

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2023
NAME OF PROVIDER OR SUPPLIER VILLA ST JOSEPH			STREET ADDRESS, CITY, STATE, ZIP CODE 11901 ROSEWOOD OVERLAND PARK, KS 66209		
(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 000	INITIAL COMMENTS	F 000			
F 554 SS=D	The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 04/03/23. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 18 residents with one resident reviewed for self-administration of medications. Based on observations, record reviews, and interviews, the facility failed to ensure safe and appropriate self-administration of medication for Resident (R) 47. This placed the resident at risk for unnecessary medication side effects and self-administration errors. Findings included: - R47's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time).	F 554			

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 554	Continued From page 1 The "Significant Change Minimum Data Set" (MDS) dated 01/18/23 documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented that R47 required extensive assistance of one staff member for activities of daily living (ADL). The MDS documented R47 required physical assistance of one staff member for bathing activity. The MDS documented R47 had received antipsychotic medication (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions) for three days, antibiotic (class of medication used to treat bacterial infections) for four days, antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) for five days, anti-anxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), and an opioid (a class of medication used to treat pain) for six days during the look back period. R47's "Cognitive Loss Care Area Assessment" (CAA) dated 01/20/23 documented R47 had moderate cognitive loss. R47's "Care Plan" dated 01/24/23 directed staff to administer medication as ordered and monitor for side effects. The care plan lacked documentation or direction for R47's ability for self-administration of medications. R47's clinical record lacked an assessment for self-administration of medications. On 03/14/23 at 01:22 PM R47 laid on the bed with personal items on the bed. A plastic cup	F 554			

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F 554	Continued From page 2 which contained pills sat on the bedside table within R47's reach. On 03/20/23 at 02:30 PM Licensed Nurse (LN) H stated R47 was not able to self-administer her own medication and medication should never be left at her bedside at any time. On 03/20/23 at 04:49 PM Administrative Nurse E stated only a few residents were able to self-administer their own medication. Administrative Nurse E stated the nursing staff would complete an assessment to determine if a resident was safe to be able to self-administer medications. Administrative Nurse E stated R47 was not able to self-administer her medication and medication should never be left at her bedside at any time. The facility's "Self-Administration of Medications" policy last revised December 2017 documented residents had the right to self-administer medication if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. As part of the evaluation, the nursing associates would assess each resident's mental and physical abilities, to determine whether self-administering medications was clinically appropriate for the resident. The facility failed to ensure safe and appropriate self-administration of medications for R47 who was cognitively impaired. This deficient practice placed the resident at risk for unnecessary medication side effects and self-administration errors.	F 554			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580			

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F 580	Continued From page 3 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 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	F 580			

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F 580	Continued From page 4 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 identified a census of 90. The sample included 18 residents with one resident reviewed for notification of changes. Based on observation, record review and interview, the facility failed to notify Resident (R)30 and/or his family/durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) of a significant change in skin condition when R30 developed a pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) during his stay at an acute hospital which was identified when R30 readmitted to the facility. This deficient practice placed the resident at risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare service. Findings included: - R30's Electronic Medical Record (EMR) documented diagnoses of peripheral vascular disease (PVD - abnormal condition affecting the blood vessels), hypertension (HTN -elevated	F 580			

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F 580	Continued From page 5 blood pressure), and heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood). The "Annual Minimum Data Set" (MDS) dated 05/11/22 documented R30 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R30 required extensive assistance of one staff for activities of daily living (ADL). The MDS documented R30 had no unhealed pressure ulcers during the look back period. The "Quarterly MDS" dated 01/18/23 documented R30 had a BIMS score of 13 which indicated intact cognition. R30 required extensive assistance of one staff for his ADL. The MDS documented no unhealed pressure ulcers during the look back period. "The ADL Care Area Assessment" (CAA) dated 05/16/22 documented R30 required limited to extensive assistance with bathing, dressing, grooming and personal hygiene. R30 could shave himself and do oral care after set up. R30 was able to feed himself. R30 required assistance with bed mobility with cues to use bilateral enabler bars. R30 ambulated with staff assistance using a walker and gait belt mostly in his room with help. Staff assisted R30 with transfers using a gait belt. R30 also used a wheelchair and self-propelled most of the time, staff assisted him as needed. R30 has a history of left total knee arthroplasty (TKA-total knee replacement) with multiple revisions and lower extremity weakness. R30 needed help with toileting. R30 was alert and oriented with a BIMS score of 13. R30 was forgetful at times.	F 580			

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F 580	Continued From page 6 The "Pressure Ulcer CAA" dated 05/15/22 documented R30 required extensive assistance with bed mobility, off-loading and repositioning. R30 had urinary incontinence and occasional bowel incontinence. R30 was checked for incontinence approximately every two hours. R30 had a pressure reduction mattress to his bed and a cushion to his wheelchair. R30 currently had no pressure ulcers. A Braden scale (an assessment used to predict pressure sore risk) score was 16 indicating he was at high risk for pressure injury. R30 had a wound on the left thigh with treatment ordered. R30 has noted edema (swelling). Review of the EMR under "ID Notes" tab revealed: A "Nurses Note" dated 03/08/23 04 :17 PM documented R30 readmitted to the facility with a pressure ulcer inside his bilateral buttocks. Review of "Skin Evaluation Form" dated 03/09/23 at 11:42 AM documented a pressure ulcer length of 6.5 centimeters (cm), width 6.0cm. and depth 0.1cm. R30's clinical record lacked documentation his DPOA was notified of the pressure injury. The facility lacked a policy for notifying of changes. The facility failed to notify R30 and/or his family/DPOA of a significant change in skin condition when R30 developed a pressure ulcer during his stay at an acute hospital which was identified upon readmission to the facility This deficient practice had the risk of	F 580			

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F 580	Continued From page 7 miscommunication between facility and resident/family and possible missed opportunity for healthcare service for R30.	F 580			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 18 residents with one	F 609			

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F 609	Continued From page 8 resident reviewed for abuse and mistreatment. Based on observation, record review, and interviews, the facility failed to identify an allegation of abuse, and report to the State Agency, when Resident (R) 40 told the Hospice nurse he received rough treatment from staff, and the Hospice nurse then informed the facility Director of Nursing (DON). This placed the resident at risk for unidentified and ongoing abuse and /or neglect. Findings Included: - The "Medical Diagnosis" section within R40's Electronic Medical Records (EMR) included diagnoses of pulmonary fibrosis (scarring of the lungs), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and major depressive disorder (major mood disorder). A review of R40's "Quarterly Minimum Data Set (MDS)" dated 10/19/22 recorded a Brief Interview for Mental Status (BIMS) of 10 which indicated moderate cognitive impairment. The MDS indicated R40 was totally dependent on two staff for bed mobility and transfers. The MDS indicated he was totally dependent on one staff for personal hygiene, toileting, dressing, and bathing. The MDS documented R40 had a history of rejecting cares. A review of R40's "Quarterly MDS" dated	F 609			

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F 609	Continued From page 9 01/04/23 noted a BIMS score of three indicating severe cognitive impairment. The MDS indicated he was totally dependent on two staff for bed mobility and transfers. The MDS indicated he was totally dependent on one staff for personal hygiene, toileting, dressing, and bathing. The MDS indicated R40 had a history of rejecting cares. A review of R40's "Activities of Daily Living (ADL) Care Area Assessment (CAA)" completed 05/05/22 indicated R40 required extensive to total assistance from staff for bathing, dressing, grooming, personal hygiene, and oral care. The CAA indicated he required a Hoyer lift (total body mechanical lift) for transfers and relied on staff to propel him in his wheelchair. R40's "Cognitive Impairment CAA" completed 05/05/22 indicated R40 had mild cognitive impairment. R40's "Behavioral CAA" was not triggered. A review of R40's "Care Plan" revised 06/23/22 for cognitive impairment noted he had impaired ability to make decisions and comprehend. The care plan noted staff would orient R40 daily with activities and routines. R40's "Care Plan" for ADL initiated on 06/23/22 indicated he required a Hoyer lift for transfers and two-person assist for all transfers. The plan noted he used a Broda chair (specialized wheelchair with the ability to tilt and recline) for mobility with staff assistance. A review of an "Incident Report" dated 08/21/22 indicated direct care staff found R40 hanging off	F 609			

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F 609	Continued From page 10 his bed, attempting to reach items on the floor. The note indicated the Certified Nurse Aide (CNA) identified R40 had bleeding wounds and then placed R40 back in bed. The report indicated the CNA did not notify nursing staff of R40's injuries and left him in bed. The report indicated another direct care staff member found R40 and reported that incident to the nurse. R40's care plan lacked interventions related to his injuries or his mechanism of injury. The report indicated the CNA received counseling on failing to report skin injuries to the nurse. The CNA completed in-service for abuse, neglect, and exploitation. A review of R40's "Hospice Communication" form on 11/14/22 from the Hospice nurse revealed R40 reported to hospice that the weekend staff called R40 "obstinate" and were rough with him. The facility could not provide an investigation into the 11/14/22 allegation of abuse. On 03/16/23 at 08:30AM R40 sat in his bed and watched television. R40 reported he could not remember falling out of bed or staff being rough with him. He reported he was upset about having his feeding tube and stated he attempted to pull it out in the past. He reported he felt safe in the facility. On 03/19/23 at 10:41AM R40's representative reported that she was notified by the hospice nurse on Saturday, 11/12/22, that R40 was "roughed up" by staff during cares. She reported R40 could be difficult to work with and was easily confused due to his cognitive impairment. She stated she believed that R40 attempted to hit staff due to them being rough with him.	F 609			

