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	17E591	A. BUILDING _____ B. WING _____	C 11/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00175785. The 2567 was sent electronically on 12/06/22.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 553		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/06/2022

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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(iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:
The facility identified a census of 29 residents. The sample included three residents. Based on observations, record review, and interviews, the facility failed to invite Resident (R) 1's legal guardian to the annual care plan meeting. This deficient practice had the risk for miscommunication and lack of inclusion in all aspects of person-centered care planning for R1 and their guardian.

Findings included:

- R1 admitted to the facility on 06/07/19.

The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought]) bipolar type (includes episodes of mania and sometimes major depression [major mood disorder]) and borderline intellectual functioning (a cognitive impairment that applies to those who have lower than average intelligence).

The "Annual Minimum Data Set (MDS)" dated 08/22/22, documented a Brief Interview for Mental Status (BIMS) was not assessed. R1 was independent with activities of daily living (ADLs) with setup help only for eating.

The "Quarterly MDS" dated 11/21/22,

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documented a BIMS score of 13 which indicated intact cognition. R1 was independent with ADLs with setup help only for eating.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 08/24/22, documented R1 had borderline intellectual functioning and had trouble finding his words to voice his opinion.

The "Communication Care Plan" dated 09/16/21, directed staff allowed R1 time to respond to staff when communicating with him.

The "Notes" tab of R1's EMR revealed the following:

A "General Note" on 08/20/22 at 10:36 AM documented R1 left the facility with a family member on a home pass at that time.

A "Communication Note" on 08/24/22 at 12:36 PM documented the facility received a request of information from county jail for resident records, records were faxed to jail.

A "Resident Out/Return to Facility Note" on 09/03/22 at 01:43 PM documented R1 returned to the facility.
The "Assessments" tab of R1's EMR revealed a "Care Plan Review and Progress Note" on 09/22/22 at 03:25 PM that documented R1 had an annual care plan meeting on 09/22/22 and the assessment indicated the family was not invited.

On 11/28/22 at 12:52 PM, R1 ambulated down the hallway and conversed with the surveyor.

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F 553	Continued From page 3 On 11/28/22 at 01:02 PM, Social Services X stated the resident was always at the care plan meetings and the guardians were always invited. On 11/28/22 at 01:14 PM, Administrative Nurse E stated the guardian was invited to the care plan meeting and R1's guardian was invited and usually attended over the phone. She stated R1 was in jail at the time when the care plan meeting was due so they did not invite the family. The facility's "Care Planning" policy, dated 11/28/17, directed the Director of Nursing and the interdisciplinary team (IDT) monitored care plans on an ongoing basis to ensure they reflected the current status of the resident. The IDT consisted of the attending physician, a registered nurse with a responsibility for the resident, a nurse aide with a responsibility for the resident, a member of food and nutrition services staff, the resident, the resident's representative, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. The facility failed to invite R1's legal guardian to the annual care plan meeting. This deficient practice had the risk for miscommunication and lack of inclusion in all aspects of person-centered care planning for R1 and their guardian.	F 553		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		

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representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 29 residents. The sample included three residents. Based on observations, record review, and interviews, the facility failed to notify Resident (R) 1's legal guardian of new medication orders. This deficient practice had the risk for miscommunication and delayed treatment decisions between R1, their guardian, and the facility.

Findings included:

- R1 admitted to the facility on 06/07/19.

The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought]) bipolar type (includes episodes of mania and sometimes major depression [major mood disorder]) and borderline intellectual functioning (a cognitive impairment that applies to those who have lower than average intelligence).

The "Annual Minimum Data Set (MDS)" dated 08/22/22, documented a Brief Interview for Mental Status (BIMS) was not assessed. R1 had delusions and hallucinations during the assessment period. R1 had verbal behaviors

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directed towards others one to three days and other behavioral symptoms directed towards others four to six days in the assessment period. R1 was independent with activities of daily living (ADLs) with setup help only for eating. R1 received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medications five days in the seven-day lookback period.

The "Quarterly MDS" dated 11/21/22, documented a BIMS score of 13 which indicated intact cognition. R1 had delusions and hallucinations in the assessment period. R1 had verbal behaviors and other behavioral symptoms one to three days in the assessment period. R1 was independent with ADLs with setup help only for eating. R1 received antipsychotic medications on a daily basis during the lookback period.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 08/24/22, documented R1 had borderline intellectual functioning and had trouble finding his words to voice his opinion.

The "Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Drug Use CAA" dated 08/24/22, documented R1 took psychotropic medications to help control his mood and behaviors.

The "Behavioral Symptoms Care Plan" dated 11/15/19, documented an intervention with a start date of 09/22/22 that R1 was starting Invega (antipsychotic medication) again for auditory hallucinations and directed staff to monitor for side effects and effectiveness.

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The "Orders" tab of R1's EMR documented an order with a start date of 09/21/22 and stop date of 10/04/22 for Invega Extended Release three milligrams (mg) in the morning for schizophrenia; an order with a start date of 09/28/22 for Invega Sustenna 234 mg one time only for schizophrenia; an order with a start date of 10/05/22 for Invega Sustenna 234 mg at bedtime every 28 days for schizophrenia; and an order with a start date of 10/05/22 and stop date of 10/11/22 for lurasidone (Latuda- antipsychotic medication) hydrochloride (HCl) 60 mg in the afternoon for schizophrenia for seven days.

The "Notes" tab of R1's EMR revealed a "General Note" on 09/21/22 at 01:33 AM that documented new orders received for Invega three mg for three weeks, Invega 234 mg injection on 09/28/22 and 10/05/22 then every four weeks starting on 10/05/22, Latuda 60 mg to start on 10/05/22 daily with meal for one week. Orders were updated in EMR and faxed to pharmacy, resident was aware and agreeable to new orders.

R1's medical record lacked evidence R1's guardian was notified of new orders.

On 11/28/22 at 12:52 PM, R1 ambulated down the hallway and conversed with the surveyor.

On 11/28/22 at 12:59 PM, Licensed Nurse (LN) G stated the nurse was expected to notify the guardian on the resident's profile page for all new orders and medication changes.

On 11/28/22 at 01:14 PM, Administrative Nurse E stated if the resident was their own responsible party then they were notified, if the resident had a

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guardian then the guardian was notified of any changes. She stated R1's guardian was notified of all changes, a lot of times staff left messages for the guardian who returned the call. Administrative Nurse E stated it was facility policy to notify the guardian of changes.

The facility's "Notification of Changes" policy, last revised 04/27/18, directed the facility informed the resident, resident's physician, and the resident's representative of any changes in the resident's status.

The facility failed to notify R1's legal guardian of new medication orders. This deficient practice had the risk for miscommunication and delayed treatment decisions between R1, their guardian, and the facility.