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	175559	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN PRAIRIE SENIOR LIVING LLC	510 E SAN JACINTO AVENUE ULYSSES, KS 67880

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585		

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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grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,

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the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 41 and a sample of 12. Based on observation, interview, and record review the facility failed to ensure the right of the residents to file a grievance anonymously by lack of grievance boxes and instructions accessible and/or visible to all residents, including those in wheelchairs and with poor vision. attendance (Resident (R)12, R4, R13, R28, R23, R26, R35, R20, R19, R39, R36, R41, R16, and R15)

Findings included:

- Review of the "Resident Council Meeting Minutes" from 01/28/19-01/28/20 lacked information regarding discussions about filing grievances anonymously or how residents filed grievances anonymously within the facility.

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Observations from 02/03/20 through 02/06/20 revealed boxes mounted approximately four to five feet high on the wall at the nursing station and at the end of each of the three halls. Each grievance box included blank grievance forms. Instructions for how to file a grievance were positioned on the wall above the grievance box; however, the font was too small for residents with less than adequate vision and/or wheelchair dependent residents to read.

An interview on 02/05/20 at 10:45 AM with the Resident Council members in attendance (Resident (R)12, R4, R13, R28, R23, R26, R35, R20, R19, R39, R36, R41, R16, and R15) unanimously reported they did not know how to file a grievance.

An interview on 02/06/20 at 08:34 AM with Certified Nurse Aide (CNA) D stated she verbally communicated grievances to the nursing staff, who completed the grievance form for the resident(s) and gave the form to the administrator. CNA D reported she did not see a resident complete a grievance form independently.

An interview on 02/06/20 at 08:50 AM with Licensed Nurse (LN) E stated she completed grievance forms for the resident(s) and gave the form(s) to social services. LN E stated if social service designee (SSD) was not available, she put the form(s) in the SSD C's box mounted on the wall outside of her office door. LN E reported she had never sen a resident fill out a grievance form.

An interview on 02/06/20 at 10:02 AM with

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Administrative Nurse B stated the staff who received the complaint filled out the grievance form and gave it to Administrative Staff A. Administrative Nurse B reported staff placed the grievance forms under his office door, when Administrative Staff A was not there, since he did not have a box. Administrative Nurse B stated she preferred documents such as completed grievance forms to be placed underneath her office door for privacy.

An interview on 02/06/20 at 11:21 AM with SSD C stated the staff usually completed grievances for residents and often placed the grievances in the box by her door. SSD C stated she also completed grievances for residents and gave the form(s) to Administrative Staff A or placed the form(s) underneath his office door if he was not there.

An interview on 02/06/20 at 11:44 AM with Administrative Staff A revealed he mounted six plastic file holders on walls throughout the facility which held grievance forms and said there were instructions by each box. Administrative Staff A stated the staff gave grievance forms to him or SSD C, and if neither were there then the staff and/or person filing the grievance waited for one of them to return or gave the form to the charge nurse. Administrative Staff A agreed the grievance boxes were placed too high on the wall and the instructions were placed too high for anyone in a wheelchair to reach, as well as the instructions were placed too high and the font/print was too small to be read.

The facility's undated "504 Grievance Procedure" documented, ". . . no otherwise qualified handicapped individual. . . shall, solely by reasons

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F 585	Continued From page 5 of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . This Facility will make appropriate arrangements to assure that disabled personas can participate in or make use of this grievance process on the same basis as the nondisabled." The facility's undated policy titled, "Grievances," documented, "The right to file grievances anonymously," and lacked information or instruction for how residents could file a grievance anonymously within the facility. The facility failed to ensure the right of the residents to file a grievance anonymously by not ensuring the grievance boxes and instructions were accessible and/or visible to all residents, including those in wheelchairs and/or with poor vision.	F 585		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral	F 622		

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status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:

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(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 41 residents with 12 residents in the sample. Based on observation, interview, and record review the facility failed to appropriately prepare a resident for transfer to the hospital, when facility staff failed to document preparation for a hospitalization transfer of Resident (R) 10 on 06/25/20.

