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	175298	A. BUILDING _____ B. WING _____	03/30/2023

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00178900, KS00179438, & KS00187144. The 2567 was sent electronically 04/12/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 96 residents. The sample included 21 residents with two reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)81 received assistive cares in a dignified manner during meal service. The facility additionally failed to ensure R74 received assistive cares in a dignified manner during basic cares and interactions. This deficient practice placed the residents at risk for decreased psychosocial well-being.

Findings Included:

- The electronic medical record (EMR) for R81 documented diagnoses of type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with long term insulin (hormone which regulates blood sugar) use, vitamin d deficiency, age related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), dysphagia (swallowing difficulty), and need for assistance with personal cares.

A review of R81's "Annual Minimum Data Set

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(MDS)" noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted she required set-up assistance for meals but could eat independently.

A review of R81's "Nutrition Care area Assessment (CAA)" completed 02/14/23 indicated R81 was at potential risk for nutrition related to her dementia diagnosis. The CAA indicated she was unable to perform her ADLs without significant physical assistance.

The CAA also identified R81 had varied intakes of meals. The plan noted she could ambulate, dress, transfer, and complete personal hygiene independently. The plan noted she required set-up assistance with meals and staff should offer clothing protector for meals.

A review of R81's "Care Plan" under nutrition (created 12/20/21) noted she required a regular diet with soft and bite sized food. The plan noted to offer her meals in the dining room.

On 03/29/23 at 07:30AM R81 was escorted to the dining room and asked to sit while waiting for her breakfast. R81's meal tray arrived and she ate some of her food. R81 was not offered a clothing protector before starting her meal. R81 received a bowl of oatmeal for her breakfast. Upon seeing R81 with the oatmeal an unidentified staff member stated "I'm gonna put this on her so she can at her oatmeal." The staff placed the clothing protector on R81 without asking permission.

On 03/29/23 at 12:00PM R81 sat in the dining room. An unidentified staff member fed R81 several bites from her lasagna plates while standing over R81. At 12:08PM staff escorted

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R69 (A severely cognitively impaired resident) back to the dining area and asked him to sit next to R81. At 12:15PM R69 began eating off of R81's lasagna plate. Staff then gave R81's plate to R69 to eat. At 12:23PM R69 left the dining room after eating half the lasagna on the plate. At 12:25PM Administrative Nurse E entered the dining room and instructed the staff that residents were not allowed to share plates or eat from the same plate. Administrative Nurse E instructed staff to get new meal tray for both residents.

On 03/30/23 at 03:30PM Licensed Nurse (LN) I stated R29 stated that staff should never stand over a resident during meal service should be seated and at eye level during meal service. He stated resident should never share meals because the residents may have had different dietary needs and allergies.

A review of the facility's "Resident's Rights" policy revised 01/2022 indicated that each resident is entitled to access to quality care regardless of diagnosis, severity of condition, or payment source. The policy noted each resident had a right to a dignified existence with access to all service.

The facility failed to ensure R81 received assistive care in a dignified manner related to meal service. This deficient practice placed the resident at risk for decreased psychosocial well-being.

- The electronic medical record (EMR) for R74 documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), cerebral infarction (sudden death of brain cells due to lack

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of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), dysphagia (swallowing difficulty), aphasia (condition with disordered or absent language function), major depressive disorder (major mood disorder), muscle weakness, and cognitive communication disorder.

A review of R74's "Annual Minimum Data Set (MDS)" completed 12/27/22 noted a Brief Interview for Mental Status (BIMS) score of two indicating severe cognitive impairment. The MDS indicated she required extensive assistance from two staff for bed mobility, dressing, and personal hygiene. The MDS noted she required total dependence from two staff for transfers, toileting, and locomotion.

A review of R74's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 02/05/23 indicated she was at risk for decline in ADLs related to her medical diagnoses. The CAA noted she was totally dependent on staff for all cares.

R74's "Urinary Catheter CAA" completed 02/05/23 noted she had a urinary catheter (tube inserted into the bladder to drain urine into a collection bag) related to her medical diagnoses. The CAA noted she was at risk for skin breakdown.

A review of R74's "Care Plan" (revised 02/20/23) noted she required assistance from two staff for bed mobility, dressing, personal hygiene, and transfers. The plan noted she required a Hoyer (full body mechanical lift) for all transfers. The

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plan indicated she had an indwelling urinary catheter and wore disposable briefs due to incontinence. The plan noted that collection bag of the urinary catheter should be positioned away from the entrance door to the room.

On 03/27/23 at 08:02 AM R74 slept in her bed. R74's catheter bag was hung on the bed frame facing the entrance door. The catheter bag had no privacy barrier and was half full of dark yellow urine.

On 03/27/23 at 02:24 PM R74 was awake in her bed. R74's call light cord was tangled up in her bed linen. The cord of the call light ran around R74's back and neck around and was twisted around to her lap area. R74's blanket was twisted in her lap with the full front of her disposable brief exposed outward and visible from the door.

On 03/30/23 at 03:30 PM Licensed Nurse (LN) I stated the catheter bags should have been stored away from the entry door and with a privacy bag over it. She stated staff should be frequently checking on R74 to prevent her from falling or tangling herself up in the bed. She stated that R74 should always have her call light next to her in case she needed assistance.

On 03/30/23 at 03:49 PM Administrative Nurse D stated staff were expected to check on the resident frequently and ensure the resident's call light was in reach during each interaction. She stated staff were expected to ensure each resident received care in a dignified manner. She stated that urinary catheter bags should be stored below the resident's bladder and have a privacy bag to protect the resident's dignity.

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F 550	Continued From page 6 A review of the facility's "Resident's Rights" policy revised 01/2022 indicated that each resident is entitled to access to quality care regardless of diagnosis, severity of condition, or payment source. The policy noted each resident had a right to a dignified existence with access to all service. The facility failed to ensure R74 received assistive care in a dignified manner . This deficient practice placed the resident at risk for decreased psychosocial well-being.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 96 residents. The sample included 21 residents with three reviewed for accommodation of needs. Based on observation, record review, and interviews, the facility failed to accommodate Resident (R)29's visual acuity needs. This deficient practice placed R29 at risk for decreased psychosocial wellbeing and accidents. Findings Include: - The electronic medical record (EMR) for R29 documented diagnoses of congestive heart failure (a condition with low heart output and the body becomes congested with fluid), chronic	F 558		

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obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), major depressive disorder (major mood disorder), cognitive communication disorder, obesity, dysphagia (swallowing difficulty), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), legal blindness, and seizures (violent involuntary series of contractions of a group of muscles).

A review of R29 "Quarterly Minimum Data Set (MDS)" completed 02/25/23 noted a Brief Interview for Mental Status (BIMS) was not completed due to severe cognitive impairment. The MDS indicated R29 required total dependence from staff for transfers, bed mobility, locomotion, dressing, toileting, and bathing. The MDS indicated her vision was severely impaired.

A review of R29's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 05/13/22 indicated R29 was at risk for alteration of self-care related to her medical diagnoses.

R29's "Visual Function CAA" completed 05/13/22 indicated she had an alteration of vision related to her legal blindness. The CAA instructed staff to review her care plan.

A review of R29's "Care Plan" revised 11/18/22 indicated R29 was dependent on staff for

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activities, cognitive stimulation, and social interaction. The plan indicated she required total dependence related to dressing, toileting, personal hygiene, bed mobility, eating, bathing, and transfers. The plan noted she required a Hoyer lift (mechanical lift) with two members for all transfers. The plan indicated R29's call light should be close within reach.

R29's "Care Plan" for vision (revised 05/13/22) indicated she had an alteration in vision related to her medical diagnoses and was legally blind. The plan indicated staff will identify and record factors affecting visual function, choices, and environment (initiated 05/06/21). The plan instructed staff to monitor and report symptoms of acute changes in R12's vision, health, or ability to perform ADLs (initiated 05/25/21). The plan lacked individualized intervention related to R29's visual functioning for daily cares, and safety concerning her visual acuity.

On 03/27/23 at 01:30 PM R29 yelled for help while in her bed. R29 reported that she needed to be "pulled" upward in her bed but was unable call staff. R29 reported she could not use her call light because she could not find it. R29's call light was observed in between her mattress and the left side of the bedframe. When instructed where the call light was located, R29 reported she cannot see the call light when staff put it on the bed.

On 03/30/23 at 03:15 PM Certified Medication Aide (CMA) S stated that staff should have ensured to keep personal items were kept in close reach. He stated R29 should always be shown were items were and staff should be helping her locate items by touch. He stated staff should have completed frequent checks to

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F 558	Continued From page 9 ensure she was okay. On 03/30/23 at 03:30 PM Licensed Nurse (LN) I stated R29 would often yell out instead of using her call light, but the call light should always be shown to her and never left in a place she could not reach or access it. She stated staff should familiarize and orient her to her surroundings before attempting to move her anywhere or provide cares. She acknowledged that R29's yelling may be due to her vision problems. A review of the facility's "Resident's Rights" policy revised 01/2022 indicated that each resident is entitled to access to quality care regardless of diagnosis, severity of condition, or payment source. The policy noted each resident had a right to a dignified existence with access to all service. The facility did not provide an accommodation of needs policy as requested on 03/30/23. The facility failed to accommodate R29's visual acuity needs. This deficient practice placed R29 at risk for decreased psychosocial wellbeing and accidents.	F 558		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		

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(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 96 residents. The sample included 21 residents four sample residents were reviewed for care plan timing and revision. Based on observation, record review and interview the facility failed to ensure the care plan for Resident (R) 17 was updated to direct staff cares for R17's contractures (abnormal permanent fixation of a joint) and failed to ensure R8's care plan was updated to address falls and wandering. The facility failed to ensure R12's care plan was updated to remove an unneeded immobilizer and failed to ensure interventions were placed to encourage R71's bladder continence. These deficient practices placed these residents at risk for their needs/cares not being met and a decline in their well-being.

Findings included:

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- The electronic medical record (EMR) for R17 documented diagnoses of metabolic encephalopathy (a brain disease, damage, or malfunction usually related to inflammation within the body), hypertension (HTN - elevated blood pressure), chronic respiratory failure with hypoxia (a condition that results in the inability to effectively exchange carbon dioxide and oxygen, and induces chronically low oxygen levels or chronically high carbon dioxide levels), and tracheostomy (an opening though the neck into the trachea through which an indwelling tube may be inserted).

The "Annual Minimum Data Set" (MDS) dated 03/31/22 documented R17 had both long and short-term memory lost. R17 had severely impaired cognitive skills for daily decision making. R17 displayed continuous inattention and altered level of consciousness. R17 required assistance of one to two staff for activities of daily living (ADLS). R17 had no functional limitation in range of motion (ROM) of upper or lower extremities.

The "Quarterly MDS" dated 01/01/23 document R17 had both long and short-term memory loss. R17 required total dependence of one to two staff for all ADLS. R17 had functional limitation in ROM on one side of his lower extremity. R17 received occupational therapy (OT) since the last assessment.

The "Skin/Pressure Injury Care Area Assessment (CAA)" dated 04/13/22 documented R17 was at risk for skin injury related to bowel/bladder incontinence and required assistance with ADLs. R17 was at risk for complications related to his diagnoses.

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The "Care Plan" for R17 lacked staff direction for care regarding his contractures to upper and lower extremities.

The "Order Summary" for R17 documented an order dated 12/10/22 to wash R17's hands with soap and water daily. Dry completely. Apply rolled wash clothes to his fists and change daily.

The "Order Summary" for R17 documented an order dated 09/09/22 for OT clarification order with OT to see R17 two times a week for the next four weeks for contracture management, positioning/seating management, postural control/body mechanics, and passive ROM interventions and skin integrity training/education.

On 03/28/23 at 09:45 AM R17 rested in bed, head of bed elevated and enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew or swallow food) via gastrostomy tube (a hollow tube surgically place in the abdomen to provide nutrition). R17 had a rolled washcloth to his left hand, but not the right, and a pillow placed between his knees.

