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	175562	A. BUILDING _____ B. WING _____	07/31/2023

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RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 08/07/23.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		

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

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

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by:
The facility reported a census of 50 residents with 13 residents sampled, including one resident sampled for hospitalization. Based on interview and record review, the facility failed to provide a copy of the facility bed hold policy to Resident (R)38 and/or their representative, with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's two transfers to the hospital.

Findings included:

- Review of Resident 38's Electronic Health Record" (EHR) documented the resident had diagnoses that included atrial fibrillation (rapid, irregular heartbeat), hypertension (elevated blood pressure), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure.

Review of the "Discharge Assessment- return anticipated Minimum Data Set" (MDS), dated 02/02/23, revealed the resident had an unplanned discharge to an acute hospital.

The "Entry tracking record" MDS, dated 02/07/23, revealed the resident returned to the facility on 02/07/23.

The "Discharge assessment-return anticipated" MDS, dated 03/02/23, revealed the resident had an unplanned discharge to an acute hospital.

The "Entry tracking record" MDS, dated 03/07/23, revealed the resident returned to the facility on 03/07/23.

Review of the resident's EHR, lacked a signed

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F 625	Continued From page 2 bed hold with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfers to the hospital on 02/02/23 and 03/07/23. On 07/31/23 at 10:48 AM, Licensed Nurse (LN) G stated the charge nurse would send a face sheet and a medication list with the resident to the hospital. On 07/31/23 at 11:13 AM, Consultant GG reported the facility's social service designee (SSD) was responsible for the written notice of the bed holds, however, the SSD was unable to work, and the facility was unable to produce the written notices of the bed holds. The facility did not provide a bedhold policy. The facility failed to provide R38 and/or their representative, with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's two transfers to the hospital.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		

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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 census totaled 50 residents with 13 included in the sample. Based on observation, interview, and record review, the facility failed to develop comprehensive care plans for two of 13 residents reviewed for care plans. Resident (R)3

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and R20 regarding urinary catheter use and one resident, R12, related to pressure ulcers/wound care.

Findings included:

- Resident (R) 3's signed physician orders dated 06/04/23 revealed; CVA (any abnormal condition characterized by dysfunction of the heart and blood vessels), Hemiplegia (paralysis of one side of the body), vascular dementia (progressive mental disorder characterized by failing memory, confusion), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin).

The "Annual Minimum Data Set" (MDS) dated 09/30/22 revealed the resident was severely cognitively impaired. The resident had rejection of care on 4-6 days of the 7 day. The resident required extensive assistance of 2 staff. The resident received antipsychotic and antidepressant 7 days of the 7 day observation period.

The Quarterly MDS dated 06/30/23 revealed the resident never/rarely understood. The resident equired extensive assistance of two staff for all daily cares. The resident had an indwelling urinaty catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Cognitive loss/Dementia Care Area Assessment" (CAA) dated 09/30/22, revealed the resident only able to recognize the location of his room. His decision making skills were severely impaired. Diagnosis of Vascular dementia with

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behaviors.

The Urinary Incontinence and Indwelling Catheter CAA dated 09/30/22, revealed the resident had a urinary catheter in place. Staff assist with cares for the catheter and emptying the catheter per orders.

Review of the "Care Plan" dated 07/09/19, R3 was able to take himself to the bathroom and was continent of bowel and bladder. The resident was having more accidents with urinating so began wearing pullups and the family took his underwear home.

The care plan lacked the presence of a suprapubic catheter (urinary bladder catheter inserted through the skin) or care for the catheter.

The physician orders dated 10/17/22 revealed the resident with a large hernia of bladder with placement of indwelling urinary catheter for outlet obstruction.

The physician progress notes dated 04/25/23 revealed a placement of suprapubic catheter.

Review of the physician orders dated 06/04/23, revealed and order for suprapubic catheter care, two times a day.

Observation on 07/26/23 at 8:00 AM, the resident propelled wheelchair in the hall towards the dining room. The urinary catheter tubing had yellow urine with sediment visible in the tubing. The drainage bag was in a dignity bag.

On 07/27/23 at 11:00 AM, Licensed Nurse C reported the resident had a history of urinary

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problems and first had an indwelling urinary catheter placed but had a blockage of some sort so a suprapubic catheter was finally placed. LN C reported she did not make changes on the resident care plan.

On 07/27/23 at 12:40 PM Administrative Nurse B stated the MDS coordinator was to keep the care plans up to date.

Review of the facility policy for Care Plans, dated 11/28/17 revealed the Comprehensive Care plan should reflect individualized problems, goals and interventions with input from the care planning team, the resident and the residents family and re/or representative.

The facility failed to develop comprehensive care plans for R3 regarding urinary catheter use.

- Resident (R)20's "Electronic Health Record" (EHR) documented the resident had diagnoses that included chronic kidney failure, stage three, frequency of micturition (frequency of bladder), and benign prostatic hyperplasia (non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections.

The 06/23/23 "Annual Minimum Data Set" (MDS) documented a "Brief interview for mental status" (BIMS) score of 10, indicating moderately impaired cognition. The resident did not have a urinary catheter during the lookback period.

The 06/23/23 "Urinary Incontinence and

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Indwelling Catheter Care Area Assessment" (CAA) documented R20 wore an incontinence brief and was dependent on staff for transfers to the toilet as well as toilet hygiene.

The 02/14/23 "Care Plan" lacked any mention of an indwelling catheter or staff guidance to care for the resident's urinary catheter.

The physician's order included the resident had an indwelling Foley catheter, related to benign prostatic hyperplasia with lower urinary tract symptoms, dated 07/07/23. It further instructed to maintain the catheter until urology follow-up and as needed.

Review of the "progress Notes" revealed on 07/07/23, the resident returned from the hospital with a urinary catheter.

On 07/27/23 at 07:13 AM, observation revealed Certified nurse aide (CNA) L and CNA M dressed the resident. Staff placed the urinary catheter bag directly on the bathroom floor. Staff reported they should put the catheter collection bag on a paper towel as a barrier.

On 07/31/23 at 07:08 AM, CNA D and CNA N entered the resident's room to provide morning cares. The urinary catheter had no covering/dignity bag, and once cares provided, CNA N placed the urinary catheter collection bag directly on the floor.

On 07/27/23 at 12:40 PM Administrative Nurse B stated corporate staff updated the care plans in the past, and "until a couple of weeks ago", the MDS coordinator was to keep the care plans up to date.

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The facility's policy for "Care Plan", dated 11/28/17, revealed a care plan would be developed for each resident that included measurable objectives to meet a resident's medical, nursing, mental and psychosocial needs and were consistent with the resident's desires and preferences. The care plan must be individualized to address the resident specific needs.

The facility failed to develop and implement a person-centered care plan for this resident that required an indwelling urinary catheter.

- Resident (R)12's Electronic Medical Record (EMR) revealed the resident had a diagnosis that included cardiomyopathy (heart disease).

The "Annual Minimum Data Set" (MDS) dated 07/07/23, revealed a "Brief Interview for Mental Status" (BIMS) score of six, indicating severe cognitive impairment. The resident required limited assistance of one staff with care and was occasionally incontinent of urine. The resident had an unhealed stage two pressure ulcer. The resident had pressure relieving devices on bed and chair, and the resident received wound care.

