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F 000	INITIAL COMMENTS The following citations represent the findings of a Health resurvey. The 2567 was electronically sent to the facility on 01/09/23.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		

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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F 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This Requirement is not met as evidenced by: The facility had a census of 38 residents. The sample included 14 residents with three reviewed for pressure injuries. Based on observation, record review, and interview the facility failed to notify the physician when Resident (R) 29 had a wound on his left heel. This placed R29 at risk for delayed treatment and impaired wound healing. Findings included: - R29's Electronic Medical Record (EMR) documented R29 had diagnoses of weakness, osteoarthritis (chronic arthritis without inflammation), pain and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (medical term for a condition in which there are problems with nerves in the body; either they have been damaged or are affected by a disease). R29's "Quarterly Minimum Data Set" (MDS), dated 10/21/22, documented R29 had a Brief	F 580		

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Interview of Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The MDS documented the resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use and personal hygiene, limited staff assistance with locomotion on and off unit, and supervision with eating and used a wheelchair for mobility. The MDS documented R29 had a pressure reducing device on his chair and no pressure ulcers or skin conditions.

R29's "Activity of Daily Living (ADLs) Care Plan," dated 10/26/22, documented the resident had diagnoses of DM with neuropathy, osteoarthritis, right knee pain, and muscle weakness which contributed to the resident's inability for safe mobility/transfers and activity intolerance. The care plan documented these diagnoses increased R29's risk for pressure injury to vulnerable areas. The care plan instructed staff to assist R29 with ADLs and use a sit to stand lift for transfers.

R29's "Skin Integrity Care Plan," dated 10/26/22, instructed staff to place creams or ointments on R29's skin to prevent irritation and place a cushion in his chair. The care plan documented R29 had a pressure reduction mattress on his bed but preferred to sleep in his recliner. The care plan instructed staff to assist R29 with all transfers, repositioning for tasks, pressure relief and comfort. It directed staff to observe R29's skin during daily cares and report any concerns to the charge nurse. The care plan lacked documentation on pressure relieving interventions for R29's heels to prevent wounds or pressure ulcers or treatment for the wound.

The "Braden Scale"(tool used to identify a resident's risk of developing a pressure injury)

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documented R29 had the following scores:
07/21/22 at risk with a score of 18 (which indicated a mild risk for developing a pressure ulcer).
09/20/21 at risk with a score of 16 (which indicated a mild risk for developing a pressure ulcer).

The "Nurse's Note," dated 12/13/22 at 05:17 AM, documented R29 had a brown/red area to his left heal that was not blanchable and the day shift nurse and the director of nursing were notified.

The "Skin and Wound Evaluation," dated 12/15/22, documented R29 had a new abrasion (scraping or rubbing away of a surface, such as skin, by friction) to his left heel. The evaluation documented the abrasion measured 1.2 centimeters (cm) long, 2.7 cm wide and 0.1 cm deep. The area had no exudate (drainage), was normal in color, and had no induration (thickening or hardening of tissue) present, no edema (swelling), and no change in temperature. The periwound (area surrounding the wound) was normal. R29 had no pain, and the goal was to monitor and manage. The note recorded wound healing was not acheivable due to R29's untreatable underlying conditions; no dressing was applied.

The "Nurse's Note," dated 12/18/22 at 04:32 PM, documented R29 had a new discolored skin issue on his left heel.

The EMR lacked evidence the physician was notified and lacked documentation of notification to the Registered Dietician (RD) regarding R29's left heel wound to seek input on how to treat it.

On 12/21/22 at 10:30 AM, observation revealed

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R29 sat in a wheelchair in his room wearing shoes on both feet. Licensed Nurse (LN) H asked R29 if she could look at his left foot and he shook his head yes. LN H removed the resident's left shoe and sock to reveal a dark purple area on the bottom of the resident's left heel approximately 3-4 cm long x 2 cm wide, without a dressing. LN H stated she was unable to say what kind of wound R29 had as she was unable to diagnose wounds due to the fact she had no wound care certification.

On 12/20/22 at 02:15 PM, LN G stated the wound on the R29's left heel was caused by his shoes rubbing on the area. LN G said he thought staff were treating the area with skin prep (liquid skin barrier).

On 12/22/22 at 10:42 AM, LN H stated she was not providing any treatment to the wound on R29's foot but was monitoring it. LN H stated the physician had not been notified regarding R29's left heel wound. When asked what type of wound it was, LN H stated she was not able to diagnose it because she was a licensed practical nurse (LPN).

On 12/21/22 at 11:05 AM, Administrative Nurse D verified the physician had not been notified regarding R29's left heel wound and said she expected staff to notify the physician whenever a resident had a new skin issue . Administrative Nurse D stated the facility had a wound nurse that took care of wounds and she did not know what caused the wound.

On 12/27/22 at 9:47 AM in a phone interview, Consultant Staff GG stated he was not aware R29 had a wound to his left heel, and he expected staff to notify him right away regarding

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F 580	Continued From page 5 new skin issues, so treatment could be initiated. The facility's "Skin Integrity Policy," revised 07/22, documented the facility would ensure that resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable. The facility failed to ensure R29 received necessary treatment and services to promote healing for his left heel pressure injury. This placed R29 at risk for further injury, delayed healing and wound related pain. Upon request the facility failed to provide a policy regarding physician notification of a wound. The facility failed to immediately notify R29's physician when staff obsercved a wound on R29's left heel. This placed R29 at risk for delayed treatment and impaired wound healing.	F 580		
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	F 657		

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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 team after each assessment, including both the comprehensive and quarterly review assessments.
This Requirement is not met as evidenced by:
The facility had a census of 38 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to review and revise Resident (R) 20, and R25's plans of care with resident centered interventions to prevent falls and failed to update R29's care plan for pressure injury to the heel. This deficient practice placed the residents at risk of uncommunicated care needs as related to falls and skin breakdown.