On 03/29/23 at 09:15PM R17 laid in bed on his left side. R17 had heel protectors on his feet, and a pillow placed between his knees. R17 had a rolled washcloth in his left hand, no rolled cloth was noted in his right hand that had visibly contracted fingers.

On 03/30/23 at 02:15 PM Certified Medication Aide (CMA) T stated he had worked at the facility for nine months and typically worked on the first floor. CMA T stated he knew that R17 had contractures and had seen R17 with the rolled

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washcloth in his hands. CMA T stated the nurses or OT placed those. CMA T stated the Kardex (a report of brief overview of the patient care/assistance) told the staff how much assistance or other cares a resident required. CMA T stated he was not positive if the Kardex or care plan said if R17 was supposed to have the washcloths for his hands.

On 03/30/23 at 02:30 PM Licensed Nurse (LN) H stated R17 used to have signs up in his room to remind staff to make sure the pillow was between his knees and the washcloths were in his hands. LN H stated she believed that R17's care plan had direction for staff about his contracture care. LN H stated R17 did work with OT a couple times a week and OT would place the washcloth in his hands. LN H stated R17 should have something in his care plan to address his contractures but was not certain that it did.

On 03/30/23 at 03:20 PM LN J stated that the baseline care plan was created upon admission by the admitting nurse, then other areas would be triggered based on the assessment. LN J stated she updated the care plans all the time and the interdisciplinary team (IDT) had weekly meetings to review care plans. R17's care plan should address his contractures. LN J stated R17 was being seen by OT for treatment of the contractures.

On 03/30/23 at 03:37 PM Administrative Nurse D stated care plans should be updated at least quarterly and annually and as needed. Administrative Nurse D stated she would expect R17's care plan to address his hand and knee contractures. Administrative Nurse D stated R17 was being seen by OT for his contractures.

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The facility's "Comprehensive Person-Centered Care Plan" last revised January 2023 documented the interdisciplinary team would develop and implement a comprehensive person-centered care plan for each resident within seven days of completion of the Resident MDS and will include resident's needs identified in the comprehensive assessment, any specialized services because of the resident's goals and desired outcomes, preferences for future discharge and discharge plans.

The facility failed to ensure R17's care plan was updated to address his bilateral hand and knee contracture care needs to help maintain mobility and/or ROM. This placed R17 at risk for a decline in ROM and decreased mobility.
- The electronic medical record (EMR) for R8 documented diagnoses of cognitive communication disorder, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression disorder (major mood disorder), and dementia (progressive mental disorder characterized by failing memory, confusion).

A review of R8 "Quarterly Minimum Data Set (MDS)" completed 02/20/23 noted a Brief Interview for Mental Status (BIMS) assessment could not be conducted due to severe cognitive impairment. The MDS indicated R8 required supervision with set-up assistance for bed mobility, transfers, walking, personal hygiene, toileting, and dressing. The MDS noted R8 had a history of rejection of cares and verbal aggression towards others. The MDS indicated R8 was taking antipsychotic (class of medications used to treat psychological and mental conditions)

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medication routinely.

R8's "Dementia Care Area Assessment (CAA)" completed 02/03/23 noted she had severe cognitive impairment and instructed staff to follow the care plan. The CAA noted she had little interest in following the unit activities.

R8's "Behavior CAA" completed 02/03/23 noted she was at risk related to wandering, had poor adjustment to the unit, and rejected cares offered by staff.

R8's "Psychotropic (medications that affect the mind, mood, or behavior of a person) Medication CAA" completed 02/03/23 noted she was at risk for complications related to her medications.

A review of R8's "Care Plan" (initiated 02/03/23) related to wandering behaviors indicated she had behaviors related to wandering and rejection of care, related to her dementia diagnosis. The plan indicated staff were to administer her medications as ordered, observe for changes in behaviors related to psychotropic medications, and refer to an appropriate psychiatric provider. The plan indicated R12 required assistance from one staff for locomotion, ambulation, toileting, transfers, bed mobility, personal hygiene, and bathing.

An "Incident Report" dated 03/08/23 indicated R8 became physically aggressive with R56 (severely cognitively impaired male resident) on 03/08/23. The report indicated that R8 wandered into R56's room and believed it was her room. The note indicated that R56 asked R8 to leave and R8 became physically aggressive. The report indicated that R8 struck R56 in the face and chest. The report noted R8 came into his room

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due to his light being on. R8's representative stated she leaves the bathroom light on at night to prevent incontinence episodes. The report indicated that staff were educated on the intervention. A review of the "Care Plan" revealed this intervention was not added.

On 03/30/23 at 03:15PM Certified Medication Aide (CMA) S stated that R8 sometimes wandered the unit but was easily redirectable. He stated R8 usually prefersedto stay in her room and came out for meals. CMA S was not sure of the physical altercation related to R56 and stated that all staff had access to view the intervention on the care plans. He stated staff should be reviewing them each time an update or change occurs.

On 03/30/23 at 03:30PM Licensed Nurse (LN) I stated the residents were provided activities to keep them busy and prevent behaviors. She stated that R8 liked to stay in her room and often had no behaviors that she could remember. LN J stated that R8 was hard of hearing and often talked louder when she did not have her hearing aid. She stated all staff members had access to the care plan.

On 03/30/23 at 03:50PM LN H stated that each resident's care plans should be revised continually by the interdisciplinary team to ensure the interventions are accurate. She stated all staff had access to the information listed on the plans and nurses can update the care plans as needed.

A review of the facility's "Care Plan" policy revised 01/2023 indicated each resident's pan will be updated and revised by the IDT after each assessment that reflects person-centered care

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that meet professional standards of quality.

The facility failed to revise R8's "Care Plan" with interventions related to wandering behaviors. This deficient practice placed R8 at risk for accidents and falls.

- The electronic medical record (EMR) for R12 documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), gastro-esophageal reflux disease (backflow of stomach contents to the esophagus), contracture of left hand, dysphagia (swallowing difficulty), cognitive communication disorder, general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and dementia (progressive mental disorder characterized by failing memory, confusion).

A review of R12 "Quarterly Minimum Data Set (MDS)" completed 12/27/22 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated he required physical assistance from one staff for transfers, bed mobility, toileting, personal hygiene. The MDS noted he required limited assistance from two staff members for dressing.

R12 "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 04/08/22 recorded R12 was at risk for alteration of self-care related to his medical diagnoses. The CAA indicated he had left sided (dominant side)

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impairments due to his hemiplegia and hemiparesis.

A review of R12's "Care Plan" initiated on 09/21/21 indicated he was at risk for alterations of musculoskeletal status related to left hand contractuer and a history of nondisplaced fracture of the left shoulder. The care plan indicated he should have a left shoulder immobilizer on at all times. The plan indicated R12 was non-weightbearing on his left arm. The plan indicated he required assistance from one staff for dressing, personal hygiene, transfers, and bed mobility. The plan noted he required a Sit-to-Stand (mechanical lift) for all transfers.

A review of R12's "Physician's Orders" revealed no orders for a left shoulder immobilizer were placed.

On 03/27/23 at 08:20AM R12 sat in his wheelchair in front of his television. R12's left hand splint in place. R12 left arm dangling off the side of the chair. No immobilizer was in place to hold left arm on platform attached to wheelchair. R12 reported he was waiting on his breakfast. His breakfast arrived at 08:40AM. His breakfast was divided by serving in individual bowls.

On 03/28/23 at 02:00PM R12 was in his room. No immobilizer in place for his left shoulder.

On 03/29/23 at 10:18AM R12 sat in his room in his wheelchair. R12's left side left arm platform was in the up position and his left arm was dangled over the side of the wheelchair. No immobilizer was in place for the left shoulder.

On 03/30/23 at 03:00 PM Consultant HH reported

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R19 had a splint but was not aware that he had a left shoulder immobilizer intervention on his care plan. He stated that it may be an old intervention that was never taken out.

On 03/30/23 at 03:28 PM Certified Medication Aide (CMA) stated that therapy staff was responsible for putting on the medical devices (splints and immobilizers) each day. He stated direct care staff can remove them if the resident requested. He stated that R12 has a splint on his left hand but not aware of the immobilizer. He stated that all staff have access to the care plan for review.

On 03/30/23 at 03:30 PM Licensed Nurse (LN) I stated either therapy or the nurses would ensure the medical devices were placed daily based on the resident's order. She stated that R19 does have his left-hand splint for his contractures but not aware of him needing an immobilizer for his shoulder.

A review of the facility's "Contracture" policy revised 12/2022 indicated all residents with limited ROM will be assessed upon admission and provided with effective interventions to maintain and prevent further loss of ROM.

The facility failed to ensure R12's plan of care was revised to remove the left shoulder immobilizer which was no longer needed. This deficient practice placed R12 at risk for uncommunicated care needs and potential unnecessary restrictions to his left arm mobility.
- R71's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of need for assistance with personal care, diabetes mellitus (when the body cannot use glucose, not

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enough insulin made or the body cannot respond to the insulin), and hypertension (elevated blood pressure).

The "Admission Minimum Data Set" (MDS) dated 02/27/23 documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented that R71 required limited assistance of one staff member for activities of daily living (ADLs). The MDS documented R71 was occasionally incontinent of bladder and had no trial toileting program.

R71's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 03/03/23 documented R71 was occasionally incontinent of bowel and bladder.

R71's "Care Plan" dated 02/23/23 documented R71 required assistance of one staff member with toileting. It directed staff to establish a pre-discharge plan with R71, family/caregivers, and the assisted living facility would evaluate the progress and revise plan as needed for discharge. The "Care Plan" dated 03/03/23 directed staff to check R71 as required for incontinence and change as needed.

Review of the EMR under the "Assessment" tab revealed a "LN- Bowel and Bladder Evaluation" dated 02/22/23 which documented R71 was continent of bowel and bladder, and the evaluation did not need to be completed.

Review of the "Documentation Survey Reports' under the "Reports" tab reviewed from 02/22/23 to 03/29/23 revealed documentation of bladder incontinence daily except for 03/11/23.

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R71's EMR lacked evidence the facility identified and responded with appropriate interventions or toileting program related to R71's incontinence.

On 03/28/23 at 08:13 AM R71 sat on the edge of the bed with breakfast tray on the bedside table. A pile of clothes laid on the floor at the foot of his bed.

On03/30/23 at 02:15 PM Certified Medication Aide (CMA) T stated all nursing staff had access to each resident's care plan. CMA T stated staff reviewed the care plan or the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) to know how much assistance or any specific person-centered interventions would be listed.

On 03/30/23 at 03:20 PM Licensed Nurse (LN) J stated she reviewed all the clinical admission assessments, nursing notes and documented tasks to develop each resident's the care plan. LN J stated therapy would assist with R71's plan to return to his assisted living apartment. LN J stated then she would update the care plan to reflect any change made.

On 03/30/23 at 03:30 PM Administrative Nurse D stated all nursing staff would be able to review the care or Kardex to know how much assistance or individualized intervention that were care planned. Administrative Nurse D stated nurses had the ability to make changes to the care plan.

The facility's "Comprehensive Person-Centered

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F 657	Continued From page 22 Care Plan" last revised January 2023 documented the interdisciplinary team would develop and implement a comprehensive person-centered care plan for each resident within seven days of completion of the Resident MDS and will include resident's needs identified in the comprehensive assessment, any specialized services because of the resident's goals and desired outcomes, preferences for future discharge and discharge plans. The facility failed to revise R71's comprehensive care plan with individualized person-centered interventions to promote bladder continence to assist with possible discharge. This deficient practice placed R71 at increased risk for impaired dignity, loss of independence, and social well-being.	F 657		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: The facility identified a census of 96 residents. The sample included 21 residents. Based on record review and interview the facility failed to have an adequate system/process in place to ensure there were staff members present at all times who were properly trained and certified in cardiopulmonary resuscitation (CPR) for Healthcare Providers in order to provide CPR, for all residents who desired resuscitative measures	F 678		

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until emergency medical services arrived. This deficient practice had the potential to compromise the residents' ability to receive CPR if desired.