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Findings included:

- Review of R10's pertinent diagnoses from 01/30/20 "Physician's Order sheet" revealed: pneumonia (an inflammation of the lungs).

Review of the 05/24/19 "Annual Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of 14, indicating intact cognition. R10's total severity score was four, indicating minimal depression with no behaviors noted. She was noted to have received antidepressants and antibiotics during the seven-day review period. R10 used oxygen (O2) and had respiratory therapy noted for 112 minutes during the review period.

Review of the 11/15/19 "Quarterly MDS" revealed a BIMS of nine, indicating moderately impaired cognition. R10's total severity score was zero, indicating no depression and no behaviors noted. She received antidepressants and antibiotics daily during the seven-day review period. R10 used O2 and had respiratory therapy during the review period.

Review of the 05/24/19 "ADL Care Area Assessment" (CAA) revealed R10 was dependent on staff for all daily cares and transferred with a full mechanical lift and two staff. She occasionally needed assist with eating and could ask staff for assistance when needed. The staff would include Care Plan revisions to maintain her current level of functioning and to ensure daily needs were met.

The resident's 08/08/16 "Care Plan" lacked information about respiratory care.

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F 622	Continued From page 9 Review of transfers to hospital for R10 dated 06/25/19 revealed R10 went to the hospital for pneumonia of the right upper lobe due to an infectious organism. Review of progress notes dated 06/25/19 revealed no nursing note made about the resident's hospitalization transfer. Observation of R10 on 02/05/20 at 11:47 AM revealed Licensed Nurse (LN) E in R10's room and O2 saturation noted at 92%. Breathing treatment started at 12:05 PM and ended at 12:16 PM. Interview on 02/06/20 at 08:03 AM with LN E revealed she expected the LN to conduct an assessment, obtain vital signs, and treat any wounds when the facility transferred a resident to the hospital. LN E said the LN's charted those in a progress note. Interview with Administrative Nurse B on 02/06/20 at 10:56 AM revealed there were no in-direct forms filled out by the LN which included preparation information about who was contacted, vital signs, etc. Review of 01/03/18 "Western Prairie Senior Living Admission Packet" revealed the facility shall give notice of transfer or discharge to the ...family member or legal representative. The facility failed to complete progress notes indicating the care and preparation before transfer to the hospital for R10.	F 622		
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		

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F 625 SS=E	Continued From page 10 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 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 identified a census of 41 residents and the sample included 12. Based on observation, interview, and record review the facility failed to ensure the staff provided the residents and/or resident representative(s) a written notice of the bed-hold policy and return upon the facility-initiated hospitalization transfer of	F 625		

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Resident (R)10, R12, R21, R38, and R39.

Findings included:

- Review of R10's hospital transfer records revealed facility-initiated hospitalization transfers on 02/06/20, 07/07/19, 10/12/29, and 01/14/20. Review of R10's "Nursing Progress Note" lacked documentation of a written bed-hold notice provided to the resident and/or resident representative(s).

Review of R12's hospital transfer records revealed facility-initiated hospitalization transfers on 06/20/19 and 10/26/19. Review of R12's "Nursing Progress Notes" lacked documentation of a written bed-hold notice provided to the resident and/or resident representative(s).

Review of R38's hospital transfer records revealed facility-initiated hospitalization transfers on 06/17/19 and 02/01/20. Review of R38's "Nursing Progress Notes" lacked documentation of a written bed-hold notice provided to the resident and/or resident representative(s).

Review of R39's hospital transfer records revealed facility-initiated hospitalization transfer on 06/10/19 and 07/16/19. Review of R39's "Nursing Progress Note" lacked documentation of a written bed-hold notice provided to the resident and/or resident representative(s).