The "Pressure Ulcer Care Area Assessment" (CAA) dated 07/07/23, documented the resident had a pressure ulcer on her right buttock. It was initially staged as II when opened but since improved. The resident was under the care of a wound nurse that would make weekly wound assessments. The resident had occasional incontinent in she was unable to make it to the bathroom in time. The resident had a Low air loss

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mattress (LALM) and a cushion in her wheelchair when she is using her wheelchair for longer distances.

The "Quarterly MDS" dated 04/07/23, revealed a BIMS score of 99 indicating severe cognitive impairment. She required limited assistance for locomotion, otherwise supervision/setup for all cares. The resident was continent of bowel/bladder. The resident was not a high risk for development of pressure ulcers. The resident had a low air loss mattress to her bed.

The "Care Plan" dated 07/07/23 lacked guidance for skin/wound care.

The Electronic Health Records (EHR) "Physician Orders" lacked active orders specific to wound care/management or wound prevention.

The weekly wound/skin notes documented the following:

1. On 07/05/23, the resident had an open area on her right buttock that measured 0.4 centimeter (cm) by 0.5 cm.

2. On 07/10/23, the resident had an open area on her right buttock that measured 0.3 cm by 0.3 cm.

3. On 07/17/23, the resident had an open area on her right buttock that measured 0.3 cm x 0.3 cm.

The EMR "Progress Notes" revealed the following:

1. On 07/04/23, the resident complained of pain to her bottom. The resident had a, 0.5 cm area noted. Staff notified the wound nurse, and R12's

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Durable Power of Attorney.

2. On 07/05/23, the resident had two small open areas on her buttocks, but the clinical records lacked documented measurements.

3. On 07/10/23, a wound care note revealed that the wound care nurse would perform dressing changes until 07/19/23.

4. On 07/19/23, the resident had open areas on both buttocks. The left much improved. The right unchanged. Sacral dressing in place.

On 07/27/23 at 11:40 AM, Licensed Nurse (LN) V assisted R12 to pivot transfer to her wheelchair without the use of a gait belt, then assisted the resident into the bathroom for a skin check where the resident stood up, holding onto a grab bar in the bathroom. Observation at that time revealed R12 had redness to her sacrum (large triangular bone area between the two hip bones/coccyx (small triangular bone area at the base of the spine) with a small area that appeared to have sheared/peeling skin, redness to both buttocks with a small area that appeared to have sheared/peeling skin on her left buttock and all red areas blanched (to press on a person's skin to push blood away and wait for return to determine blood circulation). LN V acknowledged that R12 lacked active orders for wound care and stated that she did not know if the facility had any standing orders or protocols for wound care that she could initiate without a provider/physician's order. LN V stated the reddened areas on her buttocks should have some sort of skin protectant, like a foam dressing.

On 07/31/23 at 07:50 AM, LN O, announced

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herself after performing hand hygiene with alcohol-based hand rub (ABHR) and asked the resident if she could perform the dressing change and wound care. (There were no active physician orders for treatment of the wounds). The resident ambulated to the toilet by herself, and after the resident toileted, the resident stood up and held on to a walker while LN O performed cares. The resident lacked wound dressings to her buttocks area. LN O cleaned the wound to the left buttock with normal saline, then performed peri care for the resident with disposable wipes. LN O did not measure the wound but estimated to be about the size of a nickel. LN O placed hydrogel (wound gel) on the wound bed and covered with wound with mepilex (a type of foam wound dressing) dressing.

On 07/31/23 at 10:25 AM, Administrative Nurse B reported that her expectation is that if someone had a pressure wound that it would be on the care plan. States that corporate staff were the ones updating the care plan up until a couple of weeks ago, then LN W took over that role. LN W had not "caught up" for all the care plans to be up to date.

Review of the facility policy for "Care Plans" dated 11/28/17 revealed the Comprehensive Care plan should reflect individualized problems, goals, and interventions with input from the care planning team, the resident and the resident's family and re/or representative.

The facility's "Wound Assessment, Prevention and Treatment" policy, dated 11/28/17 documented that residents would be evaluated and monitored to prevent the development of pressure ulcers/injury and to promote rapid

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F 656	Continued From page 12 healing of any pressure ulcers/injury that was present. A comprehensive, individualized care plan would be developed to address prevention of pressure ulcers/injuries including management of risk factors and treatment strategies for residents with pressure ulcers/injuries through a collaboration between the resident, the resident's representative, the physician/provider, the dietitian, and the clinical staff. The facility failed to include pressure ulcer care and prevention on the comprehensive care plan.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 50 residents with 13 selected for review including three residents reviewed for wounds. Based on observation, record review, and interview, the facility failed to perform an ongoing assessment and treatment of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a	F 686		

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bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) and implement interventions to prevent further development of pressure areas for one of the three Residents (R)12.

Findings include:

- Resident (R)12's Electronic Medical Record (EMR) revealed the resident had a diagnosis that included cardiomyopathy (heart disease).

The "Annual Minimum Data Set" (MDS) dated 07/07/23, revealed a "Brief Interview for Mental Status" (BIMS) score of six, indicating severe cognitive impairment. The resident required limited assistance of one staff with care and was occasionally incontinent of urine. The resident had an unhealed stage two pressure ulcer. The resident had pressure relieving devices on bed and chair, and the resident received wound care.

The "Pressure Ulcer Care Area Assessment" (CAA) dated 07/07/23, documented the resident had a pressure ulcer on her right buttock. It was initially staged as II when opened but since improved. The resident was under the care of a wound nurse that would make weekly wound assessments. The resident had occasional incontinence in she was unable to make it to the bathroom in time. The resident had a low air loss mattress (LALM) and a cushion in her wheelchair when she is used her wheelchair for longer distances.

The "Quarterly MDS" dated 04/07/23, revealed a BIMS score of 99 indicating severe cognitive impairment. She required limited assistance for locomotion, otherwise supervision/setup for all

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cares. The resident was continent of bowel/bladder. The resident was not a high risk for development of pressure ulcers. The resident had a low air loss mattress to her bed.

The "Care Plan" dated 07/07/23 lacked guidance for skin/wound care.

The Electronic Health Records (EHR) "Physician Orders" lacked active orders specific to wound care/management or wound prevention.

The weekly wound/skin notes documented the following:

1. On 07/05/23, the resident had an open area on her right buttock that measured 0.4 centimeter (cm) by 0.5 cm.

2. On 07/10/23, the resident had an open area on her right buttock that measured 0.3 cm by 0.3 cm.

3. On 07/17/23, the resident had an open area on her right buttock that measured 0.3 cm x 0.3 cm.

The "Assessments" documented on 01/05/23 and 07/10/23 that the resident had a Braden (an assessment tool utilized to determine the risk of skin breakdown/injury) score of 21 which indicated that the resident was not at risk for skin breakdown/injury.

The EMR "Progress Notes" revealed the following:

1. On 07/04/23, the resident complained of pain to her bottom. The resident had a 0.5 cm open area noted. Staff notified the wound nurse, and R12's Durable Power of Attorney.