Findings included:

-The "Medical Diagnosis" section within R20's Electronic Medical Record (EMR) included diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), fracture (broken bone) of left femur (thigh bone), , nondisplaced fracture of greater trochanter (top of the thighbone) or right femur, repeated falls, urgency of urination, muscle weakness, lack of coordination, abnormalities of gait and mobility, diabetes mellitus (when the body cannot use glucose, not enough insulin

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made or the body cannot respond to the insulin), and pain.

The "Quarterly Minimum Data Set" (MDS), dated 10/27/22, documented R20 had intact cognition, required supervision to limited assistance of one staff member for activities of daily living, was continent of urine and bowel, was not steady, but able to stabilize without staff assistance, and had no functional range of motion impairments. The MDS further documented R20 had pain occasionally, had two or more non-injury falls and one fall with major injury. R20 had occupational and physical therapy treatments.

R20's "Care Plan" initiated 12/29/21 documented R20 had potential injury from falls with the diagnosis of Parkinson's disease, anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), hypothyroidism (condition characterized by decreased activity of the thyroid gland), low back pain, and weakness. These diagnoses could contribute to potential for dizziness, balance instability, and activity intolerance which increased R20's risk of falls and injury. R20 had multiple falls . She was being followed by a neurologist (doctor specializing in brain function) for medication management for Parkinson's disease. The care plan interventions included:
Floors would be clutter free.
Call light and favored items were within reach and encourage use of call light for assistance as needed.
Resident will receive her prescribed pain-relieving medications/treatments as requested/prescribed but within prescribing limitations set by physician.
Transferred independently with use of wheeled walker, will call staff presence/assistance if she feels unstable. Independent with use of wheeled

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walker.

The EMR "Morse Fall Risk Scale" recorded R20 scored at high risk of falling on 02/20/22, 03/30/22, and 10/21/22, and a moderate risk of falling on 06/30/22.

On 02/15/22 a "History and Physical" (H&P) hospital note documented R20 was sent to the hospital after falling at the nursing home facility and suffered a left hip periprosthetic fracture (a broken bone that occurs around the implant to a total hip replacement).

The "Progress Note", dated 08/30/22, documented R20 self-reported she fell and got herself off the floor. R20 denied hitting her head and reported she just lost her balance. The care plan recorded to continue current plan, and no new intervention implemented.

The "Progress Note", dated 09/18/22 at 06:30 PM, documented a Certified Nurse Aide (CNA) notified the nurse that R20 was on the floor. R20 reported "I lost my balance" and complained of right leg pain but refused to go to the emergency room for evaluation. R20's "Care Plan" lacked a new intervention.

The "Progress Note", dated 10/10/22 at 11:33 AM, documented R20 was found lying on her left side on the floor in front of the recliner. She reported being unsteady and let herself down on the floor. The note further documented R20 was educated on use of call light when needing to get up. The care plan lacked a new intervention.

On 10/17/22 R20's "Care Plan" documented R20 had a walker and used it independently. R20 left the walker and used furniture in her room at

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times, and staff needed to encourage and educate her to use walker at all times.

The "Progress Note", dated 10/27/22 at 07:49 AM, documented the nurse was called to R20's room whereR20 was seated in an upright position in the middle of her room. R20 had been moving around in the room so staff could vacuum and lost her balance.

On 10/31/22 R20's "Care Plan" documented an intervention which directed staff to assist R20 with opening and closing the blinds and remind R20 not to walk backwards and to always use walker when ambulating.

The "Progress Note", dated 12/02/22 at 11:59 PM, documented R20 was observed on the floor in front of the chair. R20 stated she was shaky and unstable, with no injury reported at that time. The care plan lacked new intervention related to this fall.

On 12/19/22 at 11:30 AM, observation revealed R20 independently ambulation from her room towards the dining room, using a four wheeled walker.

On 12/21/22 at 07:42 AM, Administrative Nurse F stated some residents were "chronic fallers" and the staff reviewed interventions and updated the care plans and the root cause analysis.

On 12/21/22 at 08:12 AM, Administrative Nurse D stated she did the root cause analysis for the falls, and the nurses and herself were responsible for updating the care plan. Administrative Nurse D stated if a root cause was identified then it was added to the care plan. Administrative Nurse D further stated R20 was very independent and did

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not always allow staff to implement interventions; R20 chose whether to call for assistance.

The facility's "Fall Follow-Up Protocol" policy, dated 07/2022, documented fall interventions are documented on the care plan with interventions to prevent further falls based on the determined causal factors at the time of the initial fall follow-up. To determine causal factors, a Root Cause Analysis will be conducted initially by the nursing staff and during the fall investigation process. Fall prevention interventions implemented to prevent further falls based on Root Cause Analysis of incident.

The facility failed to update R20's care plan with new interventions to prevent further falls, which placed the R20 at risk of further injuries/fractures.
- R25's Electronic Medical Record (EMR) documented the resident had diagnoses hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), and cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

R25's "Significant Change Minimum Data Set," dated 10/14/22, documented R25 had a Brief Interview of Mental Status score of eight, which indicated severe cognitive impairment. The MDS documented R25 required extensive staff assistance with transfers, dressing, toilet use, limited staff assistance with walk in corridor and room, and personal hygiene, and supervision with locomotion on and off unit, and eating. The MDS documented R25's balance not steady and only able to stabilize with staff assistance.

R25's " Activity of Daily Living (ADL) Care Area

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Assessment," (CAA) dated 10/14/22, documented the resident had impaired balance and transition during transfers and functional impairment to his right-side extremities.

R25's "Fall CAA," dated 10/14/22, documented R25 had impaired gait and mobility and had a history of falls, weakness and physical performance limitations affecting balance, gait , strength and muscle endurance.

