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F 000	INITIAL COMMENTS The following citations are the result of a recertification health resurvey and complaint investigation KS00170433. The 2567 was sent electronically on 01/31/23.	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

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 had a census of 58 residents. The sample included 16 residents with, one reviewed for dignity. Based on observation, record review, and interviews, the facility failed to promote care in a manner to maintain and enhance dignity and respect for one sampled resident, Resident (R) 38, who required assistance with meals. This placed the resident at risk for impaired dignity and decreased psychosocial well-being.

Findings included:

- The Electronic Medical Record (EMR) for R38 recorded diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and weakness (the state or condition of lacking strength).

R38's "Quarterly Minimum Data Set" (MDS), dated 01/12/23, documented R38 had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The

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assessment further documented R38 required supervision with one staff for meals; she held food in her mouth/cheeks or had residual food in her mouth after meals, and received a mechanically altered diet.

The "Activities of Daily Living [ADL] Care Plan," dated, 01/17/23 documented R38 would benefit from assistance with ADL cares due to her anxiety, cognitive impairment, and weakness. The care plan directed staff to assist with ADL cares as she allowed, as R38 had become more accepting of assistance and offer, instead of asking, if she needed help. The care plan further documented R38's left arm was weak, and some things were difficult for her to do.

The EMR documented R38 was placed into hospice care on 10/05/22.

On 01/18/23 at 12:12 PM, observation revealed R38's meal tray was on a small black table that was positioned off to her right side. Further observation revealed a Styrofoam bowl of melted chocolate ice cream, in an empty fruit bowl, positioned on its side, and the ice cream had spilled over onto the food tray. R38 had a grilled cheese sandwich, untouched that was still partially in the aluminum foil it came in. Continued observation revealed R38 had chocolate running down her chin from her mouth and had a chunk of peaches on her face. R38 did not receive staff assistance per the observation.

On 01/19/23 at 12:19 PM, R38 stated she required a lot of assistance and she would love it if staff would sit with her at meals to visit with her and to help her when she needed it.

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F 550	Continued From page 3 On 01/19/23 at 12:25 PM, Administrative Nurse E stated R38 had been declining and required assistance at meals, even if just sitting and visiting with R38. Administrative Nurse E further stated it was not dignified for R38 to have food running down her face and understood the need for staff to assist R38. On 01/23/23 at 10:40 AM, Administrative Nurse D stated anyone can get messy in a short period of time and that R38's abilities for self-care fluctuated. On 01/23/23 at 11:00 AM, Certified Nurse Aide (CNA) M stated R38 received hospice care and was totally dependent upon staff for all of her care. CNA M further stated R38 ate her meals in her room but had trouble staying awake during the meal. CNA M acknowledged R38's need for assistance with meals. The facility "Dignity" policy, undated, documented residents at the village would have certain rights and protections under Federal Law that would help and ensure they get care and services needed, the policy further documented, residents have the right to be treated with respect and dignity, and have the right to a safe, comfortable, and homelike environment that allowed residents to be as independent as possible. The facility failed to promote care for R38 in a manner to maintain and enhance dignity and respect. This placed the resident at risk for impaired dignity and decreased psychosocial well-being.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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F 677	Continued From page 4	F 677		

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
The facility had a census of 58 residents. The sample included 16 residents, with five reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to provide one sampled resident, Resident (R) 38 with the necessary level of assistance for eating. This placed the resident at risk for weight loss.

Findings included:

- The Electronic Medical Record (EMR) for R38 recorded diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and weakness (the state or condition of lacking strength).

R38's "Quarterly Minimum Data Set" (MDS), dated 01/12/23, documented R38 had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The assessment further documented R38 required supervision with one staff for meals; she held food in her mouth/cheeks or had residual food in her mouth after meals, and received a mechanically altered diet.

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The "ADL Care Plan," dated, 01/17/23 documented R38 would benefit from assistance with ADL cares due to her anxiety, cognitive impairment, and weakness. The care plan directed staff to assist with ADL cares as she allowed, as R38 had become more accepting of assistance and offer, instead of asking, if she needed help. The care plan further documented R38's left arm was weak, and some things were difficult for her to do.

The EMR documented R38 was placed into hospice care on 10/05/22.

On 01/18/23 at 12:12 PM, observation revealed R38's meal tray was on a small black table that was positioned off to her right side. Further observation revealed a Styrofoam bowl of melted chocolate ice cream, in an empty fruit bowl, positioned on its side, and the ice cream had spilled over onto the food tray. R38 had a grilled cheese sandwich, untouched that was still partially in the aluminum foil it came in. Continued observation revealed R38 had chocolate running down her chin from her mouth and had a chunk of peaches on her face. R38 did not receive staff assistance per the observation.