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2. On 07/05/23, the resident had two small open areas on her buttocks, but the clinical records lacked documented measurements.

3. On 07/10/23, a wound care note revealed that the wound care nurse would perform dressing changes until 07/19/23.

4. On 07/19/23, the resident had open areas on both buttocks. The left much improved. The right unchanged. Sacral dressing in place.

On 07/27/23 at 11:40 AM, Licensed Nurse (LN) V assisted R12 to pivot transfer to her wheelchair without the use of a gait belt, then assisted the resident into the bathroom for a skin check where resident stood holding onto a grab bar in the bathroom. Observation at that time revealed R12 had redness to her sacrum (large triangular bone area between the two hip bones)/coccyx (small triangular bone area at the base of the spine) with a small area that appeared to have sheared/peeling skin, redness to both buttocks with a small area that appeared to have sheared/peeling skin on her left buttock and all red areas blanched (to press on a person's skin to push blood away and wait for return to determine blood circulation). LN V acknowledged that R12 lacked active orders for wound care and stated that she did not know if the facility had any standing orders or protocols for wound care that she could initiate without a provider/physician's order. LN V stated the reddened areas on her buttocks and areas of sheared/peeling skin appeared to be pressure ulcer/injury but declined to classify or stage the open areas. Further, LN V stated the wounds should have some sort of skin protectant, like a foam dressing.

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On 07/31/23 at 07:50 AM, LN O, announced herself after performing hand hygiene with alcohol-based hand rub (ABHR) and asked the resident if she could perform the dressing change and wound care. (There were no active physician orders for treatment of the wounds). The resident ambulated to the toilet by herself, and after the resident toileted, the resident stood up and held on to a walker while LN O performed cares. The resident lacked wound dressings to her buttocks area. LN O cleaned the wound to the left buttock with normal saline, then performed peri care for the resident with disposable wipes. LN O did not measure the wound but estimated to be about the size of a nickel. LN O placed hydrogel (wound gel) on the wound bed and covered with wound with mepilex (a type of foam wound dressing) dressing.

The facility's "Wound Assessment, Prevention and Treatment" policy, dated 11/28/17 documented that residents would be evaluated and monitored to prevent the development of pressure ulcers/injury and to promote rapid healing of any pressure ulcers/injury that was present. A comprehensive, individualized care plan would be developed to address prevention of pressure ulcers/injuries including management of risk factors and treatment strategies for residents with pressure ulcers/injuries through a collaboration between the resident, the resident's representative, the physician/provider, the dietitian, and the clinical staff.

The facility failed to perform ongoing weekly skin assessments and treatment of pressure ulcers on the resident's buttocks and sacrum/coccyx and failed to implement interventions to prevent

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F 686	Continued From page 17 further development of pressure areas for the resident.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 50 residents, with 13 residents included in the sample, including two residents reviewed for accidents. Based on observation, interview, and record review the facility failed to prevent a fall with fracture for cognitively impaired Resident (R)35 when staff did not assess for the safe use of an electric lift chair. On 07/15/23, staff found R35 on the floor in front of her fully raised electric lift chair and required transfer to the emergency room where R35 was diagnosed with a fractured (broken) clavicle (collar bone). The facility further failed to implement the immediate fall prevention intervention related to the fall with fracture, for at least 10 days, when staff did not remove the electronic lift chair, leaving the resident at risk for continued falls from the chair. Findings included: - R35's Electronic Medical Record (EMR) revealed the following diagnoses: Alzheimer's disease (progressive mental deterioration	F 689		

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characterized by confusion and memory failure), fracture to left clavicle, dementia (progressive mental deterioration characterized by confusion and memory failure), and aphasia (condition with disordered or absent language function).

The "Annual Minimum Data Set" (MDS) dated 12/06/22 revealed a Brief Interview for Mental Status (BIMS) score of 01, indicating severe cognitive impairment. The resident required extensive assistance with transfers and mobility needs. The resident had no previous falls but was at risk for falls.

The "Quarterly MDS" dated 06/09/22 revealed no significant changes in the resident's status.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 12/06/22 revealed the resident had a diagnosis of Alzheimer's disease. Staff needed to anticipate the residents needs each day for daily cares.

The "Falls CAA" dated 12/06/22 revealed the resident had no falls however continued to be at increased risk for falls. R35 required maximum assistance for transferring from surface to surface using a sit to stand lift. She was non-ambulatory and dependent on a wheelchair propelled by staff for mobility.

The "Care Plan" dated 01/06/22 revealed R35 was a fall risk, due to her dementia. The "Care Plan" did not include information regarding the safe use of the electric lift chair for R35 prior to the 07/15/23 fall.

Review of the EMR revealed lack of an assessment completed for R35 regarding the

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safe use of a lift chair prior to 07/15/23.

Review of the facility "Fall Investigation" dated 07/15/23 revealed at approximately 04:17 PM, the staff observed R35 lying on her left side on the floor in her room alongside her recliner. The resident had the remote to the lift chair in her hand and the lift chair in in the up position. The resident could not say what she was trying to do or what happened. The Licensed Nurse on duty assessed the resident and the resident voiced pain and discomfort in her left hip during the assessment. A skin tear was also noted on her left elbow measuring 5 centimeters (cm). The staff received physician orders to send the resident to the Emergency Room (ER) for x-rays. The X rays revealed negative for left hip/leg anomalies, but x-ray to left shoulder revealed a fracture of the clavicle with inferior displacement. She was last observed at 02:30 PM. Previous to the fall, the staff noted the lift chair remote was tucked into the chair cushion. The resident had no prior history of trying to change her electric lift chair position.

Corrective interventions planned and taken by the facility documented on the investigation, included:

1. The lift recliner was removed from the resident's room and a manual recliner was placed in the resident's room.

2. The Certified Nurse Aide (CNA) care sheet was updated to show staff would not place the resident in a lift chair.

3. The Director of Nurse (DON) would monitor interventions weekly for four weeks and any negative outcomes would immediately be

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addressed and reviewed in the Quality Assurance (QA) meeting.

Observation, on 07/25/23 at 01:03 PM, CNA D and CNA E brought the resident from the dining room to lay down after lunch. The room contained an electric lift recliner with remote control in R35's room. The resident had a sling on the left arm related to the fractured clavicle. The staff removed the sling to transfer the resident with a mechanical lift and the resident complained of back pain with the transfer into the bed. The staff positioned the resident on the bed without replacing the arm sling. The staff reported the resident's pain to the nurse for pain medication.

Observation on 07/26/23 at 11:02 AM revealed the resident rested in bed and the same electric lift recliner was in the room with the remote control in the seat.

Observation on 07/26/23 at 03:00 PM revealed Maintenance Staff K removed the electric lift chair from R35's room, and replaced it with a regular non-electric, non-reclining, chair. The resident remained in bed.

On 07/26/23 at 01:03 PM, CNA D reported the resident fell from her lifting chair and fell forward breaking her collar bone.

On 07/26/23 at 02:17 PM, CNA F reported since the resident's fall from her lift recliner she had not put her in her recliner. The staff repositioned and checked on the resident in the bed around every hour. The resident required two-person assistance with the use of a mechanical lift to her wheelchair and bed.