Finding included:

- Upon request of CPR certified staff members on duty 12/29/23, the facility was unable to determine which staff on shift had the appropriate CPR certification which revealed that the facility did not have a functioning process in place to ensure that the facility had licensed personnel on shift who were adequately trained and held an acceptable CPR certification. The facility further failed to maintain records or proof of CPR certifications for staff.

The facility provided a list of current CPR certified staff members. The list included 16 nursing services staff members with nine licensed staff that were certified.

On 03/30/23 at 07:09 AM Administrative Nurse D stated the facility should have had a process in place to ensure nursing staff had the appropriate CPR certifications which included hands on training and the facility should ensure there are CPR certified nurses on shift at all times. Administrative Nurse D stated the facility started a process to get all the nurses CPR certified, and then the facility will get the Certified Nurse Aides (CNA) certified.

On 03/30/23 at 07:10 AM Administrative Staff A stated the facility had initiated a plan for a CPR instructor to be at the facility all day 03/30/23 from 09:30 AM. All staff were sent a message/email to notify the nurses of the training for staff to get CPR certified. Administrative Staff A stated a plan

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F 678	Continued From page 24 will implemented immediately for the director of Nursing (DON) or designee to audit 10 random record monthly to ensure CPR cards were up to date. The facility policy "Cardiopulmonary Resuscitation (CPR)" revised January 2022 documented: it was the policy of this facility to provide basic life support (BLS), including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel in the absence of advanced directives or a "Do Not Resuscitate (DNR)" order. Only staff member with current CPR certification for Healthcare Providers should perform the procedure. The facility failed to have a system/process in place to ensure there was an adequate number of licensed staff members who were properly trained and/or certified in CPR for Healthcare Providers on duty at all times to be able to provide CPR until emergency medical services arrived. This deficient practice had the potential to compromise the resident's ability to receive resuscitative measures.	F 678		
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	F 686		

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necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 96 residents. The sample included 21 residents with five reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure Resident (R)19's pressure reducing heel protector was applied correctly in order to effectively minimize pressure. This deficient practice placed R19 at risk for wound worsening or delayed healing.

Findings Include:

- The electronic medical record (EMR) for R19 documented diagnoses of gastro-esophageal reflux disease (backflow of stomach contents to the esophagus), major depressive disorder (major mood disorder), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), cognitive communication disorder, left heel pressure ulcer, and dementia (progressive mental disorder characterized by failing memory, confusion).

A review of R19 "Quarterly Minimum Data Set (MDS)" completed 02/20/23 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment . The MDS

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indicated she was at risk for developing pressure ulcers but did not have wounds at the time of assessment. The MDS indicated she required pressure reducing devices for prevention.

A review of R19's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" was not triggered.
R19's "Pressure Ulcer/Injury CAA" completed 06/06/22 indicated she was at risk for pressure injuries related to her cognitive impairment, bowel and bladder incontinence, and medical diagnoses. The CAA indicated she required assistance with all ADLs.

A review of R19's "Care Plan" related to ADLs (created 09/27/21) noted she required assistance from one staff for transfers, bed mobility, personal hygiene, dressing, and eating meals. The plan indicated she received hospice service (end of life comfort care).

R19's "Care Plan" dated 02/23/23 noted she was at risk for pressure injuries related to bowel and bladder incontinence and decline in ADLs. The plan indicated she had a history of pressure ulcer to her coccyx (small triangular bone at the base of the spine) , left heel, and buttocks (revised 03/27/23). The plan instructed staff to provide pressure reducing devices (mattress and cushion for wheelchair), encourage good nutrition/hydration, and provide weekly skin assessments. The wound care note recommended the use of pressure reducing devices, clean with wound cleanser, cover with foam, and change the dressing as needed for soiling/daily.

A review of R19's "Physicians Orders" revealed

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F 686	Continued From page 27	F 686		

an order dated 03/03/23 to cleanse her left heel wound with normal saline solution and apply skin prep to surrounding area. The order instructed staff to apply a foam dressing three times weekly and continue with wound care.

A review of R19's "Wound Care Note" dated 03/08/23 noted R19's left heel pressure ulcer was identified on 03/01/23. The note classified her wound as a facility acquired stage two pressure ulcer (open wound in which the top two layers of the skin have been broken) with measurements of 0.5 centimeters (cm) in length, 0.1cm in wight, and 0.02cm in depth (0.5cm x 0.1cm x 0.02cm). The note indicated the wound had worsened over the week.

A review of R19's "Wound Care Note" dated 03/22/23 noted R19's left heel pressure ulcer was identified on 03/01/23. The note indicated the wound measured 6cm x 3cm x 0.1cm. The note indicated R19 was on hospice services, but the heel wound was worse.

On 03/27/23 at 11:45 AM R19 slept in her bed. She had a pressure reducing mattress. R19 had a pressure reducing boot improperly applied to her left leg. The boot's lower fasten was undone and the entire boot was pulled upward below her knee. R19's heel rested directly on the mattress.

On 03/30/23 at 03:15PM Certified Medication Aide (CMA) S stated residents at risk for skin breakdown should have interventions in place. He stated staff have access to the care plans to ensure the intervention were being followed. He stated R19 was on hospice but should be checked on frequently while in her room or in bed. He stated R19 should have a pressure

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F 686	Continued From page 28 reducing bed and pad for her wheelchair. He stated direct care staff should report to the nurse if a wound reopened or looked worse and anytime a splints or medical device needs to be adjusted. On 03/30/23 at 03:30PM Licensed Nurse (LN) I, stated that R19 should have pressure reducing devices to prevent the wounds from getting worse. She stated that it would be highly unlikely for R19 to attempt to remove the boot herself or take it off due to R19's declined abilities. She stated that staff should be checking on her at a minimum of every two hours while in her room. She stated that if a resident needed her boot reapplied or adjusted, the staff member would alert the nurse. She stated that all staff had access to the care plans to review each resident's specific care needs. On 03/30/23 at 03:50PM Administrative Nurse D stated that staff were expected to provide supervision and frequent checks to residents related to their specific care needs, She stated that staff should be monitoring the residents that are high risk for falls and injuries and following the care planned interventions. The facility was unable to provide a policy related to prevention and treatment of pressure ulcers as requested on 03/30/23. The facility failed to ensure R19's pressure reducing heel protector was applied correctly in order to effectively minimize pressure. This deficient practice placed R19 at risk for wound worsening or delayed healing.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		

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F 688	Continued From page 29 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility identified a census of 96 residents. The sample included 21 residents with eight residents reviewed for position, and mobility. Based on observation, record review, and interviews, the facility failed ensure Resident (R) 24's right hand splint was applied as directed, and the facility failed to provide treatment and services to prevent an avoidable reduction of range of motion (ROM) and/or mobility for R17's contractures (abnormal permanent fixation of a joint) of bilateral hands and knees. This deficient practice left R24 and R17 at risk for further decline and decreased ROM or mobility. Findings included: - R24's Electronic Medical Record (EMR) from	F 688		

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the "Diagnoses" tab documented diagnoses of contracture, major depressive disorder (major mood disorder), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side.

The "Annual Minimum Data Set" (MDS) dated 10/22/22 documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented that R24 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented R24 had not received any restorative programs during the look back period.

The "Quarterly MDS" dated 01/22/23 documented a BIMS score of two which indicated severely impaired cognition. The MDS documented that R24 was dependent on two staff members assistance for ADLs. The MDS documented R24 had not received any restorative programs during the look back period.

R24's "Pressure Ulcer Care Area Assessment" (CAA) dated 11/04/22 documented R24 was at risk for skin/pressure injury related to bowel/bladder incontinence and requires assistance with ADLs.

R24's "Care Plan" last revised 07/19/22 documented staff were encouraging R24 to use supportive devices (PRAFO boot -pressure ankle foot orthotic boot) to right foot and right-hand

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splint with splitters as recommended. R24's tolerance was limited by her behaviors.

Review of R24's clinical record from 07/19/22 to 03/29/23 lacked documentation of application of the supportive devices.

On 03/28/23 at 08:03 AM R24 laid on the bed, with the head of bed elevated slightly. R24's right hand rested on her chest, with no splint or brace noted. A sign was above R24's bed dated August 2022 which directed staff to clean R24's hand before splint application. A hand splint laid on top of the dresser next to the bed.

On 03/28/23 at 04:21 PM R24 sat in Broda (specialized wheelchair with the ability to tilt and recline) wheelchair in her room in front of the TV. R24's right arm rested on a lap tray with no splint or brace on right hand. A hand splint laid on top of the dresser next to the bed.

On 03/29/23 at 07:18 AM R24 laid on the bed. No splint or brace was noted on right hand. A hand splint laid on top of the dresser next to the bed.

On 03/30/23 at 02:15 PM Certified Medication Aide (CMA) T stated only therapy was allowed to apply the splint and braces, but nursing could remove them if necessary. CMA T was not sure how long R24 was to wear her splint but stated staff should go by the chart posted in R24's room if there was one.

On 03/30/23 at 02:30 PM Licensed Nurse (LN) H stated she was not aware of R24 wearing a right-hand splint. LN H stated the order would be located on the "Treatment Administration Record" (TAR).

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On 03/30/23 at 03:30 PM Administrative Nurse D stated the splint or brace orders could be found on the TAR, care plan or under the task's documentation. Administrative Nurse D stated the facility did not have a restorative program in place at the current time but was in the process of restarting the program.

The facility's "Restorative Care" policy last revised January 2023 documented restorative care would be provided lo each resident according to his/her individual needs and desires ns dctem1incd by assessment and interdisciplinary care planning. The resident's restorative care requires close intervention and follow through by physical occupational and speech therapies and the nursing department. It also requi1es participation of employees for other departments. Each resident must be assessed to determine if they can reach a higher level, must be maintained at the current level, or must cope with a declining situation. Following assessment, all information must be integrated with that of other departments at the res ident ' s care planning conference prior to developing or updating the restorative nursing plan.

The facility's "Contracture Documentation" policy last revised December 2022 documented a resident with a limited range of motion or contracture shall receive appropriate treatment and services based on the comprehensive assessment of the resident, to increase range of motion and/or to prevent further decrease.

The facility failed to ensure R24 received services and treatment for her right-hand contracture to prevent an avoidable reduction of ROM and/or

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mobility. This deficient practice left R24 at risk for further decline and decreased ROM.
- The electronic medical record (EMR) for R17 documented diagnoses of metabolic encephalopathy (a brain disease, damage, or malfunction usually related to inflammation within the body), hypertension (HTN - elevated blood pressure), chronic respiratory failure with hypoxia (a condition that results in the inability to effectively exchange carbon dioxide and oxygen, and induces chronically low oxygen levels or chronically high carbon dioxide levels), and tracheostomy (an opening though the neck into the trachea through which an indwelling tube may be inserted).

The "Annual Minimum Data Set" (MDS) dated 03/31/22 documented R17 had both long and short-term memory lost. R17 had severely impaired cognitive skills for daily decision making. R17 displayed continuous inattention and altered level of consciousness. R17 required assistance of one to two staff for activities of daily living (ADLS). R17 had no functional limitation in range of motion (ROM) of upper or lower extremities.

The "Quarterly MDS" dated 01/01/23 document R17 had both long and short-term memory loss. R17 required total dependence of one to two staff for all ADLS. R17 had functional limitation in ROM on one side of his lower extremity. R17 received occupational therapy (OT) since the last assessment.

The "Skin/Pressure Injury Care Area Assessment" dated 04/13/22 documented R17 was at risk for skin injury related to bowel/bladder incontinence and required assistance with ADLs. R17 was at risk for complications related to his

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diagnoses.

The "Care Plan" for R17 lacked staff direction for care regarding his contractures to upper and lower extremities.