Review of the "Nursing Progress Note" dated 11/19/19 at 02:30 PM revealed the facility initiated a hospitalization transfer of R21. Review of R21's "Nursing Progress Note" lacked documentation of a written bed-hold notice provided to the resident and/or resident representative(s).

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F 625	Continued From page 12 An interview on 02/06/20 at 08:03 AM with Licensed Nurse (LN) E stated the facility had bed-hold notices but did not send them when residents were transferred to the hospital. An interview with 02/06/20 at 09:02 AM with Social Service Designee (SSD) C stated the facility notified family over the phone for emergencies, but they did not send written bed-hold notices. An interview on 02/04/20 at 10:58 AM with Administrative Nurse B reported SSD C completed the emergency transfer bed holds, and nurses completed the non-emergent bed-hold notices. An interview on 02/06/20 at 11:44 AM with Administrative Staff A revealed the bed-hold notices were not being done. The facility's policy titled, "Bed-Hold Policy," revised on 11/28/17, documented, "Written notice of the bed-hold policy will be issued to the resident or resident representative upon transfer to a hospital or therapeutic leave. The notice will specify the duration of the bed-hold policy." The facility failed to ensure the facility staff provided the residents and/or resident representative(s) written notice of the bed-hold policy and return upon the resident's facility-initiated hospital transfer for R10, R12, R21, R38, and R39.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

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requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 41 residents (R) with 12 residents in the sample. Based on observation, interview, and record review the facility failed to ensure the comprehensive care plan was complete for R26, including the resident's use of antipsychotics and behavior monitoring.

Findings included:

- Review of R26's pertinent diagnoses from the 12/10/19 "Physician's Order Sheet" revealed: Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

Review of the 12/02/19 "Admission Minimum Data Set" (MDS) revealed a brief interview for mental status (BIMS) of eight, indicating moderately impaired cognition. He scored zero on the mood score indicating no signs or symptoms of depression. R26 utilized antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medications seven of the seven-day review period.

Review of the 12/02/19 "Psychotropic Medication

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Care Area Assessment" (CAA) revealed he received Seroquel (antipsychotic medication) for depression and anxiety and had Ativan (antianxiety medication) as needed (PRN) for anxiety.

Review of "Care Plan", last revised 11/26/19, revealed the resident took medications with black box warnings (BBW, a type of warning that appears on the package insert for certain prescription drugs) and he required staff to help "watch out for the indicated reactions" and notify the physician if any were seen. There was no mention of monitoring behaviors or what specific behavior was to be monitored.

Review of "Physician Orders" revealed Seroquel ordered to be administered on 11/25/19 for anxiety.

Observation of R26 on 02/04/20 at 09:05 AM revealed the resident without behaviors or signs/symptoms of medication related side effects. He was dressed and groomed appropriately and able to feed self without difficulty.

Interview with Certified Nurse Aide (CNA) I on 02/04/20 at 03:48 PM revealed R26 did reject cares at times because he liked to do everything himself. But they were expected to document if he had behaviors every shift.

Interview with Licensed Nurse (LN) E 02/05/20 at 03:02 PM revealed the staff monitored him for exit seeking when he first arrived. However, he just liked to "walk" now.

Interview with Administrative Nurse B 02/04/20 at

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F 656	Continued From page 16 01:01 PM revealed if things are pertinent for the resident, they should be on the care plan. The CNAs and LNs told the MDS coordinator if there were changes needed on a resident's care plan. Review of 11/28/17 "Care Plan" policy revealed a comprehensive care plan must be developed within seven days of completion of the MDS and CAAs or within 21 days after admission, whichever came first. The care plan should reflect individualized problems, goals, and interventions. The facility failed to ensure the completion of the comprehensive care plan for R26, including the resident's use of antipsychotics and behavior monitoring.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		

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resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 41 residents (R) with 12 residents in the sample. Based on observation, interview, and record review the facility failed to ensure R10 care plan was updated to reflect care regarding behavioral medications and respiratory care.

