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PARSONS PRESBYTERIAN MANOR	3501 DIRR AVENUE PARSONS, KS 67357

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F 000	INITIAL COMMENTS The following citations represent the finding of a Health Resurvey. This 2567 was electronically sent to the facility on 01/04/2022.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

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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§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents with 14 selected for review. Based on observation, interview and record review, the facility failed to ensure the development of a "Baseline Care Plan" for two of the 14 residents (R) R4 and 76 for pressure ulcer preventive interventions.

Findings included:

- Review of Resident (R)76's "Physician Order Sheet," dated 12/09/22, included diagnoses of femur (thigh bone) fracture, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety, and arteriosclerotic (blood vessel hardening and narrowing) heart disease. The resident admitted to the facility on 12/02/22.

The "Admission Minimum Data Set" (MDS,) dated 12/09/22, assessed the resident with severe cognitive deficits and noted R76 required extensive assistance of two staff for bed mobility and transfer. The resident had impairment in

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functional range of motion on one side of the lower extremity. The resident was at risk for pressure ulcer development and had one stage two pressure ulcer (a shallow ulceration with a red base) that were not present upon admission.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 12/14/22, assessed the resident had impaired skin integrity due to left hip surgery with surgical incision. The resident had a deep tissue pressure injury to his left heel that measured 5 by 5 centimeters (cm). The resident required off- loading of feet when in bed and required extensive assistance with repositioning.

The "Admission Nursing Screen and Care Plan," dated 12/02/22, instructed staff the resident required maximum assistance in bed for repositioning. This care plan documented the resident was at risk for pressure ulcers due to surgery. The resident had a left hip incision but lacked assessment of the resident's heels. This care plan lacked interventions for pressure relieving/reducing mattress, pressure relieving cushions to chair/wheelchair, heel protectors, or a repositioning program.

The "Care Plan," dated 12/16/22 (after the resident developed a pressure ulcer), instructed staff to provide the following measures:

1. 12/08/22, Off -load heels and apply Kerra Foam (absorbent foam dressing) dressing to the left heel and change every third day and provide air mattress.

2. 12/15/22, Heel protectors to both heels and a multi-podus (pressure relieving device) boot to the left foot.

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3. 12/16/22, The resident required extensive assistance to reposition, and staff encouraged to reposition R76 routinely. Staff instructed to off-load his heels when he was in bed or in a chair. Staff instructed to monitor the heel pressure ulcer for signs of edema (swelling), erythema (redness), bogginess (sponge like soft tissue due to fluid), or drainage.

A "Physical Therapy Note," dated 12/08/22, documented during a therapy session the resident had dried blood on his bed and left foot sock. Therapy staff removed the sock and noted an open wound on the resident's left heel.

Observation on 12/15/22 at 08:00 AM, revealed the resident positioned in bed with the multi-podus boot on the floor beside the resident's bed. The resident had bilateral heel protectors on. The resident's wheelchair lacked a cushion.

Interview on 12/15/22 at 02:46 PM, with LN G, revealed she did not know when the resident developed the heel pressure ulcer, but the resident went to wound care for treatment today.

Interview on 12/20/22 at 09:37 AM with LN H, revealed she thought the resident had the pressure ulcer when he first admitted, but LN H did not remember. LN H stated the resident was cooperative with cares.

Interview on 12/20/22 at 10:30 AM with Certified Medication Aide (CMA) R, revealed the staff were supposed to off load the resident's heels with a rolled blanket and blue heel protectors, CMA R but did not know when the interventions started.

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Interview on 12/20/22 at 11:58 AM with Administrative Nurse F, revealed she thought the resident had the left heel DTPI when he admitted to the facility, but the admission assessment lacked identification of the DTPI. Administrative Nurse F stated she noted the DTPI on 12/08/22 and instructed staff to off load the resident's heels and apply Kerra Foam every three days and as needed. Administrative Nurse F stated the wound had worsened when she assessed it on 12/12/22 and at that time they consulted wound care.

Interview, on 12/20/22 at 12:15 PM, with Administrative Nurse E, revealed the admitting nurse was responsible for initiating and completing the "Admission Nursing Screen and Care Plan".

The facility policy "Admission/Readmission," dated 05/16/22, instructed staff that licensed staff initiated the "Base Line Care Plan" and discusses it with the nursing assistants and team leaders. To assure continuity, the charge nurse reviews the "Base Line Care Plan," and serves as coordinator of the plan. Staff instructed to revise the "Resident Plan of Care as needed.