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On 07/27/23 at 10:30 AM, Licensed Nurse (LN) C reported the resident did fall out of her lift chair, and the staff were to take the lift chair out of her room last week. LN C did not know why the electric lift chair remained in the resident's room now.

On 07/27/23 at 02:30 PM, Administrative Nurse B reported she did not know the staff failed to remove the resident's electric lift chair from her room until now. Administrative Nurse B explained it was supposed to be removed last week. She thought maybe they were waiting on the family to bring another chair. She agreed the resident continued to be at risk if the lift chair remained in the resident's room and available for staff to place the resident into.

Review of the facility policy regarding Falls, revised 11/28/17, revealed the facility would ensure each resident received adequate supervision and assistive devices to reduce risk of occurrences. The policies general guidelines included all residents would be assessed for fall risk and those determined to be at risk would have interventions implemented. The interventions would be reviewed periodically and would be revised, or additional ones added, as needed. Any accident or occurrence would be thoroughly investigated to determine root cause and appropriate interventions would be developed based on the root cause analysis.

The facility failed to prevent a fall with fractured clavicle for cognitively impaired R35, when staff failed to assess for safety in use of an electric lift chair, and the resident fell out of the fully lifted chair on 07/15/23. The facility further placed the resident at risk for continued accidents when staff

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F 689	Continued From page 22 failed to remove the recliner from R35's room as identified as an immediate fall prevention intervention and replace it with a manual chair for 10 days after a fall that caused a fractured clavicle.	F 689		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist 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.	F 756		

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§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 reported a census of 50 with 13 residents in the sample that included six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the consultant pharmacist failed to identify an unnecessary medication for Resident (R)12, related to an antibiotic that the resident was resistant to. In addition, the facility failed to ensure a system to acknowledge and respond to the consultant pharmacist recommendations for R 21, R 38, R 42, and R 2.

Findings include:

- R12's diagnoses from the "Electronic Health Record" (EHR) included chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues) and extended-spectrum beta-lactamases (ESBL - enzymes produced by certain microorganisms that allow them to be resistant to the actions of some antibiotics) resistance.

The 07/07/23 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) of six, which indicated severely impaired

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cognition. R12 received an antibiotic four of the seven days in the seven-day look-back period.

The 04/07/23 quarterly MDS documented a BIMS of 99, indicating that the BIMS was not completed by the resident and documented a staff assessment of memory problems with moderately impaired cognition. R12 received an antibiotic three of the seven days in the seven-day look-back period.

The 07/07/23 "Care Area Assessment" (CAA) lacked documentation related to antibiotic use.

The 07/27/23 "Care Plan" lacked documentation related to antibiotic use.

The "Electronic Health Record" (EHR) included a physician order for Sulfamethoxazole-Trimethoprim Tablet 800-160 milligrams (mg) (Bactrim DS - an antibiotic), 0.5 tablet to be given once daily on Monday, Wednesday, and Friday, for urinary tract infection (UTI) prophylaxis (procedure or treatment to prevent something from happening), dated 10/19/22.

Review of the facility's pharmacy consultant's medication regimen reviews (MRR) revealed that antibiotic use was not addressed by the pharmacist.

Review of lab results revealed the following:

1. On 09/21/22, a urinalysis (UA - a physical, chemical and microscopic laboratory examination of the urine that is used to detect and manage a wide range of disorders and diseases) with culture and sensitivity (c/s - a laboratory test to

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check for the presence of a bacterial infection and checks which antibiotics the bacteria are sensitive or resistant to so the correct medications may be prescribed) that revealed a UTI and c/s results documented resistance to Sulfamethoxazole-Trimethoprim.

2. On 07/05/23, a UA with c/s revealed a UTI and c/s results documented resistance to Sulfamethoxazole-Trimethoprim.

The "Progress Notes" lacked documentation related to physician notification from staff the correlation between antibiotic use and urine culture and sensitivity testing.

On 07/31/23 at 01:42 PM, Licensed Nurse (LN) G was unable to give rationale why R12 was taking an antibiotic that laboratory tests indicated that she was resistant to. Further, LN G was unable to verbalize process used for MRR.

On 07/31/23 at 10:25 AM, Administrative Nurse B reported she was not able to find the physician responses, or the pharmacist recommendations as requested on 07/27/23 and 07/31/23.

The facility's "Unnecessary Medications" policy dated 11/28/17 documented that each resident's drug (medication) regimen must be free of unnecessary medications and defines that as any medication used without adequate monitoring or adequate indications. Further documents that the pharmacist would review the resident's regimen monthly to identify any unnecessary medications.

The facility failed to provide a policy that outlined the process for MRR as requested on 07/27/23 and 07/31/23.

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The facility and the consultant pharmacist failed to identify an unnecessary medication for Resident (R)12. This caused the resident to receive an unnecessary medication on 120 occasions from 10/19/22 thru 07/31/23.

- R2's diagnoses from the "Electronic Health Record" (EHR) included dementia (a progressive mental disorder characterized by failing memory, confusion) and Alzheimer's (progressive mental deterioration characterized by confusion and memory failure).

The 11/04/22 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) of 13, which indicated intact cognition. R2 received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) daily during the seven days in the seven-day look-back period.

The 05/05/23 quarterly MDS documented a BIMS of 12, which indicated moderately impaired cognition. R2 received an antipsychotic and an antidepressant daily in the seven-day look-back period.

The 11/04/22 "Psychotropic Care Area Assessment" (CAA) documented the resident had a dose reduction for Zoloft attempted on 06/06/22 without success, and a dose reduction for Zyprexa attempted on 05/09/22 without success.

The 07/27/23 "Care Plan" documented the

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following:

1. Instructed staff to contact the physician every six months to try and reduce the amount of Zyprexa and Zoloft.

2. Instructed staff to give Zoloft and Zyprexa as the provider has ordered to control behaviors.

3. Instructed staff to monitor for side effects of antipsychotic medications and notify the provider if they became present.

4. Instructed staff to monitor for side effects of antidepressant medications and notify the provider if they became present.

5. Instructed the nurse to perform an abnormal involuntary movement scale (AIMS - an assessment of abnormal movements that may be side effects of antipsychotic medications) every quarter and with any significant change in resident's condition.

The "Electronic Health Record" (EHR) included a physician order for:

1. Zyprexa (Olanzapine) 2.5 milligram (mg) to be given orally each morning, related to pseudobulbar affect (a type of emotional disturbance characterized by uncontrollable episodes of crying, laughing, anger or other emotional displays), order date on 06/01/22.

2. Zoloft (sertraline) 50 mg to be given orally each morning related to pseudobulbar affect, order date on 10/04/22.

Review of the pharmacist medication regimen

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listing sheet, revealed the hard copy paper documented the pharmacist addressed Zyprexa administration on 11/14/22 and 05/15/23, however, the facility was unable to provide what those recommendations were or how the provider responded.

The "Progress Notes" documented that on 05/19/23, staff spoke with family regarding decreasing the Zyprexa dose due to pharmacist recommendations, however; review of R2's clinical record lacked evidence the facility acknowledged and responded to the consultant pharmacist recommendations.