The "Order Summary" for R17 documented an order dated 12/10/22 to wash R17's hands with soap and water daily. Dry completely. Apply rolled wash clothes to his fists and change daily.

The "Order Summary" for R17 documented an order dated 09/09/22 for OT clarification order with OT to see R17 two times a week for the next four weeks for contracture management, positioning/seating management, postural control/body mechanics, and passive ROM interventions and skin integrity training/education.

On 03/28/23 at 09:45 AM R17 rested in bed, head of bed elevated and enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew or swallow food) via gastrostomy tube (a hollow tube surgically place in the abdomen to provide nutrition). R17 had a rolled washcloth to his left hand, but not the right, and a pillow placed between his knees.

On 03/29/23 at 09:15PM R17 laid in bed on his left side. R17 had heel protectors on his feet, and a pillow placed between his knees.R17 had a rolled washcloth in his left hand, no rolled cloth was noted in his right hand that had noted contracted fingers.

On 03/30/23 at 02:15 PM Certified Medication Aide (CMA) T stated he had worked at the facility for nine months and typically worked on the first

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floor. CMA T stated he knew that R17 had contractures and had seen R17 with the rolled washcloth in his hands. CMA T stated the nurses or OT placed those. CMA T stated the Kardex (a report of brief overview of the patient care/assistance) told the staff how much assistance or other cares a resident required. CMA T stated he was not positive if the Kardex said R17 was supposed to have the washcloths for his hands. CMA T stated the facility currently did not have a restorative aide.

On 03/30/23 at 02:30 PM Licensed Nurse (LN) H stated R17 used to have signs up in his room to remind staff to make sure the pillow was between his knees and the washcloths were in his hands. LN H stated she believed that R17's care plan had direction for staff about his contracture care. LN H stated R17 did work with OT a couple times a week and OT would place the washcloth in his hands. LN H stated the facility currently did not provide restorative services to the residents.

On 03/30/23 at 12:15 Consultant HH stated R17 had been seen by OT a couple times a week to help with his contractures. Consultant HH stated R17 should have a rolled washcloth in both hands and pillows between his knees. Consultant HH stated it was very important that staff made sure R17 had the rolled washcloths in his hands each day to prevent further contracting. Consultant HH stated the facility currently did not provide a restorative program to residents.

The facility policy "Restorative Care: dated 01/2023 documented: restorative care would be provided to each resident according to his/her individual needs and desires as determined by assessment and interdisciplinary care (IDT)

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F 688	Continued From page 36 planning. The resident would receive services to attain and maintain the highest possible mental/physical functional status and psychosocial well-being defined by the comprehensive assessment and plan of care. Resident's restorative care requires close intervention and flow-through by physical, occupational, and speech therapies and the nursing department. It also requires participation of employees for other departments. All employees will be informed and trained regarding their responsibility and role in resident restorative care. The facility failed to ensure restorative services was consistently provided to R17, who had bilateral hand contractures, to help maintain mobility and/or ROM. This placed R17 at risk for a decline in ROM and decreased mobility.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 96 residents. The sample included 21 residents with four reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure R74's call light was stored safely in her room to prevent entanglement. The facility	F 689		

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additionally failed to follow R11's care plan interventions related to safe staff transfers resulting in two non-injury falls. This deficient practice placed both residents at risk for avoidable falls and injuries.

Findings Included:

- The electronic medical record (EMR) for R74 documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), dysphagia (swallowing difficulty), aphasia (condition with disordered or absent language function), major depressive disorder (major mood disorder), muscle weakness, and cognitive communication disorder.

A review of R74 "Annual Minimum Data Set (MDS)" completed 12/27/22 noted a Brief Interview for Mental Status (BIMS) score of two indicating severe cognitive impairment. The MDS indicated she required extensive assistance from two staff for bed mobility, dressing, and personal hygiene. The MDS noted she required total dependence from two staff for transfers, toileting, and locomotion.

A review of R74's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 02/05/23 indicated she was at risk for decline in ADLs related to her medical diagnoses. The CAA noted she was totally dependent on staff for all cares.

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R74's "Urinary Catheter CAA" completed 02/05/23 noted she had a urinary catheter (tube inserted into the bladder to drain urine into a collection bag) related to her medical diagnoses. The CAA noted she was at risk for skin breakdown.

R74's "Falls CAA" completed 02/05/23 indicated she was a high fall risk related to her medical diagnoses, impaired cognition, urinary catheter, and tube feeding. The CAA indicated she required total staff assistance with all transfers.

A review of R74's "Care Plan" (revised 02/20/23) noted she required assistance from two staff for bed mobility, dressing, personal hygiene, and transfers. The plan noted she required a Hoyer (full body mechanical lift) for all transfers. The plan indicated she had an indwelling urinary catheter and wore disposable briefs due to incontinence. The plan noted that collection bag of the urinary catheter should be positioned away from the entrance door to the room.

On 03/27/23 at 02:24PM R74 was awake in her bed. R74's call light cord was tangled up in her bed linen. The cord of the call light ran around R74's back and neck. The cord was twisted around to her lap area with the button tangled in the linen. R74's blanket was twisted in her lap with the full front of her disposable brief exposed outward and visible from the door.

On 03/30/23 at 03:15 PM Certified Medication Aide (CMA) S stated direct care staff are required ensure the residents call lights are within reach and the residents are safe in their room. He stated that R74 required staff assistance for bed

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mobility, but she can still turn herself and move without assistance. He stated that R74 often gets catheter care and tube feedings, and staff should be ensuring the medical equipment is also stored properly.

On 03/30/23 at 03:30 PM Licensed Nurse (LN) I stated staff should be frequently checking on R74 to prevent her from falling or tangling herself up in the bed. She stated that R74 should always have her call light next to her in case she needed assistance. He stated that R74 required extensive assistance from staff for repositioning and transferring out of bed due to her fall risk.

On 03/30/23 at 03:49 PM Administrative Nurse D stated staff were expected to check on the resident frequently and ensure the resident's call light was in reach during each interaction. She stated staff should be checking each resident's room during each interaction to prevent accidents from happening.

A review of the Facility's "Fall Reduction Program" policy revised 06/2021 indicated staff were to anticipate each resident's need to ensure safe placement of the call light, television remote, and personal care items. The policy indicated that "high Risk" resident would be identified and receive staff checks every 30 minutes. The policy indicated staff will inspect the resident's environment to identify and report potential hazards.

The facility failed to ensure R74's environment was free from entanglement hazards. This deficient practice placed R74 at risk for avoidable injuries.

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- R11's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), cerebral infarction (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, and morbid obesity (severely overweight).

The "Annual Minimum Data Set" (MDS), dated 11/14/22, recorded R11 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that R11 was cognitively intact. The MDS recorded R11 required supervision and oversight with activities of daily living (ADLs) and received insulin (hormone that lowers the level of glucose in the blood) seven days in the seven-day lookback period of the assessment. The MDS documented that R11 had two or more non-injury falls since the last assessment.

The "Falls Care Area Assessment (CAA)" dated 11/14/22, documented R11 was at risk for falls related to bowel and bladder incontinence (lack of voluntary control over urination or defecation) and required assistance with ADLs. The CAA recorded R11was at risk for complications as evidenced by (AEB) decreased functional mobility, stroke, medication side effects, obesity, and diabetes mellitus.

Review of R11's "Care Plan," dated 11/14/19, documented that R11had an alteration in self-care and required the assistance of two staff members during transfers.

R11's EMR documented a "Nursing Note," dated

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12/26/22 at 03:52 AM, which recorded a certified nurse aid (CNA) notified the nurse that the CNA attempted to transfer R11 into bed; R11 was unable to stand so the CNA lowered her to the floor. The note recorded the nurses entered the room and observed R11 on the floor in front of the bed on her buttocks. R11 was not wearing socks at time. R11 stated that when she was getting up her legs were tired and she was unable to stand, and the CNA lowered her to floor. R11 did not have any redness or discoloration, her skin was intact. R11 denied pain at that time.

The facility's "Fall Investigation" dated 12/25/22, signed 12/26/22, documented that the CNA attempted to put R11 into bed, R11 was unable to stand, and the CNA lowered R11 to the floor. The investigation noted predisposing physiological factor of weakness. The investigation indicated that there were no predisposing situational factors. The investigation lacked a root cause analysis.

The facility's "Fall Investigation" dated 02/04/23, signed 02/04/23, documented that while the CNA was assisting R11 to bed, R11's knees gave out and the CNA lowered R11 to the floor. R11 had no injuries noted. The investigation indicated that there were no predisposing situational factors. The investigation lacked a root cause analysis.

R11's EMR documented a "Nursing Note," dated 2/6/23 at 09:55 AM, that while assisting R11 to bed, R11's knees gave out and the CNA lowered R11 to the floor. R11 had no injuries noted.

On 03/30/23 at 10:01 AM R11 sat in her wheelchair in her room and used her phone.

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On 03/30/23 at 02:46 PM Licensed Nursing (LN) I stated that R11 required an assist of two staff members during transfers. LN I further stated that if a resident's care plan required two staff to assist with transfers, it would not have been appropriate to transfer with only one staff member for any reason.

On 03/30/23 at 03:09 PM Certified Medical Assistant (CMA) S stated that staff discussed any falls that occurred before shift changed and that staff knew what residents were fall risks, and how many staff were required to transfer them, when staff checked the care plan. CMA S stated that he believed R11 was a two-person assist with transfers and that there was no acceptable time to use one staff if the resident required two staff for assistance with transfers.

03/30/23 03:38 PM Administrative Nurse D stated that if she had gone in to assist R11 with a transfer that she would have gone in with a second person to help with the assist.

The facility's policy "Fall Reduction Program," revised on 07/2021, directed that charge nurses were to document details of the fall on the risk assessment report as well as in the nurses' notes. The policy directed that the care plan must be updated immediately after the fall and that interventions should be based on the circumstances that lead up to the fall.

The facility failed to ensure staff provided appropriate amount assistance during transfers for R11 when staff attempted to transfer with one staff instead of two. This placed the resident at risk or avoidable injuries and falls.

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F 690	Continued From page 43	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		

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The facility identified a census of 96 residents. The sample included 21 residents with two residents reviewed for bowel and bladder. Based on observation, record review, and interviews, the facility failed to identify and implement interventions to promote continence for Resident (R) 71. This deficient practice placed R71 at risk of alteration in his dignity, well-being and delay his possible discharge.

Findings included:

- R71's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of need for assistance with personal care, diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and hypertension (elevated blood pressure).

The "Admission Minimum Data Set" (MDS) dated 02/27/23 documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented that R71 required limited assistance of one staff member for activities of daily living (ADLs). The MDS documented R71 was occasionally incontinent of bladder and had no trial toileting program.

R71's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 03/03/23 documented R71 was occasionally incontinent of bowel and bladder.

R71's "Care Plan" dated 02/23/23 documented R71 required assistance of one staff member with toileting. It directed staff to establish a pre-discharge plan with R71, family/caregivers,

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and the assisted living facility would evaluate the progress and revise plan as needed for discharge. The "Care Plan" dated 03/03/23 directed staff to check R71 as required for incontinence and change as needed.

Review of the EMR under the "Assessment" tab revealed a "LN- Bowel and Bladder Evaluation" dated 02/22/23 which documented R71 was continent of bowel and bladder, and the evaluation did not need to be completed.

Review of the "Documentation Survey Reports' under the "Reports" tab reviewed from 02/22/23 to 03/29/23 revealed documentation of bladder incontinence daily except for 03/11/23.

R71's EMR lacked evidence the facility identified and responded with appropriate interventions or toileting program related to R71's incontinence.

On 03/28/23 at 08:13 AM R71 sat on the edge of the bed with breakfast tray on the bedside table. A pile of clothes laid on the floor at the foot of his bed.