The facility failed to ensure the "Base Line Care Plan,"/ "Admission Nursing Screen and Care Plan" for this resident requiring extensive assistance for bed mobility included interventions for preventive measures for pressure ulcer development.

- Review of Resident (R)4's "Physician Order Sheet," dated 12/12/22, revealed diagnoses

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included fracture acetabulum (part of hip) and fractured pelvis. The resident admitted to the facility on 11/21/22.

The "Admission Minimum Data Set" (MDS), dated 11/28/22, assessed the resident with normal cognitive function. The resident required extensive assistance of two staff for bed mobility and had impairment in functional range of motion on one side of the lower extremity.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 11/28/22, assessed the resident was at high risk for pressure injuries and had an air mattress on his bed and a chair pad in his recliner to relieve pressure. Staff to elevate his heels with pillows.

The "Admission Nursing Screen and Care Plan," dated 11/22/22, assessed the resident at risk for pressure ulcer development due to hip surgery. This care plan lacked interventions for pressure relieving devices to the resident's bed, chair, wheelchair, repositioning, and other preventive measures. Staff added an intervention of a pressure relieving mattress on 11/28/22 and a "Roho" (a type of seating cushion designed to distribute weight evenly) cushion to the resident's recliner on 12/20/22.

The "Care Plan," dated 12/16/22, instructed staff the resident had a recent pressure ulcer develop on his buttocks. The resident required extensive assistance of two staff for transfers and repositioning. The resident had an air mattress on his bed with positioning bars for assistance with turning.

The "Skin Evaluation Record" dated 12/06/22,

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assess the resident with a quarter -sized open area to his left buttocks, and classified it as friction, sheer or a pressure ulcer with lack of measurements color or presence of drainage. Staff cleansed the area with normal saline and applied Kerra Foam (a type of dressing that absorbs drainage) with instruction to change every three days and as needed.

Interview, on 12/15/22 at 10:31 AM, with the resident, revealed the resident preferred to sleep in his recliner. The resident stated the air mattress on the bed was uncomfortable and would like it removed from the bed.

Interview, on 12/20/22 at 09:36 AM with Licensed Nurse (LN) H, revealed the resident did spend a lot of time in his recliner and required two staff to assist with repositioning. LN H did not know if staff tried a different air mattress as the resident did not like the one presently on his bed.

Observation, on 12.20/22 at 10:00 AM, revealed the resident positioned in his recliner. Certified Medication Aide R emptied the resident's partially filled urinal that was positioned on his overbed table. LN H placed the wound cleanser and cup of gauze sponges directly on the resident's overbed table without first sanitizing the area. Administrative Nurse F assisted the resident to stand. LN H removed the dressing from the resident's right buttocks and cleansed the area with normal saline spray. Observation revealed pink/white open area approximately 0.5 centimeter(cm) in length by 0.25 cm in width with pink tissue surrounding the area. LN H patted the area dry and applied the Kerra Foam dressing.

Interview, on 12/20/22 at 10:36 AM with Licensed

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Nurse (LN) H, revealed the resident did spend a lot of time in his recliner and required two staff to assist with repositioning. LN H did not know if staff tried a different air mattress as the resident did not like the one presently on his bed. LN H stated the over bed table should be sanitized prior to placing the dressing supplies on a paper towel.

Interview, on 12/20/22 with Certified Medication Aide (CMA) R, revealed the resident did not lay in bed but preferred his recliner. The resident required extensive assistance of two staff to reposition in his recliner and for toileting needs.

Interview, on 12/20/22 at 09:44 AM, with Administrative Nurse D, revealed the resident did not sleep in his bed at home. The resident preferred to sleep in his recliner. The resident required assistance to reposition. Administrative Nurse D stated she would expect staff to assess the resident's positioning preferences and care plan accordingly.

Interview, on 12/20/22 at 12:15 PM, with Administrative Nurse E, revealed the admitting nurse was responsible for initiating and completing the "Admission Nursing Screen and Care Plan".

The facility policy "Admission/Readmission," dated 05/16/22, instructed staff that licensed staff initiated the "Base Line Car Plan" and discusses it with the nursing assistants and team leaders. To assure continuity, the charge nurse reviews the "Base Line Care Plan," and serves as coordinator of the plan. Staff instructed to revise the "Resident Plan of Care as needed.