On 07/31/23 at 10:25 AM, Administrative Nurse B reported she was not able to find the physician responses, or the pharmacist recommendations as requested on 07/27/23 and 07/31/23.
On 07/31/23 at 01:42 PM, Licensed Nurse (LN) G was unable to verbalize the process used for the monthly medication review.

The facility's "Unnecessary Medications" policy dated 11/28/17 documented the pharmacist would review the resident's regimen monthly to identify any unnecessary medications. However, the facility lacked a policy for following-up on the pharmacist recommendations.

The facility failed to ensure a system to acknowledge and respond to the consultant pharmacist recommendations for R 2. This failure placed the resident at risk for unnecessary psychotropic medications and/or adverse side effects.

- Resident (R) 21's "Electronic Health Record"

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(EHR) documented the resident had diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and allergies.

The 09/02/22 "Annual Minimum Data Set" (MDS) documented a "Brief interview for mental status" (BIMS) score of 99 with severe impaired cognition. The resident received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), antidepressant (class of medication used to treat mood disorders and relieve symptoms of depression), and antianxiety (class of medications that calm and relax people with excessive anxiety).

The 09/02/22 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R21 had physician orders for Seroquel (antipsychotic medication), 50 milligrams (mg) twice a day; Zoloft (antidepressant medication) 100 mg daily; and Ativan (antianxiety medication) 0.5 mg, at bedtime. The "Behavioral Symptoms" CAA revealed R21 had behaviors and rejection of care, and was on Seroquel, Ativan and Zoloft to assist with management of her moods.

The physician orders included:

Remeron, 15 mg, daily for decreased appetite, dated 12/20/22.

Ativan, 0.5 mg, at bedtime, for dementia, dated 07/26/22.

Seroquel, 50 mg, twice a day, for dementia, dated

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05/17/22.

Zoloft, 100 mg, daily, for anxiety, dated 03/10/23.

Review of the pharmacist Medication review regimen listing sheet, from 11/2021 thru 07/2023 revealed the hard copy paper documented the date the pharmacist reviewed the resident's medication and had an area for a comment. The comments included the following:

On 07/17/22, Seroquel, need signed.

On 10/14/22, Zoloft, need signed.

On 01/18/23, Seroquel, need signed.

On 2/10/23, Ativan, need signed.

On 06/17/23, Remeron, Need signed.

Review of R21's clinical record lacked evidence the facility acknowledged and responded to the consultant pharmacist recommendations. Upon request, on 07/31/23 at 10:25 AM, Administrative Nurse B reported she was not able to find the physician responses or the pharmacist recommendations.

On 07/31/23 at 11:48 AM, Consultant HH revealed he would make his recommendations and check if the facility replied to the recommendations. If the facility had not replied to the recommendations, he would revisit in six months. Consultant HH verified the facility had "trouble with responses" due to regular turnover staffing of the Director of Nursing.

On 07/31/23 at 01:42 PM, Licensed Nurse (LN) G

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was not able to verbalize the process used for the monthly medication review.

The facility's "Unnecessary Medications" policy dated 11/28/17 documented the pharmacist would review the resident's regimen monthly to identify any unnecessary medications. However, the facility lacked a policy for following-up on the pharmacist recommendations.

The facility failed to ensure a system to acknowledge and respond to the consultant pharmacist repeated recommendations for R21. This failure placed the resident at risk for unnecessary psychotropic medications and/or adverse side effects.

- Resident (R) 38's "Electronic Health Record" (EHR) documented the resident had diagnosis that included anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The 10/26/22 "Significant change Minimum Data Set" (MDS) documented a "Brief interview for mental status" (BIMS) score of 0, indicating severely impaired cognition. The resident received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions).

The 06/09/23 "Quarterly MDS" documented the resident had severely impaired cognition and continued to receive an antipsychotic medication.

The 10/26/22 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R38 was seen for an inpatient psychiatric initial evaluation for

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increased behaviors including physical aggression. He returned to the facility with orders for Seroquel 25 milligrams (mg) which was discontinued on 10/28 [lacked year] after he was noted to have more difficulty communicating with others and becoming more frustrated with others along with other behaviors of defecating (feces) on the floor, and being very somnolent (drowsy, sleepy). He continued to receive Zoloft 50 mg daily for anxiety.

The physician orders included:

Seroquel, 25 mg, daily for anxiety and obsessive-compulsive disorder (OCD- anxiety disorder characterized by recurrent and persistent thoughts, ideas, and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social, or interpersonal functioning), ordered 02/08/23.

Review of the pharmacist Medication review regimen listing sheet, from 11/2021 thru 07/2023 revealed the hard copy paper documented the date the pharmacist reviewed the resident's medication and had an area for a comment. The comments included the following:

On 03/16/23, Seroquel, need signed.

Review of R38's clinical record lacked evidence the facility acknowledged and responded to the consultant pharmacist recommendations. Upon request, on 07/31/23 at 10:25 AM, Administrative Nurse B reported she was not able to find the physician responses or the pharmacist recommendations.

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On 07/31/23 at 11:48 AM, Consultant HH revealed he would make his recommendations and check if the facility replied to the recommendations. If the facility had not replied to the recommendations, he would revisit in six months. Consultant HH verified the facility had "trouble with responses" due to regular turnover staffing of the Director of Nursing.

On 07/31/23 at 01:42 PM, Licensed Nurse (LN) G was not able to verbalize the process used for the monthly medication review.

The facility's "Unnecessary Medications" policy dated 11/28/17 documented the pharmacist would review the resident's regimen monthly to identify any unnecessary medications. However, the facility lacked a policy for following-up on the pharmacist recommendations.

The facility failed to ensure a system to acknowledge and respond to the consultant pharmacist recommendations for R38. This failure placed the resident at risk for unnecessary psychotropic medications and/or adverse side effects.

- Resident (R)42's "Electronic Health Record" (EHR) documented the resident had diagnoses that included anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness.

The 09/28/22 "Annual Minimum Data Set" (MDS) documented a "Brief interview for mental status"

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(BIMS) of not assessed. The resident received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), and antidepressant (class of medication used to treat mood disorders and relieve symptoms of depression).

The 06/16/23 "Quarterly MDS" documented the resident had severely impaired cognition and received antipsychotic and antidepressant.

The 09/28/22 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R42 had psychotic symptoms and anxiety and received medications that included Ativan (medication used to treat anxiety) 0.5 milligrams (mg), every 12 hours, as needed for anxiety and Zoloft (medication used to treat depression), 25 mg, daily for depression. The resident continued to have behaviors of delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), cussing and threatening staff.

The physician orders included:

Seroquel, 50 mg, daily, for insomnia, dated 10/24/22.

Zoloft, 25 mg, daily, for depression, dated 09/22/22.

Review of the pharmacist Medication review regimen listing sheet, from 10/14/22 thru 07/16/2023 revealed the hard copy paper documented the date the pharmacist reviewed the resident's medication and had an area for a comment. The comments included the following:

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On 03/16/23, Zoloft, see signed.

On 11/14/22, Seroquel, see signed.

Review of R42's clinical record lacked evidence the facility acknowledged and responded to the consultant pharmacist recommendations. Upon request, on 07/31/23 at 10:25 AM, Administrative Nurse B reported she was not able to find the physician responses or the pharmacist recommendations.