Findings included:

- Review of R10's pertinent diagnoses from 01/30/20 "Physician's Order sheet" revealed: major depressive disorder (MDD, a major mood disorder) and pneumonia (an inflammation of the lungs).

Review of the 05/24/19 "Annual Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of 14, indicating intact cognition. R10's total severity score was four, indicating minimal depression with no behaviors noted. She was noted to have had antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression) and antibiotics (a class of medication used to treat an infection) during the seven-day review period. R10 used oxygen (O2) and had respiratory therapy provided for 112 minutes during the review period.

Review of the 11/15/19 "Quarterly MDS" revealed

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a "BIMS" of nine, indicating moderately impaired cognition. R10's total severity score was 0, indicating no depression with no behaviors noted. She received antidepressants and antibiotics daily during the seven-day review period. R10 used O2 and had respiratory therapy during the review period.

Review of the 05/24/19 "Mood Care Area Assessment (CAA)" revealed she had a diagnosis of depression with a mood interview score of four. Her care plan would include to monitor for mood and worsening of depression.

Review of the 05/24/19 "Psychotropic CAA" revealed she took Celexa (antidepressant medication) for depression and her care plan would monitor for side effect symptoms and worsening condition. Behavioral symptoms were not triggered.

Review of 08/08/16 "Care Plan" included the following interventions:
09/29/17, staff were instructed to monitor black box warnings (appears on the label of a prescription medication to alert consumers and healthcare providers about safety concerns, such as serious adverse effects or life-threatening risks) and adverse effects for all medications in her regimen and report any issues to the charge nurse. The care plan lacked specific targeted behaviors and information about breathing treatments with nebulizer cleaning schedule for R10.

Review of "Physician Orders" included:
10/17/19, Ipratropium-Albuterol Solution 0.5 - 2.5 3 milligrams (mg)/3 milliliter (ml)- 1 vial inhale orally via nebulizer four times a day related to

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abnormal finding of lung field
10/17/19, Oxygen per Nasal Cannula at 2L (liters), monitor oxygen saturation every shift related to Pneumonia
10/17/19, Budesonide Suspension 0.5 mg/2ml- 1 vial inhale orally via nebulizer two times a day for Shortness of Breath
10/17/19, Citalopram Hydrobromide Tablet 10mg- Give 10mg by mouth at bedtime related to MDD

The 08/16/19 "Abnormal Involuntary Movement Scale" (AIMS) (abnormal movements) was incomplete.

Review of staff task "Monitor- select side effects, other psychoactive medication Celexa target behavior secluding self in room" dated October 2019 to February 2020 revealed 74 missing documentations for this task, which staff were to complete on each shift.

Observation of R10 on 02/05/20 at 11:47 AM revealed Licensed Nurse (LN) E in R10's room and O2 saturation noted at 92%. Breathing treatment started at 12:05 PM and ended at 12:16 PM. LN E placed the nebulizer and tubing in the storage bag without cleaning the nebulizer.

Interview with Certified Nurse Aide (CNA) H on 02/04/20 at 03:40 PM revealed the staff were to clear the breathing treatment machine after each use. R10 wore her O2 all the time at 2 liters per nasal cannula.

Interview with CNA J on 02/05/20 at 09:22 AM revealed the nurses did the behavior monitoring every shift and said it must be charted.

Interview with Licensed Nurse (LN) E on 02/04/20

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at 09:19 AM revealed staff usually cleaned the nebulizers every night and said day shift staff did not have to clean it after every use. At night, the staff cleaned the nebulizers with soap and water. She would have to check the policy with the Director of Nursing (DON) to check and make sure the cleaning was appropriate for the nebulizers. The nurses do the AIMS scores when the residents admitted and the MDS coordinator conducted them with the MDS after that. R10's behavior included she secluded herself.

