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	175174	A. BUILDING _____ B. WING _____	07/19/2023

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 08/01/23.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/01/2023

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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(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 120 residents. The sample included 24 residents. Based on observation, record review, and interview, the facility failed to notify the physician of daily weight variances for Resident (R) 55, and R106, and failed to notify the physician of multiple days of fluid overage for R71, who was on a fluid restriction. This placed the residents at risk for physical decline due to delayed physician involvement.

Findings included:

- The Electronic Medical Record for R55 documented diagnoses of hypertension (high blood pressure), chronic kidney failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), and congestive heart failure (CHF-a condition in which the heart doesn't pump blood as well as it

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should).

R55's "Significant Change Minimum Data Set" (MDS), dated 03/18/23, documented R55 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, ambulation, and supervision and set-up assistance for eating. The MDS recorded R55 had no weight loss or gain.

The "Quarterly MDS," dated 06/14/23, documented R55 had intact cognition and required limited assistance of one staff for bed mobility transfers, and ambulation. R55 was independent with set-up assistance for eating and had no weight loss or gain.

The "Care Plan," dated 06/21/23, initiated on 11/08/20, documented R55 was on a two-liter fluid restriction, and was on medication to help manage his fluid retention. The care plan directed staff to obtain daily weights, monitor and document intake and output as per the facility policy.

The "Physician's Order," dated 01/13/23, directed staff to obtain daily weight upon rising, call the physician to notify for a three- pound (lb) weight difference (gain or loss), and document in the progress notes.

Review of the "Medication Administration Record" for June 2023 documented the following weights which reflected a gain or loss of three or more pounds that the physician was not notified.
06/15/23-209.6
06/16/23-213.1- weight gain of 3.5 lbs.

Review of the "Medication Administration Record"

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for July 2023 documented the following weights which reflected a gain or loss of three or more pounds that the physician was not notified.
07/07/23-214 lbs
07/08/23-217.6 lbs - weight gain of 3.6 lbs
07/11/23-214.1 lbs
07/12/23-217.1 lbs-weight gain of 3 lbs

On 07/17/23 at 09:42 AM, observation revealed a pitcher with approximately 700 milliliters (ml) of water on R55's bedside table in his room.

On 07/17/23 at 10:00 AM, Licensed Nurse H stated, if the resident had a three- pound weight loss or gain, staff were supposed to contact the physician and document in the progress notes.

On 07/19/23 at 09:20 AM, Administrative Nurse D stated staff were to follow the physician's order for the residents three-pound weight gain.

The facility's "Protocol for Notification of a Physician, " policy dated November 2014, documented the policy provides an appropriate procedure for physician notification. The physician would be notified of edema -known history of edema with progressive unilateral or bilateral increase; gradually progressive edema with weight gain.

The facility failed to notify R55's physician, as ordered, of his more than three-pound weight gain or loss four times in the past 30 days, placing R55 at risk for health issues related to congestive heart failure.

- R106's Electronic Medical record (EMR) documented diagnoses of congestive heart failure (CHF-a condition in which the heart

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muscle can't pump enough blood to meet the body's needs for blood and oxygen), end stage renal disease (ESRD-a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for dialysis or a transplant), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS), dated 04/19/23, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R106 required supervision for dressing and was independent with all other activities of daily living.

The "Nutrition Care Plan," dated 04/25/23, directed staff to obtain the resident's weight on non-dialysis (procedure where impurities or wastes were removed from the blood) days.

The "Physician Order," dated 06/23/22, for a diagnosis of CHF, directed staff to obtain weight on non-dialysis days upon rising; call the physician to notify them of a plus or minus three-pound (lb.) weight difference, and document in a progress note.

R106's EMR recorded the following weights with a three lb. difference:
03/21/23 4.4 lb. gain; no documentation of physician notification.
04/22/23 4 lb. loss; no documentation of physician notification
05/16/23 3.4 lb. loss; no documentation of physician notification
06/18/23 3.6 lb. gain: no documentation of physician notification

On 07/17/23 at 08:35 AM, observation revealed

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staff served R106 breakfast in his room. He had scrambled eggs, French toast, oatmeal, two slices of bacon, coffee, and water.

On 07/18/23 at 01:47 PM, Licensed Nurse (LN) K verified staff had not notified the physician of the weight gain or loss of more than three lbs. on four of six days.

On 07/19/23 at 10:12 AM, Administrative Nurse D stated staff should follow the physician direction and notify him/her of the gain or loss as ordered.

The facility's "Protocol for Notification of a Physician, " policy dated November 2014, documented the policy provides an appropriate procedure for physician notification. The physician would be notified of edema -known history of edema with progressive unilateral or bilateral increase; gradually progressive edema with weight gain.

The facility failed to notify R106's physician, as ordered, of his more than three-pound weight gain or loss four times in the past 120 days, placing R106 at risk for health issues related to congestive heart failure.

- R71's Electronic Medical Record (EMR) recorded diagnoses of end stage renal disease (decline in kidney function) and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

R71's "Admission Minimum Data Set" (MDS)," dated 06/14/23, recorded R71 had a Brief

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Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded she was independent with bed mobility, dressing, toileting, and personal hygiene. The MDS further recorded R71 received dialysis (procedure where impurities or wastes were removed from the blood) treatment.

The R71's EMR lacked a dialysis care plan.

The "Treatment Administration Record" (TAR) dated July 2023, documented staff recorded the resident's fluid intake three times a day. The physician order 1300 milliliters (ml) Monday thru Friday and 1000ml fluid restriction on Saturday and Sundays.

The "Physician Order," dated 07/21/22, documented R71 had fluid restriction of 1300 ml a day, Monday thru Friday and 1000 ml on Saturday and Sunday

The facility's "Fluid Intake" revealed the following days the resident received greater than the physician ordered 1300 ml/day:
05/04/23 - 1350 ml
05/05/23 - 1350 ml
05/08/23 - 1350 ml
05/10/23 - 1350 ml
05/12/23 - 1650 ml
05/17/23 - 1600 ml
05/22/23 - 1650 ml
05/29/23 - 1450 ml
05/30/23 - 1550 ml
06/01/23- 1550 ml
06/09/23 - 1400 ml
06/14/23 - 1650 ml
06/22/23 - 1350 ml
06/23/23 - 1400 ml

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06/28/23 - 1580 ml
06/29/23 - 1580 ml
7/17/23 - 1450 ml

The facility's "Fluid Intake" revealed the following days the resident received greater than the physician ordered 1000 ml/day:
05/20/23 - 1150 ml.
05/21/23 - 1450 ml
05/27.23 - 1300 ml
06/03/23 - 1500 ml
06/04/23 - 1500 ml
06/10/23 - 1050 ml
07/01/23 -1380 ml
07/02/23 - 1350 cc
07/16/23 - 1240 ml

R71's EMR lacked acknowledgement of follow up or notification to physician related to exceeding the physician ordered fluid amounts as listed above.

On 07/18/23 at 11:45 AM, observation revealed R71 sat on the side of her bed awaiting staff to deliver her lunch. R71 was dressed in a housecoat. Continued observation revealed the resident had an artery-vein (AV) fistula (a special connection that is made by joining a vein onto an artery) in her rt upper arm, covered with a gauze dressing and tape. R71 had a stainless-steel water cup on the bedside table with approximately 16 ounces of fluid.

On 07/18/23 at 12:30 PM Licensed Nurse (LN) L verified R71 received dialysis three times a week on Monday, Wednesday and Friday. Administrative Nurse D verified the resident was on a 1300 ml fluid restriction Monday thru Friday and 1000ml fluid restriction on Saturday and

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Sunday. LN L verified the resident had exceeded the physician order amount of fluids multiple times over the last three months and the facility had not notified the physician. LN L stated the physician should have been notified.

On 07/18/23 at 12:15 PM, Administrative Nurse D verified R71 received dialysis three times a week on Monday, Wednesday and Friday. Administrative Nurse D verified the resident was on a 1300 ml fluid restriction Monday thru Friday and 1000 ml on Saturday and Sunday, and the facility intake documentation revealed she had received greater than the 1300 ml or 1000 ml multiple times in the last few months.

The facility's "Care and Assessment of a Resident Receiving Hemodialysis Procedure," policy, dated November 2014, documented the facility would provide an appropriate procedure comply with professional standards and guidelines and provide safe care to a resident on dialysis. Residents receiving hemodialysis would be weighed on a daily basis and staff would record daily intake.

The facility's "Protocol for Notification of a Physician, " policy dated November 2014, documented the policy provides an appropriate procedure for physician notification. The physician would be notified of edema -known history of edema with progressive unilateral or bilateral increase; gradually progressive edema with weight gain.