On 07/31/23 at 11:48 AM, Consultant HH revealed he would make his recommendations and check if the facility replied to the recommendations. If the facility had not replied to the recommendations, he would revisit in six months. Consultant HH verified the facility had "trouble with responses" due to regular turnover staffing of the Director of Nursing.

On 07/31/23 at 01:42 PM, Licensed Nurse (LN) G was not able to verbalize the process used for the monthly medication review.

The facility's "Unnecessary Medications" policy dated 11/28/17 documented the pharmacist would review the resident's regimen monthly to identify any unnecessary medications. However, the facility lacked a policy for following-up on the pharmacist recommendations.

The facility failed to ensure a system to acknowledge and respond to the consultant pharmacist recommendations for R42. This failure placed the resident at risk for unnecessary psychotropic medications and/or adverse side effects.

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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 §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 reported a census of 50 residents, with 13 residents in the sample that included six residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure Resident (R)12 was free from unnecessary medications, when on two occasions, the facility administered an antibiotic medication that she was resistant (the ability not to be affected by something) to. Findings include:	F 757		

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- R12's diagnoses from the "Electronic Health Record" (EHR) included extended-spectrum beta-lactamases (ESBL - enzymes produced by certain microorganisms that allow them to be resistant to the actions of some antibiotics) resistance.

The 07/07/23 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) of six, which indicated severely impaired cognition. R12 received an antibiotic four of the seven days in the seven-day look-back period.

The 04/07/23 quarterly MDS documented a BIMS of 99, indicating that the BIMS was not completed by the resident and documented a staff assessment of memory problems with moderately impaired cognition. R12 received an antibiotic three of the seven days in the seven-day look-back period.

The "Electronic Health Record" (EHR) included a physician order for Sulfamethoxazole-Trimethoprim Tablet 800-160 milligrams (mg) (Bactrim DS - an antibiotic), 0.5 tablet to be given once daily on Monday, Wednesday, and Friday, for urinary tract infection (UTI) prophylaxis (procedure or treatment to prevent something from happening), dated 10/19/22.

Review of laboratory results revealed the following:

1. On 09/21/22, a urinalysis (UA - a physical, chemical and microscopic laboratory examination of the urine that is used to detect and manage a wide range of disorders and diseases) with culture and sensitivity (c/s - a laboratory test to

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check for the presence of a bacterial infection and checks which antibiotics the bacteria are sensitive or resistant to so the correct medications may be prescribed) that revealed a UTI and c/s results documented resistance to Sulfamethoxazole-Trimethoprim.

Review of the physician order, the physician ordered Fosfomycin (an antibiotic) 3grams (gm) to be given orally as a single dose. Review of the MAR from 09/18/22 to 09/30/22, R12 continued to receive the Sulfamethoxazole- Trimethoprim medication.

On 07/05/23, a UA with c/s revealed a UTI and c/s results documented resistance to Sulfamethoxazole-Trimethoprim.

Review of the physician order, the physician ordered Cefdinir (an antibiotic) 300 milligrams (mg) to be given orally twice daily for 10 days. Review of the MAR from 07/01/23 to 07/31/23, R12 continued to receive the Sulfamethoxazole-Trimethoprim medication.

The "Progress Notes" lacked documentation related to physician notification from staff of the correlation between the prophylactic antibiotic use and the urine culture and sensitivity testing.

On 07/31/23 at 01:42 PM, Licensed Nurse (LN) G was unable to give rationale why R12 was taking an antibiotic that laboratory tests indicated that she was resistant to.

On 07/31/23 at 10:25 AM, Administrative Nurse B reported she was unable to provide rational why staff would administer an antibiotic that would have not been effective.

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F 757	Continued From page 39 The facility's "Unnecessary Medications" policy dated 11/28/17 documented that each resident's drug (medication) regimen must be free of unnecessary medications. The facility failed to ensure Resident (R)12 was free from unnecessary medications, when on two occasions, the facility administered an antibiotic medication that laboratory results indicated the bacteria was resistant to the prescribed antibiotic.	F 757		
F 812 SS=F	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 census totaled 50 residents with one central kitchen. Based on observation, interview, and record review the facility failed to store,	F 812		

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prepare and serve foods safely and in a sanitary manner which included failure to date and reseal open food items in the refrigerator and freezer; failure to clean and disinfect the food thermometer while taking the temperature of food items; and failure to use gloves appropriately when handling/serving of food. This had the potential to affect all 50 residents receiving meals from the kitchen.

Findings Included:

- On 07/25/23 at 12:30 PM, initial tour of the kitchen revealed the following items:

The walk-in refrigerator contained a raw meat patty in a baggie with no identification of what it was or a date; cooked hamburger patties in separate bags undated; an open package of cheese slices undated; a partially sliced onion in an open bag undated; and two separate packages of corn tortillas not dated and with visible mold growing on the tortillas.

The freezer contained an open bag of French fries and an open bag of tater tots with no dates. An open to air bag of apple slices with no date.

The freestanding refrigerator contained a lidded cup of brown fluid with no date and no identifying label. Dietary staff H reported she did not know what it was, but it had been in there for quite a while.

On 07/26/23 at 12:00 PM, Dietary Staff J placed food on the steam table in a satellite kitchen in A and B. Staff J then put gloves on and took a bare thermometer not in a sheath with a bent end out of a drawer in the kitchen. He then took the

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thermometer and ran it under the water at the sink and dried with a paper towel. Dietary staff J proceeded to check the temperature of all food items with just wiping the thermometer with a paper towel between the food items. Further continued observation of food service with dietary staff J serving all food items revealed him touching and cupping the food on the plates to keep them from mingling together while serving. Dietary staff J wore the same gloves throughout the entire food service of the noon meal to the residents of the facility.

On 07/27/23 at 08:00 AM, an interview with dietary staff I confirmed dietary staff J's actions were not appropriate.

Review of the facility policy named Food Storage dated 04/06/20 revealed staff were to label all food items with the name of the food and date it was opened or prepared.

Review of the facility policy named Monitoring Food Temperatures for Meal Service dated 04/06/20 revealed a properly functioning and calibrated thermometer will be used when taking temperatures of food items. Thermometers are to be washed, rinsed, and sanitized before and after each meal use. An alcohol swab may be used to sanitize between uses while taking temperatures during the same meal or if contamination of the thermometer occurs.

Review of the facility policy Proper Hand Washing and Proper Use of Gloves dated 04/06/20 revealed staff should be reminded that gloves become contaminated just as hands do and should be changed often. When in doubt, remove gloves and wash hands again.

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F 812	Continued From page 42 The facility failed to store, prepare and serve foods safely to the residents of the facility.	F 812		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP,	F 868		

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must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:

The facility reported a census of 50 residents. Based on interview and record review, the facility failed to maintain a quality assessment and assurance committee that consisted at the minimum of the director of nursing services, the medical director or his/her designee, at least three other members of the facility's staff, at least one of who must be the administrator, owner, board member or other individual in a leadership role, and the infection preventionist, as required.

Findings included:

- Review of the facility's Quality Assurance Performance Improvement (QAPI) sign in sheets, revealed a lack of documentation of the Infection Preventionist in attendance from July 2022 until current.

