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	175457	A. BUILDING _____ B. WING _____	12/23/2019

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PEABODY OPERATOR, LLC	407 N LOCUST STREET PEABODY, KS 66866

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 12/30/19.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. The sample of 14 residents, included one resident reviewed for Activities of Daily Livings (ADL). Based on observation, interview and record review the facility failed to provide one Resident (R)16 with assistance needed to maintain proper hygiene and nail care. Findings included: - The signed "Physician Order Sheet" (POS), for Resident (R)16, dated 12/02/19, documented the resident had the following diagnoses: schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbance of language and communication, and fragmentation of thought), muscle weakness, difficulty walking, and unsteady on feet. The Annual "Minimum Data Set" (MDS), dated 07/23/19, documented the resident admitted 07/16/18. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of	F 677		

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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11, indicating she had a moderately impaired cognition. The resident's functional status was documented as the resident needed supervision with personal hygiene.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 08/07/19, documented the resident had difficulty making decisions related to not being able to focus on the subject during conversations and tends to jump from one subject to the next.

The "Activity of Daily Living Functional/Rehabilitation [ADL] Care Area Assessment" (CAA), dated 08/07/19, documented the resident was at risk for impaired ADL function. The resident required total staff assistance with bathing.

The care plan, revised on 08/13/19, documented the resident was at risk for impaired ADL function related to impaired mobility. The staff was directed to assistance the resident with showering two times a week at her preference and to help with dressing. The nurses will do her nail care and she enjoyed having her nails manicured.

The resident's shower sheets documented the following:

11/22, refused.
11/27, had a shower and nail care.
11/29, refused.
12/3, had a shower and no nail care.
12/10, refused.
12/13 shower, no nail care.
12/17, refused.
12/18, refused.
12/19, shower and nail are provided.

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The shower sheets indicated in the last 34 days the resident had only received a shower and/or nail care 3 times.

The Social Service designee note, dated 12/19/19 at 11:29 AM, documented the staff had a discussion with the resident about personal hygiene. The facility staff will ask the resident every day to see if she would want a shower or bath. The facility staff and resident agreed upon the goal of at least one shower per week. The facility staff will discuss any potential barriers to meeting this goal and how to overcome those barriers.

Observation, on 12/17/19 at 1:38 PM , revealed the resident's fingernails are very long, the nail polish was grown out from cuticle approximately 1/4 inch, the nail polish was chipped in various areas on all nails. The resident's hair was unkempt.

Observation, on 12/18/19 at 10:11 AM, revealed the resident sitting in the chair in her room, nails were still long, still needed polished, and still contained chipped polish.

Observation, on 12/18/19 at 12:16 PM, revealed the resident there were no change to nails or appearance still needed polish and a shower, as resident hair was unkempt and nails were same.

Observation, on 12/18/19 at 4:20 PM, revealed the resident walking down the hall with her walker, she had on different clothing then earlier, hair combed nicely, but her nails were still long with chipped polish.

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Observation, on 12/19/19 at 9:11 AM, revealed the resident sitting in her recliner in her room, her nails were long and chipped nail polish on most of the nails. Her hair appeared slightly dirty and greasy.

On 12/19/19 at 9:15 AM, Licensed Nurse (LN) F confirmed the resident's nails needed attention as they were long and the polish was chipped/missing in several areas. She also confirmed the resident needed a shower.

On 12/19/19 at 2:49 PM, LN F reported, the resident could voice her needs and concerns, but you had to gain her trust before she will talk to you. She does a lot on her own, she takes self to bathroom, but needed help with hygiene. She can be resistant to cares, and if she does not want to do something, then she would not. LN F further reported the nurses provided nail care for the residents who are diabetic and the CNA (certified nursing assistant) provide nail care during their showers. All residents are usually scheduled to have showers scheduled a couple times a week, unless they have a specific request for more or less. When a resident refused a shower then the CNA staff should get the nurse, and they will talk to resident to see if they could get them to shower.

On 12/23/19 at 2:10 PM, CNA N reported, the resident could voice her needs and concerns. With bathing, nail care and ADLs, she sometimes needs more help, such as setup for a shower. The nail care would be done by the nurse if diabetic, and the CNAs, if not, during their bath. CNA N further stated there was a volunteer lady that would come and do her nails, but she had not been in lately.