The facility failed to ensure the "Base Line Care

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F 655	Continued From page 8 Plan,"/ "Admission Nursing Screen and Care Plan" for this resident requiring extensive assistance for bed mobility included interventions for preventive measures for pressure ulcer development.	F 655		
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 26 residents with 14 selected for review which included two residents reviewed for Activities of Daily Living (ADL). Based on observation, interview and record review, the facility failed to offer bathing and grooming opportunities to one of the two residents (R)76 reviewed for ADLs. Findings included: - Review of Resident (R)76's "Physician Order Sheet," dated 12/09/22, included diagnoses of femur (thigh bone) fracture, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety, and arteriosclerotic (blood vessel hardening and narrowing) heart disease. The resident admitted to the facility on 12/02/22. The "Admission Minimum Data Set" (MDS,) dated 12/09/22, assessed the resident with severe cognitive deficits and noted R76 required extensive assistance of two staff for bed mobility and transfer. The resident had impairment in	F 677		

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functional range of motion on one side of the lower e extremity. The resident required extensive assistance for bathing.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 12/14/22, assessed the resident had decreased physical functioning, weakness and required extensive assistance for bed mobility, transfers, grooming, toileting, and bathing.

The "Admission Nursing Screen and Care Plan," dated 12/02/22, instructed staff the resident required maximum assistance in bed for repositioning. This care plan documented the resident required extensive assistance of two staff for bed bath and one-person assistance for personal hygiene.

The "Care Plan," dated 12/16/22, instructed staff the required extensive assistance for bathing (showers) on Monday and Thursday daytime. The resident required extensive assistance with dressing and grooming.

Observation, on 12/15/22 at 10:30 AM, revealed the resident positioned in his bed. The resident had several days' worth of facial hair.

Observation, on 12/20/22 at 07:42 AM, revealed the resident seated in his wheelchair in his room. The resident continued with several days' worth of facial hair and felt his face and stated he was due for a shave.

Interview, on 12/20/22 at 11:00 AM, with Certified Medication Aide R, revealed she thought the resident received showers on day turn but did not

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F 677	Continued From page 10 know what day. Interview, on 12/20/22 at 12:11 PM, with Administrative Nurse D, revealed the resident received a bath on 12/08/22, refused on 12/15/22 and was due on 12/19/22 but did not receive one. The facility policy "Admission/Readmission" updated 05/16/22, instructed staff to review the plan of care and discuss the resident's needs.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 26 residents, with 14 residents sampled. Based on observations, interviews, and record review, the facility failed to ensure that one sampled Resident (81), received care and services in accordance with professional standards of practice, when the facility waited over 13 days to implement the physician ordered neurostimulator (an implanted device that sends low levels of electricity directly into the spinal cord to relieve pain), following surgery to the resident. Findings included:	F 684		

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- Resident (R) 81 admitted to the facility on 12/07/2022 with diagnoses that included surgery aftercare of the nervous system, adjustment of the neurostimulator (an implanted device that sends low levels of electricity directly into the spinal cord to relieve pain), and low back pain.

The Admission Minimum Data Set (MDS), dated 12/14/22, revealed a brief interview of mental status (BIMS) of 14, that indicated intact cognition.

The "Pain Care Area Assessment" (CAA), dated 12/14/22, revealed the resident had back pain and had prior neurological (involvement of nerves) surgeries for pain relief. The resident had a neurostimulator device placement for management of nerve pain. She recently had surgery for reversal/adjustment of a malfunctioned electrode. In addition, the CAA documented the resident had surgery of the nervous system and had mechanical complication of an implanted neurostimulator of the spinal cord electrical lead removal. She had impaired mobility related to unsteadiness, pain, fatigue, and decreased activity tolerance.

Review of the "Admission nursing screen and care plan" dated 12/07/2022, revealed the resident's pain was lumbar/sacral spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities) and the resident's pain was constant and interfered with her sleep and Activity of daily living (ADL) participation. Furthermore, on 12/09/22, the baseline care plan indicated she returned from surgery related to her neurostimulator.

The physician's orders included Physical therapy

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(PT) to address the pain stimulator, to advise on charging instructions and level progression, dated 12/07/22.

Review of the "Physical Therapy PT Evaluation and Plan of Treatment", dated 12/12/22, revealed the resident had a decline in functional strength, endurance, mobility, activity tolerance and balance due to issues with the implanted stimulator and chronic pain. The resident had placement of spinal cord stimulator on 11/30/22. She continued to experience lower left extremity pain and hospitalized for a revision of failed surgery with identified lead malfunction. The resident continued to experience pain and admitted to the facility due to loss of functional independence with increased need of assistant.