The facility failed to notify R71's physician the resident exceeded the ordered 1300 ml and 1000 ml fluid restriction, placing the resident at risk for complications and health decline while receiving

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F 580	Continued From page 9 dialysis treatment.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		

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1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 120 residents. The sample included 24 residents. Based on observation, recrod review, and interview, the facility failed to provide a clean environment for two sampled residents, Resident (R) 66 and R7, who had wheelchairs which were soiled with dried food particles. This placed the affected residents at risk for impaired comfort and/or dignity.

Findings included:

- On 7/17/23 at 08:50 AM, observation revealed R66's wheelchair had dried food particles and stains on the sides of her seat that looked to be from several food services.

On 07/17/23 at 09:00 AM, observation revealed R7's high back wheelchair had dried fluid stains in the center of his wheelchair cushion.

On 07/18/23 at 07:30 AM, observation revealed R7's high back wheelchair continued to have the same dried fluid stains on his wheelchair.

On 7/18/23 at 08:30 AM, observation revealed R66's wheelchair continued to have the same dried food particles and stains on the sides of her seat.

On 07/18/23 at 09:30 AM, Licensed Nurse (LN) G stated the wheelchair's were cleaned weekly on night shift. LN G said she had also noticed the

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F 584	Continued From page 11 wheelchairs were dirty and needed to be cleaned. On 07/19/23 at 09:15 AM, Administrative Nurse D stated the wheelchair's were cleaned weekly on night shift but if the chairs were soiled before the scheduled cleaning time, the chairs should be cleaned by staff. The facility "Environmental Household Issues" policy, dated 11/20/14, documented that residents have the right to live in a safe, clean environment and each household was responsible for creating a plan to ensure a safe and clean environment for each resident. The facility failed to provide a clean environment for two sampled residents, R7 and R66, whose wheelchairs were dirty two of the four days in the facility. This placed the affected residents at risk for impaired comfort and/or dignity.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		

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paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 120 residents. The sample included 24 residents. Based on observation, interview, and record review, the facility failed to notify the Long-Term Care Ombudsman (LTCO) when Resident(R) 53 discharged to the hospital. This placed the resident at risk for decreased autonomy and quality of life.

Findings included:

- R53's "Physician Order Sheet" (POS), documented diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and heart failure.

R53's "Quarterly Minimum Data Set" (MDS), dated 06/07/23 documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS documented the resident required extensive assistance of one staff with most activities of daily living
(ADLs).

The "ADL Care Plan," dated 04/28/23 documented the resident had an ADL self-care performance deficit due to weakness and required extensive assistance with personal hygiene and staff used a sit to stand lift of one to move between surfaces.

The "Nurses Note," dated 06/23/23 at 07:26 PM, documented the resident had a change in mental

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status while utilizing the sit to stand lift while on the toilet. The resident attempted to pass a bowel movement at the time and was found to be very lethargic (excessive sleepiness) and had rapid breathing. Staff assisted R53 to lay down in bed; the resident continued to be lethargic (excessively tired), but verbally communicating. The nurse applied oxygen per nasal cannula and called the on-call physician. The physician gave an order to release to the emergency room (ER) if family chose to do that, or to keep the resident at the facility and continue to monitor. The Durable Power of Attorney (DPOA) declined the ER visit and decided to keep the resident at the facility to continue to monitor her, and to report back to him if the resident oxygen continued to decline or if she was verbally unresponsive. The staff continued to assess the resident.

The "Nurses Note," dated 06/23/23 at 09:22 PM, documented the resident ' s oxygen saturation levels dropped to the mid 80s (normal range 90-100%) and the resident was provided two liters of oxygen per nasal cannula. The resident remained lethargic which was different from baseline, but verbally responsive when spoken to. The DPOA was updated and authorized the resident to be sent to the ER per facility transport vehicle.

The "Nurses Notes," dated 06/26/23 at 01:57 PM, documented the resident returned to the facility after the hospital stay.

The facility was unable to provide documentation that staff notified the Ombudsman of the resident's transfer to the hospital.

On 07/18/23 at 02:30 PM, Administrative Staff A

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F 623	Continued From page 16 stated the facility failed to send the ombudsman notice for R53 when she was discharged to the hospital on 06/23/23. Administrative Staff A said she was aware the facility should send the notices of discharges to the LTCO. The facility ' s "Healthcare Move In, Transfer and Planned Move out," policy, dated November 2014, documented all persons seeking to move into a household at the facility would be treated with respect and recognition of their uniqueness as an individual regardless of the race, color, creed. national origin, age. sex, religion, handicap, ancestry, martial or veteran status, and /or payment. The purpose of the policy is to provide appropriate guidelines moving in, transferring and the planned moving out of a resident. The policy documented the Long-Term Care Ombudsman would be provided with a list of all residents that have left the facility at least monthly. The facility failed to notify the office of the LTCO of R53's discharge to the hospital, placing the resident at risk decreased autonomy and quality of life.	F 623		
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	F 656		

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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 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 120 residents. The sample included 24 residents. Based on

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observation, record review, and interview, the facility failed to develop an individualized comprehensive person-centered care plan related to Resident (R)26's aspiration (an inflammatory condition of the lungs caused by inhaling foreign material or vomit) risk and R71's dialysis (procedure of removing extra fluid and waste product from the blood) treatment which placed R26 and R71 at risk for unmet care needs.

Findings included:

- R26's Electronic Medical Record (EMR) documented diagnoses of gastro-esophageal reflux disease (GERD- backflow of stomach contents to the esophagus), obstructive sleep apnea (absence of breathing), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), personal history of transient ischemic attack (TIA- episode of cerebrovascular insufficiency), muscle weakness, chronic kidney disease (CKD), congestive heart disease (CHF- a condition with low heart output and the body becomes congested with fluid) and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) severe with agitation.

The "Quarterly Minimum Data Set" (MDS), dated

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06/13/23, documented R26 had moderately impaired cognition, required extensive to total assistance with activities of daily living, and ate independently with set up assistance. The MDS further documented R26 had coughing or choking during meals or when swallowing medications and received daily insulin (medication used to lower blood sugar levels), antipsychotic (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions), antidepressant (class of medications used to treat mood disorders), an anticoagulant (blood thinner), and diuretics (medication to promote the formation and excretion of urine).

The "Significant Change Nutritional Status Care Area Assessment" (CAA), dated 03/24/23, documented R26 had recently experienced a recent significant change in status demonstrated by increased weakness, had not experienced significant weight changes for review, although R26 refused or missed meals. The CAA further documented no chewing or swallowing complications, received a low concentrated sugar regular texture diet with thin liquids, and was able to consume foods and fluids with staff set up.

The "Nutritional Care Plan" dated 06/22/22, documented a potential problem related to dementia, COPD, change in condition, and was at risk for weight fluctuations related to taking a diuretic. The care plan directed staff to monitor/record/report to physician signs and/or symptoms of malnutrition. On 07/14/23, the care plan added for staff to provide a low concentrated sweet diet, blended textures, and nectar thick liquids as ordered, and to monitor intake and record every meal. On 07/16/23 the care plan

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recorded an addition of R26 to receive nectar thick liquids per speech therapy.

The "Progress Note", dated 05/09/23 at 10:05 PM, recorded the staff continued to monitor R26 after an aspiration episode on the previous shift. R26's voice was notably different, as though needing to clear throat. Staff attempted to instruct R26 to deep breath and cough, but R26 was unable to follow instructions. Staff assisted with feeding during meal. R26 was noted to be lethargic (excessively tired), used a wheelchair for mobility and a sit to stand lift for transfers.

The "Progress Note," dated 05/13/23 at 02:01 PM, recorded the nurse spoke with the on-call physician regarding the recent aspiration episode and R26's development of crackles in the right lower lung and a non-productive wet cough. The note further documented the physician ordered antibiotic treatment for ten days, and the nurse instructed the kitchen staff to puree foods due to R26 coughing during meals.

The "Progress Note", dated 06/22/23 at 01:00 PM, documented R26 had an emesis (vomit) episode which came out of R26 mouth and nose before eating lunch. During lunch, R26 had a large amount of emesis. R26 was taken to his room, and assisted to bed.

The "Progress Note" dated 06/23/23 at 10:31 AM, documented R26's physician ordered an antibiotic treatment for ten days for aspiration pneumonia.

The "Physician Order", date 07/14/23, directed staff to provide R26 with a limited concentrated sweet diet, blended texture, nectar consistency for dysphagia (swallowing difficulty).

