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	175376	A. BUILDING _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT STREET SABETHA, KS 66534

(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 Health Resurvey and Complaint #KS00180314. The 2567 was sent electronically on 07/11/23. Revised 2567 sent on 07/11/23.	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 07/11/2023

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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by:
The facility had a census of 66 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to report to the state agency Resident (R)16's injuries of unknown origin and failed to report to the state agency R14's unwitnessed fall resulting in fracture. This placed the residents at risk for unidentified and ongoing abuse or neglect.

Findings included:

- The Electronic Medical Record (EMR) for R16 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and edema (swelling).

The "Annual Minimum Data Set" (MDS), dated 02/13/23, documented R16 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting and extensive assistance of one staff for dressing, eating and personal hygiene. The MDS further documented R16 had no skin issues.

The "Quarterly MDS," dated 05/03/23, documented R16 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of two staff for dressing, eating and personal hygiene. The MDS further documented R16 had skin tears.

The "Care Plan," dated 05/05/23, initiated on 04/27/22, documented R16 would lose her

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balance, fall, or bumped into things, and could not remember. The care plan directed staff to check her skin weekly, use a pressure distribution device air mattress, and ensure that R16 had a foot cradle on her bed to prevent the sheets from rubbing on her feet. The update, dated 05/22/23, directed staff to apply sleeve protectors during the day and take them off at night.

The "Investigation," dated 03/03/23 at 03:17 PM, documented R16 had a skin tear to her right forearm that staff had noticed while getting her ready for bed. The investigation further documented R16 had severely impaired cognition, was unable to state when or how the skin tear happened and education was given to staff.

The "Investigation," dated 04/19/23 at 03:04 AM, documented R16 had a skin tear on her left forearm which measured 1.5 centimeters (cm) x 1.2 cm and had a "V" shape. The area was cleansed with normal saline, adhesive closures were applied, covered with a non stick dressing and wrapped with gauze. The investigation documented, staff did not know if the skin tear happened when changing her clothes, and due to R16's severely impaired cognition, she was unable to state when or how the skin tear happened; education was given to staff.

The "Investigation," dated 04/28/23 at 07:10 PM, documented R16 had a skin tear on her right arm which measured 0.1 cm x 2.5 cm. The area was cleansed with normal saline, skin approximated, and two closure strips were applied. The investigation further documented staff were unsure when it happened.

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The "Investigation," dated 05/22/23 at 11:24 AM, documented staff found a skin tear to R16's right forearm which measured 4.7 cm x 0.1 cm, during her shower, and staff were unsure how the skin tear was obtained.

On 06/26/23 at 08:57 AM, observation revealed R16 had sleeve protectors on her arms.

On 06/22/23 at 12:30 PM, Certified Nurse Aide (CNA) O stated R16 had to have sleeve protectors on her arms at all times because of skin tears.

On 06/26/23 at 02:17 PM, Licensed Nurse (LN) H stated when staff tell her there is a skin tear or bruise, she will complete an investigation by talking with the staff, the resident, and will look at the resident's environment to see if she can figure out what happened. LN H further stated R16 had to wear the sleeve protectors or wear long sleeve to protect her skin because it was so fragile.

On 06/27/23 at 09:45 AM, Administrative Nurse D stated she was unaware she was required to report any injuries of unknown origins.

The facility's "Resident Abuse, Neglect, Exploitation, and Mistreatment" policy, dated 06/2022, documented the facility administration shall be cooperative with the state Health Department officials in accordance with Kansas's law to protect the rights and safety of the resident. The time period for reporting a serious bodily injury is a two hour limit, if the event that causes the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but no later than two hours after forming the suspicion.

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All others within 24 hours if the events that caused the reasonable suspicion do not result in serious bodily injury to the resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion, and if a crime has been committed law enforcement will also be advised.

The facility failed to report to the state agency R16's skin tears of unknown origin. This placed the resident at risk for unidentified and ongoing abuse or neglect.

- The "Medical Diagnosis" section in R14's Electronic Medical Record (EMR) included diagnoses of dorsalgia (back pain), scoliosis (curvature of the spine), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, fatigue, kyphosis (outward curvature of the spine), cervicalgia (neck pain), fracture of left clavicle (collarbone), shortness of breath, and panic disorder.

The "Significant Change Minimum Data Set" (MDS), dated 01/16/23, documented R14 had intact cognition, and required extensive assistance of one staff for activities of daily living (ADL). The MDS recorded R14 was not steady and was only able to stabilize with human assistance. R14had occasional incontinence of urine, received scheduled and as needed pain medication, and was short of breath with exertion. The MDS further documented R14 had one fall

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with no injury and one fall with injury.

The "Activity of Daily Living Care Area Assessment" (CAA), dated 01/16/23, documented R14's family chose comfort care due to R14's decline. R14 needed extensive assistance with most of her ADL and was failing to thrive. R14 had falls on 08/15/22 and 10/14/22. The CAA further documented R14 took two antidepressants (class of medications used to treat mood disorders), a Fentanyl (narcotic pain medication) patch, and had as needed pain and antianxiety (class of medications that calm and relax people) medications

The "Quarterly MDS", dated 04/03/23, documented R14 had moderately impaired cognition.

The "Quarterly MDS", dated 06/13/23, documented R14 had severe cognitive impairment, had other behavioral symptoms not directed toward others, and required extensive assistance of one staff for ADL. R14, received scheduled, as needed, and non-medication interventions for pain, and had a fall with major injury.

The "Care Plan", dated 10/27/22, documented R14 had the potential to fall down and hurt herself because of fatigue. The nurses needed to request a therapy screen for R14 if needed, and the nurse aides were to keep R14's room well-lit when she was up and to remind her to get up slowly. On 04/16/23 the care plan added intervention to stay with R14 during toileting. On 04/24/23 the care plan further documented R14 had not met her goal of avoiding major injury due to a clavicle fracture.

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The "Fall Note" on 08/15/22 at 02:11 AM, documented the nurse heard a noise and R14 calling out for help. The nurse went to investigate and found R14 lying on her back in the bathroom with her head resting against the door frame. R14 had a hematoma to the right side of her head the size of a golf ball. R14 complained of pain in her head and buttocks. R14 was unable to tell the nurse what caused the fall. The note recorded R14 was independent and had appropriate lighting and footwear on; her floor was clean and dry, and an assistive device (walker) was with the resident. The fall note further documented no new interventions at that time.

The "Fall Note", on 10/14/22 at 08:21 PM, documented R14 was getting ready for bed, and getting clothes to her closet, when she became unsteady and fell. R14 was sitting on her bottom with her head resting against the bed and her hand on her chest. R14 was very short of breath. Staff provided teaching on the use of the call light if R14 felt unsteady. The note documented no new interventions at that time and stated the care plan was followed.

The "Fall Note" on 04/21/23 at 11:30 PM, documented the nurse heard R14 scream and went to investigate. The nurse found R14 lying on her left side with her left arm behind her. Her oxygen tubing was off, and there was candy scattered on the floor. R14 reported pain to her left arm and was unable to move her left arm without pain. R14 went to the emergency room. The note documented no interventions at that time. R14 returned from the hospital with a left clavicle fracture.

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On 06/26/23 at 09:18 AM, R14 sat in her room, in a recliner. She wore oxygen via nasal cannula. R14 reported she no longer had shoulder pain from the fractured clavicle. She stated it was healed

On 06/26/23 at 12:14 PM observation revealed Certified Nurse Aide (CNA) O assisted R14 to the bathroom. CNA O assisted R14 to a wheelchair and wheeled the resident into the bathroom. CNA O assisted R14 with toileting needs and then returned the resident to her recliner. CNA O reported R14 was usually continent, and used her call light, but recently had been calling out for assistance.

On 06/27/23 at 09:40 AM, Administrative Nurse D stated the care plan had not been updated following the fall for R14 which resulted in a clavicle fracture. Administrative Nurse D and verified no new interventions were implemented to prevent further falls. Administrative Nurse D reported she had not reported the fall to the state agency because she thought if the care plan was followed, a report did not have to be made.

The facility's "Resident Abuse, Neglect, Exploitation, and Mistreatment" policy, dated 06/2022, documented the facility administration shall be cooperative with the state Health Department officials in accordance with Kansas's law to protect the rights and safety of the resident. The time period for reporting a serious bodily injury is a two hour limit, if the event that causes the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but no later than two hours after forming the suspicion. All others within 24 hours if the events that

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F 609	Continued From page 8 caused the reasonable suspicion do not result in serious bodily injury to the resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion, and if a crime has been committed law enforcement will also be advised The facility failed to report to the state agency R14's fractured clavicle from an unwitnessed fall which placed the resident at risk for unidentified and ongoing abuse or neglect.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		

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findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 66 residents. The sample included 18 residents, with one reviewed for post-traumatic stress disorder (PTSD-psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture). Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for PTSD for one sampled resident, Resident (R) 36, to provide direction to staff to ensure R36 received care to eliminate or mitigate triggers that may cause re-traumatization of the resident. This placed the resident at risk for unmet needs.

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Findings included:

- The Electronic Medical Record (EMR) for R36 documented diagnoses of PTSD, dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), cerebral infarction (a disruption of blood flow to the brain due to problems with the blood vessels that supply it), and major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Quarterly MDS," dated 05/02/23, documented R36 had severely impaired cognition and required extensive assistance of two staff for bed mobility, toileting, and extensive assistance of one staff for transfers, ambulation, mobility in his wheelchair, dressing, and personal hygiene. The MDS further documented R36 had no behaviors and received antidepressant (medication that is used to treat mood disorders and relieve symptoms of depression) medication.

The EMR lacked documentation a Trauma Informed Care Assessment was completed for R36.

The "Care Plan," dated 05/02/23, imitated on 12/01/22, documented R36 was unaware of safety risks and directed staff to keep an eye on his behaviors. The EMR lacked documentation a care plan for R36's PTSD was developed.

The "Physician's Order," dated 11/25/22, directed staff to administer donepezil (cognition-enhancing medication), 10 milligrams (mg), by mouth, daily in the morning for dementia and directed staff to

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administer
Celexa (an antidepressant medication), 20 mg, by mouth, daily in the evening for depression.

The "Nurse's Note," dated 05/26/23 at 03:16 PM, documented R36 became agitated with his morning cares.

The "Nurse's Note," dated 06/14/23 at 04:11 PM, documented R36 was aggressive with staff during cares, hit and grabbed at staff several times during the shift. The note further documented staff explained what they were doing and out of nowhere, R36 started to hit and grab their arms.

The "Nurse's Notes," dated 06/22/23 at 04:32 PM, documented at lunch, R36 grabbed a staff members braid and pulled down on it. The noted further documented, staff were able to get the resident to let go by removing his hand from her braid.

On 06/26/23 at 12:22 PM, observation revealed staff pushed R36's wheelchair into the living room area in front of the television; R36 had no behaviors.

On 06/22/23 at -9:30 AM, Administrative Nurse E verified she had not developed a care plan for R36's PTSD and verified a trauma informed care assessment was not completed.

On 06/22/23 at 11:50 AM, Certified Nurse Aide (CNA) O stated R36 could be resistive of cares at times and staff tried to redirect him.