In addition, the February 2023 and April 2023 lacked the required members for the QAPI meeting when only the facility's medical director and the facility administrator were the only members in attendance.

On 07/31/23 at 01:46 PM, Administrative staff A reported he did not know the Infection Preventionist was to attend the QAPI meetings.

The facility's "Quality Assurance and Performance improvement" policy, dated 04/27/18, lacked guidance on the members required to attend the meetings.

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F 868	Continued From page 44 The facility failed to ensure the Infection Preventionist attended the required QAPI meetings. In addition, the facility failed to maintain a QAPI committee meeting that consisted of the required members.	F 868		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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F 880	Continued From page 45 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility reported a census of 50 residents with 13 residents sampled. Based on observation, interview and record review, the facility failed to maintain an effective infection control program	F 880		

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when they failed to provide safe and sanitary care for one Resident (R) 20, regarding his urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag), for R3, in regards to incontinent care, R2 in regards to failure to change gloves from dirty to clean during wound care, and failure to change gloves in the kitchen who served food to all of the residents of the facility.

Findings included:

- Resident (R)20's "Electronic Health Record" (EHR) documented the resident had diagnoses that included chronic kidney failure, stage three, frequency of micturition (frequency of bladder), and benign prostatic hyperplasia (non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections.

The 06/23/23 "Annual Minimum Data Set" (MDS) documented a "Brief interview for mental status" (BIMS) score of 10, indicating moderately impaired cognition. The resident did not have a urinary catheter during the lookback period.

The 06/23/23 "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) documented R20 wore an incontinence brief and was dependent on staff for transfers to the toilet as well as toilet hygiene.

The 02/14/23 "Care Plan" lacked any mention of an indwelling catheter or staff guidance to care for the resident's urinary catheter.

The physician's order included the resident had an indwelling Foley catheter, related to benign

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prostatic hyperplasia with lower urinary tract symptoms, dated 07/07/23. It further instructed to maintain the catheter until urology follow-up and as needed.

Review of the "progress Notes" revealed on 07/07/23, the resident returned from the hospital with a urinary catheter.

On 07/27/23 at 07:13 AM, observation revealed Certified nurse aide (CNA) L and CNA M dressed the resident. Staff placed the urinary catheter bag directly on the bathroom floor. Staff reported they should put the catheter collection bag on a paper towel as a barrier.

On 07/31/23 at 07:08 AM, CNA D and CNA N entered the resident's room to provide morning cares. The urinary catheter had no covering/dignity bag, and once cares provided, CNA N placed the urinary catheter collection bag directly on the floor.

On 07/31/23 at 07:22 AM, CNA N verified staff should not have placed the catheter bag directly on the floor.

On 07/31/23 at 07:32 AM, CNA D reported staff should always put a privacy cover over the resident's catheter bag.

On 07/31/23 at 07:34 AM, Licensed Nurse (LN) O stated staff should place a cover over the resident's catheter collection bag, and verified staff should not place the urinary catheter directly on the floor.

On 07/31/23 at 07:42 AM, Administrative nursing staff B stated she expected CNAs know and

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F 880	Continued From page 48 follow directions for catheter cares. The facility failed to provide a policy related to infection control with urinary catheters. The facility failed to maintain an effective infection control program when they failed to provide care for this resident that required a urinary catheter, to prevent further urinary tract infections. - R3's Electronic Medical Record dated 06/04/23 revealed the following diagnoses: CVA-cerebral vascular accident (stroke-any abnormal condition characterized by dysfunction of the heart and blood vessels), hemiplegia (paralysis of one side of the body), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin). The "Annual Minimum Data Set" (MDS) dated 09/30/22, revealed the resident was severely cognitively impaired. The resident required extensive assistance of two staff for all activities of daily care (ADL). The "Quarterly MDS" dated 06/30/23, revealed the resident never/rarely understood others. The resident required extensive assistance of two staff for ADL's. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).	F 880		

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Review of the "Care Plan" dated 07/09/19, revealed the resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) and did not always understand what was going and would often refuse cares. The resident could take himself to the toilet. The resident had more episodes of incontinence and wore pull up (disposable) briefs.

Observation on 07/26/23 at 02:58 PM, revealed Certified Nursing Assistant (CNA) L and CNA M assisted R3 to his room. Staff placed a gait belt on the resident and staff transferred the resident's catheter bag to the side of the bed, and both staff assisted the resident to stand and pivoted him to his bed. The resident's pants and brief were pulled down to expose the front of the resident. CNA M gave peri care to the front of the resident, then he was turned to his right side, and staff cleaned the resident's buttocks. The resident had an incontinent bowel movement. Staff removed the resident's soiled clothing, and staff re-dressed the resident, however, staff failed to change their soiled gloves between the soiled process of cleansing the resident to the clean brief and outer clothing.

Interview on 07/26/23 at 03:10 PM, CNA M reported they should have changed gloves between the dirty cleansing process and before they applied the clean clothing.

Interview on 07/27/23 at 10:00 AM, Administrative Nurse B reported she expected the CNAs to know how to correctly care for a resident, including proper incontinent cares.

Review of the Facility Policy named "Proper Hand

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Washing and Proper Use of Gloves" dated 04/06/20, revealed all employees would use proper hand washing procedures and glove usage in accordance with State and Federal Guidelines. When gloves must be changed, they are removed, hand washing procedure followed, and a new pair of gloves applied.

The facility failed to change gloves between clean and dirty while performing incontinent care for R3.

- R2's Electronic Medical Record (EMR) dated 07/03/23 revealed the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).

The "Quarterly Minimum data Set (MDS) dated 05/05/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 12, indicating moderate cognitive impairment. The resident required extensive assistance of two staff for all cares. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and was always incontinent of bowel. The resident was at risk for pressure ulcers and had a current stage four pressure ulcer and moisture associated skin damage (MASD).

The (11/4/22) "Annual MDS" documented a BIMS of 13, indicating intact cognition. R2 required extensive assistance of two staff for all cares. The resident had an indwelling catheter and always incontinent of bowel.

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The "Pressure Ulcer Care Area Assessment" (CAA), dated 11/04/22, documented the resident had no pressure ulcers during lookback period however was at increased risk for skin breakdown. R2 developed skin breakdown to her left and right buttocks and had dressing changes for each of these. R2 was dependent on a wheelchair for mobility and the full body lift with two staff assistance for all transfers. The resident had a catheter in place for neurogenic bladder and was always incontinent of bowel.

Observation on 07/31/23 at 08:00 AM revealed Licensed Nurse (LN) O, Certified Medication Aide (CMA) U and CMA T in the resident's room preparing to perform morning cares and LN O to perform wound care and dressing change. CMAs, using a draw sheet rolled the resident to her right side, then removed the resident's brief. The resident was incontinent of bowel. CMA T performed cares as much as possible using one wipe per swipe. LN O stepped in to remove the wound dressing and complete cleaning of the peri area. LN O removed and discarded the dressing to R2's left hip and coccyx, then proceeded to clean perineal area of BM using one wipe, folding then wiping area with clean area of wipe. LN O then cleaned the coccyx wound with normal saline (NS). LN O changed her gloves though no hand hygiene was done prior to donning clean gloves. She then cleaned the hip wound with NS and while wearing the same gloves, LN O packet the wound with with betadine-soaked packing gauze and she then changed gloves, however LN O failed to utilize hand hygiene prior to donning clean gloves.