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On 07/17/23 at 12:04 PM, observation revealed R26 sat in the dining room independently eating blended/pureed fruit.

On 07/19/23 at 08:15 AM Certified Nurse Aide (CNA) O stated she was unsure of aspiration precautions, but said R26 was to have thickened liquids and a pureed diet. CNA O stated R26 normally fed himself.

On 07/19/23 at 08:16 AM, Licensed Nurse (LN) I reported R26 had been on alert charting for coughing and choking episodes which consisted of each shift assessing lung sounds, coughing during meals, and temperature checks. LN I verified R26 received thickened liquids and pureed diet as recommended by speech therapy. LN I verified the care plan should have been initiated to instruct staff for safe eating and drinking due to aspiration history.

On 07/19/23 at 09:38 AM, Administrative Nurse D verified R26 should have a care plan to address the risk of aspiration.

The facility's "Resident Directed Care Plan Procedure" policy, dated 11/2014, documented the care planning process for each resident will include the resident, the household interdisciplinary team, representative resident and/or family member agreed to by the resident to by the resident. This group will develop a plan of service to be provided by the household and community based on the preferences, choices, and clinical needs of the resident. The care may be amended at any time the team determines it is necessary to ensure the resident receives appropriate care and services.

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The facility failed to develop a person-centered care plan for R26's aspiration placing the resident at risk for complications associated with unmet care needs related to continued aspiration and pneumonia.

- R71's Electronic Medical Record (EMR) recorded diagnoses of end stage renal disease (decline in kidney function) and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

R71's "Admission Minimum Data Set" (MDS)," dated 06/14/23, recorded R71 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded she was independent with bed mobility, dressing, toileting, and personal hygiene. The MDS further recorded R71 received dialysis (procedure where impurities or wastes were removed from the blood) treatment.

The R71's EMR lacked a dialysis care plan.

The "Treatment Administration Record" (TAR) dated July 2023, documented staff recorded the resident's fluid intake three times a day. The physician order 1300 milliliters (ml) Monday thru Friday and 1000ml fluid restriction on Saturday and Sundays.

The "Physician Order," dated 07/21/22, documented R71 had fluid restriction of 1300 ml a day, Monday thru Friday and 1000 ml on Saturday and Sunday.

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The "Physician Order," dated 07/21/22, documented R71 had fluid restriction of 1300 ml a day, Monday thru Friday and 1000 ml on Saturday and Sunday

The facility's "Fluid Intake" revealed the following days the resident received greater than the physician ordered 1300 ml/day:
05/04/23 - 1350 ml
05/05/23 - 1350 ml
05/08/23 - 1350 ml
05/10/23 - 1350 ml
05/12/23 - 1650 ml
05/17/23 - 1600 ml
05/22/23 - 1650 ml
05/29/23 - 1450 ml
05/30/23 - 1550 ml
06/01/23- 1550 ml
06/09/23 - 1400 ml
06/14/23 - 1650 ml
06/22/23 - 1350 ml
06/23/23 - 1400 ml
06/28/23 - 1580 ml
06/29/23 - 1580 ml
7/17/23 - 1450 ml

The facility's "Fluid Intake" revealed the following days the resident received greater than the physician ordered 1000 ml/day:
05/20/23 - 1150 ml.
05/21/23 - 1450 ml
05/27.23 - 1300 ml
06/03/23 - 1500 ml
06/04/23 - 1500 ml
06/10/23 - 1050 ml
07/01/23 -1380 ml
07/02/23 - 1350 cc
07/16/23 - 1240 ml

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R71's EMR lacked acknowledgement of follow up or notification to physician related to exceeding the physician ordered fluid amounts as listed above.

On 07/18/23 at 11:45 AM, observation revealed R71 sat on the side of her bed awaiting staff to deliver her lunch. R71 was dressed in a housecoat. Continued observation revealed the resident had an artery-vein (AV) fistula (a special connection that is made by joining a vein onto an artery) in her rt upper arm, covered with a gauze dressing and tape. R71 had a stainless-steel water cup on the bedside table with approximately 16 ounces of fluid. The "Physician Order," dated 07/21/22 documented R71 would receive dialysis treatment three times a week.

On 07/18/23 at 12:15 PM, Administrative Nurse D verified R71 received dialysis three times a week on Monday, Wednesday, and Friday. Administrative Nurse D verified the resident was on a 1300 ml fluid restriction Monday thru Friday and 1000 ml on Saturday and Sunday, and the facility intake documentation revealed she had received greater than the 1300 ml or 1000 ml multiple times in the last few months. Administrative Nurse D verified she expected the facility to have a dialysis care plan for R71, to be able to coordinate care with dialysis services and facility staff. Administrative Nurse D verified the facility lacked a dialysis care plan for R71.

The facility's "Care and Assessment of a Resident Receiving Hemodialysis Procedure," policy, dated November 2014, documented the facility would provide an appropriate procedure to comply with

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F 656	Continued From page 25 professional standards and guidelines and provide safe care to a resident on dialysis. Residents receiving hemodialysis would be weighed on a daily basis and staff would record daily intake. The policy documented the Care Plan should also reflect the comprehensive assessments such as: Special nutritional and fluid volume (restriction) needs. The facility failed to develop a care plan for R71 who was receiving dialysis services, placing the resident at risk for inappropriate care, risk for complications and health decline while receiving dialysis treatment.	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 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	F 657		

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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 120 residents. The sample included 24 residents. Based on observation, record review, and interview, the facility failed to revise the care plan with interventions to prevent skin tears for one sampled resident, Resident (R) 66, who received skin tears during cares. This placed R66 at risk for further injury due to uncommunicated and/or unmet care needs.

Findings included:

- The Electronic Medical Record (EMR) for R66 documented diagnoses of dementia (a condition characterized by progressive or persistent loss of intellectual functioning), hypertension (high blood pressure), anxiety (a feeling of worry, nervousness, or unease), and depression (abnormal emotional state characterized by exaggerated of sadness, worthlessness, emptiness, and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated 05/18/23, documented R66 had severely impaired cognition and required extensive assistance of one staff for dressing, toileting, and personal hygiene. R66 required limited assistance of one staff for bed mobility, transfers, and ambulation. The assessment further documented R66 did not have any skin issues.

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The "Skin Integrity Care Plan," dated 06/01/23, initiated 04/03/23, directed staff to educate the resident, family, and caregivers of the causative factors and measure to prevent skin injury; identify and document potential causative factors and eliminate where possible. The care plan lacked preventative measure to prevent skin tears.

The "Nurse's Note," dated 05/08/23 at 06:00 PM, documented R66 hit the back of her right hand on the hand rail in the bathroom as staff assisted the resident. The note further documented the skin tear measured 1.75 inches, and had minimal bleeding.

The "Nurse's Note," dated 06/18/23 at 04:57 PM, documented R66 obtained a skin tear to her right elbow after staff toileted R66 and transferred her into her wheelchair.

The "Nurse's Note," dated 07/14/23 at 01:17 PM, documented R66 obtained a skin tear to her right forearm when the Certified Nurse Aide (CNA) was changing R66's incontinence brief

On 07/17/23 at 08:500 AM, observation revealed R66 had a skin tear on her right forearm that had adhesive closure strips on it.

On 07/17/23 at 08:55 AM, CNA M stated she was unaware of how the resident obtained the skin tear on the forearm.

On 07/19/23 at 07:43 AM, Licensed Nurse (LN) G stated she was in the process of finding Geri-sleeves (provides protection for sensitive skin) for the resident but had not found a small enough pair for R66.

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F 657	Continued From page 28 On 07/19/23 at 09:35 AM, Administrative Nurse D stated she expected preventative measures put into place for prevent skin tears for the resident. The facility's "Resident Directed Care Plans" procedure, dated 10/17, documented the care plan coordinators would implement a system to ensure the care plan of residents living in the household are reviewed at least every three months and whenever there was a significant change condition or reassessment performed. The care plan may be amended at any time the team determines it was necessary to ensure the resident received appropriate care and services. The facility failed to revise R66's care plan with interventions to prevent skin tears. This placed the resident at risk for further injury due to uncommunicated and/or unmet care needs.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility has a census of 120 residents. The sample included 24 residents. Based on observation, record review, and interview, the facility failed to identify and respond to daily	F 684		

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weight variances for Resident (R) 55 and R106, and failed to identify implement preventative measures to prevent skin tears for R66. This placed the residents at risk for physical complications, decline and pain.

Findings included:

- The Electronic Medical Record for R55 documented diagnoses of hypertension (high blood pressure), chronic kidney failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), and congestive heart failure (CHF-a condition in which the heart doesn't pump blood as well as it should).

