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	175525	A. BUILDING _____ B. WING _____	12/06/2018

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PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 13 residents, of which 5 were reviewed for nutrition. Based on observation, record review, and interview the facility failed to develop and implement effective nutritional interventions for 1 of the 5 residents sampled for nutrition, who had a weight loss of 17.1(lbs) pounds, 10.1% in 6 months. (#51)	F 692		

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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Findings included:

- Resident #51 quarterly (MDS) Minimum Data Set assessment, dated 10/25/2018, recorded the resident scored 6 on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment. The MDS recorded the resident required limited assistance of 1 staff with bed mobility, transfers, toilet use, and staff supervision with set up help for eating. The MDS further documented the resident weighed 154 lbs, received a therapeutic diet, and had weight loss or gain.

The nutritional (CAA) Care Area Assessment, dated 5/28/2018, documented the resident ate independently with staff set up assistance, he/she had trouble swallowing pills, and denied any chewing/eating difficulties. The CAA lacked documentation of the resident's weight.

The care plan, dated 11/11/2018, documented the resident required a regular texture, regular consistency, no salt added diet. The care plan directed the staff to monitor, record, and report to the physician, signs and symptoms of malnutrition, and significant weight loss of 3 lbs in 1 week, > 5 % in 1 month, >7.5 % in 3 months and >10% in 6 months.

The 4/30/18 physician's order directed staff to provide the resident a regular diet, low concentrated sweets, and regular consistency.

The 8/09/2018 Nutrition Assessment completed by the (RD) Registered Dietician recorded the resident's weight was 161 lbs, height 60.25 inches, and he/she received a regular diet, low concentrated sweets, and regular consistency.

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The weight record revealed the following:
5/07/18 - 168.5 lbs
9/17/18 - 167.2 lbs
10/01/18 - 159.4 lbs
10/15/18 - 155.2 lbs
10/29/18 - 153.2 lbs
11/12/18 - 152.4 lbs
11/26/18 - 156.8 lbs
12/03/18 - 151.4 lbs (17.1 lbs, 10.1% weight loss)

On 12/06/2018 at 8:25 AM, observation revealed the resident sat in his/her recliner in his/her room eating breakfast. The resident ate sausage gravy biscuits, scrambled eggs, cinnamon crisp cereal, and orange juice. Continued observation revealed the resident ate ½ of the biscuits and gravy and did not eat the cereal.

On 12/04/2018 at 12:20 PM, Dietary Manager BB verified the RD assessed the resident's nutritional status on admission, with a significant change, and if the facility indicated a nutritional concern. Dietary Manager BB stated if the facility identified a weight loss staff would add fortified foods and supplements as indicated.

On 12/06/2018 at 10:00 AM, Administrative Nurse D verified the medical record documented the resident lost 17.1 lbs in 180 days and verified the medical record lacked a Registered Dietician assessment since 6/06/2018. Administrative Nurse D stated the facility preferred to have the RD complete an assessment on a newly admitted resident a few days after admission, with a significant change, and readmission.

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On 12/12/2018 at 10:10 AM, Consultant GG stated him/herself and his/her nurse practitioner had seen the resident a few times since May, staff had not informed them of the resident's significant weight loss. Consultant GG verified they should have been informed, and if they had known of the weight loss, they would have implemented things before 12/06/2018.

On 12/12/2018 at 10:20 AM, Dietary Consultant HH stated this resident fell through the cracks. He/she stated the CDM thought he/she had told him/her, verbally, of the resident's weight loss, but they have no paper trail with this information.