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F 677	Continued From page 4 On 12/23/19 at 3:58 PM, License Nurse E reported, generally speaking the nail care was done by the nurse, if diabetic, and the CNAs during the bath if not diabetic. When a resident refuses the CNA should try a couple times and then have the nurse try. They are signing the shower sheets when giving baths and refusals. The bath, shampoo and nail care go together. This resident often refuses and we can not make someone take a bath, and she liked her nails long. I have pled with her offered snacks, special snacks, cinnamon rolls, I have tried to entice with snacks. If she has had only three baths in the last 30 days, I agree that is not enough, but we have tried, and if only three we need to find something else to try. The policy titled, "Quality of Life-Activities of Daily Living," dated November 2017, directed residents whom are unable to carry out ADLs will receive the necessary care and services to maintain good nutrition, grooming, and personal hygiene. If a resident or representative refuses care and treatment which may contribute to a decline, then complete the following: document the substitute interventions that were tried with consent or refused, and attempt to find the underlying cause of the refusal, if related to depression, behavioral or dementia care. Update care plan appropriately and interventions as needed. The facility failed to provide adequate assistance to this dependent resident for her hygiene needs by assisting her with showers and nail care.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		

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§483.24(c) Activities.
§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. The sample of 14 residents, included three residents reviewed for activities. Based on observation, interview and record review, the facility failed to provide activities for two of the three residents, Resident (R)29 and R 31 with an individualized activity program to maintain their physical, mental and psychosocial well-being.

Findings included:

- The signed "Physician Order Sheet" (POS), for Resident (R) 29, dated 12/02/19, documented the resident had the following diagnoses: mood disorder (category of mental health problems. Feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), personal history of traumatic brain injury, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder), and depressive disorder (abnormal emotional state

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characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness)

The Annual "Minimum Data Set" (MDS), dated 01/26/19, documented the resident admitted 08/16/14. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) that was not obtainable as the resident rarely/never understood, indicating he had an impaired cognition. The resident's functional status documented the resident needed extensive assistance with activity of daily living (ADL). The resident's preferences were listed as:
Not very important - to have access to books, newspaper, magazines to read, music, to do favorite activities or religious services.
Not important at all - to take care of personal belongings, to have family or friends involved, to keep up with news, or participate in groups,
Somewhat important- to have access to animals/pets, and go outside in good weather.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 02/05/19, revealed the resident was at risk for impaired cognition due to diagnosis of Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder).

The "Activity of Daily Living Functional/Rehabilitation Care Area Assessment" (CAA), dated 02/05/19, revealed the resident was at risk for impaired ADL function due to diagnosis of Huntington's disease.

The "Activities Care Area Assessment" (CAA), did not trigger.

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The care plan, revised on 03/09/18, documented the resident preferred one to one activities. The care plan directed staff to allow the resident to express his feelings and desires related to activity attendance. Encourage him to be involved in the activities that he enjoys. Include his preferences in rendering care and services. Inform him of upcoming events by providing him with an activity calendar, verbal reminders and encouragement to attend. Escort him to the activity when possible, praise his involvement, and provide an opportunity for him to express his individuality. Staff reminded the resident enjoyed one to one activities. The care plan directed staff that the resident was to be one of the first to leave when he completed the activities.

The Activity note, dated 01/28/19 at 10:55 AM, documented the staff provided the resident a monthly calendar of activities and invited him to attend. The resident was unable to attend due to his Parkinson's (a progressive disorder of the nervous system marked by muscle tremors, muscle rigidity, decreased mobility, stooped posture, slow voluntary movements, and a mask like facial expression). He would attend special events and have one on one activities. He watched television in his room and occasionally came to the parties. Continue with current plan of care. The electronic medical record lacked any other activity notes.

The Recreation Admission/Annual assessment, dated 01/28/19, documented the resident liked family and friend visits, movies, music, social parties, sports, television, and listening to the radio. The resident could have socially inappropriate behaviors, had Parkinson's, and

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had constant body movement requiring help.

The activity calendar on the wall showed the activities for 12/19/19 as beginning at 11:00 AM going to the Senior Center, 02:00 PM bingo and at 03:00 PM a Christmas movie with ice cream. Observations revealed the resident did not attend any of these activities.

The activity calendar on the wall showed the activities for 12/23/19 as beginning at 11:00 AM with exercise and reminisce, 02:00 PM bible study, 03:00 PM Pair Up game, and 04:00 PM book club with refreshments. Observations revealed the resident did not attend any of these activities.

The electronic medical record for the past 30 days, revealed the resident participated in no activities from 11/23/19 through 12/23/19.

Observation, on 12/18/19 at 10:16 AM, revealed the resident lying in bed, appeared to be sleeping, and with the television playing in his room.

Observation, on 12/18/19 at 4:18 PM, revealed the resident lying in bed facing the wall.

Observation on 12/23/19 at 10:45 AM, revealed the resident lying in bed and appeared to be sleeping.