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F 609	Continued From page 11 On 03/19/22 at 10:58AM Consultant Licensed Nurse (LN) I reported when she talked with R40 on 11/14/22, he informed her that staff were rough with him during cares over the weekend. She reported that R40 had not made previous claims to her about the incident and she felt like R40 was not confused or disoriented at the time of the complaint. She stated that she reported the complaint to the facility's Social Service Director and Director of Nursing. On 03/20/23 at 10:50AM Social Service X stated she was not aware of an allegation related to staff being rough with R40 during cares. She stated she would have immediately reported it and investigated if notified. On 03/20/23 at 11:01AM Administrative Staff B reported she believed R40 was confused and reported the previous incident that occurred on 08/21/22. She stated that she believed he was remembering a previous incident and confused. She did not investigate it as a possible separate incident or report it due to her thought the incident was a connected event to the August incident. She stated the facility assumed it was the same incident they had already investigated and was not aware of Hospice reporting any new allegation but stated she would contact hospice to confirm. She stated the hospice communication notes would have been reviewed daily by the nurses and interdisciplinary team (IDT). She stated staff were provided annual training related to abuse, neglect, and exploitation. She stated she also provided educational in-services and floor training to all staff. On 03/20/23 at 11:10AM Administrative Nurse D	F 609			

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F 609	Continued From page 12 reported that she was informed by Hospice that staff were rough with R40 in November of 2022. Administrative Nurse D reported she believed R40 was referring to the incident that occurred on 08/21/23. She stated that if hospice had notified her of possible abuse she would have investigated as a separate event and reported the event to the State Agency. She stated that staff (including hospice) were expected to report all abuse allegations. A review of the facility's "Abuse Prevention" policy revised 06/2020 noted the facility's residents had the right to be free from abuse, neglect, misappropriation, and exploitation. The policy indicated the facility would screen, educate , and implement protective measures to prevent resident abuse. The policy indicated that all witnessed or suspected abuse will be reported and investigated. The policy indicated that facility will respond quickly to protect the alleged victim and the integrity of the investigation. The policy instructed the facility to report all alleged abuse to the investigating state agency. The facility failed to ensure incidents of alleged abuse were identified as allegations and reported, as required, to the State Agency. This placed the resident at risk for unidentified and ongoing abuse and /or neglect.	F 609			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610			

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F 610	Continued From page 13 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 18 residents with one resident reviewed for abuse and neglect. Based on observation, record review, and interviews, the facility failed to investigate an allegation of staff to resident abuse when Resident (R)40 reported rough treatment from direct care staff. This placed R40 at risk for ongoing and/or unidentified abuse and mistreatment. Findings Included: - The "Medical Diagnosis" section within R40's Electronic Medical Records (EMR) included diagnoses of pulmonary fibrosis (scarring of the lungs), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and major	F 610			

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F 610	Continued From page 14 depressive disorder (major mood disorder). A review of R40's "Quarterly Minimum Data Set (MDS)" dated 10/19/22 recorded a Brief Interview for Mental Status (BIMS) of 10 which indicated moderate cognitive impairment. The MDS indicated R40 was totally dependent on two staff for bed mobility and transfers. The MDS indicated he was totally dependent on one staff for personal hygiene, toileting, dressing, and bathing. The MDS documented R40 had a history of rejecting cares. A review of R40's "Quarterly MDS" dated 01/04/23 noted a BIMS score of three indicating severe cognitive impairment. The MDS indicated he was totally dependent on two staff for bed mobility and transfers. The MDS indicated he was totally dependent on one staff for personal hygiene, toileting, dressing, and bathing. The MDS indicated R40 had a history of rejecting cares. A review of R40's "Activities of Daily Living (ADL) Care Area Assessment (CAA)" completed 05/05/22 indicated R40 required extensive to total assistance from staff for bathing, dressing, grooming, personal hygiene, and oral care. The CAA indicated he required a Hoyer lift (total body mechanical lift) for transfers and relied on staff to propel him in his wheelchair. R40's "Cognitive Impairment CAA" completed 05/05/22 indicated R40 had mild cognitive impairment. R40's "Behavioral CAA" was not triggered. A review of R40's "Care Plan" revised 06/23/22	F 610			

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F 610	Continued From page 15 for cognitive impairment noted he had impaired ability to make decisions and comprehend. The care plan noted staff would orient R40 daily with activities and routines. R40's "Care Plan" for ADL initiated on 06/23/22 indicated he required a Hoyer lift for transfers and two-person assist for all transfers. The plan noted he used a Broda chair (specialized wheelchair with the ability to tilt and recline) for mobility with staff assistance. A review of an "Incident Report" dated 08/21/22 indicated direct care staff found R40 hanging off his bed, attempting to reach items on the floor. The note indicated the Certified Nurse Aide (CNA) identified R40 had bleeding wounds and then placed R40 back in bed. The report indicated the CNA did not notify nursing staff of R40's injuries and left him in bed. The report indicated another direct care staff member found R40 and reported that incident to the nurse. R40's care plan lacked interventions related to his injuries or his mechanism of injury. The report indicated the CNA received counseling on failing to report skin injuries to the nurse. The CNA completed in-service for abuse, neglect, and exploitation. A review of R40's "Hospice Communication" form on 11/14/22 from the Hospice nurse revealed R40 reported to hospice that the weekend staff called R40 "obstinate" and were rough with him. The facility could not provide an investigation into the 11/14/22 allegation of abuse. On 03/16/23 at 08:30AM R40 sat in his bed and watched television. R40 reported he could not	F 610			

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F 610	Continued From page 16 remember falling out of bed or staff being rough with him. He reported he was upset about having his feeding tube and stated he attempted to pull it out in the past. He reported he felt safe in the facility. On 03/19/23 at 10:41AM R40's representative reported that she was notified by the hospice nurse on Saturday, 11/12/22, that R40 was "roughed up" by staff during cares. She reported R40 could be difficult to work with and was easily confused due to his cognitive impairment. She stated she believed that R40 attempted to hit staff due to them being rough with him. On 03/19/22 at 10:58AM Consultant Licensed Nurse (LN) I reported when she talked with R40 on 11/14/22, he informed her that staff were rough with him during cares over the weekend. She reported that R40 had not made previous claims to her about the incident and she felt like R40 was not confused or disoriented at the time of the complaint. She stated that she reported the complaint to the facility's Social Service Director and Director of Nursing. On 03/20/23 at 10:50AM Social Service X stated she was not aware of an allegation related to staff being rough with R40 during cares. She stated she would have immediately reported it and investigated if notified. On 03/20/23 at 11:01AM Administrative Staff B reported she believed R40 was confused and reported the previous incident that occurred on 08/21/22. She stated that she believed he was remembering a previous incident and confused. She did not investigate it as a possible separate incident or report it due to her thought the incident	F 610			

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F 610	Continued From page 17 was a connected event to the August incident. She stated the facility assumed it was the same incident they had already investigated and was not aware of Hospice reporting any new allegation but stated she would contact hospice to confirm. She stated the hospice communication notes would have been reviewed daily by the nurses and interdisciplinary team (IDT). She stated staff were provided annual training related to abuse, neglect, and exploitation. She stated she also provided educational in-services and floor training to all staff. On 03/20/23 at 11:10AM Administrative Nurse D reported that she was informed by Hospice that staff were rough with R40 in November of 2022. Administrative Nurse D reported she believed R40 was referring to the incident that occurred on 08/21/23. She stated that if hospice had notified her of possible abuse she would have investigated as a separate event and reported the event to the State Agency. She stated that staff (including hospice) were expected to report all abuse allegations. A review of the facility's "Abuse Prevention" policy revised 06/2020 noted the facility's residents had the right to be free from abuse, neglect, misappropriation, and exploitation. The policy indicated the facility would screen, educate, and implement protective measures to prevent resident abuse. The policy indicated that all witnessed or suspected abuse will be reported and investigated. The policy indicated that facility will respond quickly to protect the alleged victim and the integrity of the investigation. The policy instructed the facility to report all alleged abuse to the investigating state agency.	F 610			

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F 610	Continued From page 18 The facility failed to ensure incidents of alleged staff to resident abuse and/or mistreatment were fully investigated by the facility. This placed the resident at risk for ongoing abuse.	F 610			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623			

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F 623	Continued From page 19 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623			

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F 623	Continued From page 20 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: The facility identified a census of 90. The sample included 18 residents. Two sampled residents were reviewed for hospitalization. Based on observation, record review and interview, the facility failed to provide written notice of transfer with the required information to Resident (R)30 and R4 and/or to their family/durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare service for R30 and R4.	F 623			

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F 623	Continued From page 21 Findings included: - The electronic medical record for R30 documented diagnoses of peripheral vascular disease (PVD - abnormal condition affecting the blood vessels), hypertension (HTN-an elevated blood pressure), and heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood). The "Annual Minimum Data Set" (MDS) dated 05/11/22 documented R30 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R30 required extensive assist of one staff for activities of daily living (ADL). The "Quarterly MDS" dated 01/18/23 documented R30 had a BIMS score of 13 which indicated intact cognition. R30 required extensive assistance of one staff for his ADL. "The ADL Care Area Assessment" dated documented R30 required limited to extensive assistance with bathing, dressing, grooming and personal hygiene. R30 could shave himself and do oral care after setting up. R30 was able to feed himself. R30 required assist with bed mobility with cues to use bilateral enabler bars. R30 ambulated with staff assistance using a walker and gait belt mostly in his room with help. Staff assisted R30 with transfers using a gait belt. R30 also used a wheelchair and self-propels most of the time, staff assist him as needed. R30 has a history of left total knee arthroplasty (TKA-total knee replacement) with multiple revisions and lower extremity weakness. R30 needed help with toileting. R30 was alert and	F 623			

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F 623	Continued From page 22 oriented with a BIMS score of 13. R30 was forgetful at times. The "Cardiovascular Care Plan" dated 06/09/22 directed staff to provide medications and treatments per physician's orders and monitor for side effects. Staff was to monitor vital signs as ordered and as needed. Report abnormalities to the physician. Staff was to monitor for signs/symptoms of cardiovascular complications. Staff to apply wraps to lower extremities as ordered. Staff was to check his circulation each shift. Staff to monitor for changes in respiratory pattern such as, new, or increased shortness of breath, new or increased wheezing, abnormal breath sounds, new or increased periods of not breathing. Review of R30 EMR under the "ID Notes" documented: A "Nursing Note" on 06/04/22 at 10:44 AM R30 was sent by ambulance to the emergency room for evaluation and was admitted to the hospital. A "Nursing Note" on 02/28/23 at 05:07 PM R30 was sent by ambulance to the emergency room for evaluation and was admitted to the hospital. A "Nursing Note" on 03/11/23 at 09:45 AM R30 was sent by ambulance to the emergency room for evaluation and was admitted to the hospital. R30's clinical record lacked evidence the facility provided a written notification of discharge which contained the required information to R30 or R30's DPOA. On 03/20/23 at 05:17 PM Social Services X	F 623			

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F 623	Continued From page 23 stated the facility notified the family/DPOA by phone of a resident's transfer from the facility to the hospital but had never provided written notification of the transfer. The facility policy "Transfer or Discharge, preparing a Resident for" last revised 11/2022 documented the social worker, or designee, was responsible for: informing the resident, or his or her representative (in writing) of the facility's readmission appeal rights, bed-holding policies. Informing the resident, his or her representative of their right to appeal the decision to be discharged off Medicare skilled services, in accordance with the Medicare Claims Processing Manual. Informing the resident, or his or her representative of the estimated financial responsibility if they wish to continue receiving Medicare skilled services that may not be paid for by Medicare, in accordance with the Medicare Claims Processing Manual. A copy of the notice shall be provided to the Office of the State Long-Term Care Ombudsman. The facility failed to provide written notice of transfer with the required information to R30 and/or to their family/DPOA in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare service for R30. - The electronic medical record (EMR) for R4 documented diagnoses of pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), hypertension (HTN- an elevated blood pressure), chronic obstructive	F 623			

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F 623	Continued From page 24 pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing chronic kidney disease), and chronic kidney disease (CKD-when your kidneys are damaged and can't filter blood the way they should). The "Significant Change Minimum Data Set" (MDS) dated 01/11/23 documented R4 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. R4 required extensive to total assistance of two staff for activities of daily living (ADL). R4 used pressure reducing devices for her bed and chair. R4's "Cognitive Loss Care Area Assessment" (CAA) dated 01/17/23 documented R4 had mild cognitive loss. R4's "Care Plan" dated 03/01/23 documented R4 required assistance of two staff members with the use of Hoyer lift (total body mechanical lift used to transfer residents) for transfer. Review of R30 EMR under the "ID Notes" documented: A "Nursing Note" on 12/12/22 at 01:43 AM documented R4 was sent by ambulance to the emergency room for evaluation and was admitted to the hospital. A "Nursing Note" on 12/27/22 at 06:57 AM documented R4 was sent by ambulance to the emergency room for evaluation and was admitted to the hospital. A "Nursing Note" on 01/17/23 at 10:57 AM			F 623			

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F 623	Continued From page 25 documented R4 was sent by ambulance to the emergency room for evaluation and was admitted to the hospital. A "Nursing Note" on 02/13/23 at 01:50 PM documented R4 was sent by ambulance to the emergency room for evaluation and was admitted to the hospital. On 03/15/23 at 10:32 AM R4 laid on the bed with her eyes closed; the TV was on in the room. On 03/20/23 at 05:17 PM Social Services X stated the facility notified the family/DPOA by phone of a resident's transfer from the facility to the hospital but had never provided written notification of the transfer. The facility policy "Transfer or Discharge, preparing a Resident for" last revised 11/2022 documented the social worker, or designee, was responsible for: informing the resident, or his or her representative (in writing) of the facility's readmission appeal rights, bed-holding policies. Informing the resident, his or her representative of their right to appeal the decision to be discharged off Medicare skilled services, in accordance with the Medicare Claims Processing Manual. Informing the resident, or his or her representative of the estimated financial responsibility if they wish to continue receiving Medicare skilled services that may not be paid for by Medicare, in accordance with the Medicare Claims Processing Manual. A copy of the notice shall be provided to the Office of the State Long-Term Care Ombudsman. The facility failed to provide written notice of transfer with the required information to R4 and/or	F 623			

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F 623	Continued From page 26	F 623			
F 677 SS=D	to their family/DPOA in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity or a delay for healthcare service for R4. ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 18 residents with two residents reviewed for activities of daily living (ADL) cares. Based on observation, record review, and interview, the facility failed to ensure bathing was provided for two residents who required assistance from staff to complete the care. This deficient practice placed Resident (R) 47 and R60 at risk for impaired psychosocial wellbeing, potential skin breakdown and/or skin complications from not maintaining good personal hygiene and bathing practices. Findings included: - R47's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more	F 677			

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F 677	Continued From page 27 intense and persistent than what may normally be felt from time to time). The "Significant Change Minimum Data Set" (MDS) dated 01/18/23 documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented that R47 required extensive assistance of one staff member for ADL. The MDS documented R47 required physical assistance of one staff member for bathing activity. The MDS documented R47 received antipsychotic medication (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions) for three days, antibiotic (class of medication used to treat bacterial infections) for four days, antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) for five days, antianxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), and opioid (a class of medication used to treat pain) for six days during the look back period. R47's "Cognitive Loss Care Area Assessment" (CAA) dated 01/20/23 documented R47 had moderate cognitive loss. R47's "Care Plan" dated 01/24/23 directed staff to assist R47 with bathing on alternate days of hospice bath days and honor R47's wishes. Review of the EMR under "Point of Care" (POC) under daily charting look back report for R47 reviewed from 12/01/22 to 12/28/22 (28 days) revealed two baths/showers on 12/23/22 and	F 677			

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F 677	Continued From page 28 12/27/22. "Activity did not Occur" on six days on 12/07/22, 12/09/22, 12/21/22, 12/22/22, 12/24/22, and 12/28/22. Review from 01/13/23 to 03/14/23 (61 days) revealed one shower/baths on 01/19/23. "Activity did not Occur" was documented 25 days on 01/14/23, 01/16/23, 01/17/23, 01/23/23, 01/30/23, 02/01/23, 02/04/23, 02/07/23, 02/10/23, 02/13/23, 02/14/23, 02/17/2, 02/18/23, 02/19/23, 02/20/2, 02/21/23, 02/24/23, 02/27/23, 02/28/23, 03/03/23, 03/05/23, 03/09/23, 03/13/23, and 03/14/23. The clinical record lacked documentation R47 refused a shower/bath. On 03/15/23 at 03:17 PM R47 laid on the bed working on a laptop computer. R47's hair was uncombed and R47 wore the same shirt as the previous day. On 03/20/23 at 01:59 PM Licensed Nurse (LN) G stated there was a bath schedule posted in the nurse's station for the staff can review and agency staff was given a Kardex (tool that gives a brief overview of each resident) sheet with that information. LN G stated if a resident refused their bath, then after several approaches by the certified nurse aide (CNA), the nurse talked with the resident to find out why they had refused the bath. LN G stated if the resident continued to refuse their bath, then the CNA would document the refusal in POC. LN G stated the assistant director of nursing did audit bathing to prevent a resident missing bathing on frequent occasions. On 03/20/23 at 02:20 PM CNA M stated there was bath schedule at each nurse's station that staff can review at the beginning of their shift. CNA M stated staff would report to the charge nurse if a resident refused their bath and	F 677			

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F 677	Continued From page 29 document in POC. On 03/20/23 at 04:49 PM Administrative Nurse E stated the bath list was posted in the nurse's station by room number. Administrative Nurse E stated the staff would document in POC if a resident was to refuse their bath. Administrative Nurse E stated she would audit the showers from shower sheets to the POC charting and stated the documentation in POC was correct. The facility's "Bath, Bathing, Shower and personal Hygiene GUIDE TO POLICY" date approved 02/20/23 referred to "Quality of Life- Self Determination" policy last revised 12/20/21 documented each resident chose activities, schedules and healthcare that was consistent with their interest, values, assessments and plans of care including personal care needs, such as bathing methods. The facility failed to ensure a shower/bath was provided for R47, who required physical assistance with bathing, which had the potential to cause impaired psychosocial wellbeing, skin breakdown and/or skin complications due to poor personal hygiene. -The "Medical Diagnosis" section within R60's Electronic Medical Records (EMR) included diagnoses of history of falls, rhabdomyolysis (breakdown of damaged skeletal tissue), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), insomnia (inability to sleep), and dysphagia (swallowing difficulty).	F 677			

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F 677	Continued From page 30 A review of R60's "Admission Minimum Data Set (MDS)" dated 01/25/23 indicated a Brief Interview for Mental Status (BIMS) of 13 indicating intact cognition. The MDS indicated she required total assistance with all activities of daily living (ADL) from one to two staff. A review of R60's "Care Area Assessment (CAA)" completed indicated R60 required assistance with bathing, grooming, dressing, personal hygiene, oral care, and bed mobility. The CAA noted she was forgetful with a BIMS of 13. The CAA indicated she required a Hoyer lift (total body mechanical lift used to transfer residents) for transfers and relied on staff to propel her in his wheelchair. R60's "Care Plan" revised 01/30/23 indicated she required Hoyer lift and two-person assist for all transfers. The plan noted she used a wheelchair and staff assist for mobility as needed. The plan noted she required extensive assistance from one staff during bathing and preferred to take showers. R60's "Care Plan" indicated she had Clostridium difficile (C-diff- contagious bacteria characterized by foul smelling frequent bowel movements) on 03/07/23. The plan indicated she would complete the antibiotic course and have ongoing infection monitoring for ongoing sign/symptoms of infection and medication side effects. A review of R60's "Bathing Lookback" reports between 01/18/23 through 03/20/23 revealed she received four bathing opportunities (1/25, 1/28, 2/14, and 2/28). The report did not document any refusals of care for R60.	F 677			

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F 677	Continued From page 31 On 03/14/23 at 08:01AM R60 sat in her room, in her wheelchair, next to her bedside table. R60 was unsure when her last shower occurred and reported she did not think she received showers consistently. R60's hair was uncombed and greasy. R60 was in isolation for C-diff. and her room smelled like urine. On 03/14/23 at 01:35PM staff propelled R60 down "A Hall" towards the "C-Hall" nursing station. R60's hair was damp and combed. On 03/20/23 at 01:59 PM Licensed Nurse (LN) G stated there was a bath schedule posted in the nurse's station for the staff can review and agency staff was given a Kardex (tool that gives a brief overview of each resident) sheet with that information. LN G stated if a resident was to refuse their bath, then after several approaches by the certified nurse aide (CNA), the nurse would talk with the resident to find out why they had refused the bath. LN G stated if the resident continued to refuse their bath, then the CNA would document the refusal in POC. LN G stated the assistant director of nursing did audit bathing to prevent a resident missing bathing on a frequent occasion. On 03/20/23 at 04:49 PM Administrative Nurse E stated the bath list was posted in the nurse's station by room number. Administrative Nurse E stated the staff would document in POC if a resident was to refuse their bath. Administrative Nurse E stated she would audit the showers from shower sheets to the POC charting and stated the documentation in POC was correct. On 03/20/23 at Administrative Staff B reported	F 677			

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F 677	Continued From page 32 that R60 was placed on isolation starting on 03/16/23. She stated that R60 could exit her room as long as she was not having explosive diarrhea or vomiting. She stated she may attend activities, church, eat in the dining hall, or be transported to other rooms in the facility as long as she does not have those symptoms. The facility's "Bath, Bathing, Shower and personal Hygiene" policy date approved 02/20/23 referred to "Quality of Life- Self Determination" policy last revised 12/20/21 documented each resident chose activities, schedules and healthcare that was consistent with their interest, values, assessments and plans of care including personal care needs, such as bathing methods. The facility failed to provide consistent bathing opportunities for R60, who had an infectious disease. This deficient practice place her at risk for infections and decreased psychosocial wellbeing.	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 18 residents. Based on	F 684			

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F 684	Continued From page 33 observations, record review, and interviews, the facility failed to provide bowel monitoring as ordered by a physician for Resident (R) 6 who received opioid (medications used to treat pain). This deficient practice placed the resident at risk for constipation (difficulty passing stools) and physical complications. Findings included: - R6's Electronic Medical Record (EMR) documented diagnoses of chronic pain syndrome and dementia (progressive mental disorder characterized by failing memory, confusion) with mood disturbance. The "Annual Minimum Data Set (MDS) dated 12/07/22, documented a Brief Interview for Mental Status (BIMS) score of ten which indicated moderate cognitive impairment. R6 required extensive assistance with two staff for bed mobility and dressing; total dependence with two staff for transfers and toileting; and supervision with setup help for eating. R6 was always incontinent (lack of voluntary control over urination or defecation) of urine and bowel movements. R6 received opioid medications seven days in the seven-day lookback period. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 12/07/22, documented R6 had moderate cognitive loss. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 12/07/22, documented R6 required extensive to total assistance with dressing, grooming, personal hygiene, incontinent care, bed mobility, and oral care.	F 684			

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F 684	Continued From page 34 The "Care Plan" dated 12/13/22, documented R6 had dementia and needed assistance with daily ADL care. The "Care Plan" directed staff assisted R6 with bed mobility, oral care, grooming, personal hygiene, and dressing. The "Care Plan" dated 12/13/22, documented R6 was incontinent of bowel and bladder and directed staff checked her for incontinence every two hours. The "Care Plan" dated 12/13/22, documented R6 had a potential for complications from constipation/opioid use and directed staff to give scheduled medications as ordered, monitor to make sure she had a bowel movement at least every three days; and give as needed (PRN) medications, monitor for effectiveness, and report concerns to her medical doctor. R6's EMR documented the following medication orders: an order with a start date of 06/30/22 for morphine (opioid pain medication) extended release 15 milligrams (mg) twice a day for pain; an order with a start date of 07/18/22 for bisacodyl (laxative- medication used to treat constipation) 10 mg daily PRN for constipation; an order with a start date of 07/31/22 for docusate sodium (stool softener) 100 mg twice a day for constipation; an order with a start date of 08/03/22 for staff to document if R6 had a bowel movement or if she did not; an order with a start date of 08/22/22 for Miralax 8.5 gram (G) dissolved in six to eight ounces (oz) of water twice a day for constipation with instructions to hold for loose stools; and an order with a start date of 11/19/22 for morphine solution 20 mg/milliliter, give one milliliter at 03:00 PM daily	F 684			

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F 684	Continued From page 35 for pain. R6's EMR documented a physician's order an order with a start date of 08/03/22 which ordered staff to document if R6 had a bowel movement, or if she did not. R6's EMR revealed a lack of evidence of bowel monitoring on 11/17/22, 11/18/22, 12/14/22 to 12/21/22, 12/23/22 to 12/25/22, 01/05/23 to 01/07/23, 01/09/23, 01/17/23 to 01/23/23, 01/27/23 to 01/30/23, 02/01/23 to 02/10/23, and 02/24/23 to 02/26/23. On 03/15/23 at 10:30 AM, R6 laid in bed and rested, she appeared comfortable. On 03/20/23 at 01:58 PM, Licensed Nurse (LN) G stated Certified Nurse Aides (CNA) charted bowel movements and she reviewed bowel movement monitoring herself. She stated if a resident had not had a bowel movement in more than three days, the resident received a PRN medication and if there were no results, she would have looked at the standing orders or call the doctor. On 03/20/23 at 02:37 PM, CNA M stated if he worked three days in a row, he knew if a resident had a bowel movement. He stated bowel movements were charted in Point of Care (POC-CNA EMR system) and he could see in the chart if a resident had not had a bowel movement in more than three days. On 03/20/23 at 04:49 PM, Administrative Nurse E stated the nurses ran a bowel movement report during the shift and if a resident had not had a bowel movement in six shifts or three days, they received a PRN medication. If the resident did not	F 684			

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F 684	Continued From page 36 have a PRN laxative then the nurse reached out to the doctor. The facility's "Administering Medications" policy, last revised December 2021, directed medications were administered in accordance with the orders. The facility's "Restorative Nursing- Toileting Program" policy, last revised May 2021, directed residents who were incontinent were assessed by nursing and/or therapy for a toileting program to promote independence and quality of life by maintaining or improving a resident's continence. The "policy" did not address bowel monitoring. The facility failed to provide bowel monitoring as ordered by a physician for R6 who received opioids routinely and was at risk for constipation. This deficient practice had the risk for constipation and physical complications.	F 684			
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 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.	F 686			

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F 686	Continued From page 37 This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 18 residents with two residents reviewed for pressure ulcer (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). Based on observation, record review, and interviews, the facility failed to ensure staff implemented infection control practices during wound care for Resident (R) 4 who received antibiotics to treat a wound infection. This deficient practice placed R4 at risk of delayed healing, ongoing infection, and worsening of her wound. Findings included: - The electronic medical record (EMR) for R4 documented diagnoses of osteomyelitis (local or generalized infection of the bone and bone marrow) of vertebra (bone of the spinal column) and sacral (large triangular bone between the two hip bones), pressure ulcer, hypertension (HTN- an elevated blood pressure), chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing chronic kidney disease), and chronic kidney disease (CKD-when your kidneys are damaged and can't filter blood the way they should). The "Significant Change Minimum Data Set" (MDS) dated 01/11/23 documented R4 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. R4 required extensive to total assistance of two			F 686			

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F 686	Continued From page 38 staff for activities of daily living (ADL). R4 was at risk for pressure ulcers. R4 used pressure reducing devices for her bed and chair. The "Pressure Ulcer Care Area Assessment (CAA)" dated 01/17/23 for R4 documented she required extensive assistance with turning and repositioning. R4's Braden scale (an assessment used to identify the risk of pressure wounds) score of 12 indicating she was at risk for pressure injury. R4 had a low air loss mattress to her bed and a cushion for her chair. R4's heels were kept off the mattress using foot pillows or regular pillows to float her heels. R4 had a stage three pressure (full thickness wound that extends past all layers of skin into the fat tissue) wound prior to her hospitalization. The pressure ulcer was surgically debrided (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) at the hospital and noted to be a stage four (a deep wound that reaches the muscles, ligaments, or even bone) after the procedure. R4 has a history of not wanting to lay down much during the day and tended to lay on her back when in bed. R4 had extra pillows to help position her and keep pressure off the coccyx/sacral (small triangular area at the base of the spine) area. R4 had vitamin and Juven supplements (a supplement used to support wound healing) ordered. R4 had a new gastrostomy tube (G-tube- a tube inserted through the belly that brings nutrition directly to the stomach) places and a new colostomy (a surgical procedure in which a piece of the colon was diverted to an artificial opening in the abdominal wall). R4's "Care Plan" dated 02/21/23 documented R4 required assistance with bed mobility, had	F 686			

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F 686	Continued From page 39 incontinence with risk for pressure ulcers. Staff was directed to complete Braden scale per facility protocol; do weekly head to toe skin assessment. Staff was to check skin during cares and bathing for signs of redness, rash, skin tears, open areas, blisters, dark discolored areas on skin and report to charge nurse for further skin assessment if skin issues were observed each shift. Staff was to assist with turning and repositioning when R4 was in her bed and wheelchair approximately every two hours. Staff was to check R4 for incontinence approximately every two hours to keep her skin clean and dry each shift. Staff was to ensure R4 had a wheelchair cushion each shift. Staff was to use pillows to float R4's heels while in bed and encourage use. R4 was to have an air mattress for her bed and check air pressure each shift and as needed to ensure mattress was inflated to proper setting. R4 had a stage four pressure ulcer on the sacral area. R4 was resistant to recommendations to off load at times and had numbness from the waist down with risk for infection, and complications. Staff was to do treatments as ordered. Staff was to monitor R4 for signs/symptoms of further infection. Staff was to monitor for healing or worsening of wound and report concerns to the physician. Staff was to encourage R4 to lay down between meals. Staff was to keep pressure off the affected areas as much as possible. Encourage her to allow staff to reposition her on left and right sides approximately every two hours while in bed and use extra pillows to help position her when off-loading approximately every two hours. Review of the EMR under "Physician Orders" tab revealed physician orders:	F 686			

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F 686	Continued From page 40 Aztreonam (antibiotic used to treat bacterial infection) inject one gram intravenous (administered through a vein directly into the blood stream) every 12 hours for wound infection dated 02/22/23 and end date of 04/01/23. Santyl (a sterile enzymatic debriding ointment) 250 unit/gram (gm) ointment apply a nickel thick layer mixed with triple antibiotic ointment (used to prevent and treat minor skin infections caused by small cuts, scrapes, or burns) fill wound bed with gauze daily for wound care started 03/02/23. Triple antibiotic 3.5-400-5000 ointment apply nickel thick layer mixed with Santyl to wound bed daily for wound care dated 03/03/23. On 03/16/23 at 01:14PM R4 had wound care provided by Licensed Nurse (LN) H. LN H put gloves on, and placed the clean wound care items on the bedside table without providing a clean barrier. He then assisted with repositioning R4 and removed her soiled dressings. LN H placed the soiled dressings in trash and removed his gloves. LN H put on new gloves without performing hand hygiene in between glove change and sprayed wound cleanser onto R4's wound. LN H dried the wound with three gauze pads and changed his gloves without performing hand hygiene. LN H mixed ointment together with a Q-tip and applied to ointment to the bed of the wound. LN H again replaced his gloves without completing hand hygiene in between changes. LN H then packed the wound with gauze and applied a dressing to cover it. LN H placed R4's nourishment drink next to her wound care dressing and restarted her tube feeding without performing hand hygiene.	F 686			

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F 686	Continued From page 41 On 03/20/23 at 03:20PM LN G reported that she would provide a barrier when handling wound care items or any clean items used for the residents. She stated she would always wash her hands before, during, and after cares provided to the residents. She stated she would always perform hand hygiene in between changing gloves. On 03/20/23 at 04:02PM Administrative Staff B reported staff were expected to complete hand hygiene in between gloves changes for all cares. She stated that she held education in-services and training to improve infection control practices for the facility. She stated that staff were expected to foam in and foam out of rooms, complete hand hygiene frequently, and ensure infections were not being spread by completing cares for residents. A review of the facility's "Wound Care" policy revised 01/2022 indicated that infection control practices will be implemented into wound care and dressing changes. The policy noted all materials will be prepared and placed on a sterile field. The policy noted that hand hygiene will occur during preparation, between glove changes, and after cares are provided. The facility failed to ensure ensure staff implemented infection control practices during wound care for R4 who received antibiotics to treat a wound infection. This deficient practice placed R4 at risk of delayed healing, ongoing infection, and worsening of her wound.	F 686			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689			

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F 689	Continued From page 42 §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 90 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to ensure foot pedals were used for Resident (R) 67 and R11, when staff pushed residents in their wheelchairs. This deficient practice placed these residents at risk of avoidable accidents. Findings included: - On 3/16/23 at 12: 00 PM Certified Nurse Aide (CNA) O pushed R67 in a wheelchair with no foot pedals into the dining room. R67's feet slid along the floor. R67 stomped her feet onto the floor while staff propelled her forward and attempted to stop her wheelchair in the middle of the dining room. - On 03/16/23 at 12:05 PM CNA N pushed R11 in a wheelchair with no foot pedals into the dining room as R11's feet slid along on the floor. - On 03/20/23 at 01:59 PM Licensed Nurse (LN) G stated all residents who were in a wheelchair and pushed by staff should have foot pedals on their wheelchair to prevent a fall or injuries that could occur if they flipped out of their wheelchairs. LN G stated all the residents had foot pedals for their	F 689			

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F 689	Continued From page 43 wheelchairs. On 03/20/23 at 03:29PM CNA M stated foot pedals should be used whenever a resident needed propelled by a staff member, or when a resident had a chance that their feet might possibly drag on the ground and the resident was not able to hold their feet up. On 03/20/23 at 05:12 PM Administrative Nurse E stated foot pedals should be used any time a resident that required staff assistance with being propelled around the facility; residents should also have foot pedals any time they leave the building. The facility did not provide a policy related to use of foot pedals. The facility failed to ensure staff used foot pedals on the wheelchairs when staff pushed R67 and R11 in the wheelchair. This deficient practice placed R67 and R11 at risk for accidents and related injuries.	F 689			
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,	F 756			

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F 756	Continued From page 44 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. §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 90 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported a lack of an appropriate diagnosis for antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions)	F 756			

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F 756	Continued From page 45 medication usage. The facility failed to ensure the CP identified and reported the lack of laboratory monitoring for R6 who was on Depakote (medication used to treat seizures) for two years, antihypertensive (medications used to treat high blood pressure) medication given outside parameters for R6, a lack of dosing instructions for Voltaren (topical pain reliever medication) gel for R6, and a lack of a 14-day stop date for a PRN (as needed) antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication for R6; the facility failed to ensure the CP identified and reported an inappropriate diagnosis for antipsychotic medication usage for R65. This deficient practice had the risk for unnecessary medication use and unwarranted physical complications for the affected residents. Findings included: - R47's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time). The "Significant Change Minimum Data Set" (MDS) dated 01/18/23 documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented that R47 required extensive assistance of one staff member for activities of	F 756			

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F 756	Continued From page 46 daily (ADL). The MDS documented R47 required physical assistance of one staff member for bathing activity. The MDS documented R47 had received antipsychotic medication (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions) for three days, antibiotic (class of medication used to treat bacterial infections) for four days, antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) for five days, antianxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), and opioid (a class of medication used to treat pain) for six days during the look back period. R47's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/20/23 documented R47 received several psychotropic medications on a regular basis. R47's "Care Plan" dated 01/24/23 directed nursing staff to administer medication as ordered, monitor for behaviors and side effects of medications given. Review of the EMR under "Orders" tab revealed physician orders: Quetiapine fumarate (antipsychotic) 300 milligrams (mg) give two tablets (600mg) by mouth at bedtime for insomnia (inability to sleep)/depression dated 02/06/23. Review of the "Monthly Medication Review" (MMR) provided by the facility, performed by the CP, reviewed from March 2022 through February	F 756			

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F 756	Continued From page 47 2023 failed to address the lack of appropriate indication for antipsychotic medication. On 03/14/23 at 01:22 PM R47 laid on the bed with personal items on the bed. A plastic cup which contained pills sat on the bedside table within R47's reach. On 03/20/23 at 01:59 PM Licensed Nurse (LN) G stated she does not see the MMR's. LN G stated she would clarify the diagnosis with physician if she noted an inappropriate diagnosis for antipsychotic medication. On 03/20/23 at 04:49 PM Administrative Nurse E stated the CP comes monthly to review the clinical record of each resident. Administrative Nurse E stated the CP should review for appropriate diagnosis for antipsychotic medications and was not sure if the CP reviewed bowel movements. On 03/21/23 at 02:00 PM CP GG stated she reviewed each resident clinical record monthly. CP GG stated she does make recommendation to the physician for appropriate use of antipsychotic medication. The facility's "Procedure: Medication Regimine Review for Nursing" policy last revised September 2019 documented the medication regimen of each resident was reviewed by a licensed pharmacist according to Federal, State, and local regulations as well as current standards of practice. The pharmacist would report any irregularities to the attending physician, the facility's medical director, and the director of nursing, and then the reports are acted upon in a manner that meets the needs of the resident.	F 756			

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F 756	Continued From page 48 The facility failed to ensure the CP identified and reported a lack of an appropriate indication for antipsychotic medication usage. This deficient practice had the risk for unnecessary medication use and physical complications. - R6's Electronic Medical Record (EMR) documented diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), unspecified dementia (progressive mental disorder characterized by failing memory, confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), seizures (violent involuntary series of contractions of a group of muscles), chronic pain syndrome, and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness). The "Annual Minimum Data Set (MDS)" dated 12/07/22 documented a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R6 had no behaviors noted. R6 complained of occasional pain rated highest of two out of ten in the last five days of the assessment period. R6 received antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression), antipsychotics (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions), anticoagulants (medication used to prevent blood from thickening or clotting), and opioids (medication used to relieve pain) seven days in the seven-day lookback period.	F 756			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2023
NAME OF PROVIDER OR SUPPLIER VILLA ST JOSEPH			STREET ADDRESS, CITY, STATE, ZIP CODE 11901 ROSEWOOD OVERLAND PARK, KS 66209		
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F 756	Continued From page 49 The "Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Drug Use Care Area Assessment (CAA)" dated 12/07/2022, documented R6 was taking multiple psychotropic medications for bipolar, psychosis, and depression. The "Cognitive Loss Dementia CAA" dated 12/07/2022, documented R6 had moderate cognitive loss. The "Care Plan" dated 12/13/2022, documented that R6 took antipsychotic medication for bipolar, psychosis and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) with risk for side effects. The "Care Plan" dated 12/13/22, documented R6 received scheduled pain medication for chronic pain, joint pain, and diagnosis of brain tumor with a risk for increased pain. The "Care Plan" directed staff gave scheduled pain medications as ordered, monitored for increased pain and uncontrolled pain, and consulted with her medical doctor for further evaluation and treatment. The "Care Plan" dated 12/13/22, documented R6 received medications for diagnosis of hypertension with risk for elevated blood pressure. The "Care Plan" directed staff administered medications per medical doctor order; monitored vital signs per facility protocol or as ordered; and monitored for complaints of headache, nosebleed, shortness of breath, fatigue, and feeling faint. The "Care Plan" dated 12/13/22, documented R6 had a seizure disorder with a risk for complications and directed staff monitored labs	F 756			

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F 756	Continued From page 50 per orders and informed physician of results. R6's EMR documented an order with a start date of 10/30/21 for metoprolol succinate (antihypertensive medication) 25 milligrams (mg) every day for hypertension with instructions to hold and notify medical doctor if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 110 millimeters of mercury (mmHg) or heart rate (HR) was less than 60 beats per minute (bpm); an order with a start date of 05/04/22 for Depakote 500 mg every 12 hours for seizures; an order with a start date of 10/06/22 for Voltaren 1% topical gel applied to right knee and low back twice a day, no dosage noted; and an order with a start date of 01/17/23 for lorazepam intensol (antianxiety medication) 2 milligrams per milliliter (mg/ml) every two hours as needed for anxiety disorder. A review of R6's "Medication Administration Record (MAR)" for January 2023 revealed metoprolol was given outside of ordered parameters on 01/07/23, 01/08/23, 01/11/23, 01/12/23, 01/21/23, and 01/29/23. A review of R6's "MAR" for February 2023 revealed metoprolol was given outside of ordered parameters on 02/01/23, 02/08/23, 02/09/23, 02/10/22, 02/22/23, 02/24/23, 02/27/23, and 02/28/23. A review of R6's "MAR" for 03/01/23 to 03/16/23 revealed metoprolol was given outside of ordered parameters on 03/02/23, 03/05/23, 03/06/23, and 03/12/23. R6's medical record lacked an order for valproic	F 756			

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F 756	Continued From page 51 acid (Depakote) laboratory test. Upon request, the facility provided the last valproic acid laboratory results which was completed on 03/31/21. Review of R6's medical record lacked documentation the PRN lorazepam intensol had a 14 day stop date or physician's rationale for extended use. Review of the "Medication Regimen Reviews (MRR)" for November 2022 through February 2023 lacked evidence the CP identified and reported metoprolol given outside of ordered parameters, laboratory monitoring for Depakote, dosing instructions for Voltaren gel, and a 14-day stop date for PRN lorazepam and/or rationale for extended usage. On 03/15/23 at 10:30 AM, observation revealed R6 was in her room resting in bed. She appeared comfortable. On, 03/20/2023 at 01:58 PM Licensed Nurse (LN) G stated antihypertensives were held if the vital signs were outside parameters and were charted in the MAR if it was held. She stated she rechecked the blood pressure before discarding the medication. LN G stated valproic acid laboratory test orders were given by the doctors if the system did not generate it. She stated if the resident was on hospice, the laboratory test would still need done but it was up to the doctor and family. LN G stated medications should have all had dosages and Voltaren came with a dosage card. She stated she called and verified dosage if the order did not have a dosage. She stated that most of the PRN medications like lorazepam would have a 14 day stop date. LN G stated that	F 756			

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F 756	Continued From page 52 if they found a PRN medication, like lorazepam, without a 14 day stop date, that they would report it to the provider. On, 03/20/23 at 04:49 PM Administrative Nurse E stated if a medication did not have a dosage on it, the computer would not complete the order. She stated Voltaren was sometimes put in as 1% and the facility reviewed those orders the next day and corrected them to add the dosage. Administrative Nurse E stated the doctors decided when laboratory tests were completed for medications and hospice residents still received laboratory tests if ordered by a physician. She stated she expected staff to hold blood pressure medications if the vitals were outside of parameters, then notify the physician. Administrative Nurse E stated that PRN medications, such as lorazepam, should have an automatic stop date. On 03/21/23 at 02:00 PM, Consultant GG stated she reviewed every resident's chart but tried to wait for the previous month's MRR to return from the physician. She stated she would not write a recommendation for a Depakote level if it was being used for mood or behaviors and she reviewed medications for dosage and location of creams/gels. Consultant GG stated she reviewed vital signs for antihypertensive medication and if the medication was held. She stated PRN antianxiety medications should have had a stop date. The facility's "Medication Regimen Review for Nursing" policy, last revised September 2019, directed the pharmacist reported any irregularities to the attending physician, the facility's Medical Director, and Director of Nursing, and the reports	F 756			

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F 756	Continued From page 53 were acted upon in a manner that meets the needs of the residents. The facility's "Behavioral Assessments, Intervention and Monitoring" policy dated 12/2019 documented the community will comply with regulatory requirements to the use of medications to manage behavioral changes. The facility's "Administering Medications" policy, last revised December 2021, directed medications were administered in accordance with the orders. The facility failed to ensure the CP identified and reported the lack of laboratory monitoring for Depakote for two years, antihypertensive medication given outside parameters, a lack of dosing instructions for Voltaren gel, and a lack of a 14-day stop date for a PRN antianxiety medication and/or physician's rationale for extended use for R6's. This deficient practice placed R6 at risk for unnecessary medications and adverse medication side effects. - The electronic medical record for R65 documented diagnoses of hypertension (elevated blood pressure), and psychosis (any major mental disorder characterized by a gross impairment in reality testing). The "Significant Change Minimum Data Set" (MDS) dated 10/10/22 documented R65 had a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognition. R65 required extensive assistance of one staff for her activities of daily living (ADLS). R65 received an anti-psychotic medication (a medication used to treat mental/mood disorders)	F 756			

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F 756	Continued From page 54 seven of seven days during the lookback period. The "Psychotropic Drug Use CAA" dated 10/12/22 for R65 documented Risperidone (antipsychotic medication) was ordered for psychosis/hallucinations (sensing things while awake that appear to be real, but the mind created). R65 continued to have problems with hallucinations at times. The "Anti-Psychotic Medication Care Plan" dated 10/12/22 for R65 directed staff to give medications as ordered and monitor for side effects. Staff was to monitor for target behaviors/symptoms and document per facility policy. Staff was to consult with the physician for gradual dose reduction/discontinuing medication per protocol. The "Physician's Order," dated 12/13/2022, documented an order for Risperidone 0.25 mg to be given at bedtime for hallucinations. Review of the "Medication Regimen Reviews (MRR)" for December 2022 through February 2023 lacked evidence the CP identified and reported an inappropriate diagnosis for the Risperidone usage for R65. On, 03/20/23 at 02:51 PM, R65 rested in her bed, awake. On, 03/20/2023 at 01:58 PM Licensed Nurse (LN) G stated that is an antipsychotic did not have an appropriate diagnosis that she would call and clarify with the doctor or go through the chart to see if there was a correct diagnosis. She stated that if she was unable to find a diagnosis, then she would contact the doctor to get the order	F 756			

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F 756	Continued From page 55 clarified. On, 03/20/23 at 04:49 PM Administrative Nurse E stated that some appropriate diagnoses for antipsychotic medication use could be bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), or schizophrenia (a serious mental disorder in which people interpret reality abnormally); however, she stated that it will sometimes depend on the doctor as to what diagnosis is assigned for the medications use. She reported being unsure if there was a benefit/risk analysis done before using antipsychotics for off label reasons. On 03/21/23 at 02:00 PM, Consultant GG stated she reviewed every resident's chart but tried to wait for the previous month's MRR to return from the physician. She stated she made recommendations for an appropriate diagnosis for antipsychotic medications. The facility's "Medication Regimen Review for Nursing" policy, last revised September 2019, directed the pharmacist reported any irregularities to the attending physician, the facility's Medical Director, and Director of Nursing, and the reports were acted upon in a manner that meets the needs of the residents. The facility's "Behavioral Assessments, Intervention and Monitoring" policy dated 12/2019 documented the community will comply with regulatory requirements to the use of medications to manage behavioral changes. The facility failed to ensure the CP identified and reported an inappropriate indication for use for R65's anti-psychotic medication Risperidone that	F 756			

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F 756	Continued From page 56	F 756			
F 757 SS=D	was used to treat her hallucinations. This placed the resident at risk for side effects and unnecessary antipsychotic medication use. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to provide bowel monitoring for Resident (R) 47, who received opioid (medication used to relieve pain) medications; failed to ensure antihypertensive	F 757			

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F 757	Continued From page 57 (medications used to treat high blood pressure) medications were not given outside of parameters for R6; failed to provide laboratory monitoring for R6 who received Depakote (medication used to treat seizures) for two years, and failed to ensure Voltaren (topical pain reliever medication) gel had dosing instructions for R6. This deficient practice had the risk for unnecessary medication use and unwarranted physical complications for the affected residents. Findings included: - R47's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time). The "Significant Change Minimum Data Set" (MDS) dated 01/18/23 documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented that R47 required extensive assistance of one staff member for activities of daily living (ADL). The MDS documented R47 required physical assistance of one staff member for bathing activity. The MDS documented R47 had received antipsychotic medication (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions) for three days, antibiotic	F 757			

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F 757	Continued From page 58 (class of medication used to treat bacterial infections) for four days, antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) for five days, antianxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), and opioid (a class of medication used to treat pain) for six days during the look back period. R47's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/20/23 documented R47 received several psychotropic medications on a regular basis. R47's "Care Plan" dated 01/24/23 directed nursing staff to administer medication as ordered, monitor for behaviors and side effects of medications given. Review of the EMR under "Point of Care" (POC) under daily charting look back report for R47 bowel movement documentation from reviewed from 12/01/22 to 12/28/22 (28 days) revealed no bowel movement documented from 12/07/22 to 12/12/22 (6 days) and 12/24/22 to 12/28/22 (5 days). Review from 01/13/23 to 03/14/23 (61 days) revealed no bowel movement documented from 01/23/23 to 01/29/23 (7 days), 01/31/23 to 02/03/23 (4 days), 02/05/23 to 02/09/23 (5 days), 02/11/23 to 02/20/23 (10 days), and 02/22/23 to 03/08/23 (15 days). Review of R47's "Medication Administration Record" from 12/01/22 to 03/14/23, no as needed laxatives was documented as given. Review of the EMR under "Physician Orders" tab revealed physician orders:	F 757			

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F 757	Continued From page 59 Dulcolax suppository laxative (medication used to stimulate or facility evacuation of the bowels) 10 milligrams (mg) give one suppository rectally daily as needed for constipation dated 01/12/23. Magnesium citrus solution (lemon) (laxative) 1.745gram (gm)/30 milliliters (ml) give 30ml by mouth daily as needed for constipation dated 01/12/23. Polyethylene glycol (laxative) 3350 (bulk) powder one packet by mouth twice a day as needed for constipation dated 01/12/23. Fleet enema [sodium phosphates] (laxative) 19-7 gm/11 19-7 gm/1 give rectally every day as needed for constipation dated 01/12/23. Lactulose (laxative) 10 gm/15 mL oral solution give 15gm by mouth three times a day as needed for constipation dated 02/02/23. On 03/14/23 at 01:22 PM R47 laid on the bed with personal items on the bed. A plastic cup which contained pills sat on the bedside table within R47's reach. On 03/20/23 at 01:59 PM Licensed Nurse (LN) G stated she reviewed the resident's chart to find out when their last bowel movement was, at the start of each shift. LN G stated the bowel movements are documented in the point of care (POC) which was reviewed in the resident's clinical record. On 03/20/23 at 04:49 PM Administrative Nurse E stated the charge nurse would run a report at the start of their shift of residents with no	F 757			

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F 757	Continued From page 60 documented bowel movement for three days of six shifts and administer any as needed laxatives or notify the physician. The facility was unable to provide a policy related to bowel monitoring. The facility failed to provide bowel monitoring for R47 who received opioid medication. This deficient had the risk for unnecessary medication use and physical complications. - R6's Electronic Medical Record (EMR) documented diagnoses of chronic pain syndrome, essential hypertension (high blood pressure), seizures, and dementia (progressive mental disorder characterized by failing memory, confusion) with mood disturbance. The "Annual Minimum Data Set (MDS) dated 12/07/22, documented a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R6 required extensive assistance with two staff for bed mobility and dressing; total dependence with two staff for transfers and toileting; and supervision with setup help for eating. R6 complained of occasional pain rated highest of two out of ten in the last five days of the assessment period. R6 received anticoagulant (medication used to prevent blood from thickening or clotting) and opioid medications seven days in the seven-day lookback period. The Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 12/07/22, documented R6 had moderate cognitive loss. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated	F 757			

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F 757	Continued From page 61 12/07/22, documented R6 required extensive to total assistance with dressing, grooming, personal hygiene, incontinent care, bed mobility, and oral care. The "Care Plan" dated 12/13/22, documented R6 had dementia and needed assistance with daily ADL care. The "Care Plan" directed staff assisted R6 with bed mobility, oral care, grooming, personal hygiene, and dressing. The "Care Plan" dated 12/13/22, documented R6 received scheduled pain medication for chronic pain, joint pain, and diagnosis of brain tumor with a risk for increased pain. The "Care Plan" directed staff gave scheduled pain medications as ordered, monitored for increased pain and uncontrolled pain, and consulted with her medical doctor for further evaluation and treatment. The "Care Plan" dated 12/13/22, documented R6 received medications for diagnosis of hypertension with risk for elevated blood pressure. The "Care Plan" directed staff administered medications per medical doctor order; monitored vital signs per facility protocol or as ordered; and monitored for complaints of headache, nose bleed, shortness of breath, fatigue, and feeling faint. The "Care Plan" dated 12/13/22, documented R6 had a seizure disorder with a risk for complications and directed staff monitored labs per orders and informed physician of results. R6's EMR documented an order with a start date of 10/30/21 for metoprolol succinate (antihypertensive medication) 25 milligrams (mg) every day for hypertension with instructions to	F 757			

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F 757	Continued From page 62 hold and notify medical doctor if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 110 millimeters of mercury (mmHg) or heart rate (HR) was less than 60 beats per minute (bpm); an order with a start date of 05/04/22 for Depakote 500 mg every 12 hours for seizures; an order with a start date of 10/06/22 for Voltaren 1% topical gel applied to right knee and low back twice a day, no dosage noted. A review of R6's "Medication Administration Record (MAR)" for January 2023 revealed metoprolol was given outside of ordered parameters on 01/07/23, 01/08/23, 01/11/23, 01/12/23, 01/21/23, and 01/29/23. A review of R6's "MAR" for February 2023 revealed metoprolol was given outside of ordered parameters on 02/01/23, 02/08/23, 02/09/23, 02/10/22, 02/22/23, 02/24/23, 02/27/23, and 02/28/23. A review of R6's "MAR" for 03/01/23 to 03/16/23 revealed metoprolol was given outside of ordered parameters on 03/02/23, 03/05/23, 03/06/23, and 03/12/23. R6's medical record lacked an order for valproic acid (Depakote) laboratory test. Upon request, the facility provided the last valproic acid laboratory results which was completed on 03/31/21. On 03/15/23 at 10:30 AM, R6 laid in bed and rested, she appeared comfortable. On 03/20/23 at 01:58 PM, Licensed Nurse (LN) G	F 757			

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F 757	Continued From page 63 stated antihypertensives were held if the vital signs were outside parameters and were charted in the MAR if it was held. She stated she rechecked the blood pressure before discarding the medication. LN G stated valproic acid laboratory test orders were given by the doctors if the system did not generate it. She stated if the resident was on hospice, the laboratory test would still need done but it was up to the doctor and family. LN G stated medications should have all had dosages and Voltaren came with a dosage card. She stated she called and verified dosage if the order did not have a dosage. On 03/20/23 at 04:49 PM, Administrative Nurse E stated if a medication did not have a dosage on it, the computer would not complete the order. She stated Voltaren was sometimes put in as 1% and the facility reviewed those orders the next day and corrected them to add the dosage. Administrative Nurse E stated the doctors decided when laboratory tests were completed for medications and hospice residents still received laboratory tests if ordered by a physician. She stated she expected staff to hold blood pressure medications if the vitals were outside of parameters then notify the physician. The facility's "Administering Medications" policy, last revised December 2021, directed medications were administered in accordance with the orders. The facility failed to ensure antihypertensive medications were not given outside of ordered parameters, failed to provide laboratory monitoring for Depakote medication usage, and failed to ensure Voltaren gel had dosing instructions for R6. This deficient practice had the	F 757			

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F 757	Continued From page 64 risk for unnecessary medication use and unwarranted physical complications.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758			

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F 758	Continued From page 65 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 90 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to ensure Resident (R)47 and R65 had an appropriate diagnosis for antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) medication use and failed to ensure an as needed (PRN) antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication had a 14-day stop date for R6 and R142. This deficient practice had the risk for unnecessary medication use and physical complications for the affected residents. Findings included: - R47's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder	F 758			

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F 758	Continued From page 66 characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time). The "Significant Change Minimum Data Set" (MDS) dated 01/18/23 documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented that R47 required extensive assistance of one staff member for activities of daily living (ADL). The MDS documented R47 required physical assistance of one staff member for bathing activity. The MDS documented R47 had received antipsychotic medication (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions) for three days, antibiotic (class of medication used to treat bacterial infections) for four days, antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) for five days, antianxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), and opioid (a class of medication used to treat pain) for six days during the look back period. R47's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/20/23 documented R47 received several psychotropic medications on a regular basis. R47's "Care Plan" dated 01/24/23 directed	F 758			

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F 758	Continued From page 67 nursing staff to administer medication as ordered, monitor for behaviors and side effects of medications given. Review of the EMR under "Orders" tab revealed physician orders: Quetiapine fumarate (antipsychotic) 300 milligrams (mg) give two tablets (600mg) by mouth at bedtime for insomnia (inability to sleep)/depression dated 02/06/23. R47's clinical record lacked physician documentation of clinical indication and rationale for use of antipsychotic without an appropriate diagnosis for a person with dementia. On 03/20/23 at 01:59 PM Licensed Nurse (LN) G stated she would clarify the diagnosis with physician if she noted an inappropriate diagnosis for antipsychotic medication. On 03/20/23 at 04:49 PM Administrative Nurse E stated the CP should review for appropriate diagnosis for antipsychotic medications. Administrative Nurse E stated the facility had approached the physician related to appropriate diagnosis or documentation for risk verse benefit of antipsychotic medication orders. The facility's "Behavioral Assessments, Interventions and Monitoring" policy last revised December 2019 documented residents would receive behavioral healthcare and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. The facility failed to ensure the physician documented a clinical justification for use of	F 758			

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F 758	Continued From page 68 antipsychotic medication for R47 who has a diagnosis of dementia, which had the potential of unnecessary psychotropic medication administration thus leading to possible harmful side effects. - The electronic medical record for R65 documented diagnoses of hypertension (elevated blood pressure), and psychosis (any major mental disorder characterized by a gross impairment in reality testing). The "Significant Change Minimum Data Set" (MDS) dated 10/10/22 documented R65 had a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognition. R65 required extensive assistance of one staff for her activities of daily living (ADLS). R65 received an anti-psychotic medication (a medication used to treat mental/mood disorders) seven of seven days during the lookback period. The "Psychotropic Drug Use CAA" dated 10/12/22 for R65 documented Risperidone (antipsychotic medication) was ordered for psychosis/hallucinations (sensing things while awake that appear to be real, but the mind created). R65 continued to have problems with hallucinations at times. The "Anti-Psychotic Medication Care Plan" dated 10/12/22 for R65 directed staff to give medications as ordered and monitor for side effects. Staff was to monitor for target behaviors/symptoms and document per facility policy. Staff was to consult with the physician for	F 758			

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F 758	Continued From page 69 gradual dose reduction/discontinuing medication per protocol. The "Physician's Order," dated 12/13/2022, documented an order for Risperidone 0.25 mg to be given at bedtime for hallucinations. On, 03/20/23 at 02:51 PM, R65 was observed resting in her bed, awake. On, 03/20/2023 at 01:58 PM Licensed Nurse (LN) G stated that is an antipsychotic did not have an appropriate diagnosis that she would call and clarify with the doctor or go through the chart to see if there was a correct diagnosis. She stated that if she was unable to find a diagnosis, then she would contact the doctor to get the order clarified. On, 03/20/23 at 04:49 PM Administrative Nurse E stated that some appropriate diagnoses for antipsychotic medication use could be bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), or schizophrenia (a serious mental disorder in which people interpret reality abnormally); however, she stated that it will sometimes depend on the doctor as to what diagnosis is assigned for the medications use. She reported being unsure if there was a benefit/risk analysis done before using antipsychotics for off label reasons. The facility's "Behavioral Assessments, Intervention and Monitoring" policy dated 12/2019 documented the community will comply with regulatory requirements to the use of medications to manage behavioral changes. The facility failed to ensure an adequate	F 758			

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F 758	Continued From page 70 indication for use for R65's anti-psychotic medication Risperidone that was used to treat her hallucinations. This placed the resident at risk for side effects and unnecessary antipsychotic medication use. - R6's Electronic Medical Record (EMR) documented diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), unspecified dementia (progressive mental disorder characterized by failing memory, confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), seizures (violent involuntary series of contractions of a group of muscles), and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness). The "Annual Minimum Data Set (MDS)" dated 12/07/22 documented a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R6 had no behaviors noted. R6 received antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression), antipsychotics (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions), anticoagulants (medication used to prevent blood from thickening or clotting), and opioids (medication used to relieve pain) seven days in the seven-day lookback period. The "Quarterly MDS" dated 09/21/2022, documented a BIMS score of 10 which indicated	F 758			

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F 758	Continued From page 71 moderate cognitive impairment. R6 had no behaviors noted. R6 received antidepressants, antipsychotics, anticoagulants, and opioids seven days in the seven-day lookback period. The "Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Drug Use Care Area Assessment (CAA)" dated 12/07/2022, documented R6 was taking multiple psychotropic medications for bipolar, psychosis, and depression. The "Cognitive Loss Dementia CAA dated 12/07/2022, documented R6 had moderate cognitive loss. The "Care Plan" dated 12/13/2022, documented that R6 took antipsychotic medication for bipolar, psychosis and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) with risk for side effects. The "Physician's Order," dated 01/17/23, directed staff to administer lorazepam intensol (anxiety medication) 2 milligrams per milliliter (mg/ml) every two hours as needed for anxiety disorder. Review of R6's medical record lacked documentation the PRN lorazepam intensol had a 14 day stop date or physician's rationale for extended use. On 03/15/23 at 10:30 AM, observation revealed R6 was in her room resting in bed. She appeared comfortable. On, 03/20/2023 at 01:58 PM Licensed Nurse (LN) G stated that most of the PRN medications like lorazepam would have a 14 day stop date. LN G	F 758			

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F 758	Continued From page 72 stated that if they found a PRN medication, like lorazepam, without a 14 day stop date, that they would report it to the provider. On, 03/20/23 at 04:49 PM Administrative Nurse E stated that PRN medications, such as lorazepam, should have an automatic stop date. The facility's "Behavioral Assessments, Intervention and Monitoring" policy dated 12/2019 documented the community will comply with regulatory requirements to the use of medications to manage behavioral changes. The facility failed to ensure a 14 day stop date or physician's rationale for extended use for R6's PRN psychotropic medication, placing the resident at risk to receive unnecessary psychotropic medications and adverse medication side effects. - The electronic medical record for R142 documented diagnoses of hypertension (elevated blood pressure), type 2 diabetes mellitus (DM when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood), and tremors (a neurological disorder that causes shaking movements in one or more parts of your body, most often in your hands). The "Admission Minimum Data Set" (MDS) dated 03/09/23 documented R142 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R142 required extensive assistance of one staff for her activities of daily living (ADL). R142 received antipsychotic	F 758			

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F 758	Continued From page 73 medications seven days, antianxiety and hypnotic (a class of medications used to induce sleep and treat insomnia) medications one day in the seven-day look back period. The "Psychotropic Drug Use CAA" dated 03/21/23 documented R142 was admitted on scheduled Abilify (aripiprazole: an anti-psychotic medication used to treat certain mental/mood disorders). R142 also had as needed alprazolam (a medication used for anxiety and panic disorders). The "Anti-anxiety Care Plan" dated 03/12/23 documented R142 was taking medication for her involuntary jerking of the left hand/arm. Staff was to administer the medication as ordered and monitor for side effects. Staff was to consult with the physician for medication review and dose reduction. The "Physician's Order," dated 03/02/2023, directed staff to administer alprazolam (antianxiety medication) 0.5 milligrams (mg) three times a day as needed for sleep/anxiety. Review of 142's medical record lacked documentation the PRN alprazolam had a 14 day stop date or physician's rationale for extended use. On, 03/15/23 at 10:45 AM R142 exercised at her physical therapy appointment. On, 03/20/2023 at 01:58 PM Licensed Nurse (LN) G stated that most of the PRN medications like alprazolam would have a 14 day stop date. LN G stated that if they found a PRN medication, like alprazolam, without a 14 day stop date that they	F 758			

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NAME OF PROVIDER OR SUPPLIER VILLA ST JOSEPH			STREET ADDRESS, CITY, STATE, ZIP CODE 11901 ROSEWOOD OVERLAND PARK, KS 66209		
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F 758	Continued From page 74 would report it to the provider. On, 03/20/23 at 04:49 PM Administrative Nurse E stated that PRN medications, such as alprazolam, should have an automatic stop date. The facility's "Behavioral Assessments, Intervention and Monitoring" policy dated 12/2019 documented the community will comply with regulatory requirements to the use of medications to manage behavioral changes. The facility failed to ensure the physician implemented an appropriate 14-day stop date or an appropriate rationale for continued use and duration for PRN alprazolam for R142. This deficient practice left R142 at risk for unnecessary medication administration and possible adverse side effects.	F 758			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880			

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F 880	Continued From page 75 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880			

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F 880	Continued From page 76 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The facility identified one resident positive for Clostridium difficile (C-diff- contagious bacteria characterized by foul smelling frequent bowel movements). Based on observations, record review, and interviews, the facility failed to follow transmission-based precautions related to isolation practices for Resident (R)60 (mildly cognitively impaired resident) and failed to perform adequate infection control practices including hand hygiene practices during wound care for R4. The deficient practice placed both residents at risk for the spread of infectious diseases and delayed healing. Findings Included: - A review of the facility's "Infection Control Log" revealed one resident on isolation precautions for March 2023; R60 for C-Diff. A review of R60's Electronic Medical Record (EMR) revealed she was placed isolation precautions related to C-diff and started Vancomycin (strong medication used to treat resistant bacterial infections) for ten days. R60's isolation was continued on 03/17/22 due to ongoing loose stool and positive test result.			F 880			

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F 880	Continued From page 77 On 03/14/23 at 08:01 AM R60 sat in her room. An isolation cart sat next to her entry door with personal protective equipment (PPE) supplies (gloves, gowns, masks, and face shields). R60's room contained two bio-hazard containers for trash and linen. A sign posted on top of the isolation box instructed isolation precautions in place due to a suspected or confirmed infectious agent. The sign instructed staff to see nurse before entry. On 03/14/23 at 01:35PM staff propelled R60 down "A Hall" towards the "C-Hall" nursing station. R60's hair was damp and combed. R60 backed into a space by the fish tank area next to R1. R1 attempted to converse with R60 before an unidentified staff female member moved R60 back to her room. R60's room still had the isolation cart and signs in place. On 03/15/23 at 12:25PM Licensed Nurse (LN) J reported R60 was still on isolation but could go onto the unit as long as she was not having diarrhea or symptoms of C-diff. She stated that staff were still required to wear full PPE when performing ADL cares for R60. On 03/20/23 at Administrative Staff B reported that R60 was placed on isolation starting on 03/16/23. She stated that R60 could exit her room as long as she was not having explosive diarrhea or vomiting. She stated she may attend activities, church, eat in the dining hall, or be transported to other rooms in the facility as long as she does not have those symptoms. She stated that staff were expected clean the room, clean to dirty surfaces, disinfect to room based on recommended infection control agent method and follow PPE	F 880			

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F 880	Continued From page 78 requirements each time a care is provided. A review of the facility's "Clostridium Difficile (C-diff) policy revised 12/2021 noted that preventative measures will be taken to prevent the occurrence of C-diff infections among residents and precautions will be taken while caring for residents with C-Diff. The policy indicated C-diff will be considered in residents with acute diarrhea (three or more unformed stools within 24 hours) or abdominal pain. The policy noted primary reservoirs for C-diff were infected people and surfaces. The policy noted that any activity that involved contact between the resident's hand and/or mouth or instruments may provide opportunities for transmission. The policy indicated residents suspected with C-diff will be placed on contact isolation (act of separating a sick individual with a contagious disease from healthy individuals). The policy noted staff will maintain proper PPE (gowns and gloves) will be maintained by staff while providing cares for the resident. The policy indicated staff will maintain vigilant hand hygiene using soap and water during cares for the resident. The policy indicated enhanced environmental cleaning will be completed including the use of Environmental Protective Agency (EPA) registered germicidal agents effective against C-diff spores. The policy indicated special attention to will be provided to disinfecting items of potential fecal soiling (bed, railings, chairs, railings, room fixtures) using approved disinfecting agent recommended for C-diff spores. The policy indicated residents suspected of C-diff will be verified by a positive cytotoxin assay. The policy indicated testing of asymptomatic residents or repeated testing would not be completed. The policy noted that residents that remained asymptomatic (diarrhea free) for 48	F 880			

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F 880	Continued From page 79 hours can be removed from precautions. The policy indicted all residents will be monitored for dehydrations related to diarrhea. The facility failed to ensure consistent isolation precautions were followed related to R60's C-diff infection. This deficient practice placed R60 at risk for the spread of infectious diseases and delayed healing. -On 03/16/23 at 01:14PM R4 had wound care provided by Licensed Nurese (LN) H in her room. LN H put gloves on and placed the clean wound care items on the bedside table without providing a clean barrier. He then assisted with repositioning R4 and removed her soiled dressings. LN H placed the soiled dressings in trash and removed his gloves. LN H put on new gloves without performing hand hygiene in between glove change and sprayed wound cleanser onto R4's wound. LN H dried the wound with three gauze pads and changed his gloves without performing hand hygiene. LN H mixed ointment together with a Q-tip and applied to ointment to the bed of the wound. LN H again replaced his gloves without completing hand hygiene in between changes. LN H then packed the wound with gauze and applied a dressing to cover it. LN H placed R4's nourishment drink next to her wound care dressing and restarted her tube feeding without performing hand hygiene. On 03/20/23 at 03:20PM LN G reported that she would provide a barrier when handling wound care items or any clean items used for the residents. She stated she would always wash her hands before, during, and after cares provided to the residents. She stated she would always perform hand hygiene in between changing	F 880			

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F 880	Continued From page 80 gloves. On 03/20/23 at 04:02PM Administrative Staff B reported staff are expected to completed hand hygiene in between gloves changes for all cares. She stated that the she holds education in-services and training to improve infection control practices for the facility. She stated that staff are expected to foam in and foam out of room, completed hand hygiene frequently, and ensure infections are not being spread by completing cares for residents. A review of the facility's "Wound Care" policy revised 01/2022 indicated that infection control practices will be implemented into wound care and dressing changes. The policy noted the all materials will be prepared and placed on a sterile field. The policy noted that hand hygiene will occur during preparation, between glove changes, and after cares are provided. The facility failed to practice hand hygiene during wound care for R4. The deficient practice placed R4 at risk for the spread of infectious diseases and delayed healing.	F 880			