R25's "Cognitive Deficit Care Plan," dated 10/26/22, documented R25 had forgetfulness and difficulty learning/retaining new information and this could increase the resident's risk of falls with injury due to lack of safety awareness and difficulty remembering safety strategies.

R25's "Fall Care Plan," dated 10/26/22, instructed staff use the following interventions to prevent the resident from falling:
Continue to place call pad alarm system in bed, wheelchair, and recliner if he sat in recliner. (initiated 11/15/22)
Fall mat alongside of bed when resident is in his bed (initiated 01/30/22)
Place pressure call pad system as resident at times forgets to use call light for assistance with transfers/ambulation (initiated 01/30/22)
Do not leave resident alone during his assisted activities of daily living (ADLs) and when he is using the bathroom (initiated 01/30/22)
Place R25's in lowest position when resident is in it to lessen chance of major injury.(initiated 01/30/22)
Staff should ask/prompt resident to use the bathroom before any activity or transfer. (initiated 01/30/22)

The fall incident reports documented the resident

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F 657	Continued From page 12 had uninjured falls on the following dates without interventions put in place to prevent further falls- 08/01/22 at 01:27 AM 10/10/22 at 06:30 PM 11/01/22-at 05:58 AM 11/11/22 at 08:47 AM On 12/15/22 at 11:20 AM, observation revealed R25 sat in a wheelchair in his room with black tennis shoes on with the laces untied. On 12/21/22 at 07:43 AM, Administrative Nurse F stated she was responsible for updating R25's care plan after a fall and verified there were no new interventions put in place to keep R25 from future falls due to he had chronic falls and already had interventions in place such as fall mat, bed in low position etc. On 12/21/22 at 09:26 AM, Administrative Nurse D verified there were no new interventions put in place to keep the resident from future falls. Administrative Nurse D stated when a fall occurred it was put into risk management and added to care plan. Administrative Nurse D said if staff cannot come up with a new intervention, the nurse should let the Administrative Nurse D know. Administrative Nurse D stated sometimes staff just run out of ideas for new interventions. The facility's "Fall Follow-Up Protocol" policy, dated 07/2022, documented fall interventions are documented on the care plan with interventions to prevent further falls based on the determined causal factors at the time of the initial fall follow-up. To determine causal factors, a Root Cause Analysis will be conducted initially by the nursing staff and during the fall investigation process. Fall prevention interventions	F 657		

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implemented to prevent further falls based on Root Cause Analysis of incident

The facility failed to update R25's care plan with new interventions to prevent further falls, which placed the R25 at risk of further injuries/fractures.

- R29's Electronic Medical Record (EMR) documented R29 had diagnoses of weakness, osteoarthritis (chronic arthritis without inflammation), pain and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (medical term for a condition in which there are problems with nerves in the body; either they have been damaged or are affected by a disease).

R29's "Quarterly Minimum Data Set" (MDS), dated 10/21/22, documented R29 had a Brief Interview of Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The MDS documented the resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use and personal hygiene, limited staff assistance with locomotion on and off unit, and supervision with eating and used a wheelchair for mobility. The MDS documented R29 had a pressure reducing device on his chair and no pressure ulcers or skin conditions.

R29's "Activity of Daily Living (ADLs) Care Plan," dated 10/26/22, documented the resident had diagnoses of DM with neuropathy, osteoarthritis, right knee pain, and muscle weakness which contributed to the resident's inability for safe mobility/transfers and activity intolerance. The care plan documented these diagnoses increased R29's risk for pressure injury to vulnerable areas. The care plan instructed staff to

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assist R29 with ADLs and use a sit to stand lift for transfers.

R29's "Skin Integrity Care Plan," dated 10/26/22, instructed staff to place creams or ointments on R29's skin to prevent irritation and place a cushion in his chair. The care plan documented R29 had a pressure reduction mattress on his bed but preferred to sleep in his recliner. The care plan instructed staff to assist R29 with all transfers, repositioning for tasks, pressure relief and comfort. It directed staff to observe R29's skin during daily cares and report any concerns to the charge nurse. The care plan lacked documentation on pressure relieving interventions for R29's heels to prevent wounds or pressure ulcers or treatment for the wound.

The "Braden Scale"(tool used to identify a resident's risk of developing a pressure injury) documented R29 had the following scores:
07/21/22 at risk with a score of 18 (which indicated a mild risk for developing a pressure ulcer).
09/20/21 at risk with a score of 16 (which indicated a mild risk for developing a pressure ulcer).

The "Nurse's Note," dated 12/13/22 at 05:17 AM, documented R29 had a brown/red area to his left heal that was not blanchable and the day shift nurse and the director of nursing were notified.

The "Skin and Wound Evaluation," dated 12/15/22, documented R29 had a new abrasion (scraping or rubbing away of a surface, such as skin, by friction) to his left heel. The evaluation documented the abrasion measured 1.2 centimeters (cm) long, 2.7 cm wide and 0.1 cm deep. The area had no exudate (drainage), was

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normal in color, and had no induration (thickening or hardening of tissue) present, no edema (swelling), and no change in temperature. The periwound (area surrounding the wound) was normal. R29 had no pain, and the goal was to monitor and manage. The note recorded wound healing was not acheivable due to R29's untreatable underlying conditions; no dressing was applied.

The "Nurse's Note," dated 12/18/22 at 04:32 PM, documented R29 had a new discolored skin issue on his left heel.

The EMR lacked evidence the physician was notified and lacked documentation of notification to the Registered Dietician (RD) regarding R29's left heel wound to seek input on how to treat it.