Review of the "Physical therapy Treatment Encounter notes" from 12/08/22 thru 12/19/22, revealed on 12/14/2022 (eight days after the physician's order), staff discussed her pain stimulator. The resident was unsure if the device was turned on. PT staff consulted with nursing staff, and they were unaware if the resident's stimulator was turned on. The record revealed PT staff should obtain orders from the surgeon on specific parameters to begin resident education and to set the device (neurostimulator) up appropriately. The record revealed the plan for the PT next visit was to address the pain stimulator.

On 12/15/2022 at 10:00 AM, the resident reported she admitted to the facility for strengthening so she could return home. She reported she had "an implant for pain" and had to have a lead repaired on 12/09/2022. She reported she had constant low back pain rated seven on a 1-10 pain scale.

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When asked what treatments were being done for pain, she indicated she had pain medication and the stimulator device for pain but stated, "nobody knows how to use the stimulator. PT should check on it today." The resident indicated the battery/ remote of the stimulator stored on her dresser and nursing staff or therapy staff had not "touched" the remote.

On 12/15/2022 at 02:30 PM, the resident sat in her recliner. She reported pain in her lower back at scale of six/ on a 1-10 scale. She reported physical therapy had not been in yet and "no one still knows how to use the pain stimulator."

On 12/19/22 at 09:08 AM, the resident sat in her recliner chair, and rested quietly with her eyes closed.

On 12/15/2022 at 02:45 PM, licensed nurse (LN)G, reported PT should take care of the stimulator, however PT was not in the facility and PT was not going to be in on 12/15/22.

On 12/19/2022 at 09:12 AM, LN H reported she was unaware if the pain neurostimulator device functioned properly and stated, she wanted to check on her chart to see what happened since she worked with her last week. She reported she was not familiar with the neurostimulator.

On 12/19/2022 at 09:32 AM, consultant GG stated OT (occupational therapy) saw her on 12/07/22, and PT saw her the next day (12/08/22). She had a follow-up appointment with her orthopedic surgeon but lacked instructions to operate the stimulator or what settings to use.

On 12/19/2022 at 12:31 PM, approximately three

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hours later, LN H reported she had not looked at the resident's chart and had not followed-up with the resident or the surgeon related to the neurostimulator.

On 12/19/2022 at 01:08 PM, LN H reported she sent a fax communication to the resident's surgeon, to request perimeters for the neurostimulator device. (a total of 13 days after the physician's order date).

On 12/19/2022 at 01:30 PM, administrative nurse D was aware the resident's neurostimulator was not being utilized. She thought nursing staff may have sent communication to the surgeon, however, she was unable to provide documentation for attempts to communicate with the surgeon related to the neurostimulator settings.

On 12/20/2022 at 09:42 AM, the resident reported her pain level was on a scale of six (one to 10 scale). Staff informed the resident that the surgeon would send one of his staff members to the facility to instruct staff how to use the settings.

The facility's policy for "Pain management" revised 10/12/22 included, "optimal use of pain control measure depends on education and cooperation between members of the health care team and should consist of appropriate and individualized nonpharmacologic comfort measures with pain medication management in addition as needed."

The facility failed to ensure this resident received care and services in accordance with professional standards of practice, when the facility waited over 13 days to implement the physician ordered

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F 684	Continued From page 15 neurostimulator (an implanted device that sends low levels of electricity directly into the spinal cord to relieve pain), following surgery to the resident.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with 14 selected for review, which included two residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review, the facility failed to ensure Resident (R)76 and R4 received timely interventions for pressure ulcer prevention, which resulted in R76's development of an unstageable pressure ulcer (unable to determine depth of the ulcer due to overlying slough (dead tissue usually yellow or white) or eschar (dried dead tissue). Findings included:	F 686		

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- Review of Resident (R)76's "Physician Order Sheet," dated 12/09/22, included diagnoses of femur (thigh bone) fracture, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety, and arteriosclerotic (blood vessel hardening and narrowing) heart disease. The resident admitted to the facility on 12/02/22.