On 01/19/23 at 12:19 PM, R38 stated she required a lot of assistance and she would love it if staff would sit with her at meals to visit with her and to help her when she needed it.

On 01/19/23 at 12:25 PM, Administrative Nurse E stated R38 had been declining and required assistance at meals, even if just sitting and visiting with R38. Administrative Nurse E further stated it was not dignified for R38 to have food running down her face and understood the need

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F 677	Continued From page 6 for staff to assist R38. On 01/23/23 at 10:40AM, Administrative Staff A stated the care plan team would look at R38's care plan and would update it to reflect R38's need for assistance at meal times. On 01/23/23 at 11:00 AM, Certified Nurse Aide (CNA) M stated R38 received hospice care and was totally dependent upon staff for all of her care. CNA M further stated R38 ate her meals in her room but had trouble staying awake during the meal. CNA M acknowledged R38's need for assistance with meals. Upon request a policy for ADL assistance was not provided by the facility. The facility failed to provide an adequate level of meal assistance for cognitively impaired R38, placing the resident at risk for weight loss.	F 677		
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---	F 758		

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§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

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

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or 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 58 residents. The sample included 16 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure an appropriate indication

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for Resident (R) 47's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment in reality testing) medication, Seroquel. This placed the resident at risk for adverse side effects related to antipsychotic use.

Findings included:

- The Electronic Medical Record (EMR) for R47 recorded diagnoses of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

R47's "5 Day Medicare Minimum Data Set", dated 11/10/22, documented R47 had long and short term memory problems with moderately impaired decision making skills and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and ambulation in the corridors. The MDS further documented R47 had disorganized thinking, verbal behaviors, rejection of care, wandering, had delusions (something that is believed to be true or real but that is actually false or unreal), and received an antipsychotic medication seven days during the lookback period.

R47's "Care Plan," dated 10/31/22, documented R47 had a history of aggressive behaviors, used antipsychotic medication for dementia with behaviors, and received psychiatric services. The care plan directed staff to administer medication as ordered by the physician, observe for and

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report any side effects, review the use of psychotropic medication use with the resident and/or family as needed.

R47's "Abnormal Involuntary Movement Scale (AIMS)," (assessment for detection of involuntary movements related to use of antipsychotic medication) dated 11/09/22, recorded a score of 0 (a score of two or higher indicated the resident has involuntary movements).

The "Physician Orders," dated 04/20/22, directed staff to administer the resident Seroquel (antipsychotic), 25 milligrams (mg) by mouth in the morning for dementia without behavioral disturbance.

The "Physician Orders," dated 09/29/22, directed staff to administer the resident Seroquel, 75 mg twice a day for dementia with behavioral disturbance. The order further directed staff to administer 25 mg and 50 mg tablets to equal 75 mg.

The "Psychiatry Progress Note" dated 11/30/22 documented R47 had diagnoses of dementia with behavioral disturbance, delusional disorder, insomnia (difficulty sleeping) and anxiety. The note, under the "Symptom Description and Subjective Report" recorded R47 was oriented to person but disoriented to place and time. R47 had exit seeking at times and was redirectable. Staff reported R47 had some falls, but no dizziness. R47 continued to have some wandering and exit-seeking at night time but was mostly redirectable. The section "Response to Medication" recorded only "not specified." The note recorded R47 continued Seroquel 25 mg in the morning, 75 mg in the afternoon and 75 mg at

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bedtime in the "Existing Prescribed Medication" and "Medication Moving Forward" sections, though both sections were blank under the "Symptoms Being Treated" fields.

On 01/17/23 at 02:31 PM, observation revealed R47 independently ambulated down the west hall without an assistive device. Further observation revealed R47 was turning right to go down a small hallway which led to another resident household. Administrative Nurse E saw the resident and went to assist him back to his room for toileting assistance.

On 01/19/23 at 09:00 AM, Administrative Nurse E stated R47 had behaviors and at times required 1:1 assistance.

On 01/23/23 at 10:40 AM, Administrative Nurse D stated staff spend a lot of time with R47 and he required Seroquel medication. Administrative Nurse D stated he would investigate the diagnosis and asked if he just needed to get the diagnosis changed.

The facility "Policy and Procedure Antipsychotic Medications" policy, undated, documented the interdisciplinary team would ensure any resident who used antipsychotic drugs received gradual dose reduction and behavioral interventions unless clinically contraindicated in an effort to discontinue these drugs to ensure the resident did not receive unnecessary medications and the lowest possible dose was administered for the shortest amount of time. The policy further documented, residents who have not used antipsychotic drugs was not given the drug unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and

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F 758	Continued From page 11 documented in the resident's clinical record. The facility failed to ensure an appropriate indication for the use of R47's Seroquel, placing the resident at risk for adverse side effects.	F 758		