STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-compliance Revisit and Complaint investigation KS00179273 and KS00179105. The 2567 was sent electronically on 06/02/23.	{F 000}		
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	{F 609}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/02/2023

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

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{F 609}	Continued From page 1	{F 609}		

by:
The facility had a census of 32 residents. The sample included six residents with three reviewed for accidents. Based on observation, record review, and interview the facility failed to report to the State Agency (SA) an unwitnessed fall for cognitively impaired Resident (R) 2. This placed the resident at risk for unidentified and/or ongoing abuse or mistreatment.

Findings included:

- R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

R2's "Quarterly Minimum Data Set" (MDS), dated 04/21/23 documented R2 had short- and long-term memory problems and severely impaired cognition. The MDS documented R2 required extensive staff assistance with activities of daily living (ADLs) and her balance was unsteady only able to stabilize with staff assistance when moving on and off toilet and surface to surface transfers. The MDS documented R2 had not ambulated during the lookback period, used a wheelchair for mobility, and had two or more non injury falls.

R2's "Fall Care Plan," dated 04/14/23, documented R2's wheelchair had anti-roll brakes. R2 had a second motion sensor on the wall to

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{F 609}	Continued From page 2	{F 609}		

alert staff when she entered her room. The care plan documented the resident had high/low bed and instructed staff to keep it in lowest position when R2 was in it; create a safe and stable environment for R2 by keeping her room and hallway free from clutter, and when observing R2 wheeling self towards her room, intervene and assist her with toileting and transferring to her bed. The care plan instructed staff to not leave R2 unattended in her wheelchair while in her room and provide frequent visual checks. The care plan directed staff to make sure R2 had appropriate footwear on and or non -skid socks during transfers/and ambulation.

The "Fall Assessments" completed on 01/16/23 and 04/18/23 recorded R2 was at high risk for falls.

The "Nurse's Note," dated 05/05/23, documented Certified Nurse Aide (CNA) M reported to Licensed Nurse (LN) H she found R2 on the floor around 02:30 PM on 05/04/23, and reported the fall to LN G. The note documented LN H could not find documentation regarding this incident.

R2's clinical record lacked evidence staff assessed R2 immediately after her fall on 05/04/23 and lacked evidence causative factors were evaluated and interventions developed and implemented to prevent further falls.

On 05/18/23 at 9:35 AM, observation revealed R2 sat in a recliner in the dining room area with her feet elevated. She was holding two baby dolls.

On 05/17/23 at 04:13 PM, LN G verified she was on duty on 05/04/23 at 02:30 PM, and stated staff had not reported to her R2 was found on the

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{F 609}	Continued From page 3 floor. LN G said if staff had told her, she would have filled out the risk management tab in the computer. On 05/17/23 at 04:10 PM, Administrative Staff A stated it was reported to her staff that R2 was found on the floor. She said administrative staff talked about it and decided there was no incident. Administrative Staff A stated the incident had not been reported to the SA. Administrative Staff A stated LN H should have filled out the risk management tab in the computer when CNA M reported the incident to him. The facility's "Abuse, Neglect, Exploitation Prevention" policy, undated, documented The Director of Nursing, Administrator or other designated investigating individual would begin their own internal investigation and notify the State of Kansas agency within twenty-four (24) hours of identifying the concern of possible abuse, neglect, or exportation and will fully cooperate with the investigating agency. The risk management committee and Quality Assurance Performance Improvement Committee will analyze occurrences to determine changes to policies and procedures to prevent further occurrences. The facility failed to report an unwitnessed fall for cognitively impaired R2, placing her at risk for unidentified and/or ongoing abuse or mistreatment.	{F 609}		
{F 610} SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	{F 610}		

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{F 610}	Continued From page 4	{F 610}		

must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included six residents with three reviewed for accidents. Based on observation, record review, and interview the facility failed to investigate an unwitnessed fall for cognitively impaired Resident (R) 2 in order to rule out abuse or neglect. This placed the resident at risk for unidentified and/or ongoing abuse or mistreatment.

Findings included:

- R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces,

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{F 610}	Continued From page 5	{F 610}		

shuffling gait, muscle rigidity and weakness).

R2's "Quarterly Minimum Data Set" (MDS), dated 04/21/23 documented R2 had short- and long-term memory problems and severely impaired cognition. The MDS documented R2 required extensive staff assistance with activities of daily living (ADLs) and her balance was unsteady only able to stabilize with staff assistance when moving on and off toilet and surface to surface transfers. The MDS documented R2 had not ambulated during the lookback period, used a wheelchair for mobility, and had two or more non injury falls.