R55's "Significant Change Minimum Data Set" (MDS), dated 03/18/23, documented R55 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, ambulation, and supervision and set-up assistance for eating. The MDS recroded R55 had no weight loss or gain.

The "Quarterly MDS," dated 06/14/23, documented R55 had intact cognition and required limited assistance of one staff for bed mobility transfers, and ambulation. R55 was independent with set-up assistance for eating and had no weight loss or gain.

The "Care Plan," dated 06/21/23, initiated on 11/08/20, documented R55 was on a two-liter fluid restriction, and was on medication to help manage his fluid retention. The care plan directed staff to obtain daily weights, monitor and document intake and output as per the facility policy.

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The "Physician's Order," dated 01/13/23, directed staff to obtain daily weight upon rising, call the physician to notify them of a three- pound (lb) weight difference (gain or loss), and document in the progress notes.

Review of the "Medication Administration Record" for June 2023 documented the following weights which reflected a gain or loss of three or more pounds that the physician was not notified.
06/15/23-209.6
06/16/23-213.1- weight gain of 3.5 lbs.

Review of the "Medication Administration Record" for July 2023 documented the following weights which reflected a gain or loss of three or more pounds that the physician was not notified:
07/07/23-214 lbs
07/08/23-217.6 lbs - weight gain of 3.6 lbs
07/11/23-214.1 lbs
07/12/23-217.1 lbs-weight gain of 3 lbs

On 07/17/23 at 09:42 AM, observation revealed a pitcher with approximately 700 milliliters (ml) of water on R55's bedside table in his room.

On 07/17/23 at 10:00 AM, Licensed Nurse H stated if the resident had a three- pound weight loss or gain, staff were supposed to contact the physician and document in the progress notes.

On 07/19/23 at 09:20 AM, Administrative Nurse D stated staff were to follow the physician's order for the residents three-pound weight gain.

A policy for CHF was not provided by the facility.

The facility failed to identify and respond to

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changes for R55's more than three-pound weight gain or loss three times in the past 30 days, placing R55 at risk for health issues related to congestive heart failure.

- The Electronic Medical Record (EMR) for R66 documented diagnoses of dementia (a condition characterized by progressive or persistent loss of intellectual functioning), hypertension (high blood pressure), anxiety (a feeling of worry, nervousness, or unease), and depression (abnormal emotional state characterized by exaggerated of sadness, worthlessness, emptiness, and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated 05/18/23, documented R66 had severely impaired cognition and required extensive assistance of one staff for dressing, toileting, and personal hygiene. R66 required limited assistance of one staff for bed mobility, transfers, and ambulation. The assessment further documented R66 did not have any skin issues.

The "Skin Integrity Care Plan," dated 06/01/23, initiated 04/03/23, directed staff to educate the resident, family, and caregivers of the causative factors and measure to prevent skin injury; identify and document potential causative factors and eliminate where possible. The care plan lacked preventative measure to prevent skin tears.

The "Nurse's Note," dated 05/08/23 at 06:00 PM, documented R66 hit the back of her right hand on the hand rail in the bathroom as staff assisted the resident. The note further documented the skin tear measured 1.75 inches, and had minimal

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bleeding.

The "Nurse's Note," dated 06/18/23 at 04:57 PM, documented R66 obtained a skin tear to her right elbow after staff toileted R66 and transferred her into her wheelchair.

The "Nurse's Note," dated 07/14/23 at 01:17 PM, documented R66 obtained a skin tear to her right forearm when the Certified Nurse Aide (CNA) was changing R66's incontinence brief

On 07/17/23 at 08:500 AM, observation revealed R66 had a skin tear on her right forearm that had adhesive closure strips on it.

On 07/17/23 at 08:55 AM, CNA M stated she was unaware of how the resident obtained the skin tear on the forearm.

On 07/19/23 at 07:43 AM, Licensed Nurse (LN) G stated she was in the process of finding Geri-sleeves (provides protection for sensitive skin) for the resident but have not found a small enough pair for the resident.

On 07/19/23 at 09:35 AM, Administrative Nurse D stated she expected preventative measures put into place for prevent skin tears for the resident.

Upon request, a policy for skin tear prevention was not provided by the facility.

The facility failed to identify causative factors and implement interventions to prevent skin tears for R66. This placed the resident at risk for further injury.

- R106's Electronic Medical record (EMR)

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documented diagnoses of congestive heart failure (CHF-a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), end stage renal disease (ESRD-a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for dialysis or a transplant), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS), dated 04/19/23, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R106 required supervision for dressing and was independent with all other activities of daily living.

The "Nutrition Care Plan," dated 04/25/23, directed staff to obtain the resident's weight on non-dialysis (procedure where impurities or wastes were removed from the blood) days.

The "Physician Order," dated 06/23/22, for a diagnosis of CHF, directed staff to obtain weight on non-dialysis days upon rising; call the physician to notify them of a plus or minus three-pound (lb.) weight difference, and document in a progress note.

R106's EMR recorded the following weights with a three lb. difference:
03/14/23 4.6lb. loss; the physician saw the resident that day.
03/21/23 4.4 lb. gain; no documentation of physician notification.
04/18/23 4.9 lb. gain: staff notified physician of weight gain.
04/22/23 4 lb. loss; no documentation of physician notification

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F 684	Continued From page 34 05/16/23 3.4 lb. loss; no documentation of physician notification 06/18/23 3.6 lb. gain: no documentation of physician notification On 07/17/23 at 08:35 AM, observation revealed staff served R106 breakfast in his room. He had scrambled eggs, French toast, oatmeal, two slices of bacon, coffee, and water. On 07/18/23 at 01:47 PM, Licensed Nurse (LN) K verified staff had not notified the physician of the weight gain or loss of more than three lbs. on four of six days. On 07/19/23 at 10:12 AM, Administrative Nurse D stated staff should follow the physician direction and notify him/her of the gain or loss as ordered. A policy for congestive heart failure was not provided by the facility. The facility failed to obtain physician assessment of R106's more than three-pound weight gain or loss four times in the past 120 days, placing R106 at risk for health issues related to congestive heart failure.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		

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accidents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 120 residents. The sample included 24 residents with 14 residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide a safe environment for Resident (R)8 who fell from her electric lift recliner during a self-transfer, and R16 who had multiple falls with staff in which the facility failed to identify the need for increased staff assistance. These deficient practices placed the residents at risk for falls and related injuries.

Findings included:

- R8's Electronic Medical Record (EMR) recorded diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R8's "Quarterly Minimum Data Set" (MDS), dated 04/14/23, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R8 required staff assistance with bed mobility and transfers.

The "Cognitive Loss Care Area Assessment" (CAA), dated 11/29/22, recorded the resident had short term memory impairments, with intermittent confusion.

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The "Fall CAA," dated 11/29/22, recorded R8 was a high fall risk due to intermittent confusion, chronic pain, with restless leg syndrome.

The "Activities of Daily Living (ADL) Care Plan," dated 07/24/23, directed staff to provide limited assistance if needed.

The "Fall Care Plan," dated 04/18/23, documented the staff would provide education and reminders on how to utilize R8's recliner as it was a brand-new recliner. The care plan documented staff would remind the resident to call for assistance during times of weakness and not refuse assistance. The staff would provide one on one assistance when ambulating to and from restroom and around R8's room until she was stronger and no longer ill.

The "Fall Risk Assessment," dated 02/21/23, documented a score of 68.0 (a score of 45.0 or greater indicated a high risk for falls).

The "Lift Chair Assessment," dated 11/19/21 recorded R8 was safe to use the electric lift chair.

The "Lift Chair Assessment," dated 04/30/23 did not record if the resident was safe or unsafe to use the electric lift chair.

The "Nurses Note," dated 04/18/23 at 09:30 PM, recorded the resident had a fall from her lift recliner when she raised the recliner chair to high position and slid forward out of the recliner. Staff used the full mechanical lift and attached a large lift sling. While lifting the resident off the ground, R8 began to complain of the sling hurting her shoulders. The resident then crossed her arms and slid out of the sling; the nurse lunged forward

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to brace as much of the fall as possible. R8 did not hit her head but obtained two skin tears to her right arm. Staff determined the sling used by staff appeared to be inappropriately sized for the resident, and staff obtained a smaller sling that was used to help the resident to the bed. Staff cleansed the skin tears, provided pain medication, initiated neurological checks, and staff continued to monitor the resident.