On 03/30/23 at 03:20 PM Licensed Nurse (LN) J stated a bowel and bladder assessment was completed at the time of admission and a significate change occurred. LN J stated a new bowel and bladder assessment should have been completed to address the bladder incontinence. LN J stated therapy would decide if he would benefit from a toileting program to assist with R71's plan to return to his assisted living apartment. LN J stated then she would update the care plan to reflect any change made.

On 03/30/23 at 03:30 PM Administrative Nurse D

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F 690	Continued From page 46 stated typically bowel and bladder assessment and a change in status would be discussed in the clinical meeting. Administrative Nurse D stated therapy would help with development of a toileting plan. The facility's "Policy-Procedure/ Nursing Administrative, Section: Resident Assessment, Subject: Bladder and Bowel Assessment" policy last revised February 2022 documented it was the policy of the facility to assess the bladder functioning and bowel and habits to identify potential problems regarding elimination. The assessment may be documented on paper format or EMR. A bladder and bowel assessment would be completed quarterly and with any significant change and annually (or with each MDS). The care plan would be updated as needed to reflect toileting schedule or other measures employed to reduce/prevent incontinence. The facility failed to identify and implement interventions to promote continence for R71. This deficient practice placed R71 at risk of alteration in his dignity, well-being and delay his possible discharge.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		

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§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 96 residents. The sample included 21 residents with five reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to follow the Registered Dietician (RD) recommendation to obtain a reweight for Resident (R)12 until 45 days after the initial request was made. This deficient practice placed R12 at risk for further weight loss and delayed intervention

Findings Include:

- The electronic medical record (EMR) for R12 documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), gastro-esophageal reflux disease (backflow of stomach contents to the esophagus), contracture of left hand, dysphagia (swallowing difficulty), cognitive communication disorder, general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), schizophrenia (psychotic disorder

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characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and dementia (progressive mental disorder characterized by failing memory, confusion).

A review of R12's "Quarterly Minimum Data Set (MDS)" completed 12/27/22 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated he required physical assistance from one staff for transfers, bed mobility, toileting, personal hygiene. The MDS noted he required limited assistance from two staff members for dressing. The MDS indicated he required set-up assistance with meals. The MDS indicated R12 was taking antipsychotic (class of medications used to treat psychological and mental conditions) medication routinely. The MDS revealed he had no significant weight since the last assessment.

A review of R12 "Nutrition Care Area Assessment (CAA)" completed 04/08/22 was triggered but comments instructed to review his care plan.

R12 "Activities of Daily Living (ADLs) CAA" completed 04/08/22 was at risk for alteration of self-care related to his medical diagnoses. The CAA indicated he had left sided (dominant side) impairments due to his hemiplegia and hemiparesis.

A review of R12's "Care Plan" dated 02/28/23 related to nutrition indicated he was at risk for alteration of nutrition related to his medical diagnoses. The plan indicated he required a mechanically soft diet with meals served in individual bowels. The plan noted that he be

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weighed weekly for four weeks and then monthly (if stable). The plan instructed staff to monitor and report changes to his nutrition intake and weight to the RD.

R12's EMR lacked orders to obtain R12's weight.

A review of R12's "Weight Record" indicated on 10/10/22 he weighed 183.4 pounds (lbs.). R12 was not weighed in November 2022. On 12/06/22 his weight record indicated he weighed 209.2 lbs. The next documented weight occurred on 01/20/23 indicating he weighed 176.0lbs.

An "RD Note" dated 12/21/22 indicated the RD recognized the weight change and requested for staff to validate R12's weigth change by reweighing him. The EMR lacked documentation showing this request was completed.

An "RD Note" dated 01/04/22 indicated the RD acknowledged the residents weight gain from 12/06 and asked staff to reweigh him again to validate the weight from 12/06. A review of the EMR revealed the reweigh occurred on 01/20/22 (45 days the first reweigh request).

On 03/27/23 at 08:20AM R12 sat in his wheelchair in front of his television. R12 had a left hand splint in place. R12's left arm dangled off the side of the chair.

On 03/30/23 at 03:15PM Certified Medication Aide (CMA) S stated direct care staff were responsible for obtaining weights on the residents. He stated the charge nurse put out a list of residents to be weighed each day and staff completed the weights. He stated that R12 was compliant with cares and would not have an issue

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F 692	Continued From page 50 being reweighed if asked. On 03/30/23 at 03:30PM Licensed Nurse (LN) I stated nursing staff created the list from the residents listed in the EMR system. She stated that if a resident had a change in weight staff documented the weight and an alert popped up the EMR. She stated the dietician was at the facility weekly and reviewed the alerts. She stated the RD notified the Director of Nursing and Medical Provider of recommendation or changes to the resident's care. On 03/30/23 at 03:50PM Administrative Nurse D stated the RD was at the facility once a week and reviewed all the weights. She stated that if the RD needed a reweigh on a resident, an alert was created in the EMR and the nurse added the resident to the list for weights that day. A review of the facility's "Nutrition" policy revised 01/2023 indicated the facility will ensure all residents maintain acceptable parameters of nutritional status (including weights). The policy noted changes in nutritional intake and weights will be reviewed by the physician and dietitian The facility failed to reweigh R12 per RD recommendation until 45 days after the initial request was made. This deficient practice placed R12 at risk for further weight loss and delayed intervention.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		

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needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 96 residents. The sample included 21 residents with five residents reviewed for respiratory services. Based on observation, record review, and interviews, the facility failed to store oxygen tubing and nasal cannula (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) in a sanitary manner for Resident (R) 77. This deficient practice placed R77 at increased risk to develop a respiratory infection.

Findings included:

- R77's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dependence on dialysis, chronic respiratory failure, and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Admission Minimum Data Set" (MDS) dated 01/13/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R77 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented R77 received dialysis during the look back period.

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R77's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 01/21/23 documented R77 required assistance with adls.

R77's "Care Plan" dated 01/06/23 documented staff was to monitor for signs/symptoms of respiratory distress and report to the physician as needed.

Review of the EMR under "Orders" tab revealed physician orders:
Change oxygen tubing and humidifier bottle every week. Keep inside plastic bag when not in use dated 01/06/23.
Oxygen at three liters per minute via nasal cannula every 24 hours as needed for shortness of breath, respiratory distress, labored breathing, or cyanosis (bluish discoloration of the skin) dated 01/06/23.
Check and record oxygen saturation every eight hour as needed for shortness of breath, respiratory distress, labored breathing, or cyanosis dated 01/06/23.
Cleaning oxygen concentrator filter week dated 01/06/23.

On 03/28/23 at 04:19 PM R77 was out of the facility at dialysis. The oxygen concentrator next to R77's bed was on. The tubing, along with the nasal cannula, laid unbagged on the floor next to the concentrator.

On 03/30/23 at 02:15 PM Certified Medication Aide (CMA) T stated oxygen tubing and nasal cannula should be stored in the drawer when not in use by the resident.

On 03/30/23 at 02:30 PM Licensed Nurse (LN) H stated oxygen tubing and nasal cannula should

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F 695	Continued From page 53 always be stored in a zip lock bag or bag tied to the oxygen concentrator when not in use. On 03/30/23 at 03:30 PM Administrative Nurse D stated oxygen tubing and nasal cannula should be wrapped in bag and placed in the handle of the oxygen concentrator when not in use by the resident. The facility failed to store oxygen equipment in accordance with professional standards of practice placing R77 at risk for developing a respiratory infection and/or illness.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 96 residents. The sample included 21 residents with two residents reviewed for hemodialysis (procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to retain communication sheets which included information from the dialysis provider for Resident (R) 77, which had the potential for unidentified physical complications related to dialysis. Findings included:	F 698		

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- R77's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dependence on dialysis, chronic respiratory failure, and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Admission Minimum Data Set" (MDS) dated 01/13/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R77 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented R77 received dialysis during the look back period.

R77's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 01/21/23 documented R77 was dependent on hemodialysis.

R77's "Care Plan" dated 01/06/23 documented staff was to encourage R77 to go for scheduled dialysis appointments three times weekly.

Review of the EMR under "Orders" tab revealed physician orders:
R77 has a central venous catheter (central line, a catheter placed in a large vein) in the right subclavian vein, monitor site every shift dated 01/06/23.
R77 received dialysis on Tuesday, Thursday, and Saturday at the dialysis center at 12:40 PM weekly dated 01/06/23.
Assess dialysis shunt every shift for signs/symptoms of bleeding every shift dated 01/06/23.

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Assess dialysis site to ensure proper dressing was in place every shift dated 01/06/23. Dialysis communication form completed and filed after dialysis dated 01/06/23.

Review of R77's EMR under the "Miscellaneous" tab revealed "Dialysis Resident Communication Report Form" from 01/07/23 through 03/25/23 revealed R77's EMR lacked dialysis communication sheets for the following dates: 01/12/23, 01/17/23, 01/19/23, 01/21/23, 01/24/23, 01/26/23, 01/28/23, n 02/02/23, 02/11/23, 02/16/23, and 03/`18/23. The clinical record lacked documentation of a verbal report.

On 03/28/23 at 08:01 AM R77 laid on the bed. R77 stated she was resting before leaving for dialysis.

On 03/30/23 at 02:15 PM Certified Medication Aide (CMA) T stated she transferred R77 into bed with another staff member and assistance of Hoyer lift (total body mechanical lift used to transfer residents) and provided R77 with a snack.

On 03/28/23 at 02:30 PM Licensed Nurse (LN) H stated she provided R77 lunch before R77 left for dialysis and filled out the communication sheet that was sent with R77 to dialysis. LN H stated if the dialysis sheet did not return with R77, LN H called the dialysis provider and got a verbal report and charted that report in the progress note.

On 03/30/23 at 03:30 PM Administrative Nurse D stated the facility had difficulty with the dialysis provider returning the communication sheets on a regular basis. Administrative Nurse D stated sometimes the sheets were not filled out,

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F 698	Continued From page 56 sometimes the resident forgot to give the communication sheets to the provider, and other times the provider failed to return the communication sheets. Administrative Nurse D stated she would expect the nurse to call to at least obtain a verbal report from the dialysis provider. The facility's "Dialysis (Renal), Pre and Post Care" policy last revised January 2023 lacked documentation related to communication with the dialysis provider. The facility failed to retain dialysis communication sheets for R77 which had the potential for adverse outcomes, delay in communication and physical complications related to dialysis.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		

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specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 96 residents. The sample included 21 residents. Based on record review and interview the facility failed to retain posted staffing data for the 18 months as required.

Findings included:

- Review of the daily posted nursing staffing data provided by the facility revealed the facility only retained the last 15 months of posted nursing staffing. The facility lacked daily posted staffing data for the months of October 2021 (31 days), November 2021 (30 days), and December 2021 (31 days).

On 03/29/23 at 12:43 PM Administrative Nurse D stated the staffing coordinator was responsible for staffing hours sheets and ensuring the sheets

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F 732	Continued From page 58 were posted daily. On 03/29/23 at 12: 45 PM Administrative Staff A stated she was only able to find the last 15 months of daily posted staffing forms. Administrative Staff A stated she could not answer for where the other three months of daily posted staffing hours might as that was before she was employed at the facility. The facility policy "Posted Hours, Nursing Department" documented it was the policy of this facility to post scheduled and actual hours worked for direct care nursing services department. A form displaying nursing staffing hours for the current 24-hour period will be posted in a public area and updated with changes during each shift. The total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift shall be included: registered nurses, licensed practical nurses, and certified nurse aides. The facility failed to retain posted staffing data for the 18 months as required.	F 732		
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	F 756		

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facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§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 96 residents. The sample included 21 residents with five sample residents reviewed for unnecessary medication review. Based on observation, record review and interview the facility failed to ensure the Consultant Pharmacist (CP) identified and reported when Resident (R) 39, R11 and R45's blood sugar (BS) reading was out of physician ordered parameters and staff did not notify the physician and/or administered insulin outside of

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ordered parameters. This deficient practice placed R39, R11, and R45 at risk of unnecessary medication administration and possible adverse side effects.