On 06/26/23 at 02:17 PM, Licensed Nurse (LN) H stated R36 had times of aggression, swung at staff and pulled hair. LN H further stated staff

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F 656	Continued From page 12 redirected him LN H said she was unaware of R36's PTSD diagnosis, and stated R36 did not receive mental health services. On 06/26/23 at 03:36 PM, Social Services X stated she had discussed R36's PTSD with his representative and had spent time with the resident but due to transporting residents to their appointments, she had not completed any assessments or been involved with the care plan team to develop a care plan for direction to staff on what would trigger his PTSD. On 06/27/23 at 09:45 AM, Administrative Nurse D stated, the facility would complete Trauma Informed Care Assessment on residents with the diagnosis of PTSD and stated a care plan for R36's PTSD was now completed. The facility's "Care Plan" policy, undated, documented, a care plan would be developed for each resident using the results of the comprehensive assessment and would include measurable objectives and timetables to meet all resident needs. The facility failed to develop a comprehensive care plan for R36, who had a diagnosis of PTSD. This placed the resident at risk for unmet needs.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

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includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 66 residents. The sample included 18 residents of which 18 were reviewed for care planning. Based on observation, record review, and interview, the facility failed to revise the care plan with interventions to prevent falls for Resident (R) 14, 57, and 21. This deficient practice placed the residents at risk for injuries to uncommunicated care needs.

Findings included:

- The "Medical Diagnosis" section in R14's Electronic Medical Record (EMR) included diagnoses of dorsalgia (back pain), scoliosis (curvature of the spine), major depressive

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disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, fatigue, kyphosis (outward curvature of the spine), cervicalgia (neck pain), fracture of left clavicle (collarbone), shortness of breath, and panic disorder.

The "Significant Change Minimum Data Set" (MDS), dated 01/16/23, documented R14 had intact cognition, and required extensive assistance of one staff for activities of daily living (ADL). The MDS recorded R14 was not steady and was only able to stabilize with human assistance. R14had occasional incontinence of urine, received scheduled and as needed pain medication, and was short of breath with exertion. The MDS further documented R14 had one fall with no injury and one fall with injury.

The "Activity of Daily Living Care Area Assessment" (CAA), dated 01/16/23, documented R14's family chose comfort care due to R14's decline. R14 needed extensive assistance with most of her ADL and was failing to thrive. R14 had falls on 08/15/22 and 10/14/22. The CAA further documented R14 took two antidepressants (class of medications used to treat mood disorders), a Fentanyl (narcotic pain medication) patch, and had as needed pain and antianxiety (class of medications that calm and relax people) medications

The "Quarterly MDS", dated 04/03/23,

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documented R14 had moderately impaired cognition.

The "Quarterly MDS", dated 06/13/23, documented R14 had severe cognitive impairment, had other behavioral symptoms not directed toward others, and required extensive assistance of one staff for ADL. R14, received scheduled, as needed, and non-medication interventions for pain, and had a fall with major injury.

The "Care Plan", dated 10/27/22, documented R14 had the potential to fall down and hurt herself because of fatigue. The nurses needed to request a therapy screen for R14 if needed, and the nurse aides were to keep R14's room well-lit when she was up and to remind her to get up slowly. On 04/16/23 the care plan added intervention to stay with R14 during toileting. On 04/24/23 the care plan further documented R14 had not met her goal of avoiding major injury due to a clavicle fracture.

The "Fall Note" on 08/15/22 at 02:11 AM, documented the nurse heard a noise and R14 calling out for help. The nurse went to investigate and found R14 lying on her back in the bathroom with her head resting against the door frame. R14 had a hematoma to the right side of her head the size of a golf ball. R14 complained of pain in her head and buttocks. R14 was unable to tell the nurse what caused the fall. The note recorded R14 was independent and had appropriate lighting and footwear on; her floor was clean and dry, and an assistive device (walker) was with the resident. The fall note further documented no new interventions at that time.

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The "Fall Note", on 10/14/22 at 08:21 PM, documented R14 was getting ready for bed, and getting clothes to her closet, when she became unsteady and fell. R14 was sitting on her bottom with her head resting against the bed and her hand on her chest. R14 was very short of breath. Staff provided teaching on the use of the call light if R14 felt unsteady. The note documented no new interventions at that time and stated the care plan was followed.

The "Fall Note" on 04/21/23 at 11:30 PM, documented the nurse heard R14 scream and went to investigate. The nurse found R14 lying on her left side with her left arm behind her. Her oxygen tubing was off, and there was candy scattered on the floor. R14 reported pain to her left arm and was unable to move her left arm without pain. R14 went to the emergency room. The note documented no interventions at that time. R14 returned from the hospital with a left clavicle fracture.

On 06/26/23 at 09:18 AM, R14 sat in her room, in a recliner. She wore oxygen via nasal cannula. R14 reported she no longer had shoulder pain from the fractured clavicle. She stated it was healed

On 06/26/23 at 12:14 PM observation revealed Certified Nurse Aide (CNA) O assisted R14 to the bathroom. CNA O assisted R14 to a wheelchair and wheeled the resident into the bathroom. CNA O assisted R14 with toileting needs and then returned the resident to her recliner. CNA O reported R14 was usually continent, and used her call light, but recently had been calling out for assistance.

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On 06/27/23 at 09:40 AM, Administrative Nurse D stated the care plan had not been updated following the fall for R14 which resulted in a clavicle fracture. Administrative Nurse D and verified no new interventions were implemented to prevent further falls. Administrative Nurse D reported she had not reported the fall to the state agency because she thought if the care plan was followed, a report did not have to be made.

The facility's undated "Care Plan" policy, documented a care plan will be developed for each resident using the results of the comprehensive assessment. Each care plan will include measurable objectives and timetables to meet all resident needs identified in the comprehensive assessment. The care plan describes services furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Care plans will be reviewed and revised on a quarterly basis by the interdisciplinary care plan team and also as needed when changes occur.

The facility failed to identify and implement interventions to the care plan to prevent R14 from falling resulting in a major injury and placed the resident at risk of further falls and uncommunicated care needs.

- R57's Electronic Medical Record (EMR) recorded diagnoses of atrial fibrillation (rapid, irregular heartbeat), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (elevated blood pressure), anemia (condition without enough healthy red blood cells to carry adequate oxygen

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to body tissues), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), pain, sleep disorder, and dystonia (movement disorder that cause slow repetitive movements).

The "Quarterly Minimum Data Set", (MDS) dated 05/30/23, documented R57 had intact cognition, rejection of care behavior one to three days during the look back period, required extensive assistance with activities of daily living, was not steady and only able to stabilize with staff assistance, and used a walker. The MDS further documented R57 was frequently incontinent of urine, received an antidepressant (medication used to treat mood disorder) and hypnotic (medication used to induce sleep) on a routine basis. R57 used bed and chair alarms.

The "Fall Care Area Assessment" (CAA), dated 03/21/23, documented R57 had a history of multiple falls, impaired balance, impulsivity, anxiety disorder and depression (mood disorder). R57 had multiple falls from self-transferring and walking without assistance. R57 had a chair and bed alarm to alert staff when he was moving about and to stay with him during toileting.

The "Care Plan" dated 12/22/22, documented R57 needed assistance because of having physical challenges, and frequent falls. R57 had trouble making decisions. The care plan directed staff to transfer R57 with a gait belt, walk using a four wheeled walker; R57 wore a Wanderguard device (personal alarm which alerts staff when close to alarmed exits) on his left ankle. The care plan further documented R57 had the potential to

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fall and hurt himself because of Parkinson's disease. The care plan further directed staff to keep an eye on his behaviors, make sure the call light was within reach, establish an activity of daily living program, to stay with R57 during toileting, make sure glasses are within reach, encourage R57 to use assistance, and to report pain and behaviors to nurse.

R57's "Care Plan" documented an intervention dated 12/29/22 which directed R57 used an alarm on his bed, chair and floor. On 01/20/23 the plan documented R57 was to use gripper socks at bedtime. On 02/16/23 the plan was updated to direct R57 had the potential to fall and hurt himself due to Parkinson's disease and dementia/Alzheimer's disease. An intervention dated 06/20/23 directed R57 used a self-locking wheelchair.

The "Fall Note" dated 01/20/23 at 01:48 AM, documented R57 had just been assisted by a Certified Nurse Aide (CNA) with getting ready for bed, and he was sitting in his recliner watching television. The CNA then went to assist R57's roommate. The CNA reported hearing a thud and R57 was sitting on the floor in front of his recliner. The fall note documented no actions were needed and direct staff to continue to observe resident. The care plan was updated for R57 to wear slipper socks at bedtime and to give R57 frequent reminders to call for assistance when getting up.

The "Fall Note" dated 01/20/23 at 10:34 PM, documented staff checked on R57 because the room door was shut. R57 was sitting in his chair with blood on the floor and his left knee. R57's walker was folded and turned on its side. R57

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informed staff he did fall. The pad alarm was on his table and unplugged enough not to alarm the pagers. R57 had previous skin issues to his left knee from a previous fall and had acquired new skin tears and abrasions to just below the left knee, left upper arm, left ankle and upper buttocks. The note documented R57 received education to use the call light and not to remove pad alarm from the chair.

The "Fall Note" dated at 02/02/23 at 05:10 AM documented staff were notified by the alarm and found R57 sitting on the floor in his room. R57 had an abrasion to his left knee, which was cleansed, and a dressing applied. The note documented action taken was to observe, teach use of call light, and safe use of devices. The intervention listed to adjust toileting schedule and staff to frequently remind R57 to use his call light for assistance for his safety.

The "Fall Note" dated 03/02/23 at 11:33 PM documented R57 was assisted to the bathroom with his walker and gait belt. R57 lost his balance and fell partially on the couch, landing on his left knee sustaining injury to left knee and first aid was immediately applied. The fall note documented no interventions at that time.

The "Fall Note" dated 03/28/23 at 12:49 PM documented staff observed R57 starting to stand up from his recliner when he fell on his left knee. Staff were not able to get to the resident before the fall. The nurse found R57 sitting on his couch. R57 reported he wanted to see what laundry had put in his closet. The fall note further documented staff educated R57 on the importance of using the call light; R57 had a bed alarm and chair alarm. He often attempted to ambulate in his

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room without calling for assistance and to give frequent reminders to use the call light to call and wait for assistance. No interventions at that time.

The "Fall Note" dated 04/25/23 at 04:24 PM documented R57 was on his left knee in front of his bed. R57 reported he was trying to get into his wheelchair for supper and stated his call light was attached to his recliner and he should have used it. The chair alarm was working and answered promptly. The fall note further documented staff visited with R57 on the importance of using the call light to call staff for assistance and waiting for staff to get there to assist him. Resident verbalized understanding. No intervention was documented.

On 06/26/23 at 03:38 PM observation revealed R57 sitting in his recliner watching television. R57 stated he had been admitted to the facility because of falling. He reported he was taking a sleeping pill and staff reported he had been walking around at night, but he does not remember this happening. R57 stated the facility wanted him to remain seated as the intervention to keep him from falling and when the alarms go off, they come running. He did report the staff remind him to use the call light and wait for assistance. R57 also reported he wanted to return home at the end of summer.

On 06/27/23 at 09:45 AM. Administrative Nurse D stated due to R57's intact cognition the facility had not implemented new interventions to prevent his falls.

The facility's undated "Care Plan" policy, documented a care plan will be developed for each resident using the results of the

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comprehensive assessment. Each care plan will include measurable objectives and timetables to meet all resident needs identified in the comprehensive assessment. The care plan describes services furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Care plans will be reviewed and revised on a quarterly basis by the interdisciplinary care plan team and also as needed when changes occur.