On 12/19/19 at 8:40 AM, Certified Nurse Aide (CNA) N reported, the resident liked television and loved sports, like when Ohio State played. He did not enjoy being with people as he was more a loner. He was easy to get agitated. CNA N further reported the resident did not go to the group activities, unless just observing for a while.

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On 12/19/19 at 9:52 AM, CNA M reported, for or during the activities the CNAs helped get people to the activities, and then take them back to their rooms after. It was discouraging because people do not really go to the activities. When someone attended an activity the CNAs tell the activity director (AD) so she can chart the attendance. In the evenings, since the AD goes home around 4 or 5, there were not very many activities. We have cards, games, coloring books and they can do puzzles, but really there are not that many activities. This resident liked to lay in bed, sometimes watched football, and he did not like to be in his chair. He gets up for meals and lays down right after he finishes.

On 12/23/19 at 2:10 PM, CNA N, reported the resident was alert, but could not really talk. He says simple things, but not long sentences only yes and no questions. The activities he likes to watch are football on TV and family visits, but he died not really do any other activities. The resident can get irritated easily, and stays in his room. If he had any activities they would be in his room and one on ones.

On 12/19/19 at 2:19 PM, License nurse F reported, as the nurse my role for activities would be to encourage them to come out. There was not a lot of participation. Staff reminded them to come out. The same five or six people attend, then on bingo more go to that. Staff tried to encourage them, but a lot preferred to stay in their rooms. The one on one activities would be with the activity director. This resident can voice his needs and concerns. You give him time to understand and he can respond. He does not like to participate in group activities, as he did not

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like that. He was insistent he wants to go to bed. He did have a television in his room and watched it occasionally. He does like his family visits.

On 12/23/19 at 4:43 PM, Activity Director (AD) Z reported, it was her job to plan the activities and get the residents' input, to see if they wanted to change things or do different activities. She made the big calendar on the wall and the small monthly calendar. The group activities, we have the same six residents and a large group that comes to bible study and bingo. One on ones are in the resident's rooms. For the one on one activities, it can be a massage to their hands mostly, a couple likes Elvis others likes country music. I will try to do 15 to 20 minutes at a time. Staff obtain their preferences annually. If they do not like the group activities, then they should do one on ones. They would rather watch television and be left alone. AD F further advised she did not attend the care plan meetings. If you go by the documentation this resident was not getting activities and his needs were not being met. I go room to room and invite people, but I do not help them come down to the activity room. I do not wait for them to answer if they are coming or not, because the staff had to go back down to the activity room to get started.

On 12/23/19 at 4:18 PM, Administrative Nurse E reported, the residents are to be encouraged by the CNAs. if they like to watch television Staff put on their favorite channel . , have at a comfortable level in room where can hear, radio in the room same, if they have a certain activity they like set that up for them. When they are confused or cannot go by themselves, the CNAs go around and get them there. He can communicate with short sentences, but hard to understand at times.

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He likes to go to his room after meals to lay down. He can and will throw a fit in his chair and or even throw self out of chair if not laid down timely. One on One activities are done by the activity director, but not sure how often. I do not believe he did any one on ones. When you do not go to the activities and no one on ones that was not meeting their psychosocial needs.

The policy titled, "Individual Activities and Room Visit Program," revised August 2006, directed individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities, or who do not wish to do so. Individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities, or who do not wish to do so. For those residents whose conditions or situation prevents participation in group activities, and for those who do not wish to participate in group activities. The activities program provides individualized activities consistent with the overall goals of an effective activities program. The activities offered are reflective of the resident's individual activity interests, as identified in the Activity Assessment, progress notes and the resident's comprehensive care plan. It is recommended that residents on a full room visit program receive, at a minimum, three room visits per week. Typically a room visit will be ten to fifteen minutes in length and tailored to address specific underlying causes of the individual's behavioral or attention limitations. Residents who choose not to attend group activities will maintain an independent program. it is the responsibility of the facility and the activity staff to make regular contacts and offer supplies, as needed.

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The facility failed to provide this resident an individualized activity program to maintain his physical, mental and psychosocial well-being.

- The signed "Physician Order Sheet" (POS), for Resident (R) 31, dated 12/02/19, documented the resident had the following diagnoses: frontotemporal dementia (progressive mental disorder characterized by failing memory, confusion), other symptoms and signs involving cognitive function and awareness, unspecified disorder of adult personality and behavior, unspecified psychosis (any major mental disorder characterized by gross impairment in reality testing) not due to substance or known physiological condition and mood disorder.