Interview with Administrative Nurse B on 02/04/20 at 10:58 AM revealed she expected pertinent items to be on the care plan for each resident. The CNAs and LNs told the MDS coordinator of changes needed on a resident's care plan. The nurse's charted the behaviors every shift and as needed. Administrative Nurse B expected the staff to clean the mask for breathing treatments and stated staff rinsed, set it out to dry, and then placed it in the holding bag. The facility had not logged the cleaning of the nebulizers at night, and she did not know if the staff used the vinegar/water mixture or if it was just a water rinse that they used to rinse the nebulizers off.

Interview with Administrative Staff G on 02/05/20 at 03:25 PM revealed the LN usually told her about resident changes or in the quarterly meetings as well. Administrative Staff G expected the staff to chart behaviors every shift and as needed when the resident experienced a behavior.

Review of 11/28/17 "Care Plan" policy revealed a comprehensive care plan must be developed within seven days of completion of the MDS and CAAs or within 21 days after admission,

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F 657	Continued From page 21 whichever came first. The care plan should reflect individualized problems, goals, and interventions. The facility failed to ensure R10 care plan was updated to reflect care regarding behavioral medications and respiratory care.	F 657		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		

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diagnosed specific condition that is documented in the clinical record; and

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

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents with 12 included in the sample and five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to monitor behaviors associated with antipsychotic medication use as well as completiion of the Abnormal Involuntary Movement Scale (AIMS) assessments for Resident (R) 5, R10, and R26, to assess for and avoid possible adverse drug reactions and unnecessary medications.

Findings included:

- Review of the "Physician Order Sheet" dated 01/29/20 documented the following diagnoses for R5: anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), atrial fibrillation (rapid, irregular heart beat), tachycardia (rapid heartbeat greater

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than 100 beats per minute), and hypertension (elevated blood pressure).

Review of the "Admission Minimum Data Set" (MDS) dated 05/21/19 documented a "Brief Mental Status" (BIMS) score of 12, indicating moderate cognitive impairment. R5 required extensive two staff assistance with all "Activities of Daily Living" (ADL) and received antipsychotic medications for seven of the seven day look back period.

Review of the "Psychotropic Drug Use Care Area Assessment" (CAA) dated 05/21/19 documented R5 had a diagnosis of anxiety and currently took Seroquel 25 milligram (mg) daily.

Review of the "Abnormal Involuntary Movement Scale" (AIMS) assessments dated 08/05/19 and 11/10/19 documented R5 with no ordered antipsychotic medications.

Review of "Physician Orders" dated 01/29/20 documented R5 received Seroquel 50 mg daily at bedtime, ordered on 06/12/19. The physician decreased the Seroquel to 25 mg at bedtime on 11/21/19.

Review of the "Behavioral Monitoring Staff Task Sheets" from 10/01/19 through 02/04/20 revealed staff did not document targeted behaviors each shift for R5 a total of 65 times.

Interview with Social Services (SS) staff G on 02/05/20 at 03:32 PM revealed SS staff G did not know why the staff did not complete the AIMs assessments or why there were incorrect ones completed. SS G stated she would complete them, she would not leave them incomplete, and

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the computer program notified her when they were incomplete. SS G said she thought it was just an oversight and could not state why it would not have been completed and stated she did them quarterly with the MDS.

Review of the facilities 11/28/17 "Abnormal Involuntary Movement Scale (AIMS)" policy documented AIMS would be performed on each resident prior to initiation of an antipsychotic medication, every six months thereafter, and with any significant change while receiving antipsychotic medications.

Review of the facilities 11/28/17 dated "Unnecessary Medication" policy documented behavior and side effect monitoring would be documented in the resident's clinical record.

The facility failed to properly monitor R5 for behaviors and AIMS to prevent the use of unnecessary medication use and adverse drug reactions related to antipsychotic medications received for R5.