The facility failed to identify and implement interventions to the care plan to prevent R57 from falling resulting in a major injury and placed the resident at risk of further falls and uncommunicated care needs.

- The Electronic Medical Record for R21 recorded diagnoses of dementia, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), other symptoms and signs involving cognitive functions and awareness, and Alzheimer's disease (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 05/08/23, documented R21 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for mobility, dressing, and personal hygiene. The MDS further documented R21 had no behaviors and received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication seven days of the look back period.

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The "Care Plan," dated 05/12/23, initiated on 05/19/22, documented R21 had the inability to remember things that happened a short time ago, and the inability to make decisions. R21 had poor safety awareness, and the plan directed staff to watch to see if R21's behavior changed. The update, dated 08/12/22 directed staff to evaluate R21 for situational stressors, evaluate effectiveness of her medication and monitor her for adverse effects of the medications. It directed to record R21's behaviors, encourage her to participate in activities, and offer comfort and support. The care plan lacked documentation of R21's behaviors and lacked person centered approached to address behaviors.

The "Physician's Order," dated 06/08/21, directed staff to monitor for side effects of Cymbalta (antidepressant medication) and monitor for behaviors.

The "Physician's Order," dated 06/12/23, directed staff to administer Cymbalta, 20 milligrams (mg), 1 capsule, by mouth, for the diagnosis of anxiety.

The "Nurse's Note," dated 08/30/22 at 04:19 PM, documented R21 kicked towards another resident, though no contact was made. Staff told her it was inappropriate to kick towards people.

The "Nurse's Note," dated 10/21/22 at 02:02 PM, documented R21 kicked at another resident's wheelchair frame and staff told her that it was inappropriate and to not do it again.

The "Nurse's Note," dated 10/23/22 at 03:34 PM, documented R21 took papers off the desk at the nurse's station and attempted to look at them. The note further documented staff retrieved the

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papers and R21 attempted to take papers and food off the medication cart. The note documented staff took R21 to her room and told her not to take things off other people's places. At 04:34 PM, the note documented R21 left her room and another resident was in the hallway and R21 kicked at the other resident's wheelchair.

The "Nurse's Note," dated 02/24/23 at 03:02 PM, documented R21 was whistling and disturbing other resident's and staff took her to her room.

The "Nurse's Note," dated 02/26/23 at 02:25 PM, documented R21 was whistling in the dining room upsetting other residents, staff asked her to stop but she continued to whistle. The note further documented R21 was taken to her room, her call light given, and staff explained that it hurt other resident's ears and she replied, "I don't care."

The "Nurse's Note," dated 03/02/23 at 02:37 PM, documented R21 was whistling and it disturbed other resident's, and she was taken to her room.

The "Nurse's Note," dated 03/05/23 at 01:36 PM, documented R21 whistled despite nursing staff asked her to quit. The note documented at 04:36 PM, R21 was asked by staff and residents to stop whistling, she refused, and staff took her to her room, and gave her call light and a magazine. The note further documented the intervention only lasted a short time and R21 began to whistle again until her family came in the afternoon to visit. The note documented, later in the dining room, R21 began to holler and progressively got louder. Staff asked R21 if she needed anything and she stated "No."

The "Nurse's Note," dated 03/14/23 at 12:11 PM,

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documented R21 whistled while in the dining room, other residents had already voiced that it was agitating to them, especially those with hearing aids. The note documented staff asked her multiple times to stop and she was taken back to her room, given her call light, lunch tray, and she stopped whistling.

The "Nurse's Note," dated 03/26/23 at 01:05 PM, documented R21 whistled in the common area, was asked to stop by staff because other residents complained of this behavior. The note further documented staff took R21 to her room, gave her a call light and a magazine.

The "Nurse's Note," dated 04/06/23 at 09:19 PM, documented R21 whistled in the hallway after dinner, was asked to stop by two staff members due to it hurt other resident's ears. The note documented staff told R21 that if she wished to keep whistling, she needed to do it in her room. R21 stated she did not want to go to her room and would stop whistling. The note documented, R21 stopped whistling until the nurse walked away, and then she continued to whistle.

The "Nurse's Note," dated 04/09/23, documented R21 was observed kicking the bird cage; she was asked to sit and watch them, and not kick the cage. The note further documented R21 continued to kick the glass, and staff took her to her room.

The "Nurse's Note," dated 04/26/23 at 03:42 PM, documented R21 whistled even after she was asked to stop. R21 started crying, and stated she never did anything right.

The "Nurse's Note," dated 05/06/23 at 03:08 AM,

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documented on the previous evening, R21 was in another resident's room and was assisted out by staff. The note further documented R21 went back into the other resident's room, and again was taken out by staff. The note documented, after R21 was taken out of the room, and while out in the hallway, she pulled on another resident's hair.

The "Nurse's Note," dated 05/11/23 at 03:44 PM, documented R21 was rude to another resident during breakfast and staff moved her to another table.

The "Nurse's Note," dated 05/14/23 at 10:55 AM, documented at 09:30 AM, R21 wheeled herself in front of another resident; staff asked her to move away from the other resident, in which she did not move away but wheeled closer and leaned toward the other resident's face and said, "move out of my way." Staff intervened and moved R21 away. The note documented R21 began to whistle and upset other residents and staff took her to her room.

The "Nurse's Note, "dated 06/06/23 at 04:02 PM, documented R21 whistled in the hallway, other residents complained and asked her to stop. The further documented R21 refused and staff told her that if she did not stop she would need to go to her room. The note documented R21 got into the nurse's face and whistled loudly, and staff took her to her room.

On 06/22/23 at 12:04 PM, observation revealed R21 sat in her wheelchair in the living room area and had no behaviors at that time.

On 06/22/23 at 12:40 PM, Certified Nurse Aide

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F 657	Continued From page 27 (CNA) O stated R21 liked to whistle, and it often disturbed other residents. CNA O said R21 had no other behaviors, and staff take R21 to her room when she has behaviors. On 06/26/23 at 02:18 PM, Licensed Nurse (LN) H stated R21 liked to whistle and it disturbed other residents. LN H said sometimes R21 would get into other residents' faces and whistle. LN H said most of the time R21 would stop when asked to stop but when she did not, staff took her to her room. On 06/26/23 at 03:31 PM, Social Services X stated when R21 had behaviors, she stepped in and helped staff redirect . Social services X said provided 1:1 with R21. Social Services X stated R21 did not receive any mental health services. On 06/27/23 at 09:45 AM, Administrative Nurse D stated R21 whistled and upset other residents. Administrative Nurse D said staff would work on other interventions for R21's behavior and verified R21 did not receive any mental health services. The facility "Care Plans" policy, undated, documented residents had personalized plan that stated specific cares needed and would be reviewed and revised on a quarterly basis by the care team and also when changes occur. The facility failed to revise the care plan for R21 with person centered interventions which addressed dementia related behaviors. This placed the resident at risk for uncommunicated and/or unmet needs.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 66 residents. The sample included 18 residents. Based on observation, record review and interview the facility failed to prevent medication administration errors for Resident (R) 10's when staff crushed and mixed the medications and placed them in R10's food. The services the facility provided R10 did not meet professional standards of quality. This deficient practice placed R10 at risk for adverse reactions by not receiving the appropriate amount of medications prescribed.

Findings included:

- R10's Electronic Medical Record (EMR), documented diagnoses of epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), bipolar disorder (a disorder with episodes of mood swings ranging from depressive lows to manic highs), and anxiety disorder (mental health disorder with feelings of worry, anxiety, or fear that interferes with daily activities).

The "Quarterly Minimum Date Set" (MDS), dated 03/27/23, documented a Brief Interview for Mental Status (BIMS) score of seven indicating severely impaired cognition. The MDS documented R10 required extensive assistance with transfers and locomotion and rejected care one to three days of the look back period.

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The revised "Safety Care Plan," dated 06/03/23, instructed staff to keep the resident safe if a seizure occured and to provide seizure medication as ordered.

The "Physician Orders," dated 06/01/23, documented to administer the following medications:
Keppra (an anticonvulsant medication to prevent seizures) 500 milligrams (mg) by mouth (PO) two times a day (BID)
Docusate Sodium (stool softener medication)100mg PO BID
Risperidone (antipsychotic medication) 2.5 mg PO BID
Depakote (seizure medication) 125 mg capsule delayed release PO BID,
Tylenol (pain medication) 500 mg PO in the evening,
Zoloft (an antidepressant medication) 100mg PO in the evening,

R10's EMR lacked an order to crush and mix medications.

The "Nurses Note" dated 06/19/23 at 07:55PM, documented R10's evening medications were crushed and mixed in his meat sandwich during the supper meal. The note recorded R10 ate half of the sandwich therefore half of R10's medications were received.

The "Nurses Note", dated 06/21/23 at 07:22PM, documented R10's evening medications were crushed and mixed in the tartar sauce and placed on his fish sandwich. The note further documented R10 ate half of the fish sandwich therefore he technically received half of his

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medication.

According to the Food and Drug Administration for the medications Keppra, Risperidone and Depakote. Crushing the medications was discouraged.

Review of R10's "Medication Administration Record" (MAR) revealed documentation on 06/19/23 and 06/21/23 that R10 received half of his evening medication.

On 06/27/23 at 08:00AM, observation revealed R10 seated in his wheelchair at a dining table.

On 06/22/23 at 08:15AM, Licensed Nurse (LN) G stated, depending on R10's mood, R10's medications were sometimes crushed and placed in his food.

On 06/27/23 at 09:15AM, Administrative Nurse D verified the documentation on 06/19/23 and 06/21/23, regarding R10's medications being crushed and placed in his meals. Administrative Nurse D verified this practice of medication administration was inappropriate.

The undated facility policy, "Medication Administration", stated medications are to be administered as prescribed by the resident's physician. All medication errors should be reported.

The facility failed to administer R10's medications in an appropriate manner, by crushing the medications and placing in his food. These services the facility provided R10 did not meet professional standards of quality for medication administration, placing R10 at risk for not

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F 658	Continued From page 31 receiving the appropriate doses of the medications.	F 658		
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). (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 66 residents. The sample included 18 residents with one reviewed for discharge. Based on record review and	F 661		

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interview, the facility failed to develop a discharge summary 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)67. This placed the resident at risk for unmet care needs.

Findings included:

- R67's Electronic Medical Record (EMR) revealed the resident admitted to the facility on 03/10/23.

The "Admission Minimum Data Set" (MDS), dated 03/21/23, documented R67 had intact cognition, delusions, and no behavioral symptoms. The MDS further documented R67 required supervision with activities of daily living, had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag), received an antidepressant (class of medications used to treat mood disorders) and an antibiotic (medication to treat infections), had no therapy services and did not have an active discharge planning already occurring.

The "Psychosocial Well-Being Care Area Assessment" dated 03/21/23, documented R67 verbally stated embarrassment being in the facility. R67 had a desire to please others and was concerned about not doing things right. The CAA further documented the facility would continue to facilitate mental health and primary care doctor appointments.