On 12/21/22 at 10:30 AM, observation revealed R29 sat in a wheelchair in his room wearing shoes on both feet. Licensed Nurse (LN) H asked R29 if she could look at his left foot and he shook his head yes. LN H removed the resident's left shoe and sock to reveal a dark purple area on the bottom of the resident's left heel approximately 3-4 cm long x 2 cm wide, without a dressing. LN H stated she was unable to say what kind of wound R29 had as she was unable to diagnose wounds due to the fact she had no wound care certification.

On 12/20/22 at 02:15 PM, LN G stated the wound on the R29's left heel was caused by his shoes rubbing on the area. LN G said he thought staff were treating the area with skin prep (liquid skin barrier).

On 12/22/22 at 10:42 AM, LN H stated she was not providing any treatment to the wound on

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F 657	Continued From page 16 R29's foot but was monitoring it. LN H stated the physician had not been notified regarding R29's left heel wound. When asked what type of wound it was, LN H stated she was not able to diagnose it because she was a licensed practical nurse (LPN). On 12/21/22 at 11:05 AM, Administrative Nurse D verified the physician had not been notified regarding R29's left heel wound and said she expected staff to notify the physician whenever a resident had a new skin issue . Administrative Nurse D stated the facility had a wound nurse that took care of wounds and she did not know what caused the wound. On 12/27/22 at 9:47 AM in a phone interview, Consultant Staff GG stated he was not aware R29 had a wound to his left heel, and he expected staff to notify him right away regarding new skin issues, so treatment could be initiated. The facility did not provide a policy on revision of care plans. The facility failed to update R29's care plan with directions to staff on how to care for R29's left heel wound. This placed the resident at risk for further injury to the wound.	F 657		
F 686 SS=D	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	F 686		

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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 had a census of 38 residents. The sample included 14 residents with five residents reviewed for pressure injuries. Based on observation, record review, and interview, the facility failed to ensure one of five residents received necessary treatment and services to promote healing for Resident (R) 29's left heel pressure injury (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). This placed R29 at risk for further injury, delayed healing and wound related pain.

Findings included:

- R29's Electronic Medical Record (EMR) documented R29 had diagnoses of weakness, osteoarthritis (chronic arthritis without inflammation), pain and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (medical term for a condition in which there are problems with nerves in the body; either they have been damaged or are affected by a disease).

R29's "Quarterly Minimum Data Set" (MDS), dated 10/21/22, documented R29 had a Brief Interview of Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The MDS documented the resident required extensive staff assistance with bed mobility, transfers,

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dressing, toilet use and personal hygiene, limited staff assistance with locomotion on and off unit, and supervision with eating and used a wheelchair for mobility. The MDS documented R29 had a pressure reducing device on his chair and no pressure ulcers or skin conditions.

R29's "Activity of Daily Living (ADLs) Care Plan," dated 10/26/22, documented the resident had diagnoses of DM with neuropathy, osteoarthritis, right knee pain, and muscle weakness which contributed to the resident's inability for safe mobility/transfers and activity intolerance. The care plan documented these diagnoses increased R29's risk for pressure injury to vulnerable areas. The care plan instructed staff to assist R29 with ADLs and use a sit to stand lift for transfers.

R29's "Skin Integrity Care Plan," dated 10/26/22, instructed staff to place creams or ointments on R29's skin to prevent irritation and place a cushion in his chair. The care plan documented R29 had a pressure reduction mattress on his bed but preferred to sleep in his recliner. The care plan instructed staff to assist R29 with all transfers, repositioning for tasks, pressure relief and comfort. It directed staff to observe R29's skin during daily cares and report any concerns to the charge nurse. The care plan lacked documentation on pressure relieving interventions for R29's heels to prevent wounds or pressure ulcers or treatment for the wound.

The "Braden Scale"(tool used to identify a resident's risk of developing a pressure injury) documented R29 had the following scores: 07/21/22 at risk with a score of 18 (which indicated a mild risk for developing a pressure ulcer).

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09/20/21 at risk with a score of 16 (which indicated a mild risk for developing a pressure ulcer).

The "Nurse's Note," dated 12/13/22 at 05:17 AM, documented R29 had a brown/red area to his left heal that was not blanchable and the day shift nurse and the director of nursing were notified.

The "Skin and Wound Evaluation," dated 12/15/22, documented R29 had a new abrasion (scraping or rubbing away of a surface, such as skin, by friction) to his left heel. The evaluation documented the abrasion measured 1.2 centimeters (cm) long, 2.7 cm wide and 0.1 cm deep. The area had no exudate (drainage), was normal in color, and had no induration (thickening or hardening of tissue) present, no edema (swelling), and no change in temperature. The periwound (area surrounding the wound) was normal. R29 had no pain, and the goal was to monitor and manage. The note recorded wound healing was not acheivable due to R29's untreatable underlying conditions; no dressing was applied.

The "Nurse's Note," dated 12/18/22 at 04:32 PM, documented R29 had a new discolored skin issue on his left heel.

The EMR lacked evidence the physician was notified and lacked documentation of notification to the Registered Dietician (RD) regarding R29's left heel wound to seek input on how to treat it.

On 12/21/22 at 10:30 AM, observation revealed R29 sat in a wheelchair in his room wearing shoes on both feet. Licensed Nurse (LN) H asked R29 if she could look at his left foot and he shook his head yes. LN H removed the resident's left

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shoe and sock to reveal a dark purple area on the bottom of the resident's left heel approximately 3-4 cm long x 2 cm wide, without a dressing. LN H stated she was unable to say what kind of wound R29 had as she was unable to diagnose wounds due to the fact she had no wound care certification.

On 12/20/22 at 02:15 PM, LN G stated the wound on the R29's left heel was caused by his shoes rubbing on the area. LN G said he thought staff were treating the area with skin prep (liquid skin barrier).

On 12/22/22 at 10:42 AM, LN H stated she was not providing any treatment to the wound on R29's foot but was monitoring it. LN H stated the physician had not been notified regarding R29's left heel wound. When asked what type of wound it was, LN H stated she was not able to diagnose it because she was a licensed practical nurse (LPN).