The facility's Nutrition and Hydration services policy, dated 7/2018, indicated the facility would ensure, through a restorative approach that residents are provided with foods and fluids that are safe, adequate in quality, nutritious and varied by dietary services. Nutritional care is aimed at improving, preventing deterioration or maintaining a resident's functional and wellness level and quality of life through an interdisciplinary approach to meal preparation and services. Nutrition and hydration is integrated into the home's program and the resident's individual plan of care and supports an enjoyable dining experience. The policy documented the dietary manager would monitor and evaluate each resident's nutritional risk utilizing the Mini Nutritional Assessment (MNA) on a quarterly, annual basis and when the plan of care is not effective or not needed. The dietary manager would print and review the weekly/vitals exception report weekly and complete on MNA on all residents with significant unplanned weight changes as defined by:
3%-5% of body weight or more in a 1 month

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F 692	Continued From page 4 period 7.5% of body weight or more in a 3 month period 10% of body weight or more over a 6 month period. The MNA assessment findings are reported to the Interdisciplinary Team weekly and residents identified as at-risk of malnutrition or malnourishment per the MNA. Any resident identified as malnourished shall be referred to the RD for further nutritional assessment. The CD and the RD reports resident specific dietary concerns weekly to the team for review. The facility failed to implement timely and effective interventions to prevent weight loss for Resident #51, who lost 17.1 pounds in 6 months, resulting in significant weight loss and placing the resident at risk for increased health concerns.	F 692		
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	F 756		

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during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a 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 had a census of 59 residents. The sample included 13 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview the facility's Pharmacist Consultant failed to provide guidance to the facility during monthly reviews for the use of antipsychotic medication for 2 of 5 sampled residents. (#3, #34)

Findings included:

- Resident #3's physician order sheet, dated 11/1/18, recorded a diagnosis of major depressive disorder, (a major health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant

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impairment in daily life).

The annual (MDS) Minimum Data Set assessment, dated 11/7/18, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 14 (intact cognition), and no psychosis (a mental disorder with impaired relationship with reality) or behaviors. The MDS recorded the resident required limited staff assistance with bed mobility and transfers and used a wheelchair for mobility. The MDS further recorded the resident received antipsychotic medication on a daily basis, had no GDR (gradual dose reduction) since starting on the antipsychotic medication, and the medical record lacked documentation by the physician the GDR as clinically contraindicated.

The 11/7/18 care plan recorded the resident has problems with short term memory and has a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The care plan recorded the resident received Zyprexa (antipsychotic medication) with the following (BBW) Black Box warning (strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug). Zyprexa is not approved for depression or dementia due to the medication is not effective for the treatment of depression or dementia, and can increase mortality (death) risk and adverse side effects in the elderly.

The physician order, dated 7/5/17, directed the staff to administer Zyprexa, 2.5 (mg) milligrams by mouth (PO) at bedtime daily.

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The facility's behavior monitoring documentation for September, October, November and December 1-3, 2018, lacked documentation the resident displayed behaviors. The last AIMS (abnormal involuntary movements) (an assessment used to rate involuntary movements from the use of an antipsychotic medication) dated 12/1/17, was the last AIMS assessment the facility completed.

Review of the monthly Pharmacy Consultant report for the months of June-November 2018, documented no recommendations for a GDR (gradual dose reduction), diagnosis, or AIMS assessment.

On 12/4/18 at 9:40 AM, observation revealed the resident sat in the dining room at his/her table, visiting with other residents.

On 12/6/18 at 8:25 AM, Administrative Nurse D verified staff had not attempted a GDR since the resident started the Zyprexa medication and the pharmacist consultant had not recommended the GDR. Administrative Nurse D also verified the staff had not completed an AIMS assessment every 6 months for the resident.

On 12/6/18 at 8:40 AM, Administrative Nurse E verified the last AIMS assessment was done 12/1/17, and should be completed every 6 months. Administrative Nurse E also verified the inappropriate diagnosis of depression for the use of Zyprexa, and a GDR was not attempted.

The undated facility's policy for Monthly Drug Review, states the pharmacist will report all recommendations to the Director of Nursing and Administrator. The pharmacist will complete

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forms on residents who are in need of gradual dose reduction, and appropriate diagnosis for the use of medications.