The "Care Plan", dated 03/21/23, documented R67 needed to determine if it was safe to return to home because R67 wanted or expected to go home in the future. The care plan directed staff to

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F 661	Continued From page 33 talk about discharge, goals, and explore discharge options. The "Nurses Note", dated 04/26/23 at 12:35 PM, documented communication to the physician, R67 plans to return home the following Monday, and requested R67's medication prescriptions sent to the pharmacy so they could be picked up on the Monday of discharge. R67's EMR lacked evidence a discharge summary which included a recapitulation was developed. On 06/27/23 at 09:44 AM, Administrative Nurse D verified the facility used a discharge summary, which did not include a complete recapitulation of R67's stay. The facility's undated "Discharge Summary" policy, documented it was the policy of this facility that residents who have a planned discharge from the facility will have a completed discharge plan and recapitulation of stay completed to facilitate continuity of care after discharge. A comprehensive discharge summary will describe for the next provider the resident's course of stay, medical conditions and diagnose, the results of relevant laboratory and other diagnostic testing completed I the facility, consultations completed in the facility and medications prescribed at discharge. The facility failed to develop a discharge summary that included a recapitulation of the resident's stay for R67. This placed the resident at risk for unmet care needs.	F 661		
F 684 SS=D	Quality of Care	F 684		

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F 684	Continued From page 34 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents, with two reviewed for skin conditions not pressure related. Based on observation, record review, and interview, the facility failed to implement interventions to prevent skin tears for one sampled resident, Resident (R) 16, and the facility failed to protect skin to prevent bruises during a transfer for R65. This placed the residents at risk for further injury. Findings included: - The Electronic Medical Record (EMR) for R16 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and edema (swelling). The "Annual Minimum Data Set" (MDS), dated 02/13/23, documented R16 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting and extensive assistance of one staff for dressing, eating and personal hygiene. The MDS	F 684		

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further documented R16 had no skin issues.

The "Quarterly MDS," dated 05/03/23, documented R16 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of two staff for dressing, eating and personal hygiene. The MDS further documented R16 had skin tears.

The "Care Plan," dated 05/05/23, initiated on 04/27/22, documented R16 would lose her balance, fall, or bumped into things, and could not remember. The care plan directed staff to check her skin weekly, use a pressure distribution device air mattress, and ensure that R16 had a foot cradle on her bed to prevent the sheets from rubbing on her feet. The update, dated 05/22/23, directed staff to apply sleeve protectors during the day and take them off at night.

The "Investigation," dated 03/03/23 at 03:17 PM, documented R16 had a skin tear to her right forearm that staff had noticed while getting her ready for bed. The investigation further documented R16 had severely impaired cognition, was unable to state when or how the skin tear happened and education was given to staff.

The "Investigation," dated 04/19/23 at 03:04 AM, documented R16 had a skin tear on her left forearm which measured 1.5 centimeters (cm) x 1.2 cm and had a "V" shape. The area was cleansed with normal saline, adhesive closures were applied, covered with a non stick dressing and wrapped with gauze. The investigation documented, staff did not know if the skin tear happened when changing her clothes, and due to

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R16's severely impaired cognition, she was unable to state when or how the skin tear happened; education was given to staff.

The "Investigation," dated 04/28/23 at 07:10 PM, documented R16 had a skin tear on her right arm which measured 0.1 cm x 2.5 cm. The area was cleansed with normal saline, skin approximated, and two closure strips were applied. The investigation further documented staff were unsure when it happened.

The "Investigation," dated 05/22/23 at 11:24 AM, documented staff found a skin tear to R16's right forearm which measured 4.7 cm x 0.1 cm, during her shower, and staff were unsure how the skin tear was obtained.

On 06/26/23 at 08:57 AM, observation revealed R16 had sleeve protectors on her arms.

On 06/22/23 at 12:30 PM, Certified Nurse Aide (CNA) O stated R16 had to have sleeve protectors on her arms at all times because of skin tears.

On 06/26/23 at 02:17 PM, Licensed Nurse (LN) H stated when staff tell her there is a skin tear or bruise, she will complete an investigation by talking with the staff, the resident, and will look at the resident's environment to see if she can figure out what happened. LN H further stated R16 had to wear the sleeve protectors or wear long sleeve to protect her skin because it was so fragile.

On 06/27/23 at 09:45 AM, Administrative Nurse D stated staff should have implemented interventions to protect R16's skin.

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The facility's "Prevention of Pressure Ulcers/Injuries" policy, undated, directed staff to review the resident's care plan and identify the risk factors as well as interventions designed to reduce or eliminate those considered modifiable, inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living, evaluate, report, and document potential changes in the skin, and review the interventions and strategies for effectiveness on an ongoing basis.

The facility failed to idenifty and implement interventions to prevent skin tears for R16 until multiple skin tears were sustained over the course of several months. This placed the resident at risk for further injuries.

- The Electronic Medical Record (ER) for R65 documented diagnoses of compression fracture (when forced together bone surfaces caused a bone to break), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), interferer disc disorder (a breakdown of one or more of the discs that separate the bones of the spine), and inflammatory spindly (when the immune system attacks the spine an sometimes the joints of the arms and legs).

The "Admission Minimum Data Set" (MD'S), dated 06/13/23, documented R65 had intact cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R65 had no skin issues.

The "Care Plan," dated 06/05/23, documented R65 had the potential for skin injury and directed

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staff to check her skin weekly, use one staff, a gait belt, and a front wheeled walker for transfers, and keep skin healthy and intact.

The "Investigation," dated 06/21/23 at 06:50 AM, documented the bath aide found four bruises on the resident's upper inner arm and notified the charge nurse. The investigation further documented the bruises on the left upper arm which measured 5.0 centimeter (cm) x 3.0 cm, was dark purple in color, the next bruise measured 2.0 cm x 0.5 cm and was a medium shade of purple, the next bruise was 3.0 cm in diameter, and the next bruise down was 2.0 cm in diameter and was dark purple. Staff interviewed R65 who stated she thought it happened when an evening shift staff helped her to stand up. The investigation documented the family and physician were notified and told to monitor the bruises. Staff were educated on how to transfer residents, and no abuse or neglect was suspected.

On 06/22/23 at 08:30 AM, observation revealed R65 in her recliner with family at her side. The resident had four purple bruises on her upper left arm. When asked by this surveyor what happened to her arm, she stated, "No one beat on me, if that's what you are worried about!" and laughed. R65 stated the nurse had measured the bruises and took pictures, and stated, she bruised easily and thought it could have been from the blood pressure cuff or when assisted with a transfer.

On 06/26/23 at 02:43 PM, Certified Nurse Aide (CNA) M stated R65 had a lot of anxiety and did not like to have a lot of staff in her room around her. CNA M stated R65 came from the hospital

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F 684	Continued From page 39 with fractures in her back, was a one person transfer with a gait belt, walker, and staff should not to pull on the resident's arms. On 06/26/23 at 02:40 PM, Licensed Nurse (LN) I stated R65 had bruises from a younger staff person who had put the gait belt on the resident but did not use it when she was assisting her in a transfer. LN I further stated, R65 had a lot of anxiety and stated she did not want to get the staff member in trouble that had transferred her. On 06/27/23 at 09:45 AM, Administrative Nurse D stated staff were educated on proper transfer techniques and a mandatory meeting was scheduled in which transfers were part of the agenda. The facility's "Prevention of Pressure Ulcers/Injuries" policy, undated, directed staff to review the resident's care plan and identify the risk factors as well as interventions designed to reduce or eliminate those considered modifiable, inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living, evaluate, report, and document potential changes in the skin, and review the interventions and strategies for effectiveness on an ongoing basis. The facility failed to prevent bruises on R65's arm during a transfer, this placed the resident at risk for further bruising and injury.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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§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 66 residents. The sample included 18 residents, with 10 reviewed for falls. Based on observation, record review, and interview, the facility failed to ensure staff provided Resident (R)52 with his call light when he went to bed, resulting in a fall in which R52 obtained a right trimalleolar ankle fracture (a break in the lower leg section that form your ankle joint). The facility further failed to assess residents for safe lift chair use, after falls out of a lift recliner for R52 and R36. The facility failed to follow R36 and R46's plan of care which resulted in falls and failed to implement meaningful, resident centered interventions for R14 and R57. This placed the residents at risk for further falls and avoidable injuries.

Findings included:

- The Electronic Medical Record (EMR) for R52 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function), tremors (an involuntary quivering movement), and Parkinson's disease (a disorder of the central nervous system that affects movement).

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The "Admission Minimum Data Set" (MDS), dated 07/21/22, documented R52 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, ambulation, wheelchair mobility, toileting, and personal hygiene. The MDS further documented R52 had unsteady balance, no functional impairments, and had no falls.

The "Annual MDS," dated 05/15/23, documented R52 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. The MDS further documented R52 had unsteady balance, no functional impairment, and had two or more non-injury falls.

The "Fall Care Area Assessment [CAA]," dated 05/15/23, documented R52 wore non-skid shoes during the day and had a large landing mat in front of his recliner.

The "Fall Assessments," dated 07/14/22 and 05/15/23, document R52 at risk for falls.

The "Fall Care Plan," dated 05/19/23, initiated on 07/14/22, directed staff to remind him to ask for help, report changes in his abilities to the nurse, monitor his safety during activities. An update, dated 08/02/22, directed staff to ensure the skid strips were in place on the floor in front of R52's recliner. An update, dated 11/18/22, directed staff to ensure R52 wore non-skid shoes during the day. An update, dated 11/21/22, directed staff to ensure there was a landing mat in front of R52's recliner when he was in it. An update, dated 05/22/23, directed staff to monitor R52 every 30 minutes and make sure his bed was in low position.

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The "Fall Investigation," dated 08/02/22 at 12:25 PM, documented R52 slid out of his recliner and was on the floor in front of the recliner, with his legs out in front of him. The investigation further documented the fall was unwitnessed and R52 slid onto the floor when he raised his lift recliner into an upright position. It directed staff to place skid strips in front of the recliner. Review of the EMR lacked documentation an assessment was completed to determine R52's safe use of a lift chair.

The "Fall Investigation," dated 09/03/22 at 04:42 PM, documented R52 slid out of his recliner and obtained a laceration (cut) to the bridge of his nose and his forehead. The investigation documented staff reviewed safety measures with R52 and instructed him to call for assistance and directed him not to elevate his chair. The investigation documented staff felt it was doubtful R52 would retain the information they provided. The EMR lacked documentation an assessment was completed to determine R52's safe use of a lift chair.

The "Fall Investigation, dated 11/19/22 at 10:43 PM, documented R52 slid out of his recliner and staff observed him lying on the floor on his back. The investigation further documented the lift chair remote was clearly marked with up and down arrows on it. The investigation documented staff encouraged R52 to call for assistance prior to raising the chair up, but with R52's moderate impaired cognition, he may not always remember to call for assistance. The investigation directed staff to place a landing pad in front of R52's lift chair.

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The "Fall Investigation," dated 05/20/23 at 07:45 AM, documented R52 was found lying on his back on the left side of the bed with his head slightly up on a bedside table and his legs straight out in front of him. The investigation further documented R52 had an abrasion (scrape) to the outer right ankle which measured 4.0 centimeters (cm) by 2.0 cm, and an abrasion to the right side of his head with a small amount of bleeding present, which measured 9.0 cm by 4.0 cm. The investigation documented R52 complained of right ankle pain; there was swelling but no deformity noted. R52 stated he was getting up to get his call light, that was still in his recliner, to call for assistance and fell. The investigation documented R52's call light should always be in reach. The investigation further documented the facility sent R52 to the emergency room for evaluation and he returned at 12:00 PM with non-weight bearing orders, a splint, and orders to see an orthopedic doctor for surgical repair, as he had a right trimalleolar ankle fracture.

