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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00176330, KS00175970, and KS00174757. The 2567 was sent electronically on 01/06/22.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/06/2023

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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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents. The sample included 18 residents with one resident reviewed for dignity. Based on observations, interviews, and record reviews, the facility failed to provide Resident (R)5 with dignity during basic cares. This deficient practice placed the residents at risk for decreased psychosocial well-being.

Findings Included:

- The "Medical Diagnosis" section within R5's Electronic Medical Records (EMR) included diagnoses of cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), epilepsy (brain disorder characterized by repeated seizures), intellectual disabilities, muscle weakness, Lennox-Gastuat syndrome (severe condition with recurrent epileptic seizures starting from early childhood), and dysphagia (swallowing difficulty).

R5's "Quarterly Minimum Data Set (MDS)" dated 09/15/22 noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated that she

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was totally dependent on two staff for transfers, locomotion (on and off unit), toileting, and bathing.

A review of R5's "Cognitive Loss Care Area Assessment (CAA)" dated 04/07/22 recorded the resident had aphasia (loss of ability to understand or express speech) and cannot make needs known to staff. The CAA instructed staff should anticipate her needs.

R5's "Care Plan" for cognitive loss dated 07/23/22 indicated that staff were to speak to R5 before providing cares. The care plan noted that she was, on occasion, able to let staff know what she liked through non-verbal communication. The care plan indicated that she was oriented to person and played an active role in decision making with her resident representative.

On 12/14/22 at 07:25AM R5 was transferred from her bed to her high-back wheelchair by Certified Nurses Aid (CNA) M and CNA N. Both staff completed hand hygiene upon entering the room and wiped down the Hoyer (full body) lift, and moved the sling into position. CNA M positioned the lift while CNA N connected the sling to the lift. R5 was raised off the bed and slowly moved towards the lift. CNA M lowered R5 into the wheelchair while CNA N guided her into position. Once seated, CNA N buckled R5's seatbelt. After completing the transfer CNA M took off R5's shirt without announcing her intent to do so or offering R5 privacy. R5's shirt was changed, and staff moved R5 to the dining room for breakfast.

On 12/19/22 at 10:22AM CNA N stated that residents should be provided care in a private environment where they felt comfortable. She

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F 550	Continued From page 3 stated that staff should always close the door while providing care and utilize the curtain in the room if other people are in the room. On 12/19/22 at 02:15PM Administrative Nurse D stated that staff were expected to ensure the residents have privacy during cares. He stated that staff should always ask permission to perform a task and move a resident to their room. A review of the facility's "Quality of Life" policy 12/2021 noted that all resident will be treated with dignity and respect. The policy noted that staff will promote, maintain, and protect the resident's privacy. The facility failed to provide R5 with dignity when removing R5's clothing. This deficient practice placed the residents at risk for decreased psychosocial well-being.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to ensure foot pedals were provided for Resident (R) 30's wheelchair to prevent his feet from dragging on the floor. This deficient practice placed R30 at risk for accidents and	F 558		

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injuries.

Findings included:

- R30's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion), and hypertension (elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 02/03/22 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R30 required extensive assistance of two staff members for activities of daily living (ADLs).

The "Quarterly MDS" dated 11/10/22 documented R30 had severely impaired cognition. The MDS documented that R30 required extensive assistance of two staff members for ADLs.

R30's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 02/16/22 documented R30 required extensive assistance of two staff members for most ADLs and transfers.

R30's "Care Plan" dated 05/09/22 documented R30 required limited assistance of one staff member with wheelchair mobility.

On 12/13/22 at 09:34 AM Certified Nurses Aide (CNA) O pushed R30 from his room into the dining room area as his bilateral feet slid along the floor with no foot pedals on the wheelchair.

On 12/14/22 at 12:15 PM CNA O pushed R30

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from his room into the dining room area as his bilateral feet slid along the floor with no foot pedals on the wheelchair.

On 12/15/22 at 12:51 PM an unidentified female nursing staff member started to push R30's wheelchair with no foot pedals from the dining room. R30 asked the staff not to push the wheelchair too fast

On 12/19/22 at 11:22 AM Certified Nurses Aide (CNA) P stated R30 propelled himself in the wheelchair at times. CNA P stated resident should have foot pedals on their wheelchair to prevent injuries from falls. CNA P stated R30 was able to hold his feet up when staff pushed him in the wheelchair.

On 12/19/22 at 11:44 AM Licensed Nurse (LN) J stated every resident should have foot pedals on their wheelchair when the staff propel the wheelchair to prevent injuries or falls. LN J stated R30 could propel himself in the wheelchair occasional, but staff did push R30's wheelchair frequently. LN J stated R30 was usually able to pick up his feet when staff pushed him the wheelchair but not always.

On 12/19/22 at 01:53 PM Administrative Nurse D stated for safety every resident should have foot pedals on their wheelchair if staff would be pushing them in the wheelchair, unless it was care planned otherwise.