On 12/21/22 at 11:05 AM, Administrative Nurse D verified the physician had not been notified regarding R29's left heel wound and said she expected staff to notify the physician whenever a resident had a new skin issue . Administrative Nurse D stated the facility had a wound nurse that took care of wounds and she did not know what caused the wound.

On 12/27/22 at 9:47 AM in a phone interview, Consultant Staff GG stated he was not aware R29 had a wound to his left heel, and he expected staff to notify him right away regarding new skin issues, so treatment could be initiated.

The facility's "Skin Integrity Policy," revised 07/22, documented the facility would ensure that

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F 686	Continued From page 21 resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable. The facility failed to ensure R29 received necessary treatment and services to promote healing for his left heel pressure injury. This placed R29 at risk for further injury, delayed healing and wound related pain.	F 686		
F 689 SS=E	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 had a census of 38 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to store paints and glue securely and failed to lock an unalarmed exit door during extremely cold weather which was accessible to two cognitively-impaired independently mobile residents. The facility further failed to investigate and identify causative factors and implement meaningful resident centered interventions to prevent falls for Resident (R)20, R25, and R29. This placed the affected residents at risk for falls and fall related injuries. Findings included: - On 12/15/22 at 08:58 AM, observation in the	F 689		

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F 689	Continued From page 22 unlocked nourishment room revealed the following: Four (4-ounce) bottles of acrylic glue, which label read not intended for use with children without adult supervision. Numerous (eight oz.) different colored bottles of acrylic paint, which label read choking hazard small parts not for children. On 12/15/22 at 08:58 AM, Activity Z verified the above findings and stated the products above should be stored in a locked room and locked the nourishment door. On 12/15/22 at 9:30 PM, Administrative Nurse D stated the items above should be stored in a locked room. The facility's "Safe Use of Chemicals Policy," revised 07/22, documented all chemical would be stored in a locked cabinet when not in use. The facility failed to provide an environment free of accident hazards to prevent an avoidable accident, when staff left paint and glue in an unlocked nourishment room. This placed the two cognitively impaired, independently mobile, residents at risk for accidents. - On 12/15/22 at 09:21 AM, in the unlocked family room the exit door opened readily upon pushing and no alarm sounded. The exit door opened to a gaited outside area. According to accucheck. com it was 38 degrees Fahrenheit (F). On 12/15/22 at 09:21 AM, Maintenance Staff (MS) U and Administrative Nurse D verified the alarm was not working on the exit door in the family room and the door was unlocked. MS U	F 689		

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stated he would check the battery and replace it if it was bad.

On 12/15/22 12:34 PM MS U stated he replaced the battery in the exit door alarm in the family room, it still was not working, so he called the alarm company to come out and fix the door alarm. MS U stated he was not sure when the company would be out to fix the alarm.

On 12/15/22 at 12:42 PM MS V stated he had contacted the door alarm company and left a message and they had not called back yet. MS V stated he was fairly new and did not know when the last time staff checked the family room exit door alarm. He stated the family room door should be locked when not in use.

On 12/15/22 at 12:48 PM, observation revealed the family room door unlocked without staff present.

On 12/15/22 03:22 PM, Administrative Nurse D verified the family room entrance door was unlocked without staff present and stated it should be locked until the alarm was fixed. She pulled the door shut and locked it and said she would go notify staff to keep it locked.

Review of the "Monthly Preventative Maintenance Package-A Checklist, " dated November 2022, documented the family room door alarm was last checked on 11/11/22.

On 12/21/22 at 09:26 AM, Administrative Nurse D stated she expected maintenance to determine how often the doors alarms were checked.

The facility's "Alarm System For Exterior Doors Policy, " revised 06/22, documented maintenance

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staff would check each door alarm monthly and document accordingly.

The facility failed to ensure it remained free of accident hazards, when staff left the family room exit door unlocked and unattended without a working exit door alarm. This placed the two cognitively impaired independently mobile residents in the main facility at risk for harm.

- The "Medical Diagnosis" section within R20's Electronic Medical Record (EMR) included diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), fracture (broken bone) of left femur (thigh bone), , nondisplaced fracture of greater trochanter (top of the thighbone) or right femur, repeated falls, urgency of urination, muscle weakness, lack of coordination, abnormalities of gait and mobility, diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and pain.

The "Quarterly Minimum Data Set" (MDS), dated 10/27/22, documented R20 had intact cognition, required supervision to limited assistance of one staff member for activities of daily living, was continent of urine and bowel, was not steady, but able to stabilize without staff assistance, and had no functional range of motion impairments. The MDS further documented R20 had pain occasionally, had two or more non-injury falls and one fall with major injury. R20 had occupational and physical therapy treatments.

R20's "Care Plan" initiated 12/29/21 documented R20 had potential injury from falls with the

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diagnosis of Parkinson's disease, anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), hypothyroidism (condition characterized by decreased activity of the thyroid gland), low back pain, and weakness. These diagnoses could contribute to potential for dizziness, balance instability, and activity intolerance which increased R20's risk of falls and injury. R20 had multiple falls. She was being followed by a neurologist (doctor specializing in brain function) for medication management for Parkinson's disease. The care plan interventions included:
Floors would be clutter free.
Call light and favored items were within reach and encourage use of call light for assistance as needed.
Resident will receive her prescribed pain-relieving medications/treatments as requested/prescribed but within prescribing limitations set by physician.
Transferred independently with use of wheeled walker, will call staff presence/assistance if she feels unstable. Independent with use of wheeled walker.

The EMR "Morse Fall Risk Scale" recorded R20 scored at high risk of falling on 02/20/22, 03/30/22, and 10/21/22, and a moderate risk of falling on 06/30/22.