The facility's Pharmacist Consultant failed to recommend an appropriate diagnosis and a gradual dose reduction for Resident #3's use of the antipsychotic medication Zyprexa, placing the resident at risk for adverse side effects.
- Resident #34's (POS) physician's order sheet, dated 12/6/18, recorded the resident had diagnoses of dementia without behavioral disorder (progressive mental disorder characterized by failing memory, and confusion), major depression (abnormal emotional state characterized by exaggerated feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

The quarterly (MDS) Minimum Data Set assessment, dated 9/28/18, recorded the resident had a BIMS (Brief Interview for Mental Status Score of 11, which indicated moderately impaired cognition. The assessment revealed the resident required supervision for bed mobility, dressing, eating, and personal hygiene. The assessment recorded the resident received 7 days of antipsychotic medication (used to treat psychosis and other mental emotional conditions), had no (GDR) gradual dose reduction of Zyprexa (an antipsychotic medication) since 6/27/17, and had no behaviors.

The annual (CAA) Care Area Assessment for psychotropic drug use, dated 07/07/18, recorded the resident received scheduled Zyprexa for

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psychosis, and was at risk for adverse side effects.

The 10/10/18 care plan directed staff to monitor and document for behaviors and side effects from medications, and notify the nurse promptly if the resident seemed easily agitated (feeling or appearing troubled or nervous). The care plan recorded the resident received scheduled Zyprexa with the following (BBW) Black Box Warning (strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug): Zyprexa has and increased mortality (death) in elderly patients with dementia related psychosis.

The physician order, dated 10/11/17 directed staff to increase and administer Zyprexa (an antipsychotic medication) from 2.5 mg (milligrams), 1 tablet, by mouth, twice daily to 5 mg, 1 tablet, by mouth, twice daily for the diagnosis of psychosis.

Review of the (MAR) Medication Administration Record for October, November, and December 2018 lacked documentation the resident exhibited behaviors.

The monthly Pharmacist Consultant records from November 2017 to November 2018, documented no irregularities and no recommendations for a GDR for the resident's Zyprexa medication.

On 12/5/18 at 10:51 AM, observation revealed staff transferred the resident with a sling lift from

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his/her bed to his/her recliner, and the resident was pleasant and thanked the staff.

On 12/4/18 at 10:39 AM, Certified Nurse Aide M stated staff documented if the resident had behaviors and notified the nurse.

On 12/6/18 at 9:07 AM, Licensed Nurse H stated the resident had days of agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition) and confusion (a lack of understanding), but was easily redirected.

On 12/6/18 at 8:37 AM, Administrative Nurse D verified a GDR was not attempted since 6/27/17 and the pharmacist consultant had not recommended a GDR.

The undated Monthly Drug Review Policy documented the consultant pharmacist would review the drug regimen of each resident to conform to state ad federal laws at least monthly. The pharmacist would report all comments, recommendations and any drug irregularities to the (DON) Director of Nursing and if applicable the attending physician. The policy further documented GDRs would be performed every 6 months for residents on antipsychotic medications. The forms for the GDR that needed signatures from the physician would be given to the DON at the completion of the review.

The facility's consultant pharmacist failed to recommend a GDR for Resident #34's use of the antipsychotic medication Zyprexa, placing the resident at risk for adverse side effects.

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

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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 had a census of 59 residents. The sample included 13 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview the facility failed to ensure an appropriate diagnosis, assessment or gradual dose reduction for the use of an antipsychotic medication (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing) and other mental illness conditions) for 2 of the 5 sampled residents. (#3 and #34)

Findings included:

- Resident #3's physician order sheet, dated 11/1/18, recorded a diagnosis of major depressive disorder, (a major health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).