The facility's "Quality of Life- Accommodation of Needs" policy last reviewed December 2021 documented the facility's environment and staff behaviors would be directed toward assisting the resident in maintaining and/or achieving

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F 558	Continued From page 6 independent function, dignity and well-being. The resident's individual needs and preferences, including the need for adaptive devices and modification to the physical environment, would be evaluated upon admission and reviewed on an ongoing basis. The facility failed to ensure foot pedals were provided for R30's wheelchair to preventhis feet from dragging on the floor. This deficient practice placed R30 vulnerable for possible injuries.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		

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team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents. The sample included 18 residents with 18 residents reviewed for care plan revisions. Base on observation, record review, and interviews, the facility failed to revise care plan interventions related to Resident (R)26's ongoing exit seeking behaviors and need for a Wanderguard bracelet (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort). This deficient practice placed R26 at risk for wandering related accidents and unmet care needs.

Findings Included:

- The "Medical Diagnosis" section within R26's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (inability to sleep), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R26's "Admission Minimum Data Set (MDS)" dated 06/08/22 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS noted that he wandered daily and his wandering placed at him at significant risk of getting to a potentially

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dangerous place. The MDS noted that R26 could walk under supervision of staff.

A review of R26's "Behaviors Care Area Assessment (CAA)" indicated that R26 had wandering behaviors. The CAA noted that he has tried to exit different doors but stopped when the alarms sounded. The CAA noted that his main issue was him leaving the unit. The CAA noted that he was a high elopement (when a resident leaves the facility or safe area without staff knowledge and supervision) risk and care plan interventions would be implemented.

A review of R26's "Care Plan" created 05/31/22 noted under "Safety" recorded that R26 would have a community elopement evaluation and monitoring process (05/31/22), orientation to the community (05/31/22), and monitor behavior changes (05/31/22). The plan noted under "Behaviors" that staff were to divert his attention (06/09/22), intervene as necessary to ensure safety (06/09/22), talk to him in a calm voice (06/09/22), and encourage him to participate in activities (06/14/22). The care plan noted that R26 would remove his clothing and walk around the court and encouraged staff to intervene (06/15/22). The care plan did not include information related to his WanderGuard device.

R26's "Elopement Risk Screening" completed 11/19/22 indicated that he was independently mobile and cognitively impaired. The screening noted that he wandered aimlessly and voiced a desire to leave the facility. The screening revealed he was at risk for elopement.

A review of R26's EMR revealed a "Nursing Admission Note" dated 06/01/22 indicating R26

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had wandering behaviors with attempts to leave the unit.

A "Nursing Note" dated 06/25/22 indicated R26 walked off the unit out into the indoor atrium unit. The note indicated that staff found him standing next to the balcony looking down at the first floor. The note indicated that he became agitated after staff instructed him that he could not leave.

A "Social Service" dated 11/21/22 indicated that R26 continued to wander on and off the unit at times.

A "Nursing Note" dated 12/04/22 noted that R26 had cut his WanderGuard off of his wrist.

A "Nursing Note" dated 12/08/22 noted that R26 was placed on one to one supervision due to his exit seeking behaviors.

A "Nursing Note" dated 12/10/22 indicated that staff could not find R26 in his room or on the unit. The note indicated that staff found him in another resident's room using the toilet.

A "Nursing Note" dated 12/15/22 noted that R26 continued to have exit seeking behaviors and was fixated on going outside.

On 12/13/22 at 07:30AM R26 wandering around "F Court" unit. He was clean and well-groomed. R26 then sat down at the dining hall tables and ate his breakfast.

On 12/19/22 at 01:20PM R26 left the "F Court" unit and was standing in the atrium looking down at the lower court. R26 stated that he was looking for a way down but was unaware how to get

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F 657	Continued From page 10 down. R26 sat in a rocking chair outside the activity's office. On 12/19/22 at 10:22AM CNA N stated that she was not sure where the WanderGuard devices were tracked or if staff check placement of them daily. She stated that if a resident does get too close to the exit doors the alarm will go off and staff will respond. On 12/19/22 at 10:45AM Licensed Nurse (LN) I stated that she was not sure how tracking of the WanderGuards were being completed. She was not aware of staff checking of the bracelets positioning, testing, and replacing the WanderGuard after expiration . On 12/19/22 at 02:00PM Administrative Nurse D stated that direct care staff should be reviewing the resident's care plan for updates as much as they can. He stated that the MDS Coordinator starts the plan and nurses can add intervention as needed. A review of the facility's "Elopement Prevention" policy 05/2021 noted that care plan interventions will be implemented for residents of higher risk. The facility did not provide a "Care Plan" policy as requested on 12/19/22. The facility failed to revise the care plan with interventions related to R26's ongoing exit seeking behaviors and need for a Wanderguard. This deficient practice placed R26 at risk for wandering related accidents and unmet care needs.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident	F 679		

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F 679	Continued From page 11 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 residents. The sample included 18 residents with one reviewed for activities. Based on observations, interviews, record review, and policy review, the facility failed to ensure Resident (R) 30 was provided with a meaningful activity program to address his assessed needs. This placed him at risk for impaired psychosocial wellbeing including boredom, agitation and restlessness. Findings Included: - R30's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion), and hypertension (elevated blood pressure). The "Annual Minimum Data Set" (MDS) dated 02/03/22 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R30 required extensive	F 679		

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assistance of two staff members for activities of daily living (ADLs).

The "Quarterly MDS" dated 11/10/22 documented R30 had severely impaired cognition. The MDS documented that R30 required extensive assistance of two staff members for ADLs.