On 02/15/22 a "History and Physical" (H&P) hospital note documented R20 was sent to the hospital after falling at the nursing home facility and suffered a left hip periprosthetic fracture (a broken bone that occurs around the implant to a total hip replacement).

The "Progress Note", dated 08/30/22, documented R20 self-reported she fell and got herself off the floor. R20 denied hitting her head

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and reported she just lost her balance. The care plan recorded to continue current plan, and no new intervention implemented.

The "Progress Note", dated 09/18/22 at 06:30 PM, documented a Certified Nurse Aide (CNA) notified the nurse that R20 was on the floor. R20 reported "I lost my balance" and complained of right leg pain but refused to go to the emergency room for evaluation. R20's "Care Plan" lacked a new intervention.

The "Progress Note" dated 09/19/22 at 10:37 AM, documented R20 complained of right hip pain with moving hip in flexion, but no pain when sitting. The note further documented an order for a mobile right hip x-ray.

The "Progress Note", date 09/19/22 at 04:14 PM, documented R20 had an acute transverse (a break is across a bone) fracture through the greater trochanter.

The "Progress Note" dated 10/10/22 at 11:33 AM, documented R20 was found lying on her left side on the floor in front of the recliner. She reported being unsteady and let herself down on the floor. The note further documented R20 was educated on use of call light when needing to get up. The care plan lacked a new intervention.

On 10/17/22 R20's "Care Plan" documented R20 had a walker and used it independently. R20 left the walker and used furniture in her room at times, and staff needed to encourage and educate her to use walker at all times.

The "Progress Note", dated 10/27/22 at 07:49 AM, documented the nurse was called to R20's room whereR20 was seated in an upright position

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in the middle of her room. R20 had been moving around in the room so staff could vacuum and lost her balance.

On 10/31/22 R20's "Care Plan" documented an intervention which directed staff to assist R20 with opening and closing the blinds and remind R20 not to walk backwards and to always use walker when ambulating.

The "Progress Note", dated 12/02/22 at 11:59 PM, documented R20 was observed on the floor in front of the chair. R20 stated she was shaky and unstable, with no injury reported at that time. The care plan lacked new intervention related to this fall.

The "Physician Progress Note" dated 12/14/22 at 10:41 AM, documented R20 fell on 12/03/22 and injured her left knee, the Xray showed a possible non-displaced fracture on inferior (lower) patella (kneecap).

The CT scan (medical imaging technique used to obtain detailed internal images of the body), dated 12/14/22, documented R20 fell one week ago and had left sided knee pain. The impression documented a non-displaced fracture of the patella (knee) appearing to involve the anterior (front) and inferior aspect, does not appear greatly displaced and does appear to be acute.

On 12/19/22 at 11:30 AM, observation revealed R20 independently ambulation from her room towards the dining room, using a four wheeled walker.

On 12/21/22 at 07:42 AM, Administrative Nurse F stated some residents were "chronic fallers" and the staff reviewed interventions and updated the

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care plans and the root cause analysis.

On 12/21/22 at 08:12 AM, Administrative Nurse D stated she did the root cause analysis for the falls, and the nurses and herself were responsible for updating the care plan. Administrative Nurse D stated if a root cause was identified then it was added to the care plan. Administrative Nurse D further stated R20 was very independent and did not always allow staff to implement interventions, R20 chose whether to call for assistance.

The facility's "Fall Follow-Up Protocol" policy, dated 07/2022, documented fall interventions are documented on the care plan with interventions to prevent further falls based on the determined causal factors at the time of the initial fall follow-up. To determine causal factors, a Root Cause Analysis will be conducted initially by the nursing staff and during the fall investigation process. Fall prevention interventions implemented to prevent further falls based on Root Cause Analysis of incident.

The facility failed to identify and implement interventions to prevent further falls, which placed R20 at risk of further injuries/fractures.
- R25's Electronic Medical Record (EMR) documented the resident had diagnoses hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), and cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

R25's "Significant Change Minimum Data Set," dated 10/14/22, documented R25 had a Brief Interview of Mental Status score of eight, which indicated severe cognitive impairment. The MDS

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documented R25 required extensive staff assistance with transfers, dressing, toilet use, limited staff assistance with walk in corridor and room, and personal hygiene, and supervision with locomotion on and off unit, and eating. The MDS documented R25's balance not steady and only able to stabilize with staff assistance.

R25's " Activity of Daily Living (ADL) Care Area Assessment," (CAA) dated 10/14/22, documented the resident had impaired balance and transition during transfers and functional impairment to his right-side extremities.

R25's "Fall CAA," dated 10/14/22, documented R25 had impaired gait and mobility and had a history of falls, weakness and physical performance limitations affecting balance, gait , strength and muscle endurance.

R25's "Cognitive Deficit Care Plan," dated 10/26/22, documented R25 had forgetfulness and difficulty learning/retaining new information and this could increase the resident's risk of falls with injury due to lack of safety awareness and difficulty remembering safety strategies.