The annual (MDS) Minimum Data Set assessment, dated 11/7/18, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 14 (intact cognition), and no psychosis (a

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mental disorder with impaired relationship with reality) or behaviors. The MDS recorded the resident required limited staff assistance with bed mobility and transfers and used a wheelchair for mobility. The MDS further recorded the resident received antipsychotic medication on a daily basis, had no GDR (gradual dose reduction) since starting on the antipsychotic medication, and the medical record lacked documentation by the physician the GDR as clinically contraindicated.

The 11/7/18 care plan recorded the resident has problems with short term memory and has a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The care plan recorded the resident received Zyprexa (antipsychotic medication) with the following (BBW) Black Box warning (strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug). Zyprexa is not approved for depression or dementia due to the medication is not effective for the treatment of depression or dementia, and can increase mortality (death) risk and adverse side effects in the elderly.

The physician order, dated 7/5/17, directed the staff to administer Zyprexa, 2.5 (mg) milligrams by mouth (PO) at bedtime daily.

The facility's behavior monitoring documentation for September, October, November and December 1-3, 2018, lacked documentation the resident displayed behaviors. The last AIMS (abnormal involuntary movements) (an assessment used to rate involuntary movements

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from the use of an antipsychotic medication) dated 12/1/17, was the last AIMS assessment the facility completed.

On 12/4/18 at 9:40 AM, observation revealed the resident sat in the dining room at his/her table, visiting with other residents.

On 12/6/18 at 8:25 AM, Administrative Nurse D verified staff had not attempted a GDR since the resident started the Zyprexa medication. Administrative Nurse D also verified the staff had not completed an AIMS assessment every 6 months for the resident.

On 12/6/18 at 8:40 AM, Administrative Nurse E verified the last AIMS assessment was done 12/1/17, and should be completed every 6 months. Administrative Nurse E also verified the inappropriate diagnosis of depression for the use of Zyprexa, and a GDR was not attempted.

The facility's policy for the use of Antipsychotic medication documented a gradual dose reduction should be attempted every 6 months and an AIMS assessment is to be done every 6 months for residents receiving antipsychotic medications.

The facility failed to ensure an appropriate diagnosis and assessment for Resident #3's use of the antipsychotic medication Zyprexa, placing the resident at risk for adverse side effects.

- Resident #34's (POS) physician's order sheet, dated 12/6/18, recorded the resident had diagnoses of dementia without behavioral disorder (progressive mental disorder characterized by failing memory, and confusion),

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major depression (abnormal emotional state characterized by exaggerated feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

The quarterly (MDS) Minimum Data Set assessment, dated 9/28/18, recorded the resident had a BIMS (Brief Interview for Mental Status Score of 11, which indicated moderately impaired cognition. The assessment revealed the resident required supervision for bed mobility, dressing, eating, and personal hygiene. The assessment recorded the resident received 7 days of antipsychotic medication (used to treat psychosis and other mental emotional conditions), had no (GDR) gradual dose reduction of Zyprexa (an antipsychotic medication) since 6/27/17, and had no behaviors.

The annual (CAA) Care Area Assessment for psychotropic drug use, dated 07/07/18, recorded the resident received scheduled Zyprexa for psychosis, and was at risk for adverse side effects.

The 10/10/18 care plan directed staff to monitor and document for behaviors and side effects from medications, and notify the nurse promptly if the resident seemed easily agitated (feeling or appearing troubled or nervous). The care plan recorded the resident received scheduled Zyprexa with the following (BBW) Black Box Warning (strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a

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serious hazard with the drug): Zyprexa has and increased mortality (death) in elderly patients with dementia related psychosis.

The physician order, dated 10/11/17 directed staff to increase and administer Zyprexa (an antipsychotic medication) from 2.5 mg (milligrams), 1 tablet, by mouth, twice daily to 5 mg, 1 tablet, by mouth, twice daily for the diagnosis of psychosis.

Review of the (MAR) Medication Administration Record for October, November, and December 2018 lacked documentation the resident exhibited behaviors.

On 12/5/18 at 10:51 AM, observation revealed staff transferred the resident with a sling lift from his/her bed to his/her recliner, and the resident was pleasant and thanked the staff.