R30's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 02/16/22 documented R30 required extensive assistance of two staff members for most ADL's and transfers.

R30's "Care Plan" recorded R30 had a diagnosis of depression (persistent feeling of sadness and loss of interest), agitation and restlessness. An intervention dated 05/09/22 directed staff to assist the resident to make new friends in the facility and participate in scheduled activities; provide R30 with a calendar of events. The care plan, dated 05/09/22, further directed staff to offer and assist R30 to activities of his choice. R30 enjoyed watching the news, history programs, sports western movies. He enjoyed gardening, being outdoors walking and Bible study. The care plan further directed R30 preferred activities in the morning, afternoon and evening in his own room and on the court.

Review of R30's daily activity charting for October 2022 revealed R30 went to Noodling on Friday 10/07/22, and manicures on 10/09/22. ON Monday 10/10/22 R30 had cards and visiting with a volunteer and then on Wednesday, 10/19/22, he attended Sit and Fit exercise group as well as celebration for his court mates' birthdays.

Review of the October 2022 activity calendar revealed Sit and Fit exercise group was offered

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every Wednesday. R30's court (C Court) had manicures scheduled one day, (Sunday 10/09/22). The calendar revealed there were no scheduled activities for C Court every other Saturday (10/08/22 and 10/22/22) and other than the one day for manicures, the only activity on Sundays was Sunday Morning Mass.

Review of R30's daily activity charting for November 2022 revealed R30 had one-to-one activities visit on 11/04/22 which was a scheduled podiatrist (foot doctor) visit. ON Sunday 11/06/22 there was a one-to-one activity visit for nail care. O Monday 11/07/22 R30 participated in Big Nickel and on Friday 11/11/22 he attended the Veterans' Day celebration. On Wednesday 11/16/22 R30 participated in the Sit and Fit exercise group and again on Wednesday 11/30/22.

Review of the November 2022 activity calendar revealed Sit and Fit exercise group was scheduled every Wednesday. There were two Saturdays (11/5/22 and 11/19/22) with no scheduled activities and other than manicures on 11/06/22, the only activity for Sunday on R30's court was Sunday Morning Mass.

Review of the available documentation for December 2022 revealed R30 had one-to-one activities of nail care on Sunday 12/04/22. On Tuesday 12/06/22 R30 attended the Christmas Caroling with kids. A one-to-one activity event was recorded for 12/07/22 (Wednesday) for activities with R30 at R30s' doctor appointment and on Tuesday 12/13/22 R30 looked at the newspaper with staff.

Review of the December 2022 Activity Calendar revealed three Saturdays on C Court with no

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scheduled activities (12/03/22, 12/17/22 an d12/24/22) and other than 12/04/22 there were no activities on C court on Sundays except Sunday Morning Mass.

On 12/14/22 at 07:56 AM R30 laid on the bed in the lowest position with floor mat next to the bed.

On 2/14/22 from 08:00 AM to 12: 15 PM the TV was on the news channel then changed to a Christmas movie and then changed to a modern music station during lunch. Three residents sat in the recliners and wheelchairs asleep.

On 12/15/22 from 12:15 PM to 02:55 PM TV was on in the common area on modern music station.

On 12/19/22 11:55 AM R30 sat in the wheelchair propelled self on the unit. TV was on in the common area. Two residents sat in recliners asleep.

On 12/19/22 at 11:22 AM Certified Nurse Aide (CNA) P stated the activities on the units were watching movies, coloring sheets sometimes and some of the residents have word search or fill in books in their rooms. CNA P stated there are some group activities during the week, but not all the residents participate.

On 12/19/22 at 11:44 AM Licensed Nurse (LN) J stated there was no group activities on the units on a regular basis, but there were group activities off the unit a couple times a week. LN J stated they watched TV on the units and family visited at times. LN J stated R30's son visited often.

On 12/19/22 at 11:52 AM Activity Director Z stated there was no daily activities scheduled for

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F 679	Continued From page 15 each unit, but a couple of group activities provided during the week. Activity Director Z stated there was weekend activities, an activity staff member came in on the weekend and painted nails on one unit every weekend. Activity Director Z stated there were activity baskets on the units for the nursing staff to do activities with the residents. Activity Director Z stated she would educate the staff about the activity baskets and the I-pads that were kept in the activity office. On 12/19/22 at 01:53 PM Administrative Nurse D stated there was group activities during the week. Administrative Nurse D stated the residents watched movies on the units. The facility's "Activities" policy dated 01/2022 recorded the community provided for an ongoing program of activities to support residents in their choices of activities, both facility- sponsored group and individual activities and independent activities. It further recorded residents were encouraged to choose the types of recreation, cultural and religious activities and social events they preferred to participate in. The policy further directed staff would record the activity attendance and participation of the resident in both group and individual activities. The facility failed to ensure a meaningful resident centered activity program including weekend activities for R30 which placed him at risk for impaired psychosocial wellbeing including boredom, agitation and restlessness.	F 679		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		

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§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 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 identified a census of 79 residents. The sample included 18 residents with two residents reviewed for limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). Based on observation, record review, and interviews, the facility failed to provide the necessary services for Resident (R) 6's multiple contractures (abnormal fixation of a joint) to prevent further loss of ROM and mobility, which placed R6 at risk of a possible decline in independence, skin breakdown and impaired psychosocial wellbeing.