The "Admission Minimum Data Set" (MDS,) dated 12/09/22, assessed the resident with severe cognitive deficits and noted R76 required extensive assistance of two staff for bed mobility and transfer. The resident had impairment in functional range of motion on one side of the lower extremity. The resident was at risk for pressure ulcer development and had one stage two pressure ulcer (a shallow ulceration with a red base) that were not present upon admission.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 12/14/22, assessed the resident had impaired skin integrity due to left hip surgery with surgical incision. The resident had a deep tissue pressure injury to his left heel that measured 5 by 5 centimeters (cm). The resident required off- loading of feet when in bed and required extensive assistance with repositioning.

The "Admission Nursing Screen and Care Plan," dated 12/02/22, instructed staff the resident required maximum assistance in bed for repositioning. This care plan documented the resident was at risk for pressure ulcers due to surgery. The resident had a left hip incision but lacked assessment of the resident's heels. This care plan lacked interventions for pressure relieving/reducing mattress, pressure relieving

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cushions to chair/wheelchair, heel protectors, or a repositioning program.

The "Care Plan," dated 12/16/22 (after the resident developed a pressure ulcer), instructed staff to provide the following measures:
1. 12/08/22, Off -load heels and apply KerraFoam (absorbent foam dressing) dressing to the left heel and change every third day and provide air mattress.

2. 12/15/22, Heel protectors to both heels and a multi-podus (pressure relieving device) boot to the left foot.

3. 12/16/22, The resident required extensive assistance to reposition and staff encouraged to reposition R76 routinely. Staff instructed to off-load his heels when he was in bed or in a chair. Staff instructed to monitor the heel pressure ulcer for signs of edema (swelling), erythema (redness), bogginess (sponge like soft tissue due to fluid), or drainage.

A "Physical Therapy Note," dated 12/08/22, documented during a therapy session the resident had dried blood on his bed and left foot sock. Therapy staff removed the sock and noted an open wound on the resident's left heel.

A "Nurse's Note" dated 12/08/22 at 11:51 AM, documented the resident had a deep tissue pressure injury (DTPI) to his left heel which measured 5cm by 5cm, with minimal drainage noted. The staff applied KerraFoam and were to change the KerraFoam every three days and as needed for soiling, and to offload his feet while in bed.

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The "Skin Evaluation Record" dated 12/08/22, documented the resident had a DTPI to his left heel which measured 5 cm by 5 cm, with minimal drainage with a treatment of a KerraFoam dressing, every three days.

The "Skin Evaluation Record", dated 12/12/22, documented the left heel worsened and the treatment changed to apply the KerraFoam dressing daily until improvement and minimal drainage. The wound measurements recorded the area as 5 cm by 5 cm, with no exudate (drainage).

The "Skin Evaluation Record", dated 12/12/22, documented the left heel worsened and the treatment changed to apply the KerraFoam dressing daily until improvement and minimal drainage. The wound measurements recorded the area as 5 cm by 5 cm, with no exudate (drainage).

A "Physician's Order," dated 12/13/22, instructed staff to consult wound care.

A "Physician's Order," dated 12/15/22, instructed staff to administer Pro-Stat Advanced Wound Care (protein supplement formulated to promote wound healing) 17 gram-100 kilocalorie per 30 milliliter twice a day, and a multivitamin with minerals daily for wound healing.

A "Physician's Order," dated 12/15/22, instructed staff to cleanse the wound with normal saline, moisturize the surrounding skin and apply Santyl (ointment that removes dead skin and aides in wound healing) ointment 60 gram (gm), daily to the wound base and cover with non-adhesive dressing, and wrap with gauze.

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The "Physician's Note" faxed 12/15/22, described the wound as a 4.3 cm by 5 cm by 0.5 cm, unstageable pressure ulcer.

A "Physician's Order," dated 12/16/22, instructed staff to administer Zinc gluconate 50 milligrams (mg) daily and Vitamin C 500 mg, daily, for wound healing. The order further instructed the staff to monitor the heel pressure ulcer for signs of edema, erythema, bogginess, or drainage.

The "Skin Evaluation Record," dated 12/19/22, documented the left heel ulcer measurements as 5 cm by 5 cm, with small amount of yellow brown drainage.

Observation on 12/15/22 at 08:00 AM, revealed the resident positioned in bed with the multi-podus boot on the floor beside the resident's bed. The resident had bilateral heel protectors on. The resident's wheelchair lacked a cushion.