R2's "Fall Care Plan," dated 04/14/23, documented R2's wheelchair had anti-roll brakes. R2 had a second motion sensor on the wall to alert staff when she entered her room. The care plan documented the resident had high/low bed and instructed staff to keep it in lowest position when R2 was in it; create a safe and stable environment for R2 by keeping her room and hallway free from clutter, and when observing R2 wheeling self towards her room, intervene and assist her with toileting and transferring to her bed. The care plan instructed staff to not leave R2 unattended in her wheelchair while in her room and provide frequent visual checks. The care plan directed staff to make sure R2 had appropriate footwear on and or non -skid socks during transfers/and ambulation.

The "Fall Assessments" completed on 01/16/23 and 04/18/23 recorded R2 was at high risk for falls.

The "Nurse's Note," dated 05/05/23, documented Certified Nurse Aide (CNA) M reported to

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{F 610}	Continued From page 6	{F 610}		

Licensed Nurse (LN) H she found R2 on the floor around 02:30 PM on 05/04/23, and reported the fall to LN G. The note documented LN H could not find documentation regarding this incident.

R2's clinical record lacked evidence staff assessed R2 immediately after her fall on 05/04/23 and lacked evidence causative factors were evaluated and interventions developed and implemented to prevent further falls.

The facility was unable to provide evidence an investigation was completed regarding the incident.

On 05/18/23 at 9:35 AM, observation revealed R2 sat in a recliner in the dining room area with her feet elevated. She was holding two baby dolls.

On 05/17/23 at 04:13 PM, LN G verified she was on duty on 05/04/23 at 02:30 PM, and stated staff had not reported to her R2 was found on the floor. LN G said if staff had told her, she would have filled out the risk management tab in the computer.

On 05/17/23 at 04:10 PM, Administrative Staff A stated it was reported to her staff that R2 was found on the floor. She said administrative staff talked about it and decided there was no incident. Administrative Staff A stated the incident had not been reported to the SA. Administrative Staff A stated LN H should have filled out the risk management tab in the computer when CNA M reported the incident to him.

The facility's "Abuse, Neglect, Exploitation Prevention" policy, undated, documented The Director of Nursing, Administrator or other

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{F 610}	Continued From page 7 designated investigating individual would begin their own internal investigation and notify the State of Kansas agency within twenty-four (24) hours of identifying the concern of possible abuse, neglect, or exportation and will fully cooperate with the investigating agency. The risk management committee and Quality Assurance Performance Improvement Committee will analyze occurrences to determine changes to policies and procedures to prevent further occurrences. The facility failed to investigate an unwitnessed fall for cognitively impaired R2 in order to rule out abuse or neglect. This placed the resident at risk for unidentified and/or ongoing abuse or mistreatment.	{F 610}		
{F 661} SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	{F 661}		

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{F 661}	Continued From page 8	{F 661}		

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included six residents. Based on record review and interview, the facility failed to develop a discharge summary for one resident reviewed for discharge that included a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) of the resident's stay for Resident (R) 6. This placed the resident at risk for unmet care needs.

Findings included:

- R6's Electronic Medical Record (EMR) revealed the resident admitted to the facility on 02/09/23, with diagnoses of major joint replacement, cognitive loss (trouble remembering, concentrating, and making decisions that affect everyday life), acute kidney failure (kidneys suddenly become unable to filter waste products from your blood) , 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 02/15/23, documented R6 had moderately impaired cognition, required supervision and

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{F 661}	Continued From page 9	{F 661}		

limited assistance with activities of daily living (ADL). R6 was not steady but able to stabilize without staff assistance, used a walker for mobility. R6 was occasionally incontinent of urine and bowel. The MDS further documented R6 expected to be discharged to the community and no active discharge planning had occurred for the resident to return to the community."

The "Progress Note" dated 04/03/23 at 02:14 PM, documented Social Service X discussed discharge plans with R6 and the things she would need to do in order to get back home. The notes documented the resident was motivated and had been independent for the last four days and did not require any staff assistance.

The "Transition Home Form" dated 04/14/23 at 08:11 AM, documented R6 would be discharged 04/17/23 to home. The form documented home health care services would be set up before the resident's discharge and home health/therapy orders were sent to the provider. The form gave the resident medication education verbal and written and the importance of obtaining and monitoring her weight due to taking a diuretic medication.

The "Progress Note" dated 04/17/23 at 11:30 AM, documented R6 was discharged to the community with home health services. R6 packed her belongings with minimal assistance and family member to transport her home. Staff educated R6 about her medications, upcoming appointments, and contact number for the physician's medical clinic, and the facility if she had questions after discharge.