Findings included:

- R6's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of cerebrovascular accident (CVA-stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or

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rupture of an artery to the brain), contracture of left hand, right knee, left knee, left wrist, left elbow and left shoulder.

The "Annual Minimum Data Set" (MDS) dated 06/09/22 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented that R6 was dependent on two staff members assistance for activities of daily living (ADLs).

The "Quarterly MDS" dated 11/24/22 documented a BIMS score of 11 which indicated moderately impaired cognition. The MDS documented that R6 was dependent on two staff members assistance of for ADLs.

R6's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 06/21/22 documented R6 required extensive assistance with most ADLs related to the CVA that affected R6's left side. R6 used a left side arm table strap when in the wheelchair.

R6's "Care Plan" lacked any direction of the treatment and prevention of R6's multiple contractures.

Review of R6's clinical record and EMR lacked any documentation of ROM or any indication of services provided to address her multiple contractures.

On 12/14/22 at 10:55 AM R6 sat asleep in a wheelchair in the common area, left arm laid across R6's chest and her hand rested on her lap.

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On 12/14/22 at 04:01 PM R6 sat in a wheelchair pushed up to the dining room table, left arm laid across her chest and left hand laid on the wheelchair cushion between her legs.

On 12/14/22 at 03:23 PM Administrative Nurse D stated the facility at this time did not have a restorative program. Administrative Nurse D stated the facility had started a process to restart a restorative program.

On 12/19/22 at 10:40 AM Certified Nurses Aide (CNA) R stated R6 was almost totally dependent on staff for assistance for ADLs. CNA R stated there were some residents that the staff provided ROM and charted in the daily tasks. CNA R stated she was not sure if R6 recieved ROM exercises or treatment from staff.

On 12/19/22 at 11:44 AM Licensed Nurse (LN) J stated the CNAs provided ROM during ADLs for all residents that required assistance. LN J stated she was not sure if that was documented anywhere. LN J stated R6 should have some type of program to prevent a decline in independence.

On12/19/22 at 01:53 PM Administrative Nurse D stated the staff provided ROM to all the residents when ADL was provided. Administrative Nurse D stated he was not sure R6 was on any type of restorative program, related to her multiple contractures. Administrative Nurse D stated if a resident was discharged from therapy with a restorative program it would be provided.

The facility's "Resident Nursing-Range of Motion Program" policy last reviewed December2021 documented residents who have or at risk of

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F 688	Continued From page 19 having difficulty with ROM would be assessed by a nurse and/or therapy for a restorative nursing ROM program to promote independence and quality pf life by improving or maintaining functional ROM. The facility failed to ensure necessary services were provided for R6's multiple contractures to promote independence and prevent a further decline, which placed R6 at risk of skin breakdown and impaired psychosocial wellbeing. .	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 residents. The sample included 18 residents with four residents reviewed for accidents. Base on observation, record review, and interviews, the facility failed utilize Resident (R)5's wheelchair seatbelt resulting in a minor-injury fall. The facility additionally failed to monitor, check placement, or function of R26's WanderGuard bracelet (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort). This deficient practice placed both residents at risk for preventable accidents and related injuries.	F 689		

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Findings Included:

- The "Medical Diagnosis" section within R5's Electronic Medical Records (EMR) included diagnoses of cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), epilepsy (brain disorder characterized by repeated seizures), intellectual disabilities, muscle weakness, Lennox-Gastuat syndrome (severe condition with recurrent epileptic seizures starting from early childhood), and dysphagia (swallowing difficulty).

R5's "Quarterly Minimum Data Set (MDS)" dated 09/15/22 noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated that she required totally dependent on two staff for transfers, locomotion (on and off unit), toileting, and bathing. The MDS indicated that she had no falls.

A review of R5's "Fall Care Area Assessment (CAA)" dated 04/07/22 indicated that she was a high fall risk related to her medical diagnosis and not being able to make her needs known. The CAA noted that she utilized a high back wheelchair that was propelled by staff. The CAA noted that she required a full body lift and two staff for all transfers.

R5's "Care Plan" for "Activities of Daily Living (ADL)" created 07/23/21 indicated that she needed assistance with ADL care and utilized a wheelchair seat belt for positioning (07/23/21), and required total assistance for personal hygiene, bathing, toileting, transfer, and mobility (07/23/21). The plan noted that she required the

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use of a high-back wheelchair and a Hoyer (full body) lift with two staff for transfers (07/23/21). The plan noted that R5 remained a high fall risk related to her medical diagnoses. On 09/15/22 an intervention of "please ensure my seatbelt is on at all times while in wheelchair" was added to her care plan after a fall occurred.

A review of R5's EMR revealed that she had a "Device Evaluation" completed 04/07/22. The evaluation included her wheelchair's seat belt. The evaluation noted that she had alterations in safety awareness due to her cognitive impairment, difficulty with balance and truncal control, and noted that she kept sliding down in her wheelchair. The evaluation indicated that her seatbelt increased her safety.