Observation on 12/20/22 at 07:52 AM, revealed Licensed Nurse (LN) H prepared to provide a dressing change to the resident's left foot. The resident's multi-podus boot was on the floor and Administrative Nurse F noted the boot lacked one of the straps to secure the boot. The resident wore blue heel protectors. LN H did not sanitize the surface of a table, used to place the dressing items on, before placing paper towels on the table surface. LN H removed the gauze wrap and non-adherent dressing. The wound bed contained black eschar(dead tissue), approximately 5 cm by 5cm, with yellow brown drainage noted on the removed dressing. LN H cleansed the wound with normal saline, applied Santyl to the wound

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bed, applied the non-adhesive dressing, applied gauze, and a protective foam heel protective cup, then wrapped the foot with gauze and applied the heel protector. The resident stated the area was tender.

Interview on 12/15/22 at 02:46 PM, with LN G, revealed she did not know when the resident developed the heel pressure ulcer, but the resident went to wound care for treatment today.

Interview on 12/20/22 at 09:37 AM with LN H, revealed she thought the resident had the pressure ulcer when he first admitted, but LN H did not remember. LN H stated the resident was cooperative with cares.

Interview on 12/20/22 at 10:30 AM with Certified Medication Aide (CMA) R, revealed the staff were supposed to off load the resident's heels with a rolled blanket and blue heel protectors, CMA R but did not know when the interventions started.

Interview on 12/20/22 at 11:58 AM with Administrative Nurse F, revealed she thought the resident had the left heel DTPI when he admitted to the facility, but the admission assessment lacked identification of the DTPI. Administrative Nurse F stated she noted the DTPI on 12/08/22 and instructed staff to off load the resident's heels and apply KerraFoam every three days and as needed. Administrative Nurse F stated the wound had worsened when she assessed it on 12/12/22 and at that time they consulted wound care.

Interview on 12/20/22 at 12:02 PM, with Administrative Nurse E, revealed she expected the admitting nurse to put interventions in place

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F 686	Continued From page 21 on the "Admission Nursing Screen and Care Plan," and confirmed the lack of pressure relieving interventions upon admission for R76. Interview on 12/20/22 at 12:09 PM, with Consulting Medical Staff HH, revealed she expected pressure relieving interventions in place upon admission to help prevent DTPI development. The facility policy "Skin Integrity: Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment," revised 08/30/22, instructed staff to evaluate skin integrity and tissue tolerance, implement preventative measures as indicated and treat skin breakdown. Risk factors should be reviewed along with possible causes and a determination made to what extent the factors can be modified. Staff instructed to use heel protectors, multi-podus boots or pillows to support heels and reduce shearing effect. Consider suspending or floating heals using lower extremity positioning devices. The facility failed to ensure pressure relieving interventions were in place for R76, a resident at risk for pressure ulcer development, who developed an unstageable pressure ulcer to his left heel.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		

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condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents with 14 residents sampled, including two residents reviewed for restorative services. Based on observation, interview, and record review, the facility failed to provide restorative services for one of the two sampled, Resident (R)14 to maintain or prevent decline in range of motion (ROM) ability.

Findings included:

- Review of Resident (R)14's electronic medical record (EMR) revealed a diagnosis of post-polio syndrome (a group of potentially disabling signs and symptoms that appear decades after the initial polio illness).

The annual "Minimum Data Set" (MDS), dated 06/11/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She required total assistance of one staff for locomotion on the unit with the use of her wheelchair. She received passive range of motion (ROM) one day and

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active ROM of the assessment period.

The "Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 06/11/22, documented the resident had limitation in ROM of her upper and lower extremities.

The quarterly "MDS," dated 09/10/22, documented the resident had a BIMS score of 15, indicating intact cognition. She required extensive assistance of one staff for locomotion on the unit with the use of her wheelchair. She received no restorative cares during the assessment period.

The restorative care plan, revised 11/07/22, instructed staff to perform active ROM to both ankles, knee flexion (the action of bending) and extension (stretching), hip flexion and abductions (the movement of a limb or other part away from the midline of the body) for 2 sets of ten repetitions each.

Review of the resident's EMR from 12/01/22 through 12/19/22, revealed no documented restorative cares.

On 12/15/22 at 10:00 AM, the resident sat in her wheelchair in her room. The resident was unable to fully straighten her left leg.

On 12/19/22 at 07:54 AM, Certified Medication Aide (CMA) R assisted the resident with getting her ready for the day. The resident was unable to fully straighten her left leg.