The "Witness Statement," dated 05/20/23 documented Certified Nurse Aide (CNA) M reported R52 used his call light to tell staff he was ready to go to bed. CNA M documented she was training another CNA and together, they assisted R52 from the recliner to his bed. CMA M stated staff forgot to give R52 his call light. CNA M further documented he did not check on R52 after placing him in bed because it was almost at the end of the shift.

The "Physician's Order," dated 05/25/23, directed staff to ensure strict elevation of R52's right foot/ankle, non-weight bearing of his right lower extremity, keep splint in place, and plan for a surgical fixation on 05/31/23.

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On 06/21/23 at 03:00 PM, observation revealed R52 sat in his recliner with his feet elevated, and a call light at his side. There was a fall mat in front of the recliner. Further observation revealed R52 had a fracture boot on his right leg. R52's representative was in the room and stated R52 broke his leg because he did not have his call light, when he was in bed.

On 06/26/23 at 12:30 PM, observation revealed CMA R and CNA N attached the sling underneath R52 to the full body lift. CNA M stood behind R52 to maneuver him to the recliner as CMA R used the lift controls to raise him up and take him to his recliner. Further observation revealed CMA R lowered R52 into his recliner, elevated his feet, gave him his call light, and put the fall mat in front of the recliner.

On 06/26/23 at 12:30 PM, CNA M stated R52 broke his leg trying to get to his call light when he was in bed. CNA M stated staff check on R52 every 30 minutes since the fall. CNA M further stated R52 had other falls out of his recliner when he would elevate the chair, but not since he broke his leg.

On 06/26/23 at 03:30 PM, Licensed Nurse (LN) G stated R52 had falls out of his recliner and staff tried to put a chair alarm in the recliner but as R52 elevated the recliner, the alarm pad would fall out, so staff took his alarm away. LN G further stated R52 had a fall with a fracture and the interventions after the fall were a low bed, 30-minute checks, and a fall mat in front of the recliner. LN G said staff made sure R52 had his call light and staff documented that, every shift, in the "Medication Administration Record."

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On 06/27/23 at 09:45 AM, Administrative Nurse D stated staff did not follow R52's care plan and did not give R52 his call light, resulting in a fall where R52 broke his leg. Administrative Nurse D further stated staff tried different interventions to prevent falls for R52 when he was in his recliner. Administrative Nurse D verified the facility had not completed an assessment for the safe use of lift chairs.

The facility's undated "Falls and Fall Risk Assessment" policy documented staff would document risk factors for falls in the resident's record and the physician would identify medical conditions affecting fall risks. The staff would evaluate, and document falls that occur while the individual was in the facility, identify them as witnessed or unwitnessed, and attempt to define possible causes of the fall. Based on the assessments, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If underlying causes could not be readily identified or corrected, staff would try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason was identified for its continuation. The staff would monitor and document the individual's response to interventions intended to reduce falls or the consequences of falling. If interventions have been successful in preventing falling, the staff would continue with current approaches or reconsider whether these measures were still needed if the problem that required the interventions had resolved. If the resident continued to fall, the staff and physician would re-evaluate the situation and consider other

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possible reasons for the resident's falls and would reevaluate the continued relevance of current interventions.

The facility failed to provide a safe environment for R52 when staff failed to place his call light within reach. As a result, R52 attempted to get his call light and subsequently fell and broke his leg. The facility further failed to assess R52's ability to safely use a lift chair after multiple lift chair related falls.

- The Electronic Medical Record (EMR) for R36 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), cerebral infarction (a disruption of blood flow to the brain due to problems with the blood vessels that supply it), major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS), dated 02/13/23, documented R36 had severely impaired cognition and required extensive assistance of two staff for bed mobility, toileting, and extensive assistance of one staff for transfers, ambulation, dressing, and personal hygiene. The assessment further documented R36 had unsteady balance, upper and lower functional impairment on one side, and had two or more non-injury falls.

The "Quarterly MDS," dated 05/02/23,

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documented R36 had severely impaired cognition and required extensive assistance of two staff for bed mobility, toileting, and extensive assistance of one staff for transfers, ambulation, mobility in his wheelchair, dressing, and personal hygiene. The MDS further documented had unsteady balance, upper and lower functional impairment on one side, and one non-injury fall.

The "Fall Assessments," dated 11/25/22 and 05/02/23, documented R36 was at risk for falls.

The "Fall Care Plan," dated 05/02/23, initiated on 07/25/22, directed staff to request a therapy screen if needed, use a bed alarm, stay with the resident during toileting, make sure his important items were within reach, assist R36 with transfers or when he walked, remind R36 to ask for help, and place a mat on the floor beside the bed in case he rolled out. The update, dated 01/16/23, directed staff to visualize R36 in the mornings at shift change. The update, dated 01/26/23, directed staff to use an alarm on his chair.

The "Fall Investigation," dated 01/26/23 at 07:45 PM, documented staff heard someone yelling for help and was R36 was discovered on the floor holding on to the footrest of the recliner, which was slightly open. The note further documented Social Services X and a Certified Nurse Aide (CNA) got R36 up and took him into the bathroom before a nurse could assess him for injuries. The investigation documented, due to R36's cognition, he did not always comprehend what was safe and had attempted to get up on his own without calling for assistance after his guest left.

The "Fall Investigation," dated 04/29/23 at 07:00 PM, documented R36 slid out of his recliner and

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education was provided to staff to make sure R36's chair alarm was under him when he is in his recliner. The investigation further documented R36 had severely impaired cognition and did not comprehend what was safe.

The "Fall Investigation," dated 05/28/23 at 09:30 PM, documented R36 was found on the floor in his room with the recliner controller in his hand; the chair was elevated in an up position. R36's drinks were spilled all over the floor, and he was still covered with a blanket he had on while in his recliner. The intervention directed to keep the remote for the recliner out of the resident's reach. The investigation further documented, R36 had severely impaired cognition and did not comprehend what was safe; it was felt by administration that keeping the recliner controller out of reach was not the appropriate intervention for this resident.

R36's EMR lacked evidence the facility assessed for safe use of a lift chair.

On 06/22/23 at 11:50 AM, observation revealed CNA O and CNA MM attached the sit to stand lift sling around the resident and hooked the sling to the lift. R36 HELD onto the handles and STAFF stood him up to transfer him to the toilet.

On 06/22/23 at 11:55 AM, CNA O stated R36 used to sit in his room but since he had falls, staff kept him in the living room area unless his family was visiting. CNA O stated R36 had falls out of his recliner; he would elevate the recliner and slide out.

On 06/26/23 at 12:22 PM, Licensed Nurse (LN) H stated R36's falls were out of his recliner, so now

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R36 stayed out in the living room area.

On 06/27/23 at 09:45 AM, Administrative Nurse D stated R36 had falls from his recliner and the facility had looked into doing the lift chair/recliner assessments. She said staff keep R36 in the living room area unless his family was with him in his room.

The facility's undated "Falls and Fall Risk Assessment" policy documented staff would document risk factors for falls in the resident's record and the physician would identify medical conditions affecting fall risks. The staff would evaluate, and document falls that occur while the individual was in the facility, identify them as witnessed or unwitnessed, and attempt to define possible causes of the fall. Based on the assessments, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If underlying causes could not be readily identified or corrected, staff would try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason was identified for its continuation. The staff would monitor and document the individual's response to interventions intended to reduce falls or the consequences of falling. If interventions have been successful in preventing falling, the staff would continue with current approaches or reconsider whether these measures were still needed if the problem that required the interventions had resolved. If the resident continued to fall, the staff and physician would re-evaluate the situation and consider other possible reasons for the resident's falls and would reevaluate the continued relevance of current

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interventions.

The facility failed to assess cognitively impaired R36 for safe lift chair use and failed to follow his plan of care which resulted in falls. This placed the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) for R46 documented diagnoses of dementia without behavioral disturbances (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and seizures (violent involuntary series of contractions of a group of muscles).

The "Annual Minimum Data Set" (MDS), dated 10/10/22, documented R46 had severely impaired cognition and required extensive assistance of two staff for transfers, dressing, toileting, and extensive assistance of one staff for bed mobility, ambulation, and personal hygiene. The assessment further documented R46 had unsteady balance, no functional impairment, had one fall with injury, and used a bed, chair, and wander alarm daily.

The "Quarterly MDS," dated 05/22/23, documented R46 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for mobility in her wheelchair, dressing and personal hygiene. The assessment further documented R46 had unsteady balance, no functional impairment, two or more non injury falls, and used a bed alarm daily.

The "Fall Assessments," dated 10/13/22 and

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05/22/23 documented R46 at risk for falls.

The "Care Plan," dated 05/23/23, initiated 07/27/22, directed staff to request a therapy screen if needed, monitor her toileting program, make sure important items are within reach, keep room well lit, use a bed and chair alarm, use a standard walker and use agait belt with one staff assistance. The update, dated 01/23/23, directed staff to not leave R46 unattended in the dining and activity room.

The "Fall Investigation," dated 10/08/22 at 04:45 PM, documented R46 was in the bathroom with staff and as the Certified Nurse Aide (CNA) pulled down R46's pants, R46 fell forward, landed on her knees, and sustained an abrasion (scrape) to her right knee. The investigation further documented R46's walker was in the southwest corner of the restroom away from the resident and when the nurse asked where the walker was positioned at the time of the fall, the CNA stated it was where it was located when the nurse entered the room. The nurse asked the CNA why it was not in front of the resident with the brakes locked, the CNA could not give an answer. The investigation documented the CNA was educated to have the resident's walker in front of her and the brakes locked when she was standing.

The "Fall Investigation," dated 06/01/23 at 06:05 PM, documented R46 was in the activity room in her wheelchair. Staff walked out of the room and when they returned, R46 scooted out of the wheelchair and was seated on the wheelchair pedals. The investigation documented R46 had severely impaired cognition and did not comprehend what was safe and staff were educated to follow R46's care plan.

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On 06/22/23 at 12:25 PM, observation revealed CNA O and CNA MM placed the sling of the sit to stand lift around the resident, attached it to the lift, and told R46 to hold onto the handles of the lift. Further observation revealed CNA O had to assist R46 by taking her hands and putting them on the lift handles to hold on. Continued observation revealed CNA MM stood R46 up and transferred her onto the toilet.

On 06/22/23 at 12:25 PM, CNA O stated R46 used to ambulate with her walker but can no longer do so and now used a Broda chair (positioning chair) for mobility. CNA O further stated R46 continued to try to self-transfer as she did not understand why she cannot do things on her own; staff were not to leave her anywhere unattended.

On 06/26/23 at 02:16 PM, Licensed Nurse (LN) H stated R46 would fall out of her wheelchair prior to having the Broda chair and staff were to be with her at all times during activities and not leave her in a room unattended.

On 06/27/23 at 09:45 AM, Administrative Nurse D verified staff had not followed the care plan and R46 had falls.