The "Nurses Note," dated 4/30/23 at 09:43 PM, recorded R8 had a fall from her recliner and noted the lift chair was tilted all the way in the up position. The resident stated she was trying to reach her tissue and did not recall putting the chair all the way up. The resident landed on her buttocks though no injuries were noted. Staff unplugged the lift chair and reminded the resident not to control her lift chair on her own. R8 verbalized she would use her call light when wanting to reposition and staff would help her.

On 07/13/23 at 12:55 PM, observation revealed R8 ambulated from one side of her room to the other and sat in the electric lift recliner in her room and elevated her feet with the lift controller.

On 07/18/23 at 08:10 AM, observation revealed R8 sat in the lift recliner in her room with the control for the lift recliner hanging on the side of the chair.

On 07/18/21 at 07:55 AM, Licensed Nurse (LN) J verified the resident had a fall out of the recliner chair in April. LN G verified the resident had impaired cognition at the time due to a hospitalization for pneumonia and had weakness and was not able to safely use the lift recliner at that time. LN J verified an electric lift recliner

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assessment had not been fully completed on the resident since November 19, 2021 and should be completed yearly or with a change in condition.

On 7/19/23 at 09:30 AM interview with Administrative Nurse D verified a lift chair assessment had not been fully completed on the resident since 11/19/21 and should be completed yearly or with change in condition.

The facility's "Fall Prevention and Management" policy, dated November 2014, stated the facility would develop a plan for services to improve or maintain the resident's risk for falls. The plan shall include specific information about the resident's routine and personal habits that may place the resident at risk for falls such as nighttime voiding, or nighttime wandering. The policy documented each resident would be assessed for falls, and the facility would include at a minimum a "Facility Fall Assessment." The policy recorded each resident would be reassessed to determine if the risk for falls has increased quarterly at a minimum or each time the resident returns from stay in another health care facility. The care plan shall be reviewed and amended based on the reassessment.

The facility failed to assess R8 for safe use of an electric lift chair, placing the resident at risk for preventable accidents or injury.

- The Electronic Medical Record (EMR) for R16 recorded diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and

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hopelessness), atrial fibrillation (rapid, irregular heartbeat), and bradycardia (low heart rate).

The "Quarterly Minimum Data Set" (MDS) dated 04/22/22) documented R16 had severely impaired cognition, required extensive assistance of one staff for all activities of daily living (ADLs), had unsteady balance, no functional impairment, and had no falls.

The "Quarterly MDS," dated 06/23/23, documented R16 had severely impaired cognition, required extensive assistance of one staff for all ADLs, had unsteady balance, no functional impairment, and had two or more falls since the last MDS.

The "Fall Risk Assessments," dated 07/27/22, 09/09/22, 10/17/22, 11/21/22, 02/20/23, 04/13/23, and 05/22/23 documented R16 was a high risk for falls.

The "Fall Care Plan," dated 07/07/23, initiated on 11/12/20, documented R16 had decreased mobility, and directed staff to anticipate and meet her needs, follow the facility fall protocol, determine the cause of the falls. It directed to educate the resident, family, caregivers as to the causes, and directed staff to ambulate with her in the hallways twice daily. The update, dated 10/22/21, directed staff to follow high risk for fall procedures. The update, dated 09/09/22, directed staff to have two staff for transfers upon arising and in the evening hours. The update, dated, 07/11/22, directed staff to use a wheelchair for locomotion in the evening hours due to increased fatigue (tiredness). The update, dated 07/27/22, directed staff to follow R16 with her wheelchair while ambulating. The update, dated 10/17/22,

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directed staff to utilize the wheelchair for transfers/locomotion while treatment for a urinary tract infection (bladder infection), then reassess. The update, dated 11/20/22, documented R16's wheelchair brakes were tightened. The update, dated 04/13/23, directed staff to keep wheelchair within reach at all times during transfers/ambulation. The update, dated 05/21/23, directed staff to place Dycem (a non-slip product) under recliner legs to prevent slipping and directed staff to use two staff for transfers and ambulation.

The "Fall Investigation," dated 07/27/22 at 12:20 PM, documented while a CNA ambulated with R16 using a gait belt and a walker, R16's knees gave out and she fell to the floor. The fall investigation further documented R16 did not obtain any injury but stated she hurt all over. She could not remember what had happened, and staff assisted her off the floor and placed her in a wheelchair.

The "Fall Investigation," dated 09/08/22 at 06:50 AM, documented staff heard R16 yell and found her on the floor in her room with a Certified Nurse Aide (CNA) at her side. The CNA stated she had a gait belt on R16 and had attempted to walk with her with R16's walker to the wheelchair when R16 started to tip over. The CNA lowered R16 to the ground. R16 was assessed, had no injury, and was assisted from the floor to her wheelchair.

The "Fall Investigation," dated 10/17/22 at 07:28 AM, documented R16 proceeded to sit down before she got to the shower chair, and the CNA had to lower her to the floor. The investigation further documented R16 could not recall what happened. Staff assessed with no injury found,

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and R16 was assisted off the floor with the use of a Hoyer lift (full body lift).

The "Fall Investigation," dated 11/20/22 at 09:56 AM, documented a CNA lowered R16 to the floor during a transfer to her wheelchair due to her wheelchair brakes were not locked. The investigation further documented R16 could not recall what happened and had no injuries.

The "Fall Investigation," dated 04/13/23 at 11:17 AM, documented R16 was on the floor, face down with her head turned to the right and her left arm was tucked underneath her body. The investigation documented staff assisted R16 out of the bathroom with her walker when R16 started to sit down. The CNA went to grab R16's wheelchair, and R16 slipped off the edge of the wheelchair seat, and fell face first to the floor. The investigation further documented R16 sustained an abrasion (scrape) to her left forehead. R16 could not recall what happened and was assisted off the floor and placed in her wheelchair.

The "Fall Investigation," dated 05/21/23 at 09:00 AM, documented a CNA assisted R16 out of her recliner and while staff tried to get her up, the recliner slid backward and R16 slid off the edge of the seat to the floor. The investigation documented R16 could not recall what happened, was assessed for injuries, and was assisted off the floor.

The "Fall Investigation," dated 05/21/23 at 03:13 PM, documented a CNA and R16 were found on the floor in R16's room. The CNA stated, during the transfers with R16, she started to lean backwards, and both lost their balance, and R16

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landed on the CNA. The Investigation further documented R16 could not recall what happened, did sustain bruising to the back of both of her hands.

On 07/17/23 at 12:03 PM, observation revealed CNA N placed a walking belt around R16's waist and CNA N and CNA M started to assist R16 to stand up but had to cue R16 multiple times before she understood she needed to stand up and place her hands on her walker. CNA M and CNA N walked with R16 to the bathroom, toileted her, and again had to cue her multiple times to stand and walk. Further observation revealed CNA N stood on R16's left side, had her right hand under R16's walking belt, but did not have a hold on the belt as she used her left hand to help guide R16's walker. Continued observation revealed CNA M walked behind them with the wheelchair as they walked to the dining room for lunch. Observation revealed halfway to the dining room, R16 got tired and sat down in her wheelchair.

On 07/17/23 at 12:10 PM, CNA M stated R16 required a lot of cuing and required two staff with transfers and ambulation due to a couple of falls that were close together but was not sure about the cause of any other falls.

On 07/18/23 at 09:30 AM, Licensed Nurse G stated R16 was impulsive, and staff have tried to implement interventions for her falls but could not state why the facility waited to have R16 be assisted with two staff during transfers and ambulation.

07/18/23 at 03:30 PM, Administrative Nurse D stated R16 was impulsive, and several

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F 689	Continued From page 43 interventions had been implemented to prevent her falls. The facility's "Fall Prevention and Management Procedure" policy, dated 11/14, documented the procedure for falls provide appropriate protocol for fall prevention and management. If a resident was a high risk for falls, the resident was assessed for the use of an assistive device or physical assist of one to two staff. The resident was also assessed to see if they are at risk for falls and the team shall develop a plan for services to improve or maintain the residents risk for falls and would be reassessed quarterly at a minimum or each time the resident returned from a stay in another health care facility. The care plan would be reviewed and amended based on the assessment. The facility failed to identify the need for increased staff assistance for R16, who had multiple falls with staff present. This placed the resident at risk for further falls and injury.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692		

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demonstrates that this is not possible or resident preferences indicate otherwise;

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

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 120 residents. The sample included 24 residents, with two reviewed for hydration. Based on observation, record review, and interview, the facility failed to monitor hydration status for Resident (R) 55, who was on a physician ordered fluid restriction. This placed the residents at risk for dehydration or fluid overload.

Findings included:

- The Electronic Medical Record for R55 documented diagnoses of hypertension (high blood pressure), chronic kidney failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), and congestive heart failure (a condition in which the heart doesn't pump blood as well as it should).

