders" lacked pulse parameters for staff to follow and to know when to notify the physician for R20.

Review of October 2019 to February 2020 "Medication Administration Record" (MAR) revealed the documentation of pulses under 60 beats per minute (bpm) at 08:00AM medication pass on October 5th, November 19th, January 9th, 12th, 19th, 22nd, 25th, and February 3rd, 5th.

Review of 10/02/19 to 02/02/20 "ID notes" and "Physician Order Scanned Documents" revealed no documentation of physician communication regarding the pulse rates below 60 bpm.

Observation of R20 on 02/20/20 at 12:29 PM revealed the resident in her wheelchair, seated at a desktop computer and fiddling with documents sitting in front of the computer with no signs or symptoms of distress noted.

Interview with Certified Medication Aide (CMA) P on 02/25/20 at 08:14 AM revealed BBW were on the medication cart and on the medications on the MAR. CMA P said when staff charted medications, it popped up to let staff know what was a BBW medication.

Interview with Licensed Nurse (LN) J on 02/25/20 at 08:28 AM revealed R20 got monthly vital signs (VS), daily BP, and pulse rate for her Losartan. LN J said the BBW could be found on the MAR, and on the care plan.

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F 757	Continued From page 24 Interview with Administrative Nurse D on 02/24/20 at 09:47 AM revealed the facility faxed the physician just now for orders regarding the parameters for pulse. Interview with Administrative Nurse D on 02/25/20 at 10:45 AM revealed she expected the nursing staff to call the doctor if the resident's pulse was under 60 bpm per the parameters the facility followed. Interview with Consultant Pharmacist GG on 02/24/20 at 03:11 PM revealed he usually checked pulses on beta blockers (any of a class of drugs that are used to reduce high blood pressure), but said it depended on what medication required a pulse check. Review of 06/18/19 "Medication Administration" policy revealed that there must be a primary care provider (PCP) order that includes dosage, route, frequency, duration and other required considerations required for the administration of medication. Review of 06/10/19 "Drug Regimen Review" policy revealed the consultant pharmacist will conduct DRRs to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. The facility failed to ensure R20 had appropriate parameters for pulses for heart medications received and continued to administer digoxin medication when R20's pulse rates were out of parameter per standards of practice.	F 757		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812 SS=F	Continued From page 25 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility census totaled 33 residents. Based on observation, interview, and record review the facility failed to ensure proper glove use/hand washing, proper documentation (logs) of testing sanitizer, appropriate food storage which included outdated and improperly stored/thawing food, and failed to ensure the dishwasher operated correctly with the appropriate sanitizer. These failurse had the ability to affect the entire resident population. Findings included: - Observation on 02/19/20 at 09:53 AM revealed Dietary staff DD running the dishwasher cycle. The wash temperature reached 130 degrees	F 812		

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F 812	Continued From page 26	F 812		

Fahrenheit (F) and the rinse cycle temperature reached 170 degrees F. The labeled minimum wash temperature was 140 degrees F and the minimum rinse temperature was 140 degrees F. The staff had not completed the temperature check log on 02/18/20 for the noon or evening checks. The only chemicals noted were the "ACS CHAMP" Machine Warewash Detergent and "ACS" Rinse Dry Aid. The recommendations on the "ACS CHAMP" detergent stated, "Sanitize using recommended sanitizer." It was noted that the top of the dishwasher machine was dirty, with crumbs and other debris present.

Observation on 02/19/20 at 11:17 AM revealed food server Dietary Aide (DA) CC exited the kitchen to deliver food to the residents in the dining room and returning utilizing the same, single glove. Then DA CC served plates in the dining room, returned to the kitchen, removed gloves, washed hands, and donned one glove.

Observation on 02/19/20 at 11:40 AM in the satellite kitchen for Long Term Care revealed the unidentifed staff took orders at the dining room table, then brought the order sheets into kitchens, and prepped the plates. The sheets from dining area were placed on the prepping surface. The unidnetified staff exited the kitchen to serve plates to residents and did not wash hands or don gloves upon return to the kitchen.