R5's EMR revealed a "Nursing Note" dated 09/15/22 at 05:30PM indicated R5 had a fall. The note indicated that the staff failed to buckle her into wheelchair. The reporting nurse noted that R5 had fallen face first out of her wheelchair to the floor and suffered a laceration under her right eye with blood loss. The note indicated that she was sent to an acute care facility for treatment and evaluation at 05:00PM.

R5's EMR revealed another note that she returned to the facility on 09/16/22 at 07:30PM. The note indicated that her right eye laceration was treated with glue and covered with a bandage for protection.

On 12/14/22 at 07:25AM R5 was being transferred from her bed to her high-back wheel by Certified Nurses Aid (CNA) M and CNA N. Both staff completed hand hygiene upon entering the room and wiped down the Hoyer lift, and

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moved the sling into position. CNA M positioned the lift while CNA N connected the sling to the lift. R5 was raised off the bed and slowly moved towards the lift. CNA M lower R5 into the wheelchair while CNA N guided her into position. Once seated, CNA N buckled R5's seatbelt.

On 12/19/22 at 10:22AM CNA N reported that she worked with R5 when the fall occurred on 09/15/22. She stated that she was transferring R5 from her bed to her chair with Certified Medication Aid (CMA) S. She stated that she had only been working on the unit for two days before the accident and did not remember to buckle R5's seat belt after the transfer had occurred. She stated that when she went to reposition the wheelchair R5 fell forward landing on the floor. CNA N stated that she immediately notified the nurse of the incident. She assisted the other staff with transferring R5 back up to her wheelchair after the nurse assessed R5.

On 12/19/22 at 10:45AM Licensed Nurse (LN) G reported that she responded to the fall the occurred on 09/15/22. She stated that CNA N reported she had forgotten to buckle R5's seatbelt and the fall occurred. She stated that R5 was lying face down on the floor when she entered the room in a pool of blood. She stated that R5 had a laceration under her right eye. She reported that she took R5's vitals and contacted the medical provider and the resident's representative. She stated that the medical provider approved for R5 to been sent out to an acute care facility for further evaluation.

On 12/19/22 at 02:15PM Administrative Nurse D stated that when a fall occurs staff are expected to first ensure the safety and wellbeing of the

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resident, reported the occurrence to the medical provider and resident representative, and then an investigation would be completed to identify why the fall occurred. He stated that interventions would be reviewed and added to the resident's care plan and the results of the fall would be reviewed by the interdisciplinary team and the QAPI (Quality Assurance and Performance Improvement) team.

A review of the facility's "Safe Lifting and Moving of Patients" policy dated 01/2022 stated that residents will be transferred in a manner that promotes quality care, safety, and dignity.

The facility failed to utilize R5's wheelchair seatbelt resulting in a fall with an injury. This deficient practice placed R5 at risk for preventable falls and injuries.

- The "Medical Diagnosis" section within R26's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (inability to sleep), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R26's "Admission Minimum Data Set (MDS)" dated 06/08/22 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS noted that he wandered daily and his wandering placed at him at significant risk of getting to a potentially

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dangerous place. The MDS noted that R26 could walk under supervision of staff.

A review of R26's "Behaviors Care Area Assessment (CAA)" indicated that R26 had wandering behaviors. The CAA noted that he has tried to exit different doors but stopped when the alarms sounded. The CAA noted that his main issue was him leaving the unit. The CAA noted that he was a high elopement risk and care plan interventions would be implemented.

A review of R26's "Care Plan" created 05/31/22 noted under "Safety" that R26 would have a community elopement evaluation and monitoring process (05/31/22), orientation to the community (05/31/22), and monitor behavior changes (05/31/22). The plan noted under "Behaviors" that staff were to divert his attention (06/09/22), intervene as necessary to ensure safety (06/09/22), talk to him in a calm voice (06/09/22), and encourage him to participate in activities (06/14/22). The care plan noted that R26 would remove his clothing and walk around the court and encouraged staff to intervene (06/15/22). The care plan did not include information related to his WanderGuard device (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort).

R26's "Elopement Risk Screening" completed 11/19/22 indicated that he was independently mobile and cognitively impaired. The screening noted that he wandered aimlessly and voiced a desire to leave the facility. The screening revealed he was at risk for elopement.

A review of R26's EMR revealed no orders related to the placement, monitoring, or changing

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of R26's WanderGaurd.

A review of R26's EMR revealed a "Nursing Admission Note" dated 06/01/22 indicating R26 had wandering behaviors with attempts to leave the unit.

A "Nursing Note" dated 06/02/22 noted that R26 walked around the unit and attempted to go out the patio door until the alarm sounded and walked away from the door.

A "Nursing Note" dated 06/05/22 indicated that R26 continued to exhibit exit seeking behaviors. The note indicated that R26 attempted to open the unit fire exit and the balcony doors but was redirected by staff.

A "Nursing Note" dated 06/14/22 indicated that R26 was exhibiting increased exit seeking behaviors. The note indicated that he set off the patio and fire exit door alarms, followed staff into other peer's rooms, and showed signs of increased agitation upon redirection.

A "Nursing Note" dated 06/25/22 indicated R26 walked off the unit out into the indoor atrium unit. The note indicated that staff found him standing next to the balcony looking down at the first floor. The note indicated that he became agitated after staff instructed him that he could not leave.