R6's EMR lacked a recapitulation of stay and care

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{F 661}	Continued From page 10 recived in the facilty. On 05/17/23 at 09:14 AM, Social Services X and Administrative Staff A reported they failed to provide a recapitulation of R6's stay and did not have a form or guidelines to document the needed information. The facility's "Resident Discharge" policy, dated 03/28/23, documented the facility would complete a "Nursing Discharge Summary and Recapitulation" and medication reconciliation will be completed in full and placed in clinical record. The facility failed to develop a discharge summary that included a recapitulation of the resident's stay for R6. This placed the resident at risk for unmet care needs.	{F 661}		
{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 had a census of 32. The sample included five residents with three reviewed for accidents. Based on observation, record review, and interview the facility staff failed to ensure Resident (R) 2 received adequate post-fall assessment and failed to evaluate causative factors for the fall and identify and implement	{F 689}		

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{F 689}	Continued From page 11	{F 689}		

interventions to prevent further falls after staff found R2 on the floor in her room. This placed R2 at risk for further falls and preventable injuries.

Findings included:

- R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

R2's "Quarterly Minimum Data Set" (MDS), dated 04/21/23 documented R2 had short- and long-term memory problems and severely impaired cognition. The MDS documented R2 required extensive staff assistance with activities of daily living (ADLs) and her balance was unsteady only able to stabilize with staff assistance when moving on and off toilet and surface to surface transfers. The MDS documented R2 had not ambulated during the lookback period, used a wheelchair for mobility, and had two or more non injury falls.

R2's "Fall Care Plan," dated 04/14/23, documented R2's wheelchair had anti-roll brakes. R2 had a second motion sensor on the wall to alert staff when she entered her room. The care plan documented the resident had high/low bed and instructed staff to keep it in lowest position when R2 was in it; create a safe and stable environment for R2 by keeping her room and hallway free from clutter, and when observing R2

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{F 689}	Continued From page 12	{F 689}		

wheeling self towards her room, intervene and assist her with toileting and transferring to her bed. The care plan instructed staff to not leave R2 unattended in her wheelchair while in her room and provide frequent visual checks. The care plan directed staff to make sure R2 had appropriate footwear on and or non -skid socks during transfers/and ambulation.

The "Fall Assessments" completed on 01/16/23 and 04/18/23 recorded R2 was at high risk for falls.

The "Nurse's Note," dated 05/05/23, documented Certified Nurse Aide (CNA) M reported to Licensed Nurse (LN) H she found R2 on the floor around 02:30 PM on 05/04/23, and reported the fall to LN G. The note documented LN H could not find documentation regarding this incident.

R2's clinical record lacked evidence staff assessed R2 immediately after her fall on 05/04/23 and lacked evidence causative factors were evaluated and interventions developed and implemented to prevent further falls.

On 05/18/23 at 9:35 AM, observation revealed R2 sat in a recliner in the dining room area with her feet elevated. She was holding two baby dolls.

On 05/17/23 at 04:13 PM, LN G verified she was on duty on 05/04/23 at 02:30 PM, and stated staff had not reported to her R2 had been found on the floor, if they had she would have filled out the risk management tab in the computer.

On 05/17/23 at 04:10 pm, Administrative Staff A stated it was reported to her staff on the prior shift, had reported to CNA (Leah) R2 had been

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(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 689}	Continued From page 13 found on the floor, administrative staff talked about it and decided there was no incident. Administrative Staff A stated the incident had not been reported to the state. Administrative Staff A stated LN H should have filled out the risk management tab in the computer when CNA M reported the incident to him. The facility's "Fall Prevention Protocol," revised 05/18/23, documented all staff members would be educated on the fall reduction program annually through the mandated safety in-service and more often based on need identified by the process and the staff member's competency evaluation. The protocol documented every team member is responsible for checking the care plan of residents who are at risk for falls when beginning each day and throughout the assigned shift. The facility staff failed to ensure R2 received adequate post-fall assessment and failed to evaluate causative factors for the fall and identify and implement interventions to prevent further falls after staff found R2 on the floor in her room. This placed R2 at risk for further falls and preventable injuries.	{F 689}		
{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;	{F 758}		

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{F 758}	Continued From page 14 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs 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.	{F 758}		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included six residents with three reviewed for medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R)2 and R5s' as needed (PRN) lorazepam (antianxiety medication) had a stop date as required, placing the resident at risk for adverse side effects related to psychotropic (altering mood and mind) medication use.

Findings included:

- R2's Electronic Medical Record (EMR) recorded diagnoses of hallucinations (sensing things while awake that appear to be real, but the mind created), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), adjustment disorder with anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia(progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 04/21/23, documented R2 had severe cognitive impairment, had inattention and disorganized behavior which fluctuated. R2 required extensive assistance of one or two staff for activities of daily living and had two or more non-injury falls. The MDS further documented R2 received daily antianxiety, antidepressant (medication used to treat depression), and diuretic (medication to

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promote the formation and excretion of urine).