R25's "Fall Care Plan," dated 10/26/22, instructed staff use the following interventions to prevent the resident from falling:
Continue to place call pad alarm system in bed, wheelchair, and recliner if he sat in recliner. (initiated 11/15/22)
Fall mat alongside of bed when resident is in his bed (initiated 01/30/22)
Place pressure call pad system as resident at times forgets to use call light for assistance with transfers/ambulation (initiated 01/30/22)
Do not leave resident alone during his assisted activities of daily living (ADLs) and when he is

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F 689	Continued From page 30 using the bathroom (initiated 01/30/22) Place R25's in lowest position when resident is in it to lessen chance of major injury.(initiated 01/30/22) Staff should ask/prompt resident to use the bathroom before any activity or transfer. (initiated 01/30/22) The fall incident reports documented the resident had uninjured falls on the following dates without interventions put in place to prevent further falls- 08/01/22 at 01:27 AM 10/10/22 at 06:30 PM 11/01/22-at 05:58 AM 11/11/22 at 08:47 AM On 12/15/22 at 11:20 AM, observation revealed R25 sat in a wheelchair in his room with black tennis shoes on with the laces untied. On 12/21/22 at 07:43 AM, Administrative Nurse F stated she was responsible for updating R25's care plan after a fall and verified there were no new interventions put in place to keep R25 from future falls due to he had chronic falls and already had interventions in place such as fall mat, bed in low position etc. On 12/21/22 at 09:26 AM, Administrative Nurse D verified there were no new interventions put in place to keep the resident from future falls. Administrative Nurse D stated when a fall occurred it was put into risk management and added to care plan. Administrative Nurse D said if staff cannot come up with a new intervention, the nurse should let the Administrative Nurse D know. Administrative Nurse D stated sometimes staff just run out of ideas for new interventions. The facility's "Fall Follow-Up Protocol" policy,	F 689		

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dated 07/2022, documented fall interventions are documented on the care plan with interventions to prevent further falls based on the determined causal factors at the time of the initial fall follow-up. To determine causal factors, a Root Cause Analysis will be conducted initially by the nursing staff and during the fall investigation process. Fall prevention interventions implemented to prevent further falls based on Root Cause Analysis of incident

The facility failed to identify and implement interventions to prevent further falls, which placed R25 at risk of further injuries/fractures.

- R29's Electronic Medical Record (EMR) documented he had diagnoses of osteoarthritis (chronic arthritis without inflammation), pain in left arm and right knee, and history of repeated falls.

R29's "Quarterly Minimum Data Set," (MDS), dated 10/21/22, documented R29 had a Brief Interview of Mental Status (BIMS) of five, which indicated severe cognitive impairment. The MDS documented the resident required extensive staff assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene, limited staff assistance with locomotion on and off unit, and supervision with eating. The MDS documented R29's balance was not steady, he was only able to stabilize with staff assistance and had lower extremity impairment on both sides.

R29's "Fall Care Plan," revised 10/26/22, documented the following interventions for preventing a fall:
Fall mat when resident was in bed. (initiated 06/28/22)
Adequate lighting. (initiated on 12/15/22)
Floors would be kept clutter free (initiated on

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F 689	Continued From page 32 12/15/21) Call light and favored items within reach at all times (initiated on 12/15/21) The "Morse Fall Scale (rapid and simple method of assessing a patient's likelihood of falling) documented R29 had scores for the following dates for his risk for falls: 09/20/21- 55 high risk for falling 03/30/33-30 moderate risk for falling 06/30/22- 50 high risk for falling 10/17/22- 15 low risk for falling R29's EMR documented he had an unwitnessed uninjured fall on 11/22/22 at 06:31 AM and no new intervention were placed to prevent R29 from future falls. On 12/15/22 at 02:52 PM, observation revealed R29 sat in a recliner in his room with foot rest up, call light clipped to left arm of recliner on his blanket. On 12/21/22 at 07:43 AM, Administrative Nurse F stated she was responsible for updating R29's care plan after a fall and verified there were no new interventions put in place to keep R29 from future falls due to he had chronic falls and already had interventions in place. On 12/21/22 at 09:26 AM, Administrative Nurse D verified there were no new interventions put in place to keep the resident from future falls. Administrative Nurse D stated when a fall occurred it was put into risk management and added to care plan. Administrative Nurse D said if staff cannot come up with a new intervention, the nurse should let the Administrative Nurse D know. Administrative Nurse D stated sometimes staff just run out of ideas for new interventions.	F 689		

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F 689	Continued From page 33 The facility's "Fall Follow-Up Protocol" policy, dated 07/2022, documented fall interventions are documented on the care plan with interventions to prevent further falls based on the determined causal factors at the time of the initial fall follow-up. To determine causal factors, a Root Cause Analysis will be conducted initially by the nursing staff and during the fall investigation process. Fall prevention interventions implemented to prevent further falls based on Root Cause Analysis of incident The facility failed to identify and implement interventions to prevent further falls for R29, which placed the R29 at risk of further injuries/fractures.	F 689		
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 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;	F 690		

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F 690	Continued From page 34 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 had a census of 38 residents. The sample included 14 residents with three reviewed for bowel and bladder and urinary tract infection (UTI-infection of any part of the urinary system). Based on observation, record review, and interview the facility failed to provide appropriate treatment and services to prevent UTIs when staff failed to change gloves during perineal (genital areas) care for Resident (R) 29, who had a history of UTIs. This placed R29 at risk for recurring UTI and related complications. Findings included: - R29's Electronic Medical Record (EMR) documented he had a diagnose of UTIs. R29's "Quarterly Minimum Data Set" (MDS), dated 10/21/22, documented R29 required extensive staff to supervision assistance with activities of daily living (ADLs). The MDS documented R29 was frequently incontinent of urine, and occasionally incontinent of bowel. R29's "ADLs and Incontinence Care Plan," revised 10/26/22, documented his increased risk	F 690		

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of incontinence could increase his risk of skin irritation and breakdown. The care plan instructed staff to assist R29 to and from the bathroom, manage toileting tasks, and ensure to provide him good perineal care.

R29's EMR documented he had a UTI on 12/04/21, 05/25/22, and 10/21/22.

On 12/19/22 at 01:01 PM, observation revealed R29 sat in a wheelchair in his room. Certified Nurse Aide (CNA) M and CNA N applied gloves, told R29 the procedure, and then transferred the resident using a sit to stand lift into the bathroom. CNA M pulled down R29's pants, removed the wet incontinent liner from his incontinent brief, and placed it in the trash can. Further observation revealed R29 urinated in the toilet. CNAM then asked R29 if he was done, and R29 replied yes. CNA M assisted the resident in standing with the sit to stand lift, CNA N provided perineal care, then ,with the same contaminated gloves, placed a new incontinent liner in the resident's incontinent brief, pulled up the resident's incontinent brief and pants, then removed and discarded gloves.