The Annual "Minimum Data Set" (MDS), dated 11/01/19, documented the resident admitted 08/30/16. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating she had an severely impaired cognition. The resident's preferences were listed as she liked to stay up late, family involvement, listen to music, animals, and outdoors. The resident required total assistance for transfers and extensive assistance for all other activities of daily living (ADL)s.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 11/15/19, documented the resident was at risk for impaired cognition related to diagnosis of frontotemporal dementia.

The "Activity of Daily Living Functional/Rehabilitation Care Area Assessment" (CAA), dated 11/15/19, revealed the resident was at risk for impaired ADL functions related to

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impaired mobility.

The "Activities Care Area Assessment" (CAA), dated 11/15/19, documented the resident was at risk for not participating in activities due to inattention.

The care plan, revised on 04/25/19, documented the resident preferred one on one activities. The activities of interest to the resident were animals, family/friend visits, movies, music, social parties, and television or radio. She liked to hold the babies which her family has brought for her to care for. The care plan directed staff to allow the resident to express her feelings and desires related to activity attendance. Encourage her to be involved in activities. Include her preferences in rendering care and services, inform her of upcoming events, provide an activity calendar, give verbal reminders and encouragement to attend. The staff were to escort her to the activity when possible. Provide an opportunity for the resident to express her individuality. The care plan further advised staff that she enjoyed rocking in the recliner, watching television, taking care of her baby dolls, listening to music, and looking at pictures.

The activity calendar on the wall, for 12/19/19, showed activities at 11:00 AM going to the Senior Center, 02:00 PM, bingo and at 03:00 PM a Christmas movie with ice cream. The resident did not attend any of these activities.

The activity calendar on the wall, for 12/23/19, showed 11:00 AM exercise and reminisce, 02:00 PM bible study, 03:00 PM Pair Up game, and 04:00 PM book club with refreshments. The resident did not attend any of these activities.

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The Recreation (Activities) Admission/Annual/COC Assessment, dated 11/01/19, documented the following:
Important, but can't do or no choice.
Activity pursuits- animals/pets, family/friend visit, music, television, and radio.
Other preferences- preferred location in own room, day or activity room, inside facility only.
Psychosocial well being-disinterested, uncooperative, needs encouragement/willing to try.
Special considerations-socially inappropriate behavior, wanderer, physically abusive, incontinent, has a short attention span, talks gibberish, gets agitated easy, one on one's would be better for her.
MDS associated items- important, but can't do or no choice to have books, newspapers or magazines to read and to do things in groups.
Very important to have music, pets or animals.
Not important to keep up with news or to do favorite activities.
Somewhat important to go outside for fresh air.

The electronic medical record for the past 30 days revealed the resident had no activities (11/23/19 to 12/23/19).

Observation, on 12/18/19 at 10:38 AM, revealed the resident lying in bed, she appeared awake as she was lifting her head off the pillow then laid it back down. The resident had no television or music playing or visual items to look at in her room.

Observation, on 12/18/19 at 04:17 PM, the resident was lying in bed, awake and moving her legs around. She did not have a television

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playing or music.

Observation, on 12/19/19 at 08:31 AM, the resident was brought out of the assisted dining room and placed in front of the television in the day room. Staff took the resident to her room at 8:45 AM.

Observation on 12/23/19 at 10:45 AM, revealed the resident sitting in the day room in a recliner. She had her eyes closed and appeared to be sleeping. The television in the room played quietly.

On 12/19/19 at 09:52 AM, Certified Nurse Aide (CNA)M reported, for and during the activities the CNAs helped get people to the activities and take them back to their rooms after. It was discouraging because people do not go really go to the activities. When someone attended an activity the CNAs told the activity director so she could chart the attendance. In the evenings, since the activity direct went home around 4 or 5, there were not very many activities. The facility had cards, games, coloring books and the residents could do puzzles, but really there were not that many activities. The resident was also dependent on staff, and she was required a full body mechanical lift. She could not voice her needs or concerns. She did not go to the group activities. Staff would place her in front of the television in the living room. The staff did this while getting people out of the dining room until they could lay her down, other than that she was always in her bed laying down.

On 12/23/19 at 02:10 PM, CNA N, reported the resident was very confused, and could not make her needs or wants known, you just anticipate

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and help her. She did not attend any activities. She needed one on ones activities, because she could not handle the groups. She did like her babies and had a doll. the staff would give her it sometimes to hold. The activity director charted in the computer when someone attended an activity.