The "Anxiety Care Plan," dated 04/14/23, documented R2 had an actual psychosocial well-being problem related to anxiety and lack of acceptance to her current condition. The care plan directed staff to acknowledge R2's anxiety, maintain a calm demeanor while interacting with her, allow R2 time to answer questions she may have without compromising the privacy of others, and to verbalize feelings perceptions, and fears as her anxiety levels fluctuate throughout the day.

The "Physician Order" dated 12/05/22, directed staff to administer lorazepam 1 milligrams (mg) 1 tab twice a day for anxiety and agitation. The order lacked a stop date.

The "Electronic Medication Administration Record" (EMAR), documented R2 received the lorazepam since 12/05/22 with no 14 day stop date.

The 05/13/23 at 11:16 AM nurses notes documented R2 had no behaviors that day, and no distress noted. R2 moved about the facility in her wheelchair that she propelled herself. Staff would continue to monitor the resident.

On 05/168/23 at 09:35 AM observation revealed the resident sat in a recliner in the living room, dressed in street clothes with her feet elevated. Continued observation revealed the resident had a baby doll in each arm and stated, "don't take my babies."

On 05/18/23 at 09:45 AM, Administrative Nurse D verified the lorazepam did not have 14 day stop date and said she would send a fax to the

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physician to get clarification and a stop date for the medication.

The facility's "Psychotropic Medication Monitoring" policy, documented orders for as needed psychotropic medication will be limited to fourteen (14) days or less and only for specific clearly documented circumstances. An antianxiety medication order on as needed bases for mood stabilization may be reordered at the end of 14 days after the ordering practitioner has evaluated the resident for continued need and the provide a rationale for continuation of the as needed medication rational and risk/benefit statement with a specific duration for the continuation of the order not to exceed six months.

The facility failed to ensure R2's psychotropic medication had the required stop date placing the resident at risk for adverse side effects

- R5's Electronic Medical Record (EMR) recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion), amnesia (loss of memory caused by brain damage or severe emotional trauma), psychotic disorders (any major mental disorder characterized by a gross impairment in reality testing) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The "Quarterly Minimum Data Set" (MDS), dated 04/16/23, documented R5 had severe cognitive impairment, had inattention and disorganized

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behavior which fluctuated. R5 required extensive assistance of one or two staff for activities of daily living and had two or more non-injury falls.

The "Cognitive Loss/Dementia Care Plan," dated 04/14/23, documented R5 one caretaker would speak to the resident at a time, as the resident was unable to process multiple voices and instructions resulting in fear-based agitation. The care plan directed staff to intervene if the resident became agitated and guide her away from the source of distress then engage calmly in conversation and if the resident became aggressive staff would walk away and approach later.

The "Physician Order" dated 12/22/22, directed staff to administer lorazepam 2 milligrams (mg)/1 milliliter (ml) to give 0.5 ml by mouth every eight hours as needed for anxiety. The order lacked a stop date.

The "Electronic Medication Administration Record" (EMAR), documented R5 received the PRN lorazepam on 04/22/23.

The "Behavior Note," dated 04/04/23 at 02:42 PM, documented R5 became agitated, frustrated, and anxious due to another resident being anxious and yelling in the memory care unit. R2 became physical with her daughter due to being frustrated and wandering the halls and when her daughter redirected her, she would push her away. The nurse separated R5 and the daughter then the resident calmed down and sat in a recliner in the living room.

On 05/18/23 at 09:30AM, observation revealed R5 lying in a recliner in the memory care unit

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living room with her feet elevated eyes closed, and a blanket on her. She laid on her right side, dressed in street clothes, and her gray hair was in a pony tail.

On 05/18/23 at 09:33 AM, Certified Medication Aide (CNA) N reported R5 recently had not had behaviors and anxiety. CNA N stated R5 was in the living room area because staff liked to "keep an eye on her" because she has had some falls in the past.

On 05/18/23 at 10:00 AM, Licensed Nurse (LN) G reported R5 had behaviors with another resident. LN G did not know about the stop date for the as needed lorazepam order.

On 05/18/23 at 10:30 PM, Administrative Nurse D verified the as needed lorazepam did not have a stop date and said she would fax the physician for a stop date.

The facility's "Psychotropic Medication Monitoring" policy, documented orders for as needed psychotropic medication will be limited to fourteen (14) days or less and only for specific clearly documented circumstances. An antianxiety medication order on as needed bases for mood stabilization may be reordered at the end of 14 days after the ordering practitioner has evaluated the resident for continued need and the provide a rationale for continuation of the as needed medication rational and risk/benefit statement with a specific duration for the continuation of the order not to exceed six months.

The facility failed to ensure R5's as needed psychotropic medication had the required stop

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{F 758}	Continued From page 20 date placing the resident at risk for adverse side effects	{F 758}		