On 12/19/22 at 01:20 PM, CNA N verified she had not changed gloves and performed hand hygiene after providing perineal care and stated she should have.

On 12/21/22 at 09:26 AM, Administrative Nurse D stated she expected staff to change gloves between dirty and clean when providing perineal care.

The facility's "Perineal Care Policy and Procedure," revised 04/22, instructed staff to apply gloves, remove soiled items and assist

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F 690	Continued From page 36 resident onto a clean soaker pad or transfer to toilet, wash perineal area with soap and water(rinse or pat dry) or facility product as indicated, remove soiled gloves, wash hands, and apply new gloves, then apply clean/dry clothing or undergarments, as needed. The facility failed to appropriate treatment and services to prevent UTIs when staff failed to change gloves after providing perineal care for R29, and with the same contaminated gloves, applied new incontinent liner, brief, and touched his clothing. This placed the resident at increased risk for UTI.	F 690		
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	F 758		

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contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This Requirement is not met as evidenced by:
The facility had a census of 38 residents. The sample included 14 residents, of which five were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to obtain a stop date for Resident (R) 17 for use of as needed (PRN) antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication, which placed R17 at risk of receiving unnecessary psychotropic (medication that affects a person's mental status) medication.

Findings included:

- The "Medical Diagnosis" section within R17's Electronic Medical Record (EMR) included

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diagnoses of atrial fibrillation (rapid, irregular heartbeat), weakness, repeated falls, pain due to trauma and anxiety disorder.

The "Quarterly Minimum Data Set" (MDS), dated 10/03/22, documented R17 had intact cognition, required extensive assistance of one staff for activities of daily living, received scheduled and PRN pain medication, and had two or more non-injury falls. The MDS further documented R17 received a diuretic (medication to promote the formation and excretion of urine), opioid (medication used to treat moderate to severe pain) and antianxiety medication during the seven day look back period.

The "Mood State Care Area Assessment" (CAA), dated 07/21/22, documented R17 had a lack of interest in activities, anxiety, and self-isolation.

The "Medication Care Plan," dated 10/17/22, documented the medication regime was reviewed monthly by a consulting pharmacist.

The "Physician Order," dated 09/12/22, directed staff to administer Ativan (antianxiety medication) 0.5 milligrams (mg) tablet by mouth every four hours as needed for anxiety. The order lacked a stop date.

Review of the electronic "Medication Administration Record" (MAR) documented the use of Ativan:
September 14 and 30, 2022.
October 4, 7, 14, and 16, 2022.
November 4, 5, 8, and 19, 2022
December 1, 5, and 16, 2022.

The "Pharmacy Review Progress Notes" documented PRN lorazepam (Ativan) ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 39	F 758		

09/12/22 was beyond the 14-day limit and required documentation of need and duration of use on 10/03/22, 11/01/22, and 12/01/22.

On 12/21/22 at 08:15 AM, Administrative Nurse D reported the pharmacist reported findings to the facility and the physician, then Administrative Nurse D also sent a fax to the physician in addition to the pharmacist doing so. Administrative Nurse D verified the physician had not replied to the three previous months of recommendation and she would call the physician to follow up.

The facility's "Psychotropic Medication Use" policy, dated 07/2022, documented The Centers for Medicare and Medicaid Services (CMS) regulations state that each resident's drug regimen must be free from unnecessary drugs and define what is considered and an unnecessary drug. The elder's need for the psychotropic medication will be monitored, as well as when the elder received optional benefits from the medication and when the medication dose can be lowered, and both the physician and the nursing staff will evaluate the effectiveness of PRN orders for psychotropic drugs to manage behavior. Any psychotropic ordered by a physician as an emergency treatment for behaviors will have an automatic 72 hour stop order, during which time the physician and nursing staff will assess the potential root causal factors for the behaviors and potential behavioral and environmental interventions which may replace or be used as adjunct therapy for the behaviors.

The facility failed to obtain a stop date for R17's PRN Ativan as recommended by the pharmacist and required by the Centers for Medicare and

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F 758	Continued From page 40 Medicaid Services (CM)S, which placed the resident at risk of receiving unnecessary psychotropic medication.	F 758		
F 761 SS=E	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 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 had a census of 38 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to store drugs and biologicals under proper temperature controls in one of two medication rooms. This placed the affected residents at risk for ineffective medication regimen.	F 761		

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F 761	Continued From page 41	F 761		

Findings included:

- On 012/15/22 at 09:00 AM, observation during initial tour of the medication room in the main building revealed the temperature log for the medication refrigerator lacked daily temperatures for 11 days in October 2022, six days in November 2022, and three days in December.

On 12/15/22 at 09:00 AM, Licensed Nurse (LN) E verified there were missing days on the medication refrigerator temperature log. LN E stated evening shift staff were responsible for checking the refrigerator temperatures.

On 12/21/22 at 10:30 AM, Administrative Nurse D stated that she expected nursing staff to check the temperatures of the medication refrigerator in the medication room daily to ensure it was running at the appropriate temperature for medication storage.

The facility's "Thermometers in Refrigerators and Freezers" policy, dated October 2018, documented monitoring was done to maintain temperatures at recommended levels in refrigerators and freezers. Temperature readings are be taken at least once daily. The temperatures for refrigerators shall not exceed 38 degrees and the freezers shall not exceed 0 degrees. If the temperatures did not meet the parameters, Environmental Services team would be notified immediately.

The facility failed to store drugs and biologicals under proper temperature controls, placing the residents at risk for receiving ineffective medications.