The facility's undated "Falls and Fall Risk Assessment" policy documented staff would document risk factors for falls in the resident's record and the physician would identify medical conditions affecting fall risks. The staff would evaluate, and document falls that occur while the individual was in the facility, identify them as witnessed or unwitnessed, and attempt to define possible causes of the fall. Based on the

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assessments, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If underlying causes could not be readily identified or corrected, staff would try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason was identified for its continuation. The staff would monitor and document the individual's response to interventions intended to reduce falls or the consequences of falling. If interventions have been successful in preventing falling, the staff would continue with current approaches or reconsider whether these measures were still needed if the problem that required the interventions had resolved. If the resident continued to fall, the staff and physician would re-evaluate the situation and consider other possible reasons for the resident's falls and would reevaluate the continued relevance of current interventions.

The facility failed to follow R46's plan of care which resulted in falls. This placed the resident at risk for further falls and injury.

- The "Medical Diagnosis" section in R14's Electronic Medical Record (EMR) included diagnoses of dorsalgia (back pain), scoliosis (curvature of the spine), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, fatigue,

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kyphosis (outward curvature of the spine), cervicalgia (neck pain), fracture of left clavicle (collarbone), shortness of breath, and panic disorder.

The "Significant Change Minimum Data Set" (MDS), dated 01/16/23, documented R14 had intact cognition, and required extensive assistance of one staff for activities of daily living (ADL). The MDS recorded R14 was not steady and was only able to stabilize with human assistance. R14had occasional incontinence of urine, received scheduled and as needed pain medication, and was short of breath with exertion. The MDS further documented R14 had one fall with no injury and one fall with injury.

The "Activity of Daily Living Care Area Assessment" (CAA), dated 01/16/23, documented R14's family chose comfort care due to R14's decline. R14 needed extensive assistance with most of her ADL, and was failing to thrive. R14 had falls on 08/15/22 and 10/14/22. The CAA further documented R14 took two antidepressants (class of medications used to treat mood disorders), a Fentanyl (narcotic pain medication) patch, and had as needed pain and antianxiety (class of medications that calm and relax people) medications

The "Quarterly MDS", dated 04/03/23, documented R14 had moderately impaired cognition.

The "Quarterly MDS", dated 06/13/23, documented R14 had severe cognitive impairment, had other behavioral symptoms not directed toward others, and required extensive assistance of one staff for ADL. R14, received

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scheduled, as needed, and non-medication interventions for pain, and had a fall with major injury.

The "Care Plan", dated 10/27/22, documented R14 had the potential to fall down and hurt herself because of fatigue. The nurses needed to request a therapy screen for R14 if needed, and the nurse aides were to keep R14's room well lit when she was up and to remind her to get up slowly. On 04/16/23 the care plan added intervention to stay with R14 during toileting. On 04/24/23 the care plan further documented R14 had not met her goal of avoiding major injury due to a clavicle fracture.

The "Fall Note" on 08/15/22 at 02:11 AM, documented the nurse heard a noise and R14 calling out for help. The nurse went to investigate and found R14 lying on her back in the bathroom with her head resting against the door frame. R14 had a hematoma to the right side of her head the size of a golf ball. R14 complained of pain in her head and buttocks. R14 was unable to tell the nurse what caused the fall. The note recorded R14 was independent, and had appropriate lighting and footwear on; her floor was clean and dry, and an assistive device (walker) was with the resident. The fall note further documented no new interventions at that time.

The "Fall Note", on 10/14/22 at 08:21 PM, documented R14 was getting ready for bed,and getting clothes to her closet, when she became unsteady and fell. R14 was sitting on her bottom with her head resting against the bed and her hand on her chest. R14 was very short of breath. Staff provided teaching on the use of the call light if R14 felt unsteady. The note documented no

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new interventions at that time, and stated the care plan was followed.

The "Fall Note" on 04/21/23 at 11:30 PM, documented the nurse heard R14 scream and went to investigate. The nurse found R14 lying on her left side with her left arm behind her. Her oxygen tubing was off, and there was candy scattered on the floor. R14 reported pain to her left arm and was unable to move her left arm without pain. R14 went to the emergency room. The note documented no interventions at that time. R14 returned from the hospital with a left clavicle fracture.

On 06/26/23 at 09:18 AM, R14 sat in her room, in a recliner. She wore oxygen via nasal cannula. R14 reported she no longer had shoulder pain from the fractured clavicle. She stated it was healed

On 06/26/23 at 12:14 PM observation revealed Certified Nurse Aide (CNA) O assisted R14 to the bathroom. CNA O assisted R14 to a wheelchair and wheeled the resident into the bathroom. CNA O assisted R14 with toileting needs and then returned the resident to her recliner. CNA O reported R14 was usually continent, and used her call light, but recently had been calling out for assistance.

On 06/27/23 at 09:40 AM, Administrative Nurse D stated the care plan had not been updated following the fall for R14 which resulted in a clavicle fracture. Administrative Nurse D and verified no new interventions were implemented to prevent further falls. Administrative Nurse D reported she had not reported the fall to the state agency because she thought if the care plan was

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followed, a report did not have to be made.

The facility's undated "Falls and Fall Risk, Managing" policy documented based on previous evaluations and current data, the staff will identify interventions related to resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

The facility failed to identify and implement interventions to prevent R14 from falling resulting in a major injury and placed the resident at risk of further falls.

- R57's Electronic Medical Record (EMR) recorded diagnoses of atrial fibrillation (rapid, irregular heartbeat), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (elevated blood pressure), anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), pain, sleep disorder, and dystonia (movement disorder that cause slow repetitive movements).

The "Quarterly Minimum Data Set", (MDS) dated 05/30/23, documented R57 had intact cognition, rejection of care behavior one to three days during the look back period, required extensive assistance with activities of daily living, was not steady and only able to stabilize with staff assistance, and used a walker. The MDS further

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documented R57 was frequently incontinent of urine, received an antidepressant (medication used to treat mood disorder) and hypnotic (medication used to induce sleep) on a routine basis. R57 used bed and chair alarms.

The "Fall Care Area Assessment" (CAA), dated 03/21/23, documented R57 had a history of multiple falls, impaired balance, impulsivity, anxiety disorder and depression (mood disorder). R57 had multiple falls from self-transferring and walking without assistance. R57 had a chair and bed alarm to alert staff when he was moving about and to stay with him during toileting.

The "Care Plan" dated 12/22/22, documented R57 needed assistance because of having physical challenges, and frequent falls. R57 had trouble making decisions. The care plan directed staff to transfer R57 with a gait belt, walk using a four wheeled walker; R57 wore a Wanderguard device (personal alarm which alerts staff when close to alarmed exits) on his left ankle. The care plan further documented R57 had the potential to fall and hurt himself because of Parkinson's disease. The care plan further directed staff to keep an eye on his behaviors, make sure the call light was within reach, establish an activity of daily living program, to stay with R57 during toileting, make sure glasses are within reach, encourage R57 to use assistance, and to report pain and behaviors to nurse.

R57's "Care Plan" documented an intervention dated 12/29/22which directed R57 used an alarm on his bed, chair and floor. On 01/20/23 the plan documented R57 was to use gripper socks at bedtime. On 02/16/23 the plan was updated to direct R57 had the potential to fall and hurt

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himself due to Parkinson's disease and dementia/Alzheimer's disease. An intervention dated 06/20/23 directed R57 used a self-locking wheelchair.

The "Fall Note," dated 01/20/23 at 01:48 AM, documented R57 had just been assisted by a Certified Nurse Aide (CNA) with getting ready for bed, and he was sitting in his recliner watching television. The CNA then went to assist R57's roommate. The CNA reported hearing a thud and R57 was sitting on the floor in front of his recliner. The fall note documented no actions were needed and direct staff to continue to observe resident. The care plan was updated for R57 to wear slipper socks at bedtime and to give R57 frequent reminders to call for assistance when getting up.

The "Fall Note" dated 01/20/23 at 10:34 PM documented staff checked on R57 because the room door was shut. R57 was sitting in his chair with blood on the floor and his left knee. R57's walker was folded and turned on its side. R57 informed staff he did fall. The pad alarm was on his table and unplugged enough not to alarm the pagers. R57 had previous skin issues to his left knee from a previous fall and had acquired new skin tears and abrasions to just below the left knee, left upper arm, left ankle and upper buttocks. The note documented R57 received education to use the call light and not to remove pad alarm from the chair.

The "Fall Note" dated at 02/02/23 at 05:10 AM documented staff were notified by the alarm and found R57 sitting on the floor in his room. R57 had an abrasion to his left knee, which was cleansed, and a dressing applied. The note

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documented action taken was to observe, teach use of call light, and safe use of devices. The intervention listed to adjust toileting schedule and staff to frequently remind R57 to use his call light for assistance for his safety.

The "Fall Note" dated 03/02/23 at 11:33 PM documented R57 was assisted to the bathroom with his walker and gait belt. R57 lost his balance and fell partially on the couch, landing on his left knee sustaining injury to left knee and first aid was immediately applied. The fall note documented no interventions at that time.

The "Fall Note" dated 03/28/23 at 12:49 PM documented staff observed R57 starting to stand up from his recliner when he fell on his left knee. Staff were not able to get to the resident before the fall. The nurse found R57 sitting on his couch. R57 reported he wanted to see what laundry had put in his closet. The fall note further documented staff educated R57 on the importance of using the call light; R57had a bed alarm and chair alarm. He often attempted to ambulate in his room without calling for assistance and to give frequent reminders to use the call light to call and wait for assistance. No interventions at that time.

The "Fall Note" dated 04/25/23 at 04:24 PM documented R57 was on his left knee in front of his bed. R57 reported he was trying to get into his wheelchair for supper and stated his call light was attached to his recliner and he should have used it. The chair alarm was working and answered promptly. The fall note further documented staff visited with R57 on the importance of using the call light to call staff for assistance and waiting for staff to get there to assist him. Resident verbalized understanding. No intervention was

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F 689	Continued From page 61 documented. On 06/26/23 at 03:38 PM observation revealed R57 sitting in his recliner watching television. R57 stated he had been admitted to the facility because of falling. He reported he was taking a sleeping pill and staff reported he had been walking around at night, but he does not remember this happening. R57 stated the facility wanted him to remain seated as the intervention to keep him from falling and when the alarms go off, they come running. He did report the staff remind him to use the call light and wait for assistance. R57 also reported he wanted to return home at the end of summer. On 06/27/23 at 09:45 AM Administrative Nurse D stated due to R57's intact cognition the facility had not implemented new interventions to prevent his falls. The facility's undated "Falls and Fall Risk, Managing" policy documented based on previous evaluations and current data, the staff will identify interventions related to resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The facility failed to identify and implement interventions to prevent R57 from falling which placed the resident at risk of further falls and injuries.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		

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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:
The facility had a census of 66 residents. The sample included 18 residents with two being reviewed for bowel/bladder incontinence, indwelling catheter (tube placed in the bladder to drain urine into a collection bag), and urinary tract

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infections (UTI). Based on observation, record review and interviews, the facility failed to provide Resident (R) 35 with sanitary catheter care while draining the urine drainage bag which placed R35 for risk of infection and cathter related complications.

Findings included:

-The "Medical Diagnosis" section within R35's Electronic Medical Record (EMR) included diagnoses of mild cognitive impairment, diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, benign prostatic hyperplasia (BPH-age-associated prostate gland enlargement that can cause urination difficulty) with lower urinary tract symptoms, mechanical complication of other urinary catheter, urinary incontinence, hematuria (blood in the urine), urine retention, and UTI.