A "Social Service" dated 11/21/22 indicated that R26 continued to wander on and off the unit at times.

A "Nursing Note" dated 12/04/22 noted that R26 had cut his WanderGuard off of his wrist.

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A "Nursing Note" dated 12/08/22 noted that R26 was placed on one to one supervision due to his exit seeking behaviors.

A "Nursing Note" dated 12/10/22 indicated that staff could not find R26 in his room or on the unit. The note indicated that staff found him in another resident's room using the toilet.

A "Nursing Note" dated 12/15/22 noted that R26 continued to have exit seeking behaviors and was fixated on going outside.

On 12/13/22 at 07:30AM R26 wandering around "F Court" unit. He was clean and well-groomed. R26 then sat down at the dining hall tables and ate his breakfast.

On 12/19/22 at 01:20PM R26 left the "F Court" unit and was standing in the atrium looking down at the lower court. R26 stated that he was looking for a way down but was unaware how to get down. R26 sat in a rocking chair outside the activity's office.

On 12/19/22 at 10:22AM CNA N stated that she was not sure where the WanderGuard devices were tracked or if staff check placement of them daily. She stated that if a resident does get too close to the exit doors the alarm will go off and staff will respond.

On 12/19/22 at 10:45AM Licensed Nurse (LN) I stated that she was not sure how tracking of the WanderGuards were being completed. She was not aware of staff checking of the bracelets positioning, testing, and replacing the WanderGuard after expiration .

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F 689	Continued From page 27 On 12/19/22 at 02:00PM Administrative Nurse D stated that maintenance was responsible for checking the WanderGuard systems functioning but was not sure if daily checks on the WanderGuard bracelets were being documented by staff. A review of the facility's "Elopement Prevention" policy 05/2021 noted that individuals at risk for elopement will be evaluated upon admission, quarterly, and after an elopement occurrence or significant change in the resident. The policy noted that a interventions will be implements for residents at higher risk. The policy indicated that the physical environment would also be assessed for hazards and the facility would complete routine door alarm for functioning. The facility failed to monitor and check placement, or function for R26's WanderGuard bracelet. This deficient practice placed R26 at risk for preventable accidents and injuries.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 residents. The sample included 18 residents with one resident reviewed for dementia care services. Based on observation, record review, and interviews, the facility failed to provide dementia (progressive mental disorder characterized by	F 744		

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failing memory, confusion) care and treatment for Resident (R)76, a cognitively impaired resident displaying dementia related symptoms. This deficient practice placed R76 at risk for impaired ability to achieve and/or maintain her highest practicable level of physical and emotional wellbeing.

Finding Included:

- The "Medical Diagnosis" section within R76's Electronic Medical Records (EMR) included diagnoses of dysphagia (swallowing difficulty), difficulty walking, hearing loss, atrial fibrillation (rapid, irregular heartbeat), cognitive communication deficit, and a history of malignant neoplasm (cancer).

R76's "Quarterly Minimum Data Set (MDS)" dated 11/24/22 noted a Brief Interview for Mental Status (BIMS) score of eight indicating moderate cognitive impairment. The MDS indicated that R76 exhibited verbal aggression, rejection of cares, and wandering. The MDS indicated that she required limited assistance from one staff to walk (on and out of room). The MDS noted the R76 used a walker to ambulate.

A review of R76's " Cognitive Loss Care Area Assessment" dated 09/16/22 indicated that she recently had a decline in cognition and was found unresponsive in her apartment before her admission to the facility. The CAA noted that she was living by herself, was hard of hearing, and had visual impairments.

R76's "Care Plan" created 09/07/22 noted that R76 had memory problems , impaired decision-making skills and comprehension

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related to moderate cognitive loss (09/16/22). It directed staff to anticipate R76's needs and observe for non-verbal cues. It further directed staff to use environmental cues to stimulate R76's memory and promote appropriate behavior. The plan instructed staff to support and allow resident to express feelings, fears , and concerns (09/07/22). The plan noted potential for decreased safety awareness and was a risk for falls. The care plan lacked goals and interventions related to wandering, sun downing (condition where a person tends to become confused or disoriented toward the end of the day), and aggressive behaviors.

A review of R76's EMR revealed she had an "Elopement Risk Screening" completed on 109/26/22. The screening noted that she was independently mobile, cognitively impaired, and wandered aimlessly. The screening asked if R76 had dementia, delirium (sudden severe confusion, disorientation and restlessness), Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), hallucination (sensing things while awake that appear to be real, but the mind created), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), auditory disorder, or depression(abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The screener identified that R76 had two or more of the diseases listed. The screen identified that R76 was at risk for elopement.

A review of R76's "Medication Administration Record (MAR)" revealed an order for 250

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milligrams (mg) of Depakote delayed (medication used as a mood stabilizer) released tablets to be given twice a day for "Sundown syndrome." R76's MAR also indicated that she was taking 10mg of Prevagen (supplement that may to improve memory) daily for memory care.

A "Nursing Note" dated 10/26/22 noted the R76 wandered of her unit twice during the shift claiming the facility was holding her hostage. The note indicated she made several unsuccessful attempts to exit the unit.

A "Nursing Note" dated 11/05/22 noted that R76 wandered into another resident's room. The note indicated that when staff attempted to intervene R76 became agitated and began cursing at staff.