On 12/15/22 at 10:00 AM, the resident stated she was unable to fully straighten her left leg. The

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F 688	Continued From page 24 resident stated the leg felt better when staff worked with her on stretching her muscles, but staff no longer did exercises with her. On 12/19/22 at 07:54 AM, CMA R stated staff no longer did restorative care with the resident. On 12/20/22 at 10:14 AM, Certified Nurse Aide (CNA) M stated she was responsible for doing restorative care with the resident. CNA M stated she had only done passive ROM with the resident a couple of times and restorative care was not done with the resident on a regular basis. On 12/20/22 at 09:45 AM, Administrative Nurse E stated restorative cares were to be done to residents on a daily basis. On 12/20/22 at 09:56 AM, Administrative Nurse D stated it was the expectation that staff do restorative cares for the resident on a daily basis. The facility policy for "Nursing Restorative Care Program", revised 10/11/21, included: Through effective rehabilitation/restorative, the staff assists the resident to do for him/herself rather than doing everything for the resident. The resident is to be encouraged to use their abilities; no matter how limited they may be so that the resident can attain his or her maximum functional potential. The facility failed to complete restorative cares for this dependent resident on a routine basis.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		

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resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents with 14 residents sampled, that included two residents sampled for urinary catheter care.
Based on observations, interviews, and record review, the facility failed to provide appropriate

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and sufficient services, treatment, and care based upon current standards of practice to ensure that Resident (R) 176 received appropriate treatment and services to prevent urinary tract infections to the extent possible.

Findings included:

- Resident (R) 176 admitted to the facility on 12/12/2022 with a diagnosis of urinary retention (lack of ability to urinate and empty the bladder).

The entry tracking record for the Minimum Data Set, dated 12/12/22, documented the resident entered from an acute hospital.

Review of the "Admission Nursing Screen and Care Plan" dated 12/12/22, revealed the resident was incontinent of urine and had an indwelling urinary catheter (a tube inserted into the bladder to drain urine into a collection bag) and required extensive assistance with perineal care.

The physician's hospital discharge orders included follow-up in one to two weeks for urinary retention and catheter removal.

On 12/15/22 at 08:50 AM, revealed the resident sat in his recliner. His urine collection bag hung uncovered from the side of a small trash can and the bottom of the collection bag touched the floor.

On 12/15/22 at 02:53 PM, revealed the resident sat in his recliner. His urine collection bag hung uncovered from the side of a small trash can and the bottom of the collection bag touched the floor.

On 12/19/22 at 12:40 PM, revealed the resident sat in his recliner. His urine collection bag was in

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F 690	Continued From page 27 a covered bag, however, the whole bag laid directly on the floor. On 12/15/22 at 09:09 AM, Licensed Nurse (LN) G reported staff should not store indwelling urinary catheter collection bags on the sides of the resident's trash can. Staff should not keep catheter bags directly on the floor. On 12/19/22 at 01:00 PM, Administrative Nurse D reported her expectation for indwelling urinary catheter collection bags is for staff to cover the collection bag with a dignity bag and the bag should not touch the floor. Review of the facility's policy titled "Urinary Catheter Care" revised on 10/08/21 revealed, "The collection bag must be off the floor to prevent infection." The facility failed to provide appropriate and sufficient services, treatment, and care based upon current standards of practice to ensure that the resident received appropriate treatment and services to prevent urinary tract infections to the extent possible.	F 690		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility reported a census of 26 residents.	F 730		

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Based on interview and record review the facility failed to complete an annual performance review at least once every 12 months for five of five Certified Nurse Aides (CNA) and Certified Medication Aides (CMA) reviewed, including CNA O, P and CNA Q and CMA T and RR.

Findings included:

- Review of these five employee personnel files, revealed the following concerns:

1. Certified Nurse Aide (CNA) O, hired 07/02/21, lacked an annual performance review in his personnel file.

2. CNA P, hired 07/28/21, lacked an annual performance review in her personnel file.

3. CNA Q, hired 08/02/21, lacked an annual performance review in her personnel file.

4. Certified Medication Aide (CMA) T, hired 02/14/17, lacked an annual performance review in her personnel file.

5. CMA RR, hired 07/27/21, lacked an annual performance review in her personnel file.

The facility policy for "Performance Evaluations", undated, included: Employees may receive performance evaluations annually based on the anniversary date.

On 12/20/22 at 12:51 PM, Administrative Staff C stated the annual performance reviews were not completed in a timely manner.