On 12/19/19 at 02:19 PM, License nurse (LN) F reported, as the nurse her role for activities would be to encourage them to come out. There was not a lot of participation. Staff reminded the residents to come out. The same five or six residents would attend. Then on bingo more go to that. Staff tried to encourage them, but a lot preferred to stay in their rooms. The one on one activities would be done by the activity director. This resident is one that did not attend activities. She would be better in a one on one situation instead of a group. She did not voice her needs or concerns as staff had to anticipate her needs.

On 12/23/19 at 04:43 PM, Activity Director (AD) Z reported, it was her job to plan the activities and get the residents input. she would see if they wanted to change things or do different activities. She made the big calendar on the wall and the small monthly calendar. The group activities had the same six residents and a large group that comes to bible study and bingo. One on ones are in the resident's rooms. For the one on ones, it could be a massage to their hands mostly, a couple likes Elvis others likes country music. AD Z would try to do 15 to 20 minutes at a time. Staff obtained the residents' preferences annually. If they do not like the group activities then they should do one on ones. They would rather watch television and be left alone. AD Z further advised she did not attend the care plan meetings. If you

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go by the charting they are not getting activities, her needs are not being met. I go room to room and invite people, but I do not help them come down to the activity room. I do not wait for an answer if they are coming or not, because AD Z had to go back down to the activity room to get started. AD Z further advised she would say this resident's psychosocial needs were not being met.

On 12/23/19 at 04:18 PM, Administrative Nurse E reported, the residents are to be encouraged by the CNAs, if they like to watch television, staff put on their favorite channel, have it at a comfortable level in the room where the resident can hear it, keep a radio in the room same, if they have a certain activity they like set that up for them. When they are confused or can not go to an activity by themselves, the CNAs go around and get them there. One on One activities were done by the activity director, but Nurse E was not sure how often. I do not believe she does any one on ones. When the residents do not go to the activities and no one on ones, that was not meeting their psychosocial needs.

The policy titled, "Individual Activities and Room Visit Program," revised August 2006, directed individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities, or who do not wish to do so. Individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities, or who do not wish to do so. For those residents whose conditions or situation prevents participation in group activities, and for those who do not wish to participate in group activities. The activities program provides

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F 679	Continued From page 18 individualized activities consistent with the overall goals of an effective activities program. The activities offered are reflective of the resident's individual activity interests, as identified in the Activity Assessment, progress notes and the resident's comprehensive care plan. It is recommended that residents on a full room visit program receive, at a minimum, three room visits per week. Typically a room visit will be ten to fifteen minutes in length and tailored to address specific underlying causes of the individual's behavioral or attention limitations. Residents who choose not to attend group activities will maintain an independent program. it is the responsibility of the facility and the activity staff to make regular contacts and offer supplies, as needed. The facility failed to provide this resident an individualized activity program to maintain their physical, mental and psychosocial well-being.	F 679		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		

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

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents with five reviewed for unnecessary medications. Based on record review and interview, the facility failed to ensure one Resident (R) 6, of the five residents remained free of unnecessary medications, when facility staff failed to monitor pain with the administration of pain medication to ensure no unnecessary medication usage.

Findings included:

- The "Physician Orders" (PO), dated 12/02/19, documented the resident with the diagnosis of osteoarthritis (when the protective cartilage that cushions the ends of your bones wears down over time).

The annual "Minimum Data Set" (MDS), dated 04/09/19, documented the resident with a Brief Interview for Mental Status (BIMS) score of six, indicating moderately impaired cognition and had mild occasional pain.

The quarterly MDS, dated 09/20/19, documented the resident with a BIMS score of seven, indicating moderately impaired cognition. The resident had occasional pain which did not affect daily activities and sleep.

The care plan, dated 11/12/19, documented the

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resident with impaired mobility and required staff assistance with "Activities of Daily Living" (ADL). She used a wheelchair for mobility. She had pain due to osteoarthritis and the charge nurse was to assess her for pain every day.

A physician order, dated 08/22/18, instructed the staff to administer acetaminophen (Tylenol), 500 milligrams (mg), give two tablets by mouth three times a day for osteoarthritis.

Review of the October, November, and December medication administration records (MAR) and under the vital signs tab in the resident's electronic medical record (EMR), revealed the facility staff failed to complete the scheduled daily pain assessments with the administration of resident's acetaminophen.

Interview, on 12/23/19 at 03:53 PM, with Administrative Nurse F, revealed pain assessments should be done per the care plan. Pain assessments should be done with any pain medication that residents received.

The facility policy for "Pain - Clinical Protocol / Guidelines" revised 11/2017, documented: "...Assessment and Recognition . . . a. Staff will assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level..."

The facility failed to ensure adequate pain monitoring for this resident who received pain medication.