A "Nursing Note" dated 11/09/22 noted that R76 sat in a recliner in the living area without her shirt. The note indicated that when staff attempted to assist her, R76 became agitated. The note indicated that she was cursing out staff.

A "Nursing Note" dated 11/10/22 noted the at 03:00AM R76 left her unit (E Court) and wandered to "F Court" looking for her recliner.

On 12/13/22 at 11:55AM R76 sat at the table waiting for lunch. At 12:05PM R76 asked to leave the table to go to her room. R76 was told by staff to wait for her lunch to be prepared. R76 again asked to go to her room to lay down. R76 moved her chair backwards and told staff she was going to her room. R76 was told again to wait to eat her lunch. R76 continued to stand up and go to her room. R76 and her chair were pushed back towards the table. R76's walker was then placed directly behind her chair to block her chair from

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going backwards. R76 was served lunch at 12:10PM.

On 12/19/22 at 10:22AM CNA N stated that R76 often was easy to redirect when becoming agitated or upset. She stated that staff should offer activities or games to keep residents engaged on the unit. She stated that staff should never put R76's walker directly behind her chair because it would cause her to fall. She stated that resident should be able to choose when they want to eat, or sleep and staff should never force them to do something. She stated that the resident should never leave the unit unless supervised by staff. She stated that all staff have access to view the care plans.

On 12/19/ On 12/19/22 at 02:00PM Administrative Nurse D stated staff should not bee placing the walkers behind the residents and should be allowing the residents to choose what they want to do as long as it complies with the resident's care plan. He stated that all staff have access to view the care plans and nurses can add interventions to assist with behaviors or other areas if needed.

A review of the facility's "Memory Support" policy 05/2021 noted that residents will be evaluated for the presence of behavioral expressions such as wandering, repetitive vocalizations, and aggressive actions. The plan noted that the facility would promote a provide supportive care, evaluate and intervene, and therapeutically communicate with the resident. The policy noted a supportive care plan will be provided with interventions reflecting a safe environment and resident centered choices.

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F 744	Continued From page 32 The facility failed to identify and implement interventions for R76, who displayed wandering, agitation, confusion, and Sundowning behaviors. This deficient practice placed R76 at risk for impaired ability to achieve her highest practicable level of wellbeing.	F 744		
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 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.	F 756		

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§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 identified a census of 79 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified an inappropriate indication for use an antipsychotic (medication used to treat severe mental conditions) medication for Resident (R) 30 who had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). This deficient practice had the potential of unnecessary psychotropic medication administration, thus leading to possible harmful potential side effects.

Findings included:

- R30's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of muscle weakness, dementia, and hypertension (elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 02/03/22 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R30 required extensive assistance of two staff members for activities of

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daily living (ADLs).

The "Quarterly MDS" dated 11/10/22 documented R30 had severely impaired cognition. The MDS documented that R30 required extensive assistance of two staff members for ADLs.

R30's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/16/22 documented R30 received antidepressant, antianxiety and antipsychotic medications for the diagnosis of depression, anxiety, and dementia without behaviors with no adverse effects noted.

R30's "Care Plan" dated -5/09/22 documented CP would review R30's drug regimen. The "Care Plan" documented staff would monitor R30 and document and report to the physician as needed any signs or symptoms of any drug related complications.

Review of the EMR under "Orders" tab revealed physician orders:

Risperidone (antipsychotic medication) 0.25 milligrams (mg) tablet, one tablet by mouth daily for unspecified dementia without behavioral disturbance and major depressive disorder recurrent (mild) dated 05/09/22.

Review of the "Monthly Medication Review" (MMR), performed by the CP, reviewed November 2021 through November 2022 failed to address the inappropriate indication for use of an antipsychotic medication for R30 who had a diagnosis of dementia.

On 12/14/22 at 10:56 AM R30 laid on the bed in the lowest position asleep, no behaviors or

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distress noted.

On 12/19/22 at 11:44 PM Licensed Nurse (LN) J stated the pharmacy sent the MMR out to the physician to be reviewed and then were faxed back to the facility. LN J stated the nurse would review the MMR and note any new orders. LN J stated dementia was not good indication for antipsychotic medication use for a resident with a diagnosis of dementia.

On 12/19/22 at 01:53 PM Administrative Nurse D stated the MMR were emailed to him, he forwarded the email to medical records who sent them the physician to be reviewed signed and returned. Administrative Nurse D stated the charge nurse would review the signed MMR for any new ordered and the returned to medical records to be scanned into the resident's clinical record. Administrative Nurse D stated he would count on the CP to review the clinical record monthly and report and irregularities such as an appropriate indication for use an antipsychotic and antidepressant medication use for residents with dementia.

On 12/20/22 at 01:49 PM CP was unavailable for an interview.

The facility policy "Pharmacy Services-Role of the Consultant Pharmacist" revised July 2020 documented the community obtained the services of a licensed pharmacist who determined that drug records were in order. If any irregularity was noted during the Medication Regimen Review (MRR), the pharmacist was required to notify the attending physician, Director of Nursing (DON) and medical director. The MRR would be conducted monthly.