R55's "Significant Change Minimum Data Set" (MDS), dated 03/18/23, documented R55 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, ambulation, and supervision and set-up assistance for eating.

The "Quarterly MDS," dated 06/14/23, documented R55 had intact cognition and

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required limited assistance of one staff for bed mobility transfers, ambulation. R55 was independent after set-up assistance for eating.

The "Fluid Overload Care Plan," dated 06/21/23, initiated on 11/08/20, documented R55 was on a two liter fluid restriction; R55 was on mediation to help manage his fluid retention. The care plan directed staff to ensure the resident's snacks and beverages offered at activities complied with the diet and fluid restrictions, obtain daily weights, monitor, and document intake and output as per the facility policy.

The "Physician's Order," dated 11/09/20, directed staff to implement a two liter fluid restriction for R55. Staff were to provide 320 cubic centimeters (cc) in his early AM pitcher, 240cc with breakfast, 320cc in his morning pitcher, 240cc with lunch, 320cc in his noon pitcher, 240cc with dinner, and 320cc in his bedtime pitcher.

Review of the "Treatment Administration Record" for May 2023 documented the following daily fluid totals:
05/03/23-2100cc
05/17/23-2820cc
05/23/23-2320cc
05/24/23-2320cc
05/27/23-2280cc

Review of the "Treatment Administration Record" for June 2023 documented the following daily fluid totals:
06/04/23-2120cc
06/07/23-640cc
07/08/23-2320cc
06/09/23-2160cc
06/11/23-2170cc

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06/14/23-640cc
06/15/23-2350cc
06/19/23-2280cc
06/24/23-880cc

Review of the "Treatment Administration Record" for July 2023 documented the following daily fluid totals:
07/06/23-2240cc
07/09/23-2370cc
07/10/23-2320cc

On 07/17/23 at 09:42 AM, observation revealed a pitcher with approximately 700cc of water on R55's bedside table in his room.

On 07/18/23 at 12:30 PM, observation revealed a pitcher with 900cc of water on R55's meal tray.

On 07/18/23 at 12:40PM, Certified Nurse Aide (CNA) M stated R55 was on a fluid restriction but was unsure of the amount he was supposed to get daily. CNA M displayed a paper care plan for the resident, which she removed from her packet, and the daily fluid amount was not on it. CNA M further stated that she gave R55 a full pitcher of water in the morning along with a cup of coffee and a glass of juice; at lunch R55 received another pitcher of water as well as one at supper.

On 07/17/23 at 10:34 AM, Licensed Nurse (LN) G stated she tracked the resident's fluid intake and would contact the physician for clarification. LN G further stated staff should follow the physician order.

On 07/19/23 at 09:20 AM, Administrative Nurse D stated she expected staff to follow the physician orders.

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F 692	Continued From page 47 "The facility's "Hydration Procedure," policy, dated November 2018, documented the facility would offer each resident sufficient fluid intake to maintain proper hydration and health. The Interdisciplinary Care Team would develop an individualized care plan that addresses the resident's specific nutritional and hydration concerns and preferences. Monitoring of the care planned interventions would be on an ongoing basis for all residents and should include. The physician would be informed of dehydration concerns and may order interventions as appropriate. Intake and output would be documented as appropriate. The dietician or designee may be consulted to assist with interventions and record actions in the nutrition progress notes. Observations pertinent to the resident's hydration status should be recorded in the nursing notes as appropriate. The facility failed to monitor R55's physician's order fluid intake, placing the resident at risk dehydration or fluid overload.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 120 residents. The sample included 24 residents with two reviewed for dialysis (the process of removing waste	F 698		

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products and excess fluid from the body when the kidneys are not able to adequately filter the blood). Based on observation, record review, and interview, the facility failed to ensure ongoing fluid restriction implementation for Resident (R)71, who received dialysis treatment. This placed the resident at risk for complications and health decline.

Findings included:

- R71's Electronic Medical Record (EMR) recorded diagnoses of end stage renal disease (decline in kidney function) and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

R71's "Admission Minimum Data Set" (MDS)," dated 06/14/23, recorded R71 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded she was independent with bed mobility, dressing, toileting, and personal hygiene. The MDS further recorded R71 received dialysis treatment.

The R71's EMR lacked a dialysis care plan.

The "Treatment Administration Record" (TAR) dated July 2023, documented staff recorded the resident's fluid intake three times a day. The physician order 1300 milliliters (ml) Monday thru Friday and 1000ml fluid restriction on Saturday and Sundays.

The "Physician Order," dated 07/21/22 documented R71 would receive dialysis treatment three times a week.

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The "Physician Order," dated 07/21/22, documented R71 had fluid restriction of 1300 ml a day, Monday thru Friday and 1000 ml on Saturday and Sunday.

The facility's "Fluid Intake" revealed the following days the resident received greater than the physician ordered 1300 ml/day for weekdays:
05/04/23 - 1350 ml
05/05/23 - 1350 ml
05/08/23 - 1350 ml
05/10/23 - 1350 ml
05/12/23 - 1650 ml
05/17/23 - 1600 ml
05/22/23 - 1650 ml
05/29/23 - 1450 ml
05/30/23 - 1550 ml
06/01/23- 1550 ml
06/09/23 - 1400 ml
06/14/23 - 1650 ml
06/22/23 - 1350 ml
06/23/23 - 1400 ml
06/28/23 - 1580 ml
06/29/23 - 1580 ml
07/17/23 - 1450 ml

The facility's "Fluid Intake" revealed the following days the resident received greater than the physician ordered 1000 ml/day for Saturdays/Sundays:
05/20/23 - 1150 ml.
05/21/23 - 1450 ml
05/27.23 - 1300 ml
06/03/23 - 1500 ml
06/04/23 - 1500 ml
06/10/23 - 1050 ml
07/01/23 -1380 ml
07/02/23 - 1350 ml

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F 698	Continued From page 50 07/16/23 - 1240 ml R71's EMR lacked acknowledgement, follow up or communication to the physician or dialysis center related to exceeding the physician ordered fluid amounts as listed above. On 07/18/23 at 11:45 AM, observation revealed R71 sat on the side of her bed awaiting staff to deliver her lunch. R71 was dressed in a housecoat. Continued observation revealed the resident had an artery-vein (AV) fistula (a special connection that is made by joining a vein onto an artery) in her right upper arm, covered with a gauze dressing and tape. R71 had a stainless-steel water cup on the bedside table with approximately 16 ounces of fluid. On 07/18/23 at 12:15 PM, Administrative Nurse D verified R71 received dialysis three times a week on Monday, Wednesday and Friday. Administrative Nurse D verified the resident was on a 1300 ml fluid restriction Monday thru Friday and 1000 ml on Saturday and Sunday, and the facility intake documentation revealed she had received greater than the 1300 ml or 1000 ml multiple times in the last few months. The facility's "Hydration Procedure," policy, dated November 2018, documented the facility would offer each resident sufficient fluid intake to maintain proper hydration and health. The Interdisciplinary Care Team would develop an individualized care plan that addresses the resident's specific nutritional and hydration concerns and preferences. Monitoring of the care planned interventions would be on an ongoing basis for all residents and should include. The physician would be informed of dehydration	F 698		

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F 698	Continued From page 51 concerns and may order interventions as appropriate. Intake and output would be documented on the MAR/TAR and Point of Care as appropriate. The dietician or designee may be consulted to assist with interventions and record actions in the nutrition progress notes. Observations pertinent to the resident's hydration status should be recorded in the nursing notes as appropriate. The facility's "Care and Assessment of a Resident Receiving Hemodialysis Procedure," policy, dated November 2014, documented the facility would provide an appropriate procedure comply with professional standards and guidelines and provide safe care to a resident on dialysis. Residents receiving hemodialysis would be weighed on a daily basis and staff would record daily intake. The facility failed to implement R71's physician ordered fluid restriction related to dialysis and failed to involve the physician or dialysis center, placing the resident at risk for complications and health decline while receiving dialysis treatment.	F 698		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		

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

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 120 resident. The sample included 24 residents. Based on observation, record review, and interview, the facility failed to ensure a system to review and respond to the Consultant Pharmacist's (CP) repeated recommendation to complete an Abnormal Involuntary Movement Scale (AIMS) for Resident (R) 84 and R66 who received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions)

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medication which placed the R84 and R66 at risk of adverse side effects associated with psycotropic (alters mood or thought) medications.

Findings included:

- R84's Electronic Medical Record (EMR) documented diagnoses of hypertension (elevated blood pressure), dysphagia (swallowing difficulty), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion) with agitation, and unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing) not due to a substance or known physiological condition.