Interview on 07/31/23 at 01:36 PM, CNA D stated

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F 880	Continued From page 52 staff should always wash their hands when going from dirty phase to clean phase of providing cares. On 07/31/23 at 08:10 AM, LN O stated staff could fold a wipe to make a second pass with a clean portion of the wipe. On 07/31/23 at 10:25 AM Administrative Nurse B reported during cares, gloves should be changed, and hand hygiene performed between gloves when transitioning from the dirty phase to the clean phase. Hands should be sanitized and/or changed between resident contact. Review of the facility's policy for "Proper Hand Washing and Proper Use of Gloves" dated 04/06/20, revealed all employees would use proper hand washing procedures and glove usage in accordance with State and Federal Guidelines. When gloves must be changed, they are removed, hand washing procedure is followed, and a new pair of gloves applied. The facility failed to perform hand hygiene when changing gloves between dirty and clean dressing changes.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a	F 881		

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system to monitor antibiotic use.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 50 residents. The sample included 13 residents with five reviewed for medications. Based on observation, interview, and record review, the facility failed to implement antibiotic use protocols to avoid unnecessary and/or inappropriate antibiotic use to reduce the risk of adverse events, including antibiotic resistance, when the facility failed to monitor effectiveness and identify inappropriate extended administration of antibiotic administration for Resident (R) 12. This placed the resident at risk for complications related to extended antibiotic use.

Findings include:

- Review of the facility infection control log from October 2022 thru June 2023 lacked documentation of R12's on-going usage of Sulfamethoxazole-Trimethoprim Tablet 800-160 milligrams (Bactrim DS - an antibiotic). R12's diagnoses from the "Electronic Health Record" (EHR) included extended-spectrum beta-lactamases (ESBL - enzymes produced by certain microorganisms that allow them to be resistant to the actions of some antibiotics) resistance.

The 07/07/23 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) of six, which indicated severely impaired cognition. R12 received an antibiotic four of the seven days in the seven-day look-back period.

The 04/07/23 quarterly MDS documented a BIMS of 99, indicating that the BIMS was not completed

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by the resident and documented a staff assessment of memory problems with moderately impaired cognition. R12 received an antibiotic three of the seven days in the seven-day look-back period.

The 07/07/23 "Care Area Assessment" (CAA) lacked documentation related to antibiotic use.

The 07/27/23 "Care Plan" lacked documentation related to antibiotic use.

The "Electronic Health Record" (EHR) included a physician order for Sulfamethoxazole-Trimethoprim Tablet 800-160 milligrams (mg) (Bactrim DS - an antibiotic), 0.5 tablet to be given once daily on Monday, Wednesday, and Friday, for urinary tract infection (UTI) prophylaxis (procedure or treatment to prevent something from happening), dated 10/19/22.

Review of R12's laboratory results revealed the following:

1. On 09/21/23, a urinalysis (UA - a physical, chemical and microscopic laboratory examination of the urine that is used to detect and manage a wide range of disorders and diseases) with culture and sensitivity (c/s - a laboratory test to check for the presence of a bacterial infection and checks which antibiotics the bacteria are sensitive or resistant to so the correct medications may be prescribed) that revealed a UTI and c/s results documented resistance (the ability not to be affected by something) to Sulfamethoxazole-Trimethoprim (Bactrim DS).

2. On 07/05/23, a UA with c/s revealed a UTI and

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	175562	A. BUILDING _____ B. WING _____	07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

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c/s results documented the infection was resistant to Sulfamethoxazole-Trimethoprim (Bactrim DS).

The "Progress Notes" lacked documentation related to physician notification from staff the correlation between antibiotic use and urine culture and sensitivity testing.

On 07/31/23 at 01:42 PM, Licensed Nurse (LN) G was unable to give rationale why R12 was taking an antibiotic that laboratory tests indicated that she was resistant to.

On 07/31/23 at 02:31 PM, LN O reported she was responsible for the antibiotic stewardship program that included monitoring of antibiotic use for the residents. She was not aware R12 received an antibiotic for UTI prophylaxis. Upon review of R12's orders, LN O confirmed that R12 was on Sulfamethoxazole-Trimethoprim Tablet 800-160 mg (Bactrim DS), 0.5 tablet once daily on Monday, Wednesday, and Friday, for UTI prophylaxis since 10/19/22.

The facility's policy, "Antibiotic Stewardship", dated 04/27/19, documented that the use of antibiotics would be used for conditions that meet clinically approved indications for use. Further documented that antibiotic stewardship would be an integral part of the infection control program. The Director of Nursing Services (DNS or director of nursing [DON]) had primary responsibility along with the pharmacist consultant and medical director. Antibiotic prescriptions would be reviewed monthly to assess for appropriateness and included laboratory test results and compared to McGeer Criteria. The DON or infection control nurse would then report to the

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F 881	Continued From page 56 pharmacy consultant and medical director for review. The facility failed to monitor effectiveness and identify inappropriate extended administration of antibiotic administration for Resident (R) 12. This placed the resident at risk for complications related to extended antibiotic use.	F 881		
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility reported a census of 50 residents. Based on interview and record review, the facility failed to maintain an in-service training program for nurses' aides that was appropriate and effective to ensure the continuing competence of	F 947		

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F 947	Continued From page 57	F 947		

nurse aides. Four of five current certified nurse aide records reviewed for the required annual in-service trainings revealed the lack of dementia management training, resident abuse prevention training, and/or social media training, out of the 12 required in-service trainings, to ensure the continuing competence of nurse aides and appropriate care and services to all the residents of the facility.

Findings included:

- During the survey, review of five certified nurse aides' in-service records revealed four of the five, lacked all 12 required trainings as follows:

1. Certified Nurse's Aide (CNA) P lacked dementia management training, resident abuse prevention training, and/or social media training.

2. CNA Q lacked dementia management training, resident abuse prevention training, and/or social media training.

3. CNA R lacked dementia management training.

4. CNA N lacked dementia management training.

On 07/31/23 at 01:18 PM, CNA D reported she completed the annual dementia training.

On 08/02/23 at 01:40 PM, Administrative Nurse B reported when a staff member is first hired, the social media should be part of the orientation training. The facility "just transitioned to an on line system" on 07/01/23, and she would be responsible for assigning and auditing staff to make sure the required training completed. Administrative Nurse B reported she was aware

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F 947	Continued From page 58 that that staff lacked the required training. The facility's policy for "Abuse, Neglect and Exploitation", dated 11/28/17, revealed the facility would conduct an orientation process and annual in-servicing which would review resident rights, grievances process and facility process for investigation of abuse neglect, involuntary seclusion and misappropriation of property, exploitation, and mistreatment ... The facility failed to maintain an in-service training program that was appropriate and effective for these four certified nurse aides, who lacked all of the required 12 in-services within the prior year, to ensure the continuing competence of nurse aides and appropriate care and services to all of the residents of the facility.	F 947		