Observation during tour of the satellite kitchen on 02/19/20 at 11:40 AM revealed the ice machine appeared dirty with black and green spore-like growth/substance across underside of the opening, where the ice dumped. The cabinet labeled "Sandwich Bread" contained three bagels in an opened leftover bag with no date or labeling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175306	A. BUILDING _____ B. WING _____	02/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE DODGE CITY, KS 67801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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of any form. Further observation revealed a large leftover bag that contained 19 "Cinna-Mini Pull Apart Cinnamon Rolls" with expiration dates of 02/17/20 (found on 2/20/20) and the instructions on the food label read "thaw at room temperature for 90 minutes prior to serving" and the contents were at room temperature.

Observation of the walk-in fridge on 02/19/20 at 11:40 AM revealed opened mozzarella shredded cheese bag not labeled/dated, opened ham dated 02/10/20 with no use-by date stored in the leftover bag, and opened roast beef dated 02/02/20 with no use by date in the leftover bag. There was a bag of brown granules, possibly breadcrumbs, in large clear plastic bag with no description or dates, and eight sleeves of taco shells with no labeling or expiration dates.

Review of "weekly cleaning schedule sample form" for between 11/01/19 to 02/01/20 revealed seventeen opportunities to complete the tasks noted below and included the following missing documentation:
Seven areas of miss documentation for sweeping/mopping the storage room.
Five areas of missed documentation for de-liming the steamtable.
Six areas of missed documentation for cleaning the microwave.
Six areas of missed documentation for cleaning the can opener.
Six areas of missed documentation for cleaning the plate warmer.
Seven areas of missed documentation for sweeping/mopping the walk-in fridge.
Eight areas of missed documentation for cleaning the spice shelf.
Eight areas of missed documentation for staff

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putting freight in the freezer.
Eight areas of missed documentation for cleaning the ovens.
Eight areas of missed documentation for cleaning out the white bins.
Eight areas of missed documentation for cleaning the fryer in the main kitchen.
Nine areas of missed documentation for sweeping and mopping the freezer.
Eight areas of missed documentation for cleaning the stainless walls.
16 areas of missed documentation for cleaning the fridge/salt and pepper shakers and sugar caddies.

Interview with Certified Dietary Manager (CDM) BB on 02/19/20 at 09:53 AM revealed the dishwasher was high temperature, but she did not know if the sanitizer solution was present. She said there were no sanitizing chemicals identified and the only chemicals near the washing machine were those listed above. The CDM confirmed with the surveyor the lack of sanitizing solution connected to the dishwasher. CDM BB also confirmed it appeared as if the dishwasher detergent was being sent through the rinse cycle. CDM BB said the company that maintained the dishwasher checked the sanitizer monthly, but stated "no one at the facility has ever checked it" and there were no sanitizing/test strips noted. CDM BB expected her staff to clean according to her number system. CDM BB said she had a non-English speaking staff member who cleaned at night but he did not sign off on the sheets due to lack of communication.

Interview with Dietary Staff (DS) DD on 02/19/20 at 11:52 AM revealed she expected the ice machine to be cleaned once weekly, and she did

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	175306	A. BUILDING _____ B. WING _____	02/25/2020

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not know of the substance, that appeared to be mold, on it.

Review of 03/07/19 "Dietary Services" policy revealed nutrition was an important factor in the quality of care of residents. An organized, well-staffed and equipped nutritional service ensured the nutrition program for the residents was safe, appetizing, and met their individual nutritional needs. All items of equipment would be cleaned and sanitized in accordance with state and federal guidelines. Cleaning schedules would be posted and included regular cleaning assignments. Food production areas, refrigeration, storage, and dining areas would be included in the cleaning schedule. Food would be stored, prepared, and served under sanitary conditions. There was no mention in the policy of sanitizer testing procedure.

The facility failed to ensure proper glove use/hand washing, proper documentation logs/testing of sanitizer, appropriate food storage which included outdated and improperly stored/thawing food and failed to ensure the dishwasher operated correctly with appropriate sanitizer present. These failures had the ability to affect the entire resident population.