The "Quarterly Minimum Data Set" (MDS), dated 05/18/23, documented R84 had severe cognitive impairment, delirium (sudden severe confusion, disorientation and restlessness), and exhibited no behaviors. R84 required supervision from staff for activities of daily living. The MDS further documented R84 routinely received an antipsychotic, antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), and diuretic (medication to promote the formation and excretion of urine).

The "Psychotropic Medication Care Plan," dated 08/22/22, documented R84 used psychotropic medication related to behavior management. The care plan directed staff to give medications as ordered, monitor for side effects and effectiveness every shift. Educate the

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resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of antipsychotic Seroquel. Monitor/document/report as needed any adverse reactions for psychotropic medications of unsteady gait dyskinesia, extrapyramidal side effects (EPS-shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. On 06/01/23 the intervention of Licensed Nurse to complete AIMS assessment quarterly was added.

The "Physician Order," updated 05/30/23, directed staff to administer Seroquel (antipsychotic) 25 milligrams (mg) twice a day.

The CP record review report documented to "Please perform an AIMS assessment" for R84 at least every six months for involuntary muscle movements which might be caused by antipsychotics on 08/17/22, 10/21/22, 12/22/22, and 02/23/23.

On 05/18/23 the AIMS was completed and scored 1.0 with minimal neck, shoulders, hips, e.g. rocking, twisting, squirming, pelvic gyrations. The record lacked evidence of an AIMS prior to this assessment.

On 07/17/23 at 10:14 AM, observation revealed R84 sat on the commons area couch with family member, dressed and groomed appropriately. R84 sharing a blanket with the family member, with constant soft verbalization in singing type voice.

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F 756	Continued From page 55	F 756		

On 07/19/23 at 08:21 AM Licensed Nurse (LN) I stated the CP monthly report was initially sent to health information management, then the household coordinator would get the recommendations to address with the physician. LN I reported there was a glitch in that system and the household coordinators were only getting physician recommendations to be addressed and not the nursing recommendations.

On 07/19/23 at 09:31 AM, Administrative Nurse D verified the CP request for the AIMS should have been addressed.

The facility's "Monitoring Residents on Antipsychotic Drug Procedure" policy, dated 11/2014, documented the facility shall monitor residents receiving antipsychotic drugs as indicated by standard protocol or physician directs. AIMS shall be completed every six months on each resident who receives an antipsychotic medication.

The facility failed to ensure a system to review and respond to CP's repeated recommendation for R84 which placed the resident at risk for adverse side effects.

- The Electronic Medical Record (EMR) for R66 documented diagnoses of dementia (a condition characterized by progressive or persistent loss of intellectual functioning), anxiety (a feeling of worry, nervousness, or unease), and depression (abnormal emotional state characterized by exaggerated of sadness, worthlessness, emptiness, and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated

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F 756	Continued From page 56	F 756		

05/18/23, documented R66 had severe cognitive impairment and required extensive assistance of one staff for dressing, toileting, personal hygiene, and limited assistance of one staff for bed mobility, transfer, and ambulation. The MDS further documented R66 had no behaviors and received an antipsychotic, antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression).

The "Behavior Care Plan," dated 06/01/23, initiated on 01/24/23, directed staff to administer medications as ordered, monitor and document side effects, and report any adverse reactions. The "Care Plan" further directed staff to anticipate and meet her needs, and caregivers provide the opportunity for positive interaction, and document behaviors every shift.

The "Physician Order," updated 12/28/22, directed staff to administer risperidone (antipsychotic medication) 0.5 milligrams (mg) twice a day.

The "Consultant Pharmacist" Review documented to "Please perform an AIMS assessment" for R66 at least every six months for involuntary muscle movements which might be caused by antipsychotics on 10/20/22, 12/22/22, 02/22/23, and 04/20/23.

Review of R66's EMR lacked evidence the AIMS assessment was completed.

On 07/18/23 at 07:30 AM, observation revealed R66 sat in her wheelchair in a commons area watching television.

On 07/18/23 at 09:30 AM, Licensed Nurse (LN) G

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F 756	Continued From page 57 stated that she was unaware that the AIMS assessment needed completed as there had been a glitch in the system and the nursing recommendations from the pharmacist were not flagged for her to complete. On 07/18/23 at 04:00 PM, Administrative Nurse D verified AIMS assessments were not completed timely for R66 due to a glitch in the system. The facility's "Consultation By Pharmacist To Household" procedures, dated 03/17, documented the consultant pharmacist would prepare a written report that included findings and recommendations, this report shall be provided to the director of nursing and/or clinical coordination. The director of nursing or clinical coordinator would perform the necessary follow-up based on the recommendations received. The facility failed to ensure a system was in place to review and respond to Consultant Pharmacist's repeated recommendation to complete AIMS assessments for R66 which placed her at risk for adverse side effects.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		

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F 757	Continued From page 58 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 120 residents. The sample included 24 residents. Based on observation, record review and interview the facility failed to hold diuretic medications multiple times for blood pressure readings outside of physician ordered parameters for Resident (R)26, which placed the resident at risk for continued low blood pressure. Findings included: - R26's Electronic Medical Record (EMR) documented diagnoses of gastro-esophageal reflux disease (GERD- backflow of stomach contents to the esophagus), obstructive sleep apnea (absence of breathing), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in	F 757		

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breathing), personal history of transient ischemic attack (TIA- episode of cerebrovascular insufficiency), muscle weakness, chronic kidney disease (CKD), congestive heart disease (CHF- a condition with low heart output and the body becomes congested with fluid) and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) severe with agitation.

The "Quarterly Minimum Data Set" (MDS), dated 06/13/23, documented R26 had moderately impaired cognition, required extensive to total assistance with activities of daily living, and ate independently with set up assistance. The MDS further documented R26 had coughing or choking during meals or when swallowing medications and received daily insulin (medication used to lower blood sugar levels), antipsychotic (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions), antidepressant (class of medications used to treat mood disorders), an anticoagulant (blood thinner), and diuretics (medication to promote the formation and excretion of urine).

The "Nutritional Care Plan" dated 06/22/22, documented a potential problem related to dementia, COPD, change in condition, and was at risk for weight fluctuations related to taking diuretic. The care plan directed staff to monitor/record/report to physician signs and/or symptoms of malnutrition. On 07/14/23, the care plan added for staff to provide a low concentrated sweet diet, blended textures, and nectar thick liquids as ordered, and to monitor intake and record every meal. On 07/16/23 the care plan

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recorded an addition of R26 to drink nectar thick liquids per speech therapy.

The "Progress Note", dated 06/22/23 at 01:00 PM, documented R26 had an emesis (vomit) episode which came out of R26 mouth and nose before eating lunch. During lunch R26 had a large amount of emesis. R26 was taken to his room and while being assisted on the toilet R26 became unresponsive for about 20 seconds.

The "Progress Note", dated 06/24/23 at 05:32 PM, documented R26 had an unresponsive episode getting up from the toilet. R26's blood pressure (BP) reading of 72/48 millimeters (mm) of Mercury (Hg) initially and BP 86/48 mmHg after 15 minutes. R26 continued to be lethargic (excesssively tired) and was not responding to questions. The physician was notified and ordered to hold diuretics Lasix and spironolactone through the weekend and the physician would follow up on Monday.

The "Progress Note", dated 06/26/23 at 12:34 PM, documented the physician ordered to resume Lasix and spironolactone medications as ordered and added hold parameters for the medications for systolic blood pressure (SBP-the pressure caused by heart contracting and pushing out blood) of less than 110.

Review of the medical record revealed Lasix and spironolactone was given with a SBP outside of ordered parameters on the following dates:
06/27/23 midday dose with SBP reading of 100
06/28/23 morning dose with SBP reading of 109
06/29/23 morning dose with SBP reading of 107
07/17/23 morning and midday doses with SBP reading of 105

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F 757	Continued From page 61 On 07/17/23 at 12:04 PM, observation revealed R26 sat in the dining room independently eating blended/pureed fruit. On 07/19/23 at 08:16 AM, Licensed Nurse (LN) I verified the low blood pressure readings were out of physician ordered parameters and the diuretics Lasix and spironolactone should have been held as directed by the physician. On 07/19/23 at 09:38 AM, Administrative Nurse D verified R26's diuretic medications should have been held as directed by the physician. The facility's "Physician Orders for Medications and Treatment Procedure" policy, dated 11/2014, documented the facility's objective is to provide an appropriate procedure to the when receiving physician's orders for medication and treatments. All medications shall be administered as ordered by a health care professional authorized by the state or order medications. The facility failed to hold R26's diuretic medications for SBP readings outside of physician ordered parameters which placed the resident at risk for continued low blood pressure.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		

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F 758	Continued From page 62 (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. §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	F 758		

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the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 120 resident. The sample included 24 residents. Based on observation, record review, and interview, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) for Resident (R) 84 and R66 who received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medication which placed the R84 and R66 at risk of adverse side effects of psychotropic (alters mood or thoughts) medications.