- Review of R10's pertinent diagnoses from 01/30/20 "Physician's Order sheet" revealed: major depressive disorder (MDD, a major mood disorder).

Review of the 05/24/19 "Annual Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of 14, indicating intact cognition. R10's total severity score was four, indicating minimal depression with no behaviors noted. She was noted to have had antidepressants and antibiotics during the seven-day review period.

Review of the 11/15/19 "Quarterly MDS" revealed

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a BIMS of nine, indicating moderately impaired cognition. R10's total severity score was 0, indicating no depression and no behaviors noted. She received antidepressants, and antibiotics daily during the seven-day review period.

Review of the 05/24/19 "Mood State Care Area Assessment" (CAA) revealed she had a diagnosis of depression with a mood interview score is four. Her care plan would instruct staff to monitor the resident for mood and worsening of depression.

Review of the 05/24/19 "Psychotropic CAA" revealed she took Celexa for depression and her care plan instructed staff to monitor for side effect symptoms and worsening condition.

Review of 08/08/16 "Care Plan" included the following interventions:
09/29/17: Staff were to monitor black box warnings (BBW, appears on the label of a prescription medication to alert consumers and healthcare providers about safety concerns, such as serious adverse effects or life-threatening risks) and adverse effects for all medications in her regimen and report any issues to the charge nurse. She required two-person assistance for all transfers. The care plan lacked specific targeted behaviors for R10.

Review of "Physician Orders" revealed the following:
10/07/18, Reglan Tablet 5 milligrams (mg)- Give 5mg by mouth three times a day before meals related to gastro-esophageal reflux disease (GERD, backflow of stomach contents to the esophagus).
10/17/19, Citalopram Hydrobromide Tablet 10

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mg- Give 10 mg by mouth at bedtime related to MDD.

The "Abnormal Involuntary Movement Scale" (AIMS) (abnormal movements) dated 08/16/19 was not completed.

Review of staff task "Monitor- select side effects, other psychoactive medication Celexa target behavior secluding self in room" dated October 2019 to February 2020 revealed 74 missing documentations for this task, which staff were to complete on each shift.

Observation of R10 on 02/05/20 at 11:47 AM revealed Licensed Nurse (LN) E in R10's room for blood glucose (BG) check, resident interaction appropriate, no behaviors noted.

Interview with Licensed Nurse (LN) E on 02/04/20 at 09:19 AM revealed the nurses do the AIM's scores when the residents admitted and the MDS coordinator conducted them with the MDS after that. R10's behavior included that she secluded herself.

Interview with Certified Nurse Aide (CNA) J on 02/05/20 at 09:22 AM revealed the nurses did the behavior monitoring every shift and said it must be charted.

Interview with Administrative Nurse B on 02/04/20 at 10:58 AM revealed the nurse's charted the resident's behaviors every shift and as needed.

Interview with Administrative Staff G on 02/05/20 at 03:25 PM revealed staff were expected to chart behaviors every shift and as needed when the resident experienced a behavior.

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WESTERN PRAIRIE SENIOR LIVING LLC	510 E SAN JACINTO AVENUE ULYSSES, KS 67880

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Review of 11/28/17 "Unnecessary Medications" policy revealed "an unnecessary drug was any drug used ...without adequate monitoring. Psychoactive drugs include Anti-psychotics. The care plan for psychotropic medications included the name of the medication used, the indicated behaviors being treated ...behavior ...monitoring will be documented in the resident's clinical record".

Review of 11/28/17 "Abnormal Involuntary Movement Scale (AIMS) Examination " policy revealed the facility performed AIMS testing on all resident's receiving antipsychotic medications or Reglan.

The facility failed to complete behavior monitoring and the Abnormal Involuntary Movement Scale (AIMS) for R10.