The "Quarterly Minimum Data Set", dated 04/10/23, documented R35 had intact cognition, rejected care four to six days of the seven day look back period, and required extensive assistance of one staff for activities of daily living (ADLs). R35 was not steady and only able to stabilize with human assistance and used a walker for mobility. The MDS further documented R35 had an indwelling urinary catheter and was frequently incontinent of bowel. R35 took antianxiety and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression [(abnormal emotional state characterized by exaggerated

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feelings of sadness, worthlessness, emptiness and hopelessness]) medications daily.

The "Urinary Incontinence/Catheter Care Area Assessment" (CAA), dated 01/16/23, documented R35 had an indwelling catheter due to obstructive uropathy (obstructed urinary flow). The physician attempted to remove the catheter while R35 was in the hospital and facility but was unsuccessful due to urinary retention. R35 had no signs of infection or retention at that time.

The "Urinary Catheter Care Plan", dated 01/10/23, documented R35 had a catheter because of an obstruction. The care plan directed staff to offer fluids, provide care for the catheter, and to keep track of R35's urine output.

The "Physician Order" on 01/20/23, instructed staff to change the catheter and drainage bags monthly and to irrigate the catheter with 60 cubic centimeters (cc's) normal saline or sterile water daily in the evening.

The "Nurses Note", dated 01/25/23 at 02:32 PM, documented R35 received an antibiotic (medication used to treat infection), had a catheter in place, and was self- transferring from wheelchair to bed. The note further documented the nurse explained to R35 that self-transferring created a risk to pull on the catheter.

On 06/22/23 at 12:34 PM, observation revealed Certified Nurse Aide (CNA) P assisted R35 to his bathroom to empty the urine drainage bag. CNA P removed the urine drainage bag from the privacy bag attached to the lower part of the walker, laid it directly on the floor, without a barrier between the soiled floor and drainage bag.

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CNA P drained the urine into a urinal to measure the amount, then wiped the drainage spout with an alcohol swab and returned the soiled drainage bag to the privacy bag.

On 06/26/23 at 12:42 PM, observation revealed CNA Q assist R35 to his bathroom to empty the urine drainage bag. CNA Q removed the urine drainage bag from the privacy bag attached to the lower part of the walker, laid it directly on the floor, without a barrier between the soiled floor and drainage bag, to drain the urine from the tubing. CNA Q drained the urine into a urinal to measure the amount, then wiped the drainage spout with an alcohol swab and returned the drainage bag into the privacy bag.

On 06/26/23 at 03:30 PM, Licensed Nurse (LN) L stated the CNAs should not have laid the catheter drainage bag directly on the floor to drain the tubing.

On 06/26/23 at 03:36 PM, Administrative Nurse D stated she expected the staff not ensure the drainage bag was not placed directly on the floor to drain and measure the urine.

The facility's undated "Catheter Care" policy documented to never allow a catheter drainage bag or tubing on the floor or above the level of the bladder. The facility utilizes catheter bags with an anti-reflux valve to prevent urine from back flowing into the bladder.

The facility failed to provide sanitary catheter care by placing the drainage bag directly on the floor which placed R35 at risk for urinary tract infections and catheter related complications.

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F 699	Continued From page 66	F 699		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents, with one reviewed for post -traumatic stress disorder (PTSD-psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture). Based on observation, record review, and interview, the facility failed to ensure Resident (R) 36 received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident which placed the resident at risk for unmet behavioral health care needs. Findings included: - The Electronic Medical Record (EMR) for R36 documented diagnoses of PTSD, dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), cerebral infarction (a disruption of blood flow to the brain due to problems with the blood vessels that supply it), and major depression (abnormal emotional state	F 699		

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characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Quarterly MDS," dated 05/02/23, documented R36 had severely impaired cognition and required extensive assistance of two staff for bed mobility, toileting, and extensive assistance of one staff for transfers, ambulation, mobility in his wheelchair, dressing, and personal hygiene. The MDS further documented R36 had no behaviors and received antidepressant (medication that is used to treat mood disorders and relieve symptoms of depression) medication.

The EMR lacked documentation a Trauma Informed Care Assessment was completed for R36.

The "Care Plan," dated 05/02/23, imitated on 12/01/22, documented R36 was unaware of safety risks and directed staff to keep an eye on his behaviors. The EMR lacked documentation a care plan for R36's PTSD was developed.

The "Physician's Order," dated 11/25/22, directed staff to administer donepezil (cognition-enhancing medication), 10 milligrams (mg), by mouth, daily in the morning for dementia and directed staff to administer
Celexa (an antidepressant medication), 20 mg, by mouth, daily in the evening for depression.

The "Nurse's Note," dated 05/26/23 at 03:16 PM, documented R36 became agitated with his morning cares.

The "Nurse's Note," dated 06/14/23 at 04:11 PM,

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documented R36 was aggressive with staff during cares, hit and grabbed at staff several times during the shift. The note further documented staff explained what they were doing and out of nowhere, R36 started to hit and grab their arms.

The "Nurse's Notes," dated 06/22/23 at 04:32 PM, documented at lunch, R36 grabbed a staff members braid and pulled down on it. The noted further documented, staff were able to get the resident to let go by removing his hand from her braid.

On 06/26/23 at 12:22 PM, observation revealed staff pushed R36's wheelchair into the living room area in front of the television; R36 had no behaviors.

On 06/22/23 at -9:30 AM, Administrative Nurse E verified she had not developed a care plan for R36's PTSD and verified a trauma informed care assessment was not completed.

On 06/22/23 at 11:50 AM, Certified Nurse Aide (CNA) O stated R36 could be resistive of cares at times and staff tried to redirect him.

On 06/26/23 at 02:17 PM, Licensed Nurse (LN) H stated R36 had times of aggression, swung at staff and pulled hair. LN H further stated staff redirected him LN H said she was unaware of R36's PTSD diagnosis, and stated R36 did not receive mental health services.

On 06/26/23 at 03:36 PM, Social Services X stated she had discussed R36's PTSD with his representative and had spent time with the resident but due to transporting residents to their appointments, she had not completed any

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F 699	Continued From page 69 assessments or been involved with the care plan team to develop a care plan for direction to staff on what would trigger his PTSD. On 06/27/23 at 09:45 AM, Administrative Nurse D stated, the facility would complete Trauma Informed Care Assessment on residents with the diagnosis of PTSD and stated a care plan for R36's PTSD was now completed. Upon request, a policy for PTSD/Trauma Informed Care was not provided by the facility. The facility failed to ensure R36, who was diagnosed with PTSD, received trauma informed care and services for his behavioral health needs This placed the resident at risk for unmet behavioral health care needs.	F 699		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents, with five reviewed for dementia (progressive mental disorder characterized by failing memory, confusion) care. Based on observation, record review, and interview, the facility failed to provide the necessary treatment and services to attain or maintain the highest practicable physical and psychosocial well-being for Resident (R) 21, who had dementia and related behaviors. This placed	F 744		

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the resident at risk for decreased quality of life.

Findings included:

- The Electronic Medical Record (EMR) for R21 recorded diagnoses of dementia, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), other symptoms and signs involving cognitive functions and awareness, and Alzheimer's disease (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 05/08/23, documented R21 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for mobility, dressing, and personal hygiene. The MDS further documented R21 had no behaviors and received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication seven days of the look back period.

The "Care Plan," dated 05/12/23, initiated on 05/19/22, documented R21 had the inability to remember things that happened a short time ago, and the inability to make decisions. R21 had poor safety awareness, and the plan directed staff to watch to see if R21's behavior changed. The update, dated 08/12/22 directed staff to evaluate R21 for situational stressors, evaluate effectiveness of her medication and monitor her for adverse effects of the medications. It directed to record R21's behaviors, encourage her to participate in activities, and offer comfort and support. The care plan lacked documentation of R21's behaviors and lacked person centered

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approached to address behaviors.

The "Physician's Order," dated 06/08/21, directed staff to monitor for side effects of Cymbalta (antidepressant medication) and monitor for behaviors.

The "Physician's Order," dated 06/12/23, directed staff to administer Cymbalta, 20 milligrams (mg), 1 capsule, by mouth, for the diagnosis of anxiety.

The "Nurse's Note," dated 08/30/22 at 04:19 pm, documented R21 kicked towards another resident, though no contact was made. Staff told her it was inappropriate to kick towards people.

The "Nurse's Note," dated 10/21/22 at 02:02 PM, documented R21 kicked at another resident's wheelchair frame and staff told her that it was inappropriate and to not do it again.

The "Nurse's Note," dated 10/23/22 at 03:34 PM, documented R21 took papers off the desk at the nurse's station and attempted to look at them. The note further documented staff retrieved the papers and R21 attempted to take papers and food off the medication cart. The note documented staff took R21 to her room and told her not to take things off other people's places. At 04:34 PM, the note documented R21 left her room and another resident was in the hallway and R21 kicked at the other resident's wheelchair.

The "Nurse's Note," dated 02/24/23 at 03:02 PM, documented R21 was whistling and disturbing other resident's and staff took her to her room.

The "Nurse's Note," dated 02/26/23 at 02:25 PM, documented R21 was whistling in the dining room

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upsetting other residents, staff asked her to stop but she continued to whistle. The note further documented R21 was taken to her room, her call light given, and staff explained that it hurt other resident's ears and she replied, "I don't care."

The "Nurse's Note," dated 03/02/23 at 02:37 PM, documented R21 was whistling and it disturbed other resident's, and she was taken to her room.

The "Nurse's Note," dated 03/05/23 at 01:36 PM, documented R21 whistled despite nursing staff asked her to quit. The note documented at 04:36 PM, R21 was asked by staff and residents to stop whistling, she refused, and staff took her to her room, and gave her call light and a magazine. The note further documented the intervention only lasted a short time and R21 began to whistle again until her family came in the afternoon to visit. The note documented, later in the dining room, R21 began to holler and progressively got louder. Staff asked R21 if she needed anything and she stated "No."

The "Nurse's Note," dated 03/14/23 at 12:11 PM, documented R21 whistled while in the dining room, other residents had already voiced that it was agitating to them, especially those with hearing aids. The note documented staff asked her multiple times to stop and she was taken back to her room, given her call light, lunch tray, and she stopped whistling.

The "Nurse's Note," dated 03/26/23 at 01:05 PM, documented R21 whistled in the common area, was asked to stop by staff because other residents complained of this behavior. The note further documented staff took R21 to her room, gave her a call light and a magazine.

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The "Nurse's Note," dated 04/06/23 at 09:19 PM, documented R21 whistled in the hallway after dinner, was asked to stop by two staff members due to it hurt other resident's ears. The note documented staff told R21 that if she wished to keep whistling, she needed to do it in her room. R21 stated she did not want to go to her room and would stop whistling. The note documented R21 stopped whistling until the nurse walked away, and then she continued to whistle.

The "Nurse's Note," dated 04/09/23, documented R21 was observed kicking the bird cage; she was asked to sit and watch them, and not kick the cage. The note further documented R21 continued to kick the glass, and staff took her to her room.

The "Nurse's Note," dated 04/26/23 at 03:42 PM, documented R21 whistled even after she was asked to stop. R21 started crying, and stated she never did anything right.