The facility failed to complete annual

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F 730	Continued From page 29 performance reviews for these three CNAs and two CMAs, who had been employed for over one year to ensure quality of cares to the residents.	F 730		
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	F 758		

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§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 26 residents with 14 selected for review, which included five residents reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure two of the five residents reviewed were monitored for extrapyramidal (abnormal involuntary body movements caused by medications) symptoms for Resident (R) 12 and R 76.

Findings included:

- Review of Resident (R)12's "Physician Order Sheet," dated 12/01/22, revealed diagnoses included arteriosclerotic (hardening and thickening of the blood vessels) heart disease, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness) and nausea.

The "Significant Change Minimum Data Set" (MDS), dated 09/22/22, assessed the resident

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with severe cognitive impairment, and received one day of antipsychotics and seven days of antidepressant medications during the seven-day look-back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 09/22/22, assessed the resident was on end of life services through hospice due to continued decline. The resident received Haldol (an antipsychotic medication) gel to her inner wrist for nausea.

The "Care Plan," revised 12/17/22, assessed the resident received Ativan (an antianxiety medication) for seizures and Haldol topical gel for nausea and vomiting.

The "Physician's Order," dated 10/1/22, instructed staff to administer Haldol gel 0.5milliliter (ml) to the resident's inner wrist, daily at hour of sleep, for nausea/vomiting.

The Physician's Order," dated 12/17/22, instructed staff to administer Haldol gel 0.5 ml, every four hours to her inner wrist as needed for nausea/vomiting for 14 days.

The medical record lacked an assessment for extrapyramidal symptoms.

Observation, on 12/20/22 at 10:30 AM, revealed the resident seated in her wheelchair in her room. The resident did not respond verbally to questions. No abnormal movements noted.

Interview, on 12/20/22 at 11:30 AM, with Administrative Nurse D, confirmed lack of assessment for extrapyramidal symptoms. Administrative Nurse D stated the resident

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received Haldol gel for nausea/vomiting and did not realize she would need an assessment for the extrapyramidal movements. Administrative Nurse D stated the facility utilized an Abnormal Involuntary Movement Scale (AIMS) assessment.

The facility policy "Health Risk Screenings," revised 04/11/2019, instructed staff the health risk screening are tools which included AIMS, were used to develop an appropriate plan of care.

The facility did not provide a policy for the frequency of the AIMS for residents administered antipsychotic medications.

The facility failed to assess this resident receiving antipsychotic medications for extrapyramidal movements as required.

- Review of Resident (R)76's "Physician Order Sheet," dated 12/09/22, included diagnoses of femur (thigh bone) fracture, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety, and arteriosclerotic (blood vessel hardening and narrowing) heart disease and major depressive disorder (major mood disorder). The resident admitted to the facility on 12/02/22.

The "Admission Minimum Data Set" (MDS,) dated 12/09/22, assessed the resident with severe cognitive deficits and noted R76 required extensive assistance of two staff for bed mobility and transfer. The resident received four days of antipsychotic medications during the seven-day look-back period.

The "Cognitive Loss Care Area Assessment"

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(CAA), dated 12/14/22, assessed the resident cognitive loss and dementia but could make his needs known.

The "Admission Nursing Screen and Care Plan," dated 12/02/22, lacked documentation the resident received antipsychotic medications.

The "Care Plan," dated 12/16/22, instructed staff the resident could make his needs known, but had memory issues and could become agitated.

The "Physician's Order," dated 12/03/22, instructed staff to administer Ziprasidone (an antipsychotic medication), 20 milligrams (mg), daily for major depressive disorder.

Review of the medical record revealed staff completed an Abnormal Involuntary Movement Scale (AIMS), on 12/19/22, 17 days after admission.

Observation, on 12/19/22 at 08:12 AM, revealed Consulting therapy staff GG, assisted the resident to transfer from his bed to chair. The resident followed commands and did not display abnormal movements, although he displayed anxiousness with the transfer.

Interview, on 12/20/22 at 11:30 AM, with Administrative Nurse D, confirmed staff completed the AIMS assessment 17 days after admission. Administrative Nurse D stated the facility utilized an Abnormal Involuntary Movement Scale (AIMS) assessment.

The facility policy "Health Risk Screenings," revised 04/11/2019, instructed staff the health risk screening are tools which included AIMS, were

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F 758	Continued From page 34 used to develop an appropriate plan of care. The facility did not provide a policy for the frequency of the AIMS for residents administered antipsychotic medications. The facility failed to assess this resident receiving antipsychotic medications for extrapyramidal movements as required.	F 758		