- Review of R26's pertinent diagnoses from the 12/10/19 "Physician's Order Sheet" revealed: Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

Review of the 12/02/19 "Admission Minimum Data Set" (MDS) revealed a brief interview for mental status (BIMS) of eight, indicating moderately impaired cognition. He scored zero on

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the mood score indicating no signs or symptoms of depression. R26 utilized antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medications seven of the seven-day review period.

Review of the 12/02/19 "Psychotropic Medication Care Area Assessment" (CAA) revealed he received Seroquel (antipsychotic medication) for depression and anxiety and had Ativan (antianxiety medication) as needed (PRN) for anxiety.

Review of "Care Plan", last revised 11/26/19, revealed the resident took medications with black box warnings (BBW, a type of warning that appears on the package insert for certain prescription drugs) and he required staff to help "watch out for the indicated reactions" and notify the physician if any were seen.

Review of "Physician Orders" revealed Seroquel ordered to be administered on 11/25/19 for anxiety.

Review of the staff task "Monitor- select side effects, other psychoactive medication" documentation from 12/06/19 to 02/04/20 revealed missing documentation for over 30 areas/days related to behaviors the resident did or did not display related to the use of Seroquel.

The "Abnormal Involuntary Movement Scale" (AIMS, a 12-item clinician-rated scale to assess severity to execute voluntary movements) completed on 11/29/19, marked incorrectly, noted

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the resident did not receive antipsychotics (which were initiated on 11/25/19).

Observation of R26 on 02/04/20 at 09:05 AM revealed the resident without behaviors or signs/symptoms of medication related side effects. He was dressed and groomed appropriately and able to feed self without difficulty.

Interview with Certified Nurse Aide (CNA) I on 02/04/20 at 03:48 PM revealed R26 did reject cares at times because he liked to do everything himself. But the CNA's were expected to report to the nurse for documentation if he had behaviors every shift.

Interview with Licensed Nurse (LN) E 02/05/20 at 03:02 PM revealed the staff monitored him for exit seeking when he first arrived. However, he just liked to "walk" now.

Interview with Administrative Nurse B 02/04/20 at 01:01 PM revealed they expected the AIMS assessment to be correct according to the resident's diagnosis, medications (antipsychotics), and assessments.

Review of 11/28/17 "Unnecessary Medications" policy revealed "an unnecessary drug was any drug used ...without adequate monitoring. Psychoactive drugs include Anti-psychotics. The care plan for psychotropic medications included the name of the medication used, the indicated behaviors being treated ...behavior ...monitoring will be documented in the resident's clinical record".

Review of 11/28/17 "Abnormal Involuntary

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F 758	Continued From page 30 Movement Scale (AIMS) Examination " policy revealed the facility performed AIMS testing on all resident's receiving antipsychotic medications or Reglan. The facility failed to ensure the staff completed behavioral documentation on R26 to ensure the reason for the antipsychotic medication Seroquel. The facility also failed to ensure the staff completed the "AIMS" assessment correctly.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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This REQUIREMENT is not met as evidenced by:
The facility census totaled 41 residents with 12 residents in the sample. Based on observation, interview, and record review the facility failed to ensure appropriate cleaning of the nebulizers after each use and did not have logs for nightly nebulizer cleanings as well for Resident (R)10.

Findings included:

- Review of R10's pertinent diagnoses from 01/30/20 "Physician's Order sheet" revealed: pneumonia (an inflammation of the lungs).

Review of the 05/24/19 "Annual Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) of 14, indicating intact cognition. She used oxygen (O2) and had respiratory therapy noted for 112 minutes during the seven-day review period.

Review of the 11/15/19 "Quarterly MDS" revealed a BIMS of nine, indicating moderately impaired cognition. She used O2 and had respiratory therapy during the seven-day review period.

Review of the 05/24/19 "ADL Care Area Assessment" (CAA) revealed R10 was dependent on staff for all daily cares and transferred with a full mechanical lift and two staff. The staff would include care plan revisions to maintain her current level of functioning and to ensure daily needs were met.

Review of 08/08/16 "Care Plan" revealed lack of nebulizer treatments on the care plan.