The "Nurse's Note," dated 05/06/23 at 03:08 AM, documented on the previous evening, R21 was in another resident's room and was assisted out by staff. The note further documented R21 went back into the other resident's room, and again was taken out by staff. The note documented, after R21 was taken out of the room, and while out in the hallway, she pulled on another resident's hair.

The "Nurse's Note," dated 05/11/23 at 03:44 PM, documented R21 was rude to another resident during breakfast and staff moved her to another table.

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The "Nurse's Note," dated 05/14/23 at 10:55 AM, documented at 09:30 AM, R21 wheeled herself in front of another resident; staff asked her to move away from the other resident, in which she did not move away but wheeled closer and leaned toward the other resident's face and said, "move out of my way." Staff intervened and moved R21 away. The note documented R21 began to whistle and upset other residents and staff took her to her room.

The "Nurse's Note, "dated 06/06/23 at 04:02 PM, documented R21 whistled in the hallway, other residents complained and asked her to stop. The further documented R21 refused and staff told her that if she did not stop she would need to go to her room. The note documented R21 got into the nurse's face and whistled loudly, and staff took her to her room.

On 06/22/23 at 12:04 PM, observation revealed R21 sat in her wheelchair in the living room area and had no behaviors at that time.

On 06/22/23 at 12:40 PM, Certified Nurse Aide (CNA) O stated R21 liked to whistle, and it often disturbed other residents. CNA O said R21 had no other behaviors, and staff take R21 to her room when she has behaviors.

On 06/26/23 at 02:18 PM, Licensed Nurse (LN) H stated R21 liked to whistle and it disturbed other residents. LN H said sometimes R21 would get into other residents' faces and whistle. LN H said most of the time R21 would stop when asked to stop but when she did not, staff took her to her room.

On 06/26/23 at 03:31 PM, Social Services X

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F 744	Continued From page 75 stated when R21 had behaviors, she stepped in and helped staff redirect . Social Services X said provided 1:1 with R21. Social Services X stated R21 did not receive any mental health services. On 06/27/23 at 09:45 AM, Administrative Nurse D stated R21 whistled and upset other residents. Administrative Nurse D said staff would work on other interventions for R21's behavior and verified R21 did not receive any additonal behavioral or mental health services. Upon request, a policy for dementia care was not provided by the facility. The facility failed to provide the necessary dementia care and services for R21, who had dementia related behaviors. This placed the resident at risk for decreased quality of life.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, 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	F 756		

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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 had a census of 66 residents. The sample included 18 residents, with six reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure the Pharmacy Consultant addressed the facility's lack of assessing and monitoring behaviors and side effects for Resident (R) 60's use of Haldol (antipsychotic medication class used to treat major mental disorder characterized by a gross impairment in reality and other mental emotional conditions). This deficient practice placed the resident at risk for unnecessary psychotropic (alters mood or thought) medication.

Findings included:

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- R60's Electronic Health Record (EHR) documented diagnoses of schizophrenia (a psychiatric disorder that affects a person's ability to think, feel, and behave clearly).

The "Admission Minimum Data Set" (MDS), dated 05/08/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The MDS documented the resident received antipsychotic medication on a routine basis, and had verbal behaviors, hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) and delusions (a false belief or judgment about external reality).

The "Black Box Warning (BBW-most stringent warning for drugs and alert to serious side effects, such as injury or death) Care Plan," dated 05/08/23, documented the use of antipsychotic medications.

The "Physician Order Sheet (POS)," dated 05/04/23, directed staff to administer Haldol 3 milligrams by mouth at 09:00AM and 09:00 PM daily for diagnosis of schizophrenia.

Review of R60's EHR for May 2023 and June 2023, laced evidence of behavior monitoring, and lacked evidence staff monitored for adverse side effects of the administration of Haldol.

The "Registered Pharmacy Consultant Visit" on 06/05/23 lacked recommendations to the facility regarding the lack of monitoring of adverse side effects and behaviors for the use of the Haldol.

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F 756	Continued From page 78 On 06/27/23 at 07:45AM, observation revealed R60 sat on a dining chair in the dining room with no behaviors noted. On 06/26/23 at 08:40AM, Licensed Nurse (LN) G verified the lack of documentation or monitoring of adverse reactions or behaviors for the use of the Haldol. On 06/27/23 at 09:10AM, Administrative Nurse D verified the facility lacked documentation and monitoring of the resident for behaviors and potential side effects for the use of the Haldol. The facility's undated "Psychotropic Medication Use" policy, documented residents receiving antipsychotic medications are to be assessed for adverse reactions and behaviors and to document on the MAR (Medication Administration Record). The facility's undated "Consultant Pharmacy" policy, documented residents are to have medications reviewed monthly by the Registered Pharmacist and recommendations are to be provided to the facility and the resident's physician. The facility's Pharmacy Consultant failed to ensure the facility was assessing and monitoring R60's use of Haldol, placing the resident at risk for adverse side effects.	F 756		
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	F 758		

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	175376	A. BUILDING _____ B. WING _____	06/27/2023

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processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

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

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

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

§483.45(e)(4) PRN orders for psychotropic drugs 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.

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§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 66 residents. The sample included 18 residents, with six reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to assess and monitor behaviors and side effects related to Resident (R) 60's use of Haldol (antipsychotic medication class used to treat major mental disorder characterized by a gross impairment in reality and other mental emotional conditions). This deficient practice placed the resident at risk for unnecessary psychotropic (alters mood or thought) medication.

Findings included:

- R60's Electronic Health Record (EHR) documented diagnoses of schizophrenia (a psychiatric disorder that affects a person's ability to think, feel, and behave clearly).

The "Admission Minimum Data Set" (MDS), dated 05/08/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The MDS documented the resident received antipsychotic medication on a routine basis, and had verbal behaviors, hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) and delusions (a false belief or judgment about external reality).

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The "Black Box Warning (BBW-most stringent warning for drugs and alert to serious side effects, such as injury or death) Care Plan," dated 05/08/23, documented the use of antipsychotic medications.

The "Physician Order Sheet (POS)," dated 05/04/23, directed staff to administer Haldol 3 milligrams by mouth at 09:00AM and 09:00 PM daily for diagnosis of schizophrenia.

Review of R60's EHR for May 2023 and June 2023, lacked evidence of behavior monitoring, and lacked evidence staff monitored for adverse side effects of the administration of Haldol.

On 06/27/23 at 07:45AM, observation revealed R60 sat on a dining chair in the dining room with no behaviors noted.

On 06/26/23 at 08:40AM, Licensed Nurse (LN) G verified the lack of documentation or monitoring of adverse reactions or behaviors for the use of the Haldol.

On 06/27/23 at 09:10AM, Administrative Nurse D verified the facility lacked documentation and monitoring of the resident for behaviors and potential side effects for the use of the Haldol.

The facility's undated "Psychotropic Medication Use" policy, documented residents receiving antipsychotic medications are to be assessed for adverse reactions and behaviors and to document on the MAR.

The facility failed to ensure appropriate assessment and monitoring for R60's use of Haldol, placing the resident at risk for adverse

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F 758	Continued From page 82 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 had a census of 66 residents. The sample included 18 residents. Based on observation, record review and interview the facility failed to prevent medication administration errors for Resident (R) 10 when staff crushed and mixed his medications and placed them in R10's food. This deficient practice placed R10 at risk for adverse reactions by not receiving the appropriate amount of medications prescribed. Findings included: - R10's Electronic Medical Record (EMR), documented diagnoses of epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), bipolar disorder (a disorder with episodes of mood swings ranging from depressive lows to manic highs), and anxiety disorder (mental health disorder with feelings of worry, anxiety, or fear that interferes with daily activities). The "Quarterly Minimum Date Set" (MDS), dated 03/27/23, documented a Brief Interview for Mental Status (BIMS) score of seven indicating severely impaired cognition. The MDS documented R10 required extensive assistance with transfers and locomotion and rejected care one to three days of the look back period.	F 760		

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The revised "Safety Care Plan," dated 06/03/23, instructed staff to keep the resident safe if a seizure occurred and to provide seizure medication as ordered.

The "Physician Orders," dated 06/01/23, documented to administer the following medications:
Keppra (an anticonvulsant medication to prevent seizures) 500 milligrams (mg) by mouth (PO) two times a day (BID)
Docusate Sodium (stool softener medication)100mg PO BID
Risperidone (antipsychotic medication) 2.5 mg PO BID
Depakote (seizure medication) 125 mg capsule delayed release PO BID,
Tylenol (pain medication) 500 mg PO in the evening,
Zoloft (an antidepressant medication) 100mg PO in the evening,

R10's EMR lacked an order to crush and mix medications.

The "Nurses Note" dated 06/19/23 at 07:55PM, documented R10's evening medications were crushed and mixed in his meat sandwich during the supper meal. The note recorded R10 ate half of the sandwich therefore half of R10's medications were received.

The "Nurses Note", dated 06/21/23 at 07:22PM, documented R10's evening medications were crushed and mixed in the tartar sauce and placed on his fish sandwich. The note further documented R10 ate half of the fish sandwich therefore he technically received half of his

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medication.

Review of R10's "Medication Administration Record" (MAR) revealed documentation on 06/19/23 and 06/21/23 that R10 received half of his evening medication.

According to the Food and Drug Administration for the medications Keppra, Risperidone and Depakote, crushing the medications was discouraged.

On 06/27/23 at 08:00AM, observation revealed R10 seated in his wheelchair at a dining table.

On 06/22/23 at 08:15AM, Licensed Nurse (LN) G stated, depending on R10's mood, R10's medications were sometimes crushed and placed in his food.

On 06/27/23 at 09:15AM, Administrative Nurse D verified the documentation on 06/19/23 and 06/21/23, regarding R10's medications being crushed and placed in his meals. Administrative Nurse D verified this practice of medication administration was inappropriate.

The undated facility policy, "Medication Administration", stated medications are to be administered as prescribed by the resident's physician. All medication errors should be reported.

The facility failed to administer R10's medications in an appropriate manner when staff crushed and mixed the medications without an order, and placed in the resident's food. This deficient practice placed R10 at risk for inappropriate doses of the medications and decreased

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F 760	Continued From page 85 effectiveness.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to prepare pureed foods (a texture-modified diet in which all foods have a soft, pudding-like consistency) by methods that conserve nutritive value, flavor, and appearance for nine residents who received pureed diets placing the residents at risk for inadequate nutrition. Findings included: - On 06/22/23 at 08:35 AM, observation revealed Dietary Staff (DS) CC prepare pureed meal for nine residents. DS CC placed nine plus servings of refrigerated meatloaf into a blender, then added milk from a gallon jug, blending the mixture until desired consistency. DS CC placed the blended meat into serving pans placing additional milk on top of the mixture before placing in the oven for heating.	F 804		

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F 804	Continued From page 86 On 06/26/23 at 02:16 PM DS BB stated DS CC should have used beef broth to puree the meat. DS BB stated the facility was getting used to using the recipes obtained recently from a consulting diet source. The pureed meat recipe instructions directed to combine beef base and water to make a broth, place portions in a sanitized food processor and to add bread and broth and to blend until smooth. The facility's "Pureed" policy, dated 2022, documented the actual processing of pureed food is a simple task when the right equipment and proper techniques are used. It is important to follow the recipe or any community policy/procedure regarding pureeing foods. The facility failed to prepare foods by methods that conserve palatable and nutritive value for nine residents who received a pureed diet, placing the residents at risk for inadequate nutrition.	F 804		