On 12/4/18 at 10:39 AM, Certified Nurse Aide M stated staff documented if the resident had behaviors and notified the nurse.

On 12/6/18 at 9:07 AM, Licensed Nurse H stated the resident had days of agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition) and confusion (a lack of understanding), but was easily redirected.

On 12/6/18 at 8:37 AM, Administrative Nurse D verified staff had not attempted a GDR for Zyprexa since 6/27/17.

On 12/6/18 at 8:37 AM, Administrative Nurse D

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F 758	Continued From page 17 verified a GDR had not been attempted since 6/27/17. The facility's policy for the use of Antipsychotic medication documented a gradual dose reduction should be attempted every 6 months and an AIMS assessment is to be done every 6 months for residents receiving antipsychotic medications. The facility failed to attempt a GDR for Resident #34's use of the antipsychotic medication Zyprexa, placing the resident at risk for side effects from the medication.	F 758		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of	F 790		

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dentures determined in accordance with facility policy to be the facility's responsibility;

§483.55(a)(4) Must if necessary or if requested, assist the resident;
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services location; and

§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 13 residents, of which 1 reviewed for dental services. Based on observation, record review and interview, the facility failed to provide dental care for 1 of 1 sampled resident. (#22)

Findings included:

- Resident 22's annual (MDS) Minimum Data Set assessment, dated 4/04/2018, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 12, indicating moderately impaired cognition. The assessment recorded the resident required extensive staff assistance for personal hygiene, dressing, and had no oral or dental issues.

The (CAA) Care Area Assessment, dated

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4/18/2018, for (ADLs) Activities of Daily Living documented the resident was completely dependent on staff with most ADLs. The CAA documented the staff would monitor, document, and report any signs and symptoms of oral/dental problems, pain with his/her gums, toothache, abscess (mouth sore), missing, loose, broken, or decayed teeth, and staff would provide oral mouth cares and personal hygiene.

The care plan, dated 10/02/2018, directed the staff to assist the resident with ADLs, personal hygiene and oral cares. The care plan documented the resident had his/her natural teeth and he/she preferred to brush them with a sponge. The care plan directed the staff to encourage and assist the resident with oral cares and report any changes to the nurse. The care plan indicated the resident had a risk of nutritional problems related to occasional trouble chewing and swallowing, the resident stated he/she had a dry mouth and teeth that were in poor condition. The care plan lacked any documentation of the resident's broken, missing and carious teeth.

On 12/04/2018 at 1:15 PM, observation of the resident's mouth revealed he/she had decayed, carious teeth and some broken off to the gum line.

On 12/06/2018 at 9:38 AM, Nurse G documented the resident had complained of dental pain and discomfort, was in the hospital and returned, and had no dental appointments since his/her return.

On 12/06/2018 at 10:15 AM, Administrative Nurse D stated the resident had broken, carious teeth, and it was documented on his/her assessment. He/she verified the resident had dental

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appointments a few months ago, was hospitalized, and had not resumed any appointments since. Administrative Nurse D verified the resident's lack of dental care after his/her return from the hospital, and verified he/she required dental care due to his/her broken, carious and painful teeth.

The facility's Dental Service Policy, dated 8/2006, documented routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care, and the following are the policy interpretation and implementation guide lines:

1) Oral and dental services are available to meet the resident's needs.

2) Routine and emergency dental services are provided to our residents through referral to the residents' personal dentist, community dentist, or dental care organization that provides dental services.

3) The facility has a contract with a dentist that comes to the facility and provides dental services quarterly and as needed.

4) The charge nurse, or his/her designee, is responsible for notifying Social Services of a resident's need for dental services.

5) Social Services personnel will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.

The facility failed to provide professional dental

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F 790	Continued From page 21 care for Resident #22, who had broken, carious teeth, placing the resident at risk for infection, weight loss and pain.	F 790		