Findings included:

- R84's Electronic Medical Record (EMR) documented diagnoses of hypertension(elevated blood pressure), dysphagia (swallowing difficulty), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion) with agitation, and unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing) not due to a substance or known physiological condition.

The "Quarterly Minimum Data Set" (MDS), dated 05/18/23, documented R84 had severe cognitive impairment, delirium (sudden severe confusion, disorientation and restlessness), and exhibited no behaviors. R84 required supervision from staff for activities of daily living. The MDS further documented R84 routinely received an antipsychotic, antidepressant (class of

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medications used to treat mood disorders and relieve symptoms of depression), and diuretic (medication to promote the formation and excretion of urine).

The "Psychotropic Medication Care Plan," dated 08/22/22, documented R84 used psychotropic medication related to behavior management. The care plan directed staff to give medications as ordered, monitor for side effects and effectiveness every shift. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of antipsychotic Seroquel. Monitor/document/report as needed any adverse reactions for psychotropic medications of unsteady gait dyskinesia, extrapyramidal side effects (EPS-shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. On 06/01/23 the intervention of Licensed Nurse to complete AIMS assessment quarterly was added.

The "Physician Order," updated 08/05/22, directed staff to administer Seroquel (antipsychotic) 25 milligrams (mg) twice a day.

The CP record review report documented to "Please perform an AIMS assessment" for R84 at least every six months for involuntary muscle movements which might be caused by antipsychotics on 08/17/22, 10/21/22, 12/22/22, and 02/23/23.

On 05/18/23 the AIMS was completed and scored 1.0 with minimal neck, shoulders, hips, e.g.

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rocking, twisting, squirming, pelvic gyrations.

On 07/17/23 at 10:14 AM, observation revealed R84 sat on the commons area couch with family member, dressed and groomed appropriately. R84 shared a blanket with the family member, with constant soft verbalization in singing type voice.

On 07/19/23 at 09:31 AM, Administrative Nurse D verified the AIMS should have been addressed sooner

The facility's "Monitoring Residents on Antipsychotic Drug Procedure" policy, dated 11/2014, documented the facility shall monitor residents receiving antipsychotic drugs as indicated by standard protocol or physician directs. AIMS shall be completed every six months on each resident who receives an antipsychotic medication.

The facility failed to complete an AIMS assessment which placed R26 at risk for adverse side effects related to the psychotropic medication.

- The Electronic Medical Record (EMR) for R66 documented diagnoses of dementia (a condition characterized by progressive or persistent loss of intellectual functioning), anxiety (a feeling of worry, nervousness, or unease), and depression (abnormal emotional state characterized by exaggerated of sadness, worthlessness, emptiness, and hopelessness).

The "Quarterly Minimum Data Set" (MDS), dated 05/18/23, documented R66 had severe cognitive

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impairment and required extensive assistance of one staff for dressing, toileting, personal hygiene, and limited assistance of one staff for bed mobility, transfer, and ambulation. The MDS further documented R66 had no behaviors ad received an antipsychotic, antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression).

The "Behavior Care Plan," dated 06/01/23, initiated on 01/24/23, directed staff to administer medications as ordered, monitor and document side effects, and report any adverse reactions. The "Care Plan" further directed staff to anticipate and meet her needs, and caregivers provide the opportunity for positive interaction, and document behaviors every shift.

The "Physician Order," updated 12/28/22, directed staff to administer risperidone (antipsychotic medication) 0.5 milligrams (mg) twice a day.

The "Consultant Pharmacist Review" documented to "Please perform an AIMS assessment" for R66 at least every six months for involuntary muscle movements which might be caused by antipsychotics on 10/20/22, 12/22/22, 02/22/23, and 04/20/23.

Review of R66's EMR lacked evidence the AIMS assessment was completed.

On 07/18/23 at 07:30 AM, observation revealed R66 sat in her wheelchair in a commons area watching television.

On 07/18/23 at 09:30 AM, Licensed Nurse (LN) G stated that she was unaware that the AIMS

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 67 assessment needed completed as there had been a glitch in the system and the nursing recommendations from the pharmacist were not flagged for her to complete. On 07/18/23 at 04:00 PM, Administrative Nurse D verified AIMS assessments were not completed timely for R66 due to a glitch in the system. The facility's "Monitoring Residents on Antipsychotic Drugs Procedure" policy, dated 11/14, documented each resident who had an order for an antipsychotic drug shall be assessed and periodically reassessed during their residency to determine the effectiveness of the medication. The AIMS shall be completed every six months on each resident who received an antipsychotic medication. The facility failed to complete AIMS assessments every six months for R66, who received an antipsychotic medication. This placed the resident at risk for adverse side effects.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175174	A. BUILDING _____ B. WING _____	07/19/2023

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F 761	Continued From page 68	F 761		

biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 120 residents and identified four medication rooms. Based on observation, recrod review, and interview the facility failed to ensure expired medications were disposed of in a timely manner. This deficient practice placed residents at risk to receive ineffective medication.

Findings included;

- On 07/12/23 at 10:06 AM, observation in one of four facility medication rooms revealed one dose of influenza (flu) vaccine with an expiration date of 05/12/23 and six doses of the influenza vaccine with an expiration date of 06/30/23.

On 07/13/23 at 10:06 AM, Licensed Nurse (LN) K verified the vaccines were expired and should have been disposed of.

The facility's "Storage of Medications in the Medication Room Procedure," did not include direction for expired medications.

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F 761	Continued From page 69 The facility failed to dispose of expired vaccine doses in a timely manner, placing residents at risk to receive ineffective vaccines.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 120 residents. Based on observation, interview, and record review the facility failed to serve food in a sanitary manner for residents in one of seven households. This deficient practice placed the 22 residents of the household at risk for food borne illness. Findings included: - On 07/17/23 at 11:37 AM, observation revealed Certified Nurse Aide (CNA)/Homemaker Staff P	F 812		

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F 812	Continued From page 70	F 812		

preparing and serving meals to the residents.
Continued observation during the lunch meal revealed the homemaker did the following without washing her hands:

Removed soiled dishware from a table and rinsed off the resident's used plate.
Removed a bag of chicken breast strips from the freezer and used her bare hand to place two in the air fryer.
Handled clean silverware to put in a drawer.
Wiped her hands on her apron several times throughout the meal.
Retrieved a bowl out of the upper cupboard with her finger inside then filled it with food for a resident.
Handled two soiled plates with soiled napkins and rinsed them.
Retrieved another bowl out of the cupboard and filled it with fruit balls by hand.
Rinsed her hands with water only, then used a spoon to fill another bowl with mandarins, scratched at her forehead, then handled soiled dishes and napkins,
Used tongs to pick up chicken strips then handled them with bare hands when cutting them.
Picked up more soiled dishes and pushed the leftover food into the trash with the soiled napkin.
Rinsed dishes, then plated another meal,
Removed clean plates and bowls from the dishwasher tray and held them against her apron before putting them in the cabinet.

During the above meal service CNA/Homemaker P had several long strands of hair out of her hair net while leaning over the warmer drawer to plate food.

On 7/18/23 at 07:55 AM, CNA/Homemaker Q

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F 812	Continued From page 71	F 812		

stated staff were to wash their hands after handling soiled dishware.

On 07/19/23 at 10:14 AM, Administrative Nurse D verified staff should wash their hands after touching soiled items and before touching clean dishware. She said staff should not handle residents' food with bare hands and hair should be restrained or covered when staff are plating residents' food.

The facility's "Preparing and Serving Lunch and Supper" policy, undated, directed staff to wash their hands after handling used dishes and before serving food to a resident.

The undated "Hand Hygiene for Team Members who Prepare Food" policy directed staff to don a hair restraint, thoroughly wash hands with soap and water. After touching their face, handling soiled items, staff shall wash their hands.

The undated "Cleaning Up After Serving a Meal" policy directed staff to remove used dishes between courses and rinse. Wash hands before removing clean items from the dishwasher when dry and put in the cabinets.

The facility failed to serve food in a sanitary manner for residents in one of seven households, placing the 22 residents of the household at risk for food borne illness.