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F 756	Continued From page 36 The facility failed to ensure the CP identified and reported the inappropriate indication use for R30's antipsychotic medications. This deficient practice placed R30 at risk for unnecessary medications leading to adverse side effects.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		

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F 758	Continued From page 37 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure AN appropriate indication for use of an antipsychotic (medication used to treat severe mental conditions) medication for Resident (R) 30 who had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). This deficient practice had the potential of unnecessary psychotropic medication administration, thus leading to possible harmful potential side effects. Findings included: - R30's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of muscle weakness, dementia, and hypertension	F 758		

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(elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 02/03/22 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R30 required extensive assistance of two staff members for activities of daily living (ADLs).

The "Quarterly MDS" dated 11/10/22 documented R30 had severely impaired cognition. The MDS documented that R30 required extensive assistance of two staff members for ADLs.

R30's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/16/22 documented R30 received antidepressant, antianxiety and antipsychotic medications for the diagnosis of depression, anxiety, and dementia without behaviors with no adverse effects noted.

R30's "Care Plan" dated -5/09/22 documented CP would review R30's drug regimen. The "Care Plan" documented staff would monitor R30 and document and report to the physician as needed any signs or symptoms of any drug related complications.

Review of the EMR under "Orders" tab revealed physician orders:

Risperidone (antipsychotic medication) 0.25 milligrams (mg) tablet, one tablet by mouth daily for unspecified dementia without behavioral disturbance and major depressive disorder recurrent (mild) dated 05/09/22.

On 12/14/22 at 10:56 AM R30 laid on the bed in

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F 758	Continued From page 39 the lowest position asleep, no behaviors or distress noted. On 12/19/22 at 11:44 PM Licensed Nurse (LN) J stated dementia was not good indication for antipsychotic medication use for a resident with a diagnosis of dementia. On 12/19/22 at 01:53 PM Administrative Nurse D stated he would count on the pharmacist to review the clinical record monthly and report and irregularities such as an appropriate indication for use an antipsychotic medication use for residents with dementia. The facility policy "Pharmacy Services-Role of the Consultant Pharmacist" revised July 2020 documented the community obtained the services of a licensed pharmacist who determined that drug records were in order. If any irregularity was noted during the Medication Regimen Review (MRR), the pharmacist was required to notify the attending physician, Director of Nursing (DON) and medical director. The MRR would be conducted monthly. The facility failed to ensure an appropriate indication use for R30's antipsychotic medications. This deficient practice placed R30 at risk for unnecessary medications leading to adverse side effects.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		

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	175465	A. BUILDING _____ B. WING _____	12/19/2022

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appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 79 residents and 10 medication carts. Based on observation, record review, and interview, the facility failed to discard an outdated individual insulin (a hormone which regulates blood sugar) pen in one of the medication carts. This deficient practice left the affected resident at risk for adverse consequences or less effective medication treatment.

Findings included:

- On 12/14/22 at 10:58 AM Licensed Nurse (LN) I unlocked the nurse's medication cart for E Court. Upon observation of the top-drawer contents it was noted that one Novolog aspart insulin pen (a

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short-acting insulin that lasted four to six hours) was opened and dated 10/29/22.

According to the "Health Direct Pharmacy Services" Novolog aspart insulin expired 28 days after opening.

On 12/14/22 at 10:58 AM LN I stated that the nurse should check medications in the medication cart daily for expired medications including insulin. LN I stated she had noted that the Novolog apart insulin pen was outdated and had called the pharmacy to send more. LN I discarded the outdated insulin pen.

On 12/19/22 at 01:53 PM Administrative Nurse D stated the nurse and medication aide on each court was responsible for checking the medication carts daily for any expired/outdated medications. Any outdated/expired medication including insulin should be discarded appropriately and replaced with new. Administrative Nurse D stated he had ordered cards that had medication expiration guidelines on them. Administrative Nurse D stated the insulin should have been discarded after being open for 28 days.

The facility policy "Storage of Medications" last revised December 2017 documented the community shall not use discontinued, outdated, or deteriorated drugs or biologicals.

The facility failed to ensure that nursing staff disposed of an outdated/expired insulin pen for one resident's insulin pens after it was opened, which had the potential for adverse consequences or ineffective treatment to the resident.

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 79 residents and one kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to food storage. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns. Findings Included: - On 12/13/22 at 07:06AM an initial walkthrough of the facility's kitchen was completed. An inspection of the kitchen's walk-in refrigerator revealed that the air-conditioning unit was leaking clear liquid. The fluid was dripping down onto several shelves stored below the unit. An	F 812		

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inspection of the shelves revealed two bags of collard greens, one box of cut okra, and one box of hot dogs were covered in ice.

On 12/19/22 at 01:20PM Dietary Staff BB stated that staff should be going in an inspecting the storage areas daily for cleanliness and equipment function. He was not aware of the leak in the freezer unit but would report it to the director.

A review of the facility's "Food Storage" policy dated 01/2019 indicated that all foods stored in the walk-in refrigerator units will be stored above the floor on racks, shelves dollies, or other surfaces that facilitate cleaning. The policy noted that food storage areas shall be clean and dry at all times.

The facility failed to maintain sanitary dietary standards related to food storage. This deficient practice placed the residents at risk related for food borne illnesses and food safety concerns.