Review of "Physician Orders" revealed the

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following:
10/17/19, Ipratropium-Albuterol Solution 0.5 - 2.5 3 milligrams (mg)/3 milliliter (ml)- 1 vial inhale orally via nebulizer four times a day related to abnormal finding of lung field.
10/17/19, Oxygen per Nasal Cannula at 2 liters (L), monitor oxygen saturation every shift related to pneumonia.
10/17/19, Budesonide Suspension 0.5mg/2ml- 1 vial inhale orally via nebulizer two times a day for shortness of breath.
01/16/20, Cefdinir Capsule 300mg- Give 300mg by mouth two times a day related to pneumonia for six days ends 01/21/20.

Review of transfers to hospital for R10 dated 06/25/19 revealed R10 went to the hospital for pneumonia of the right upper lobe due to an infectious organism. Review of progress notes dated 06/25/19 revealed no nursing note was made about resident's hospitalization.

Review of 07/06/19 "ED to Hospital Admission" revealed R10's pneumonia was "slightly worsening", and she was admitted 07/07/19 for low O2 saturations and respiratory distress.

Review of transfers to hospital for R10 dated 09/30/19 revealed R10 had low oxygen saturations.

Review of general note dated 10/11/2019 at 11:37 PM revealed the resident admitted from the hospital on 10/09/19 after treatment for pneumonia.

Review of transfers to hospital for R10 dated 10/12/19 revealed the resident tested positive for influenza B (a strain of the flu virus) and

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Rhinovirus (a group of viruses including one that causes the common cold).

Review of 01/14/20 "ED Provider Notes" revealed R10 with a diagnosis of pneumonia and influenza B.

Observation of R10 on 02/05/20 at 11:47 AM revealed Licensed Nurse (LN) E in R10's room and O2 saturation noted at 92%. Breathing treatment started at 12:05 PM and ended at 12:16 PM. LN E placed the nebulizer and tubing in the storage bag without cleaning the nebulizer.

Interview with R10 on 02/03/20 at 11:05 AM revealed she went to the hospital at least six times in the last year.

Interview with Certified Nurse Aide (CNA) H on 02/04/20 at 03:40 PM revealed the staff were to clean the breathing treatment machine and nebulizer after each use. R10 wore her O2 all the time at 2 liters per nasal cannula.

Interview with CNA I on 02/04/20 at 03:56 PM revealed R10 was sick a lot. CNA I said R10 went to the hospital in the past for pneumonia and influenza B.

Interview with LN E on 02/04/20 at 09:19 AM revealed staff usually cleaned the nebulizers every night and said day shift staff did not have to clean it after every use. At night, the staff cleaned the nebulizers with soap and water. She would have to check the policy with the Director of Nursing (DON) to check and make sure the cleaning was appropriate for the nebulizers.

Interview with Administrative Nurse B on 02/04/20

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at 10:58 AM revealed she expected the staff to clean the mask for breathing treatments and stated staff rinsed, set it out to dry, and then placed it in the holding bag. The facility had not logged the cleaning of the nebulizers at night, and she did not know if the staff used the vinegar/water mixture or if it was just a water rinse that they used to rinse the nebulizers off.

Review of 11/28/17 "Infection Control" policy revealed (the facility) will monitor episodes of infection ...or increases in the rate of infection. Each resident identified as having an acute infection will be reviewed at the weekly Resident-at-Risk meeting.

Review of 11/28/17 "Hand-held Nebulizer Cleaning" policy revealed in between each use the plastic cups, lids, mouth pieces will be cleaned with warm soapy water, rinsed thoroughly, and placed on paper towels to air dry. After cleaning and air-drying, place all pieces in a plastic bag that has been labeled with the resident's name.

The facility failed to ensure appropriate cleaning of the nebulizers after each use and did not have logs for nightly cleanings of the nebulizer as well for R10.