Findings included:

- The electronic medical record for R39 documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN- elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set (MDS)" dated 04/07/22 documented R39 had a Brief Interview for Mental Status (BIMS) score of four which indicated a severely impaired cognition. R39 required limited to extensive assistance of one staff for her activities of daily living (ADLs). R39 received insulin (hormone which regulates blood sugar) injections on seven of seven lookback days.

The "Quarterly MDS" dated 03/04/23 documented R39 had a BIMS score of 14 which indicated intact cognition. R39 required supervision to limited assist of one staff for sit to stand, chair/bed to chair transfer, and toilet transfers. R39 wheeled herself independently in her wheelchair.

The "Nutrition Care Area Assessment (CAA)" dated 04/21/22 documented R39 had type 2 DM and required hemodialysis (a treatment to filter

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wastes and water from your blood when your kidney are no longer able to) and was at risk of weight fluctuation due to being on dialysis, refusing of medications, meals, and cares.

The "Diabetes Care Plan" revised 03/16/23 for R39 directed staff to give diabetes medication as ordered.

The "Dialysis Care Plan" Revised 03/16/23 for R39 documented she would refuse medication on dialysis days.

Under the "Orders" tab R39 had an order dated 03/22/22 for accu-cheks (device used to measure blood glucose reading) before meals and at bedtime. Notify physician if blood sugar (BS) was below 70 or above 400.

Under the "Orders" tab R39 had an order dated 03/22/22 for Insulin aspart (short-acting, manmade version of human insulin) to inject four unit with meals for DM. Hold if BS less than 100.

Under the "Orders" tab R39 had an order dated 11/23/22 for Novolog flex pen Insulin Aspart 100units/milliliter (ml) to inject as per sliding scale before meals. Notify the physician for blood glucose level greater than 600. This order was discontinued on 03/15/2023.
Review of the December 2022 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) for R39 revealed on 27 of 124 opportunities R39's blood glucose reading was above 400.

Review of the January 2023 MAR and TAR for R39 revealed of 41 of 124 blood glucose readings R39's reading was above 400.

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Review of the February 2023 MAR/TAR for R39 revealed on 20 of 112 occasions R39's blood glucose reading was above 400.

Review of R39's "Medication Administration Note" documentation from 01/01/22 to 02/28/23 revealed that staff documented when R39 refused insulin administration, but the nurse failed to document that the physician was notified when R39's blood glucose was above 400.

Upon review of the CP's "Medication Regimen Review" (MRR) for 12/22 it was recommended to discontinue listed medications but R39 was to continue take her Atorvastatin (a medication used to treat high cholesterol) and Aricept (a medication used to treat Alzheimer's). The MRR lacked mention of the lack of notification for BS outside of parameters per physician orders.

The 01/30/23 MRR had no recommendations at this time.

The 02/28/23 MRR was completed with a recommendation to obtain labs the next lab date. The MRR lacked mention of the lack of notification for BS outside of parameters per physician orders.

On 03/28/23 at 04:07PM R39 sat in her wheelchair in the doorway of her room and stated she was tired after going to dialysis today. R39 stated that being tired was just part of life now.

On 03/30/23 at 02:30 PM Licensed Nurse (LN) H stated R39 refused to get her blood sugar taken and refused her medications frequently, so a lot of her medications were discontinued by the

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physician. LN H stated she would chart when R39 would refuse her medications and would call to notify the physician when the blood glucose was over 400. LN H stated she was not aware of the note on the sliding scale aspart insulin to notify the physician when the blood sugar was over 600, she typically would call the physician any time the blood sugar was 400 or above. LN H stated she did not always document when the physician had been notified when R39's blood sugar was over 400.

On 03/30/23 at 03:37 PM Administrative Nurse D stated the CP would e-mail the pharmacy recommendations to her and the two-assistant director of nursing (ADON). Administrative Nurse D stated a couple of people on that e-mail chain who printed out and distributed the recommendations. Administrative Nurse D stated the facility had a physician folder that the recommendation would be put in for them to respond and sign. The printed recommendations would be handed out to the nurses after getting them back to make the changes as needed.

On 04/02/23 at 04:15 PM Consultant GG was unable to be reached.

The "Medication Regimen Review (MRR)" policy dated revised 04/23 documented the Pharmacist's review considers factors such as whether the physician and staff have documented progress towards, or maintenance of, the goal(s) for the medication therapy. Upon conduction the MRR, the pharmacist may identify, and report concerns the use of an appropriate medication that is not helping attain the intended treatment goals because of timing of administration, dosing intervals, sufficiency of dose, techniques of

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administration, or other reasons.

The facility failed to ensure the CP identified and reported when R39's blood glucose reading was above 400 and the physician was not notified. This deficient practice left R39 at risk for unnecessary medication administration and adverse side effects.
- R11's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), cerebral infarction (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, and morbid obesity (severely overweight).

The "Annual Minimum Data Set" (MDS), dated 11/14/22, recorded R11 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that R11 was cognitively intact. The MDS recorded R11 required supervision and oversight with activities of daily living (ADLs) and received insulin (hormone that lowers the level of glucose in the blood) seven days in the seven-day lookback period of the assessment.

The "Falls Care Area Assessment (CAA)" dated 11/14/22, documented R11 was at risk for falls related to bowel and bladder incontinence (lack of voluntary control over urination or defecation) and required assistance with ADLs. The CAA recorded R11was at risk for complications as evidenced by (AEB) decreased functional mobility, stroke, medication side effects, obesity, and diabetes mellitus.

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Review of R11's "Diabetic Care Plan," dated 11/15/19, directed staff to administer diabetes medications as ordered and monitor/document for side effects and effectiveness.

R11's EMR recorded the following "Physician's Order" under the "Orders" tab:

An order dated 09/21/22 which directed staff to check blood sugar before meals and at bedtime; notify the physician if the blood sugar was less than 60 milligrams (mg) per deciliter (dl) or greater than 400 mg/dl.

An order dated 12/05/21 Novolog (fast acting insulin) Flexpen 12 units before meals. Hold for blood sugar less than 100 mg/dl.

An order dated 12/05/21 insulin detemir (long-acting insulin) 30 units at bedtime. Hold for blood sugar less than 100 mg/dl.

Review of R11's "Medication Administration Record (MAR)" for 01/01/23 to 02/28/23 revealed the following dates when insulin was given outside of ordered parameters:

01/25/23 at 11:30 AM - 99 mg/dl.
01/30/23 at 06:30 AM - 97 mg/dl.
01/31/23 at 06:30 AM - 95 mg/dl.
02/02/23 at 06:30 AM - 97 mg/dl.
02/03/23 at 06:30 AM - 96 mg/dl.
02/04/23 at 11:30 AM - 92 mg/dl.
02/06/23 at 06:30 AM - 92 mg/dl.
02/07/23 at 06:30 AM - 91 mg/dl.
02/12/23 at 11:30 AM - 87 mg/dl.
02/18/23 at 06:30 AM - 99 mg/dl.
02/25/23 at 11:30 AM - 83 mg/dl.
02/26/23 at 06:30 AM - 94 mg/dl.

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RIVERBEND POST ACUTE REHABILITATION	7850 FREEMAN AVENUE KANSAS CITY, KS 66112

(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
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R11's EMR recorded a "Pharmacy Review" dated 01/30/23 which recorded the MRR was completed and directed to see report for recommendations.

R11's EMR recorded a "Pharmacy Review" dated 02/28/23 which recorded the MRR was completed and directed to see report for recommendations.

Review of the 01/30/23, and 02/28/23 MRRs lacked evidence that the CP identified and reported the lack of physician notification for out of parameter blood sugars.

On 03/29/23 at 08:37 AM, observation revealed that R11 was awake, and laid in her bed.

On 03/30/23 at 02:30 PM Licensed Nursing (LN) H stated that when nurses held a medication, a number was documented on the MAR showing that the medication had not been given; she gave the example of the number 14 and stated that it meant no insulin was required. She further stated that after a number had been entered, the system would open a text box that would have allowed for a note to be made as to the reason the medication was held.

On 03/30/23 at 03:38 PM Administrative Nurse D stated that if insulin was held, it would have been recorded on the MAR and a progress note could have been entered.

The facility policy "Medication Regimen Review," revised on 04/2023, noted it was the facility's policy for the pharmacist to report any irregularities to the attending physician, and the

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director of Nursing Services.

The facility failed to ensure the CP idenitfied and reported insulin given outside of ordered parameters for R11. This deficient practice had the risk for physical complications and unnecessary medication usage.

- R45's Electronic Medical Record (EMR), under the "Diagnoses" tab recorded diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion).

R45's "Quarterly Minimum Data Set" (MDS) dated 03/04/23 documented R45 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact. R45 required extensive assistance from one to two staff for most activities of daily living (ADL) except eating, for which he was independent after set-up assistance. The MDS noted R45 received insulin (medication the level of blood sugar) all seven of the look-back days.

R45's "Care Plan" revised on 06/22/17 noted R45 had diabetes mellitus and directed staff to administer R45's diabetic medications as ordered by his physician and monitor and document side effects and effectiveness. An intervention directed staff to monitor and report to R45's doctor signs of hypoglycemia (low blood sugar) and signs of hyperglycemia (high blood sugar).

R45's EMR recorded the following "Physician's Order" under the "Orders" tab;

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An order dated 06/15/22 which directed to check a blood sugar before meals and at bedtime; notify the physician if the blood sugar was less than 60 milligrams (mg) per deciliter (dl) or greater than 400 mg/dl.

An order dated 12/02/22 for insulin glargine solution (long-acting insulin) 15 units in the morning.

An order dated 12/01/22 for Novolog (fast acting insulin) Flexpen seven units before meals. Call for blood sugar less than 100 mg/dl or greater than 400 mg/dl.

Review of R45's "Mediation Administration Record (MAR)" for 12/01/22 to 01/31/23 revealed the following dates where R45's blood sugar level was outside of parameters and there was no evidence of physician notification:

12/05/22 at 04:30 PM - 98 mg/dl
12/08/22 at 04:30 PM - 94 mg/dl
12/09/22 at 06:30 AM - 99 mg/dl
12/19/22 at 04:30 PM - 68 mg/dl
12/22/22 at 11:30 AM - 96 mg/dl
01/03/23 at 06:30 AM - 89 mg/dl
01/05/23 at 06:30 AM - 72 mg/dl
01/06/23 at 11:30 AM - 96 mg/dl
01/09/23 at 04:30 PM - 68 mg/dl
01/15/23 at 06:30 AM - 88 mg/dl
01/16/23 at 04:30 PM - 97 mg/dl
01/20/23 at 06:30 AM - 91 mg/dl
01/26/23 at 06:30 AM - 77 mg/dl

R45's EMR recorded a "Pharmacy Review" dated 01/30/23 which recorded the "Medication Regimen Review" (MRR) was completed and directed to see report for recommendations.

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F 756	Continued From page 69 R45's EMR recorded a "Pharmacy Review" dated 2/28/23 which recorded the MRR was completed and directed to see report for recommendations. Review of the 01/30/23 and 02/28/23 MRRs lacked evidence that the CP identified and reported the lack of physician notification for out of parameter blood sugars. On 03/29/23 at 03:08 PM observation revealed that R45 laid in his bed and watched TV. On 03/30/23 at 02:30 PM Licensed Nursing (LN) H stated that if a blood sugar was outside of parameters, she would have contacted the provider. LN H further stated that when the physician is notified there would be a note on the MAR or entered as a progress note. LN H stated that these are the two places that notes would be entered if the physician would have been contacted for blood sugars outside of parameters. The facility policy "Medication Regimen Review," revised on 04/2023, noted it was the facility's policy for the pharmacist to report any irregularities to the attending physician, and the director of Nursing Services. The facility failed to ensure the CP idenitfied and reported when blood sugar levels were not reported to R45's physician when outside of parameters as ordered by the physician. This deficient practice had the risk for physical complications and unnecessary medication usage.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		

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§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 96 residents. The sample included 21 residents with five sample residents reviewed for unnecessary medication review. Based on observation, record review and interview the facility failed to ensure staff notified the physician when Resident (R) 39, R11 and R45's blood sugar (BS) reading was out of physician ordered parameters. The facility failed to ensure R8's antihypertensive (a medication used to lower the blood pressure) medication was not given outside of physician ordered parameters. This deficient practice placed R39, R11, R45, and R8 at risk of unnecessary medication administration and

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possible adverse side effects.

Findings included:

- The electronic medical record for R39 documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN- elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set (MDS)" dated 04/07/22 documented R39 had a Brief Interview for Mental Status (BIMS) score of four which indicated a severely impaired cognition. R39 required limited to extensive assistance of one staff for her activities of daily living (ADLs). R39 received insulin (hormone which regulates blood sugar) injections on seven of seven lookback days.

The "Quarterly MDS" dated 03/04/23 documented R39 had a BIMS score of 14 which indicated intact cognition. R39 required supervision to limited assist of one staff for sit to stand, chair/bed to chair transfer, and toilet transfers. R39 wheeled herself independently in her wheelchair.

The "Nutrition Care Area Assessment (CAA)" dated 04/21/22 documented R39 had type 2 DM and required hemodialysis (a treatment to filter wastes and water from your blood when your kidney are no longer able to) and was at risk of weight fluctuation due to being on dialysis,

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refusing of medications, meals, and cares.

The "Diabetes Care Plan" revised 03/16/23 for R39 directed staff to give diabetes medication as ordered.

The "Dialysis Care Plan" Revised 03/16/23 for R39 documented she would refuse medication on dialysis days.

Under the "Orders" tab R39 had an order dated 03/22/22 for accu-cheks (device used to measure blood glucose reading) before meals and at bedtime. Notify physician if blood sugar (BS) was below 70 or above 400.

Under the "Orders" tab R39 had an order dated 03/22/22 for Insulin aspart (short-acting, manmade version of human insulin) to inject four unit with meals for DM. Hold if BS less than 100.

Under the "Orders" tab R39 had an order dated 11/23/22 for Novolog flex pen Insulin Aspart 100units/milliliter (ml) to inject as per sliding scale before meals. Notify the physician for blood glucose level greater than 600. This order was discontinued on 03/15/2023.

Review of the December 2022 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) for R39 revealed on 27 of 124 opportunities R39's blood glucose reading was above 400.

Review of the January 2023 MAR and TAR for R39 revealed of 41 of 124 blood glucose readings R39's reading was above 400.

Review of the February 2023 MAR/TAR for R39

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revealed on 20 of 112 occasions R39's blood glucose reading was above 400.

Review of R39's "Medication Administration Note" documentation from 01/01/22 to 02/28/23 revealed that staff documented when R39 refused insulin administration, but the nurse failed to document that the physician was notified when R39's blood glucose was above 400.

On 03/28/23 at 04:07PM R39 sat in her wheelchair in the doorway of her room and stated she was tired after going to dialysis today. R39 stated that being tired was just part of life now.

On 03/30/23 at 02:30 PM Licensed Nurse (LN) H stated R39 refused to get her blood sugar taken and refused her medications frequently so a lot of her medications were discontinued by the physician. LN H stated she would chart when R39 would refuse her medications and would call to notify the physician when the blood glucose was over 400. LN H stated she was not aware of the note on the sliding scale aspart insulin to notify the physician when the blood sugar was over 600, she typically would call the physician any time the blood sugar was 400 or above. LN H stated she did not always document when the physician had been notified when R39's blood sugar was over 400.

On 03/30/23 at 03:37 PM Administrative Nurse D stated she would expect the nurses to be notifying the physician when a resident had a blood sugar reading above 400 as well as making a note on the MAR/TAR as well as a nurse progress note to be documented.

The facility failed to provide a policy regarding

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blood sugar/insulin administration.

The facility failed to ensure that R39 had matching physician orders when to notify him/her when R39's blood glucose reading was above 400. This deficient practice left R39 at risk for unnecessary medication administration and adverse side effects.
- R11's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), cerebral infarction (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, and morbid obesity (severely overweight).

The "Annual Minimum Data Set" (MDS), dated 11/14/22, recorded R11 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that R11 was cognitively intact. The MDS recorded R11 required supervision and oversight with activities of daily living (ADLs) and received insulin (hormone that lowers the level of glucose in the blood) seven days in the seven-day lookback period of the assessment.

The "Falls Care Area Assessment (CAA)" dated 11/14/22, documented R11 was at risk for falls related to bowel and bladder incontinence (lack of voluntary control over urination or defecation) and required assistance with ADLs. The CAA recorded R11was at risk for complications as evidenced by (AEB) decreased functional mobility, stroke, medication side effects, obesity, and diabetes mellitus.

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Review of R11's "Diabetic Care Plan," dated 11/15/19, directed staff to administer diabetes medications as ordered and monitor/document for side effects and effectiveness.

R11's EMR recorded the following "Physician's Order" under the "Orders" tab:

An order dated 09/21/22 which directed staff to check blood sugar before meals and at bedtime; notify the physician if the blood sugar was less than 60 milligrams (mg) per deciliter (dl) or greater than 400 mg/dl.

An order dated 12/05/21 Novolog (fast acting insulin) Flexpen 12 units before meals. Hold for blood sugar less than 100 mg/dl.

An order dated 12/05/21 insulin detemir (long-acting insulin) 30 units at bedtime. Hold for blood sugar less than 100 mg/dl.

Review of R11's "Medication Administration Record (MAR)" for 01/01/23 to 02/28/23 revealed the following dates when insulin was given outside of ordered parameters:

01/25/23 at 11:30 AM - 99 mg/dl.
01/30/23 at 06:30 AM - 97 mg/dl.
01/31/23 at 06:30 AM - 95 mg/dl.
02/02/23 at 06:30 AM - 97 mg/dl.
02/03/23 at 06:30 AM - 96 mg/dl.
02/04/23 at 11:30 AM - 92 mg/dl.
02/06/23 at 06:30 AM - 92 mg/dl.
02/07/23 at 06:30 AM - 91 mg/dl.
02/12/23 at 11:30 AM - 87 mg/dl.
02/18/23 at 06:30 AM - 99 mg/dl.
02/25/23 at 11:30 AM - 83 mg/dl.
02/26/23 at 06:30 AM - 94 mg/dl.

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On 03/29/23 at 08:37 AM, observation revealed that R11 was awake, and laid in her bed.

On 03/30/23 02:30 PM Licensed Nursing (LN) H stated that when nurses held a medication, a number was documented on the MAR showing that the medication had not been given; she gave the example of the number 14 and stated that it meant no insulin was required. She further stated that after a number had been entered, the system would open a text box that would have allowed for a note to be made as to the reason the medication was held.

On 03/30/23 at 03:38 PM Administrative Nurse D stated that if insulin was held, it would have been recorded on the MAR and a progress note could have been entered.

The facilities "Medication Administration" policy dated 12/22 instructed staff to follow all directions when administering medications.

The facility failed to ensure that insulin was not given outside of ordered parameters for R11. This deficient practice had the risk for physical complications and unnecessary medication usage.

- R45's Electronic Medical Record (EMR), under the "Diagnoses" tab recorded diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion).

R45's "Quarterly Minimum Data Set" (MDS) dated

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03/04/23 documented R45 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact. R45 required extensive assistance from one to two staff for most activities of daily living (ADL) except eating, for which he was independent after set-up assistance. The MDS noted R45 received insulin (medication the level of blood sugar) all seven of the look-back days.

R45's "Care Plan" revised on 06/22/17 noted R45 had diabetes mellitus and directed staff to administer R45's diabetic medications as ordered by his physician and monitor and document side effects and effectiveness. An intervention directed staff to monitor and report to R45's doctor signs of hypoglycemia (low blood sugar) and signs of hyperglycemia (high blood sugar).

R45's EMR recorded the following "Physician's Order" under the "Orders" tab;

An order dated 06/15/22 which directed to check a blood sugar before meals and at bedtime; notify the physician if the blood sugar was less than 60 milligrams (mg) per deciliter (dl) or greater than 400 mg/dl.

An order dated 12/02/22 for insulin glargine solution (long-acting insulin) 15 units in the morning.

An order dated 12/01/22 for Novolog (fast acting insulin) Flexpen seven units before meals. Call for blood sugar less than 100 mg/dl or greater than 400 mg/dl.

Review of R45's "Mediation Administration Record (MAR)" for 12/01/22 to 01/31/23 revealed

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the following dates where R45's blood sugar level was outside of parameters and there was no evidence of physician notification:

12/05/22 at 04:30 PM - 98 mg/dl
12/08/22 at 04:30 PM - 94 mg/dl
12/09/22 at 06:30 AM - 99 mg/dl
12/19/22 at 04:30 PM - 68 mg/dl
12/22/22 at 11:30 AM - 96 mg/dl
01/03/23 at 06:30 AM - 89 mg/dl
01/05/23 at 06:30 AM - 72 mg/dl
01/06/23 at 11:30 AM - 96 mg/dl
01/09/23 at 04:30 PM - 68 mg/dl
01/15/23 at 06:30 AM - 88 mg/dl
01/16/23 at 04:30 PM - 97 mg/dl
01/20/23 at 06:30 AM - 91 mg/dl
01/26/23 at 06:30 AM - 77 mg/dl

On 03/29/23 at 03:08 PM observation revealed that R45 laid in his bed and watched TV.

On 03/30/23 02:30 PM Licensed Nursing (LN) H stated that if a blood sugar was outside of parameters, she would have contacted the provider. LN H further stated that when the physician is notified there would be a note on the MAR or entered as a progress note. LN H stated that these are the two places that notes would be entered if the physician would have been contacted for blood sugars outside of parameters.

The facility policy "Medication Administration," revised on 12/22 noted it was the facility policy to administer and document medication in compliance with federal and state regulations and in accordance with current standards of practice and guidelines.

The facility failed to ensure that blood sugar

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levels were being reported to R45's physician when outside of parameters as ordered by the physician. This deficient practice had the risk for physical complications and unnecessary medication usage.

- The electronic medical record (EMR) for R8 documented diagnoses of cognitive communication disorder, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression disorder (major mood disorder), hypertension (high blood pressure), and dementia (progressive mental disorder characterized by failing memory, confusion).

A review of R8 "Quarterly Minimum Data Set (MDS)" completed 02/20/23 noted a Brief Interview for Mental Status (BIMS) assessment could not be conducted due to severe cognitive impairment. The MDS indicated R8 required supervision with set-up assistance for bed mobility, transfers, walking, personal hygiene, toileting, and dressing. The MDS noted R8 had a history of rejection of cares and verbal aggression towards others. The MDS indicated R8 received antipsychotic (class of medications used to treat psychological and mental conditions) medication routinely.

R8's "Dementia Care Area Assessment (CAA)" completed 02/03/23 noted she had severe cognitive impairment and instructed staff to follow the care plan. The CAA noted she had little interest in following the unit activities.

A review of R8's "Care Plan" (initiated 02/03/23) indicated staff were to administer her cardiac medications as ordered related to changes in

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blood pressure and heart rate.

A review of R8's "Physician's Orders" revealed an order dated 01/23/23 for staff to administer 25 milligram (mg) of Carvedilol (medication used to treat high blood pressure) twice a day for hypertension (high blood pressure). The order instructed staff to hold the medication if R8's systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110 millimeters of mercury (mmHg) or pulse (heart rate) < 60 beats per minute (bpm).

A review of R8's "Medication Administration Record" (MAR) between 01/23/23 and 03/30/23 (68 days reviewed) revealed R8's Carvedilol medication was given outside of the providers parameters on six occasions (2/6, 2/19, 2/24, 3/8, 3/9, and 3/11).

On 03/30/23 at 03:30 PM Licensed Nurse (LN) I stated that when a resident was admitted to the facility each medication was reviewed and parameters were added based on the type of medication. She stated that if a medication needed to be held due to the parameters, it would be noted in the chart why it was held. She stated that medications should not be given outside of the parameters unless approved by the attending physician. She stated that a note should be entered showing why the medication was given or held.

On 03/30/23 at 03:50 PM Administrative Nurse D stated that nursing staff were required to review the medication parameters before administering the medications and notifying the physician. She

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F 757	Continued From page 81 stated that medications given should always be noted. She stated that the physicians were always around to ask in person if a medication should have been given and the nurse would not have noted it down. The undated facility policy "Medication Administration" noted it was the facility policy to administer and document medication in compliance with federal and state regulations and in accordance with current standards of practice and guidelines. The facility failed to follow R8's physician's order parameters for blood pressure medication. This deficient practice placed R8 at risk for unnecessary medication administration and side effects.	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	F 758		

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specific condition as diagnosed and documented in the clinical record;

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

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

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

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 96 residents. The sample included 21 residents with five reviewed for unnecessary medications. Based on record review, and interviews, the facility failed to provide an acceptable indication for use for Resident (R)8's Seroquel (antipsychotic - class of medications used to treat psychological and emotional conditions medication). This deficient

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practice placed R8 at risk for unnecessary medications and side effects.

Findings included:

- The electronic medical record (EMR) for R8 documented diagnoses of cognitive communication disorder, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depression disorder (major mood disorder), and dementia (progressive mental disorder characterized by failing memory, confusion).

A review of R8 "Quarterly Minimum Data Set (MDS)" completed 02/20/23 noted a Brief Interview for Mental Status (BIMS) assessment could not be conducted due to severe cognitive impairment. The MDS indicated R8 required supervision with set-up assistance for bed mobility, transfers, walking, personal hygiene, toileting, and dressing. The MDS noted R8 had a history of rejection of cares and verbal aggression towards others. The MDS indicated R8 received antipsychotic medication routinely.

R8's "Dementia Care Area Assessment (CAA)" completed 02/03/23 noted she had severe cognitive impairment and instructed staff to follow the care plan. The CAA noted she had little interest in following the unit activities.
R8's "Behavior CAA" completed 02/03/23 noted she was at risk related to wandering, had poor adjustment to the unit, and rejected cares offered by staff.

R8's "Psychotropic (medications that affect the mind, mood, or behavior of a person) Medication CAA" completed 02/03/23 noted she was at risk

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for complications related to her medications.

A review of R8's "Care Plan" (initiated 02/03/23) related to wandering behaviors indicated she had behaviors related to wandering and rejection of care, related to her dementia diagnosis. The plan indicated staff were to administer her medications as ordered, observe for changes in behaviors related to psychotropic medications, and refer to an appropriate psychiatric provider. The plan indicated R8 required assistance from one staff for locomotion, ambulation, toileting, transfers, bed mobility, personal hygiene, and bathing. The plan indicated R8 had behaviors and took Seroquel for agitation. The plan instructed staff to monitor for side effects and changed in behaviors.

A review of R8's "Physician's Orders" revealed an order dated 02/20/23 for staff to administer 125 milligrams (mg) of Seroquel (quetiapine fumarate- antipsychotic medication) by mouth at bedtime related to unspecified dementia with other behavioral disturbances.

A review of the facility's "Consultant Pharmacist's Recommendations" notes for February 2023 revealed the Consultant Pharmacist (CP) noted R8's dementia care diagnosis for her Seroquel medication as inappropriate for the use of the medication. The CP recommended a change in R8's diagnosis. The facility responded to the request with suggesting the diagnosis be changed to schizoaffective disorder. A review of R8's diagnoses indicated the change never occurred.

On 03/30/23 at 03:30PM Licensed Nurse (LN) I stated she was not sure if dementia was a correct

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F 758	Continued From page 85 diagnosis for the use of antipsychotic medication. On 03/30/23 at 03:50PM Administrative Nurse D stated that dementia was not an acceptable diagnosis for the use of antipsychotic medication. She stated that facility had been working with the pharmacy to review the diagnosis related to antipsychotic medications. A review of the facility's "Psychotropic Drug Use" policy revised 08/2020 indicated licensed nurse will review the appropriateness of psychotropic medication in use including the history of the medication, dosage, appropriateness, diagnosis, and consents. The facility failed to provide an acceptable indication for use for R8's Seroquel medication. This deficient practice placed R8 at risk for unnecessary medications and side effects.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 96 residents. The sample included 21 residents with two residents reviewed for discharge. Based on interview and record review, the facility failed to prevent a significant medication error when the facility failed to administer metoprolol (medication used to treat cardiac conditions such as high blood pressure and irregular heart rate) as ordered by the physician for Resident (R) 99. This deficient practice placed R99 at increased risk for	F 760		

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cardiac complications and/or high blood pressure.

Findings included:

- R99's Electronic Medical record (EMR) under the "Diagnoses" tab, recorded diagnoses of hypertension (high blood pressure), and atrial fibrillation (rapid, irregular heartbeat).

R99's "Entry Tracking Minimum Data Set" (MDS) documented R99 admitted to the facility on 12/23/23.

R99's "Discharge Assessment-Return not Anticipated" MDS recorded R99 discharged to the community on 12/28/23.

R99's baseline "Care Plan" documented R99 had heart failure and an intervention dated 12/24/22 directed staff to report to R99's physician signs of heart failure which included edema (swelling) of the legs and feet, shortness of breath on exertion, distended neck veins, weakness, and fatigue (abnormal feeling of tiredness or lack of energy).

R99's "Discharge Summary," dated 12/23/22, which served as the admission orders to the facility, directed R99 would change how she took metoprolol succinate extended release (ER) 100 milligrams (mg) 24hour tablet. The order directed to take one tablet by mouth daily for 30 days.

Review of R99's medications under the "Orders" tab in the EMR lacked evidence the order for metoprolol was entered into R99's EMR.

Review of R99's December "Medication Administration Record" (MAR) lacked evidence the metoprolol was administered during R99's

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admission between 12/23/23 and 12/28/23.

A "Nursing Note" dated 12/28/23 at 10:12 AM in R99's EMR recorded R99's representative and a staff member went over R99's medication list from the hospital because R99's representative was concerned that R99 was not on the same home medications. The staff member explained to R99's representative that the facility staff followed the medication orders from hospital. Staff explained R99's breathing treatments were as needed (PRN) and resident needed to request the breathing treatment if she wanted it.

A "Nursing Note" dated 12/28/22 at 10:10 AM documented R99 left the facility against medical advice (AMA) with her representative. R99 signed AMA paperwork and left the facility with all her belongings.

On 03/30/23 at 03:21 PM Licensed Nurse (LN) J stated that the facility had daily clinical meetings and that ordered medications were reviewed during the meetings to ensure they were entered correctly. LN J also stated that the assistant director of nursing (ADON) reviewed medication orders to ensure they were accurate. LN J reported that if an ADON was not available to review medication orders, LN J reviewed them.

On 03/30/23 at 03:38 PM Administrative Nurse D stated that when a resident was admitted from the hospital to the facility, the admitting nurse entered the medication orders for the resident. She stated that the ADON oversee that process and that the pharmacist would review the orders in 24 hours.

The undated facility policy "Medication

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F 760	Continued From page 88 Administration" noted it was the facility policy to administer and document medication in compliance with federal and state regulations and in accordance with current standards of practice and guidelines. The facility failed to prevent a significant medication error when the facility failed to administer metoprolol as ordered by the physician for R99. This deficient practice placed R99 at increased risk for cardiac complications and/or high blood pressure.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 96 residents and one kitchen. Based on observation, record	F 812		

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review, and interviews, the facility failed to maintain sanitary dietary standards related to food storage and equipment cleanliness. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.

Findings Included:

- On 03/27/23 at 07:02AM an initial walkthrough was completed in the facility's kitchen. An inspection of the facility's walk-in freezer revealed water leaked from the unit's freezer down onto the food boxes stored below. An inspection of the food stored below the freezer unit revealed two boxes of onion rings, 1 box of dinner rolls, and box of butter and eggs covered in ice from the leaking condenser.
An inspection of the kitchen's microwave revealed old food particles on the inside.

An inspection of the facility spice rack revealed spice debris covering the bottle and shelf.

On 03/30/23 at 02:50PM Dietary Staff BB reported that a work order for the leaking freezer unit was being placed and the microwave had been cleaned out.

A review of the facility's "Food Handling and Storage" policy indicated that all dietary equipment be handled and maintained in a safe and sanitary manner. The policy noted that refrigerator temperature must be maintained in a consistent manner and to notify maintenance of any concerns.

The facility failed to maintain sanitary dietary standards related to food storage and equipment

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F 812	Continued From page 90 cleanliness. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.	F 812		
F 880 SS=D	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 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	F 880		

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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.

§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 96 residents. Based on observation, record review, and interviews, the facility failed to ensure staff practiced standard infection control practices regarding appropriate cleaning and disinfecting of shared equipment, use of a clean barrier and

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hand hygiene, to prevent the spread of infection. This had the potential to increase the residents' risk for transmission of infectious disease.

Findings included:

- On 03/29/23 at 07:18 AM Licensed Nurse (LN) G placed a glucometer (blood sugar machine), lancet, and alcohol wipe onto the medication cart with no barrier. LN G gathered items into hands, entered room and explained the procedure to Resident (R) 40. LN G placed all items onto the bedside table with no clean barrier. LN G donned gloves, wiped the resident's finger with the alcohol wipe, applied lancet to the finger, then applied blood to the strip. LN G set the glucometer machine back onto the bedside table. LN G gathered the soiled equipment, left the resident room and then placed the soiled glucometer onto the medication cart. LN G disposed of other items into the red biohazard container. LN G doffed the gloves, and then cleaned the glucometer machine with alcohol wipes.

On 03/29/23 at 09:15 AM Certified Nurse's Aide (CNA) M and Certified Medication Aide (CMA) R entered R45's room to provide catheter care. CNA M explained the procedure, CMA R gathered supplies. CNA M and CMA R washed their hands and donned gloves. CNA M untaped R45's incontinence brief and washed the catheter (tube inserted into the bladder to drain urine) and peri-area using a clean wipe for each swipe. CNA M placed the soiled wipes onto the mattress next to R45. CNA M then assisted CMA R with repositioning R45 onto his right side. CNA M removed R45's soiled brief and disposed of the brief and soiled wipes lying on the bed into the

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	175298	A. BUILDING _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND POST ACUTE REHABILITATION	7850 FREEMAN AVENUE KANSAS CITY, KS 66112

(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 880	Continued From page 93	F 880		

trash. CNA M doffed the gloves and donned clean gloves. As CNA M leaned over the bed, her hair drug along the mattress where the soiled wipes had been placed as she applied a clean brief under R45 and rolled him onto his back.

On 03/30/23 at 02:15 PM CMA T stated staff should wash hands between each resident after giving care.

On 03/30/23 at 02:30 PM LN H stated staff should wash hands before and after providing care or a procedure. LN H stated staff should do hand hygiene between donning and doffing gloves. LN H stated a clean barrier should always be placed between clean care items and the potentially soiled environment to prevent against infection.

On 03/30/23 at 03:30 PM AdministrativePM Administrative Nurse D stated hand hygiene should be performed between donning and doffing gloves, between resident care, and clean barrier should always be placed between the care equipment and any surface.

The facility's "Infection Control and Prevention Policy" last revised December 2021 documented perform hand hygiene according to the CDC guidance.

The facility's "Prevention and Control of Transmission of Infection" policy last revised September 2017 documented frequently used equipment should be disinfected to prevent the spread of pathogenic microorganisms.

The facility failed to ensure staff practiced standard infection control practices regarding

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F 880	Continued From page 94 appropriate use of clean barriers, cleaning and disinfecting of shared equipment, and hand hygiene, to prevent the spread of infection. This had the potential to increase the residents' risk for transmission